Women, class, racism and the British NHS

by Professor Lesley Doyal

The creation of the National Health Service (NHS) in 1948 brought considerable benefits to the majority of the British people. Women, in particular, appeared to benefit from the new system because of their special health needs connected with fertility and reproduction, and because many of them had only limited access to medical care. As the health service expanded it also became an important new source of jobs for women. The NHS is now the single largest employer of women in the country.

It would seem, then, that British women should be well satisfied with the NHS. Yet if we look more closely it becomes apparent that these achievements have been limited. Most notably the NHS seems to have played little role in lessening class and race inequalities in health and the utilisation of health services. Furthermore, it has contributed to the emergence of new forms of control over women's lives and perpetuated the domination of men in the health care system.

Class Inequalities and the Treatment of Women

Mortality variations

Mortality statistics show that the average British woman can expect to live about six years longer than her male counterpart. However, it can be misleading to treat men and women as homogeneous groups, since there are also marked differences in mortality rates within gender groups - differences relating to marital status, to region of residence, to race and especially to social class.

On the basis of evidence drawn form the early 1970s, the ratio of male to female deaths in roughly 2:1 within each social class. In social class I (professional and managerial) the death rate for men aged 15-64 is 3.98 per 1 000, while for women it is only 2.15. The comparable figures for social class V (unskilled) are 9.88 and 5.31,

showing not only a marked difference between the sexes but also a steep social class gradient. Thus women and men in different social classes have continued to have different mortality rates. These differences are significant because they show that for women as well as for men, the potential benefits of the NHS have been limited by the basic inequalities that still characterise British society.

Patterns of female sickness and ill-health

Despite their greater life expectancy, women continue to report more sickness than men and make more visits to their doctors. But again these sex differences mask the very different experiences of women in different social classes. Annual figures for self-reported sickness taken from the General Household Survey 1976 show that the rate of "limiting long-standing illness" is about three times greater for women in social class V than for professional women (Townsend, Davidson and Whitehead, 1988).

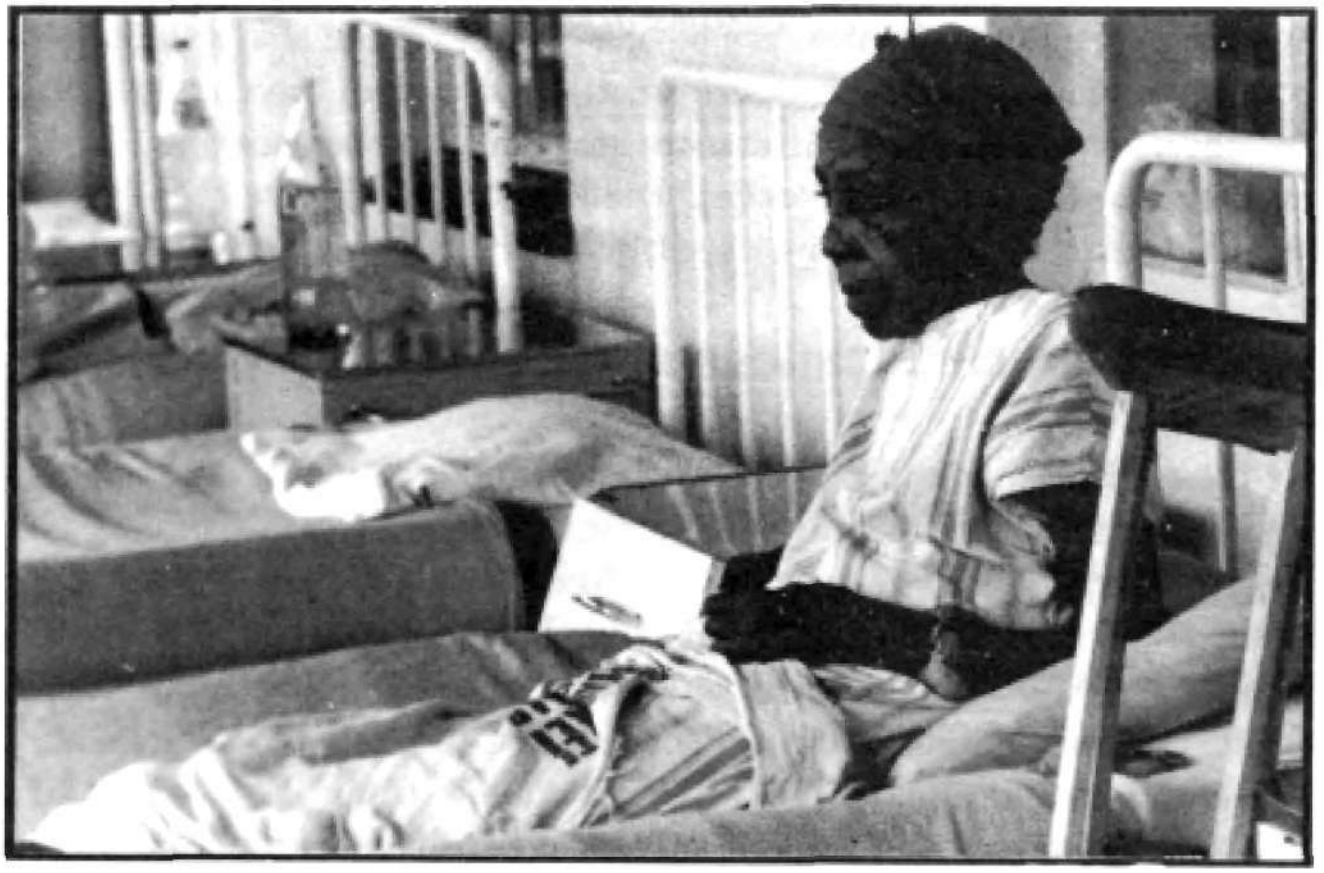
Thus the creation of the NHS has not equalised the life chances of British women, nor their standards of health. The reasons for this are complex and stem in part from continuing inequalities in living and working conditions. But the reasons are also related to the fact that the NHS has not equalised access to medical care. While women as a group make greater overall use of the health service than men (due to their reproductive longevity) there are still very marked differences in utilisation of general practitioner services, of inpatient and outpatient hospital facilities and of preventive services.

Official statistics show that both the number of women consulting a doctor and the average number of consultations for each individual tend to increase with falling social class. This is not surprising given the much higher rates of mortality and morbidity we have already identified in social classes IV and V.

However, researchers have now measured utilisation in a more sophisticated way, by comparing consultation rates, not simply against the numbers in the population, but according to the need for care (Le Grand, 1978). This shows that women in the semiskilled and unskilled groups make relatively less use of general practitioners (GPs) services than other groups when their higher rates of sickness are taken into account.

Quality of care

However, even these relatively sophisticated measures of use and need are still only partial since they do not take into account the quality of care provided. The technical standard of care is difficult to assess but there is evidence that GPs in working class districts tend to have fewer facilities for diagnosis and treatment compared with their



Working class women tend to have shorter consultations than middle class women.
Photo: Medico Health Project

colleagues in more affluent areas.

Moreover, the quality of the personal relationships that are so important in health care also vary between social classes. Several studies have shown that middle-class patients (both male and female) tend to have longer consultations with more extensive discussion of their problems than their working class counterparts. Surveys suggest that these variations in the subjective experience of health care are even more important to women than to men (Cartwright and Anderson, 1981).

Part of the reason for this is that women are more likely to visit their doctors when they are not "sick" - when they are seeking advice about contraception, for instance, or when they need reassurance in a state of depression or anxiety. They appear to bring different expectations to the medical encounter and working class women, in particular, frequently find that their need for communication and for information is not met (Roberts, 1985).

Utilisation of preventive services

One of the main advantages of the NHS for women as a group was their improved access to preventive services and to techniques of fertility control, in particular. However, it is important to determine how far these services have been made equally available to all. This poses considerable methodological problems, since no regular

statistics are collected on the utilisation of preventive services. However, most of the research in this area suggests that women in social classes IV and V make markedly less use of most of these services than those higher up the occupational hierarchy (Townsend, Davidson and Whitehall, 1988).

Cervical screening, for example, is an important service that has been of genuine value in identifying potential cancers in women and in preventing their further development. Yet it is clear that the working class women are much less likely to obtain cervical smears than their middle class counterparts. This class differential in the utilisation of cervical cytology is highlighted when seen against the background of class differentials in death from cervical cancer. The standardised mortality ratio (SMR) for deaths from cervical cancer in 1970-72 was 42 for women in social class I compared with 140 in social class IV and 161 in social class V (Registrar General's Decennial Supplement, 1978). This makes cancers of the cervix one of the most class-linked of all female cancers, yet those women most at risk are still the least likely to obtain smear tests.

Control over fertility

If we look at the areas of control over fertility there appears to be a marked class differential in use of services, with middle class women being more likely to attend a family planning clinic or discuss birth control with their GP. There is also evidence of a higher proportion of unwanted pregnancies among working class women.

In the case of abortion, there is little evidence available to indicate the class origin of the women using such services. However, we do know that the NHS does not meet current needs and that the women with fewest resources are most likely to lose out. The NHS now performs less than 50% of all abortions carried out in the UK, the rest being performed within what is called the "charity sector". These providers are not profit making but charge a "reasonable" sum for their services (currently about 160 pounds).

Thus for many women, the ability to obtain an abortion (especially a quick and easy one) may still depend on whether or not they have the means to pay. In addition the standard of abortions performed (as measured by subsequent mortality and morbidity rates) is considerably better in the charity sector than the NHS, thus bestowing an even greater benefit on those who can pay.

As with abortion and contraception, sterilisation continues to be an issue where women's rights and ability to choose are not always taken seriously. There is, however, something of a reversal in class patterns of use in that childless (often middle class) women frequently have difficulty obtaining sterilisation on the NHS while those (usually black and/ or working class) defined by doctors as "ignorant" or "feckless"

will often be persuaded to do so. In 1973, 10.8% of all abortions (and 20.6% of NHS abortions in England and Wales) were accompanied by sterilisation.

Thus poor women who cannot "opt out" of the NHS are more likely to be coerced into a sterilisation they would not have freely chosen, while those with more resources can pay to obtain the treatment they would prefer.

Race and Health Status

In recent years it has increasingly been recognised that these class differences are exacerbated by racial factors, leading to a situation of double discrimination for many of the most deprived women in the British population. Claims of this kind are extremely hard to substantiate in any quantitative way since British official statistics do not include any racial breakdown (Radical Statistics Race Group, 1980).

However, most black women are to be found at the bottom end of the occupational hierarchy and this inevitably affects their health. Although some ethnic groups have a higher incidence of particular problems (sickle-cell anaemia among blacks being a case in point), patterns of morbidity among black women are broadly similar to those of other women in social classes IV and V, reflecting their low income and unhealthy living and working conditions.

However, black women also have to bear the added burden of the racial discrimination that still permeates many aspects of the functioning of the NHS. In some cases this is manifested by a lack of concern by health workers for the needs, desires and lifestyle of the patient, or even a straightforward attack on values and practices perceived to be alien. This can be a particular problem when the patient's native language is not English, and Asian women receiving obstetric care have often suffered in this way. But it can also amount to a more institutionalised form of racism as recent writers have documented (Mares, Henley and Saxler, 1985).

New Forms of Control over Women's Lives

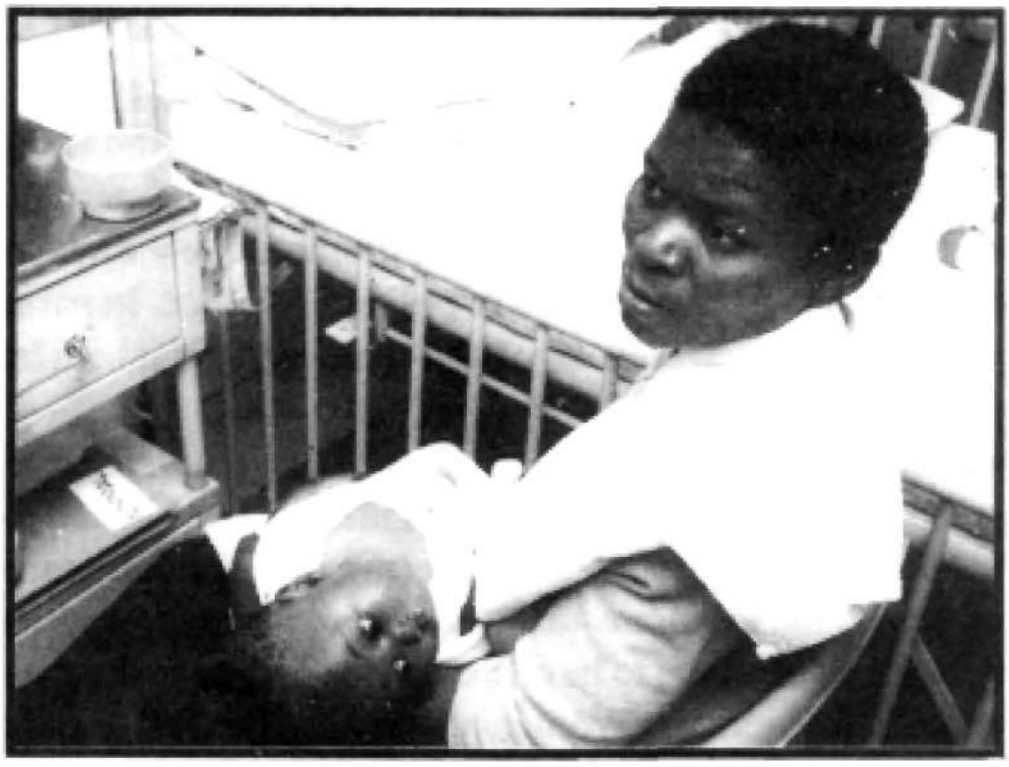
As feminists have pointed out, many of the gains women have made in access to medical care have been accompanied by a growth in the degree of control doctors are able to exert over fundamental aspects of their lives (Leesom and Gray, 1978; Roberts, 1981; Doyal and Elston, 1986).

This is particularly clear in the case of medical control over reproductive technology. Perfectly healthy women are still dependent on doctors for information, advice, and sometimes even physical access to contraception, while abortion, in particular, remains firmly in medical hands. Doctors increasingly control not just the means to prevent pregnancy but also the conditions under which women give birth.

While medical intervention has played some part in improving rates of infant and maternal mortality, its importance has often been greatly overestimated. In fact, there is a growing belief that the medicalisation of childbirth in Britain goes beyond what is necessary. Attempts by administrators to cut the costs of maternity services and to increase bureaucratic efficiency and the desire of doctors to develop more sophisticated technology have often been allowed to override the interests of mothers and babies. Indeed there is a real sense in which doctors whose job satisfaction often lies in high technology intervention have been able to appropriate much of the satisfaction of childbirth from the woman concerned.

Male Domination

Women continue to experience discrimination and disadvantage (Beechley and Whitelegg, 1986) and are seen as inferior to men, whatever, their social and economic status. This general denigration of women has been reflected in the functioning of the



Women have increasingly less control over issues of their reproductive capacity and childbirth. Photo: Medico Health Project

health service.

As users women have little say in the running of the NHS. Just as importantly, the majority of health workers who are women have very little control over their own working conditions. Power has remained firmly in the hands of white middle class men and as a result the NHS has continued to reflect their interests and priorities.

Thus the NHS has failed to live up to its potential for improving women's health or for providing equal opportunities in the workplace. Moreover, it has facilitated the development of new sources of control over women. As a result, women have become involved not just with defending the services as provided, but also with the formulation of proposals for qualitative changes in their organisation and control (Doyal, 1983).

Women and Organisation around Health Care

With the development of the contemporary women's movement in the 1960s medical care became an important focus for political action (Doyal, 1983). The earliest of these feminist health campaigns were concerned primarily with medical sexism. Women began to discuss their experiences of health care, to identify the particular forms of sexism encountered in medical practice, and to formulate strategies for their elimination. The emphasis was on women taking care of themselves and each other; challenging the policies and priorities of the NHS itself was not seen as a major priority.

However, economic and political developments during the Thatcher years have demonstrated that strategies of this kind can provide only a partial solution to the health problems facing British women. This has prompted new ways of thinking about women's health needs and a reorientation of political practice. In particular, it has led women to a much greater awareness of the class and racial differences in their experiences of health care.

Thus women have become active participants in the defence of the NHS and their growing recognition of the race and class inequalities has led to the forging of important links between feminist health strategies and wider political campaigns. Not surprisingly, however, the problems many women have experienced with the health service have sometimes led them to be critical of the orthodox defensive strategies of the male dominated trade unions. Women are seeking not just to defend the NHS as it is, but to make it more responsive to the needs of the consumers.

In its early stages the feminist critique of the NHS concentrated on the treatment

women received at the hands of doctors, and the development of health problems was given little attention. However, attention has now shifted towards an exploration of what it is that makes women sick. British feminists have begun to examine the illnesses and disabilities that bring women into the medical care system and to explore the ways in which these problems can be explained by particular aspects of women's lives. They have recognised that the National Health Service is in reality a National Sick Service because while it provides a certain level of medical care for women, it plays only a very small part in the active promotion of their health.

In theoretical terms this has meant the beginnings of a socialist feminist understanding of health and health care and in more practical terms it has led to campaigns to improve the living and working conditions of women.

Lesley Doyal is Professor of Health Studies at Bristol Polytechnic. This is a shortened version of an article which appeared in Lewin and Oleson, (1985). Women, Health and Healing: Toward a new Perspective. Tavistock.

References

1. Beechey V and Whitelegg E. (eds.) (1986). Women in Britain Today. Open University Press.

2. Cartwright A and Anderson R. (1981). General Practice Revisited. Tavistock.

3. Doyal L. (1983). Women, Health and the Sexual Division of Labour: a case study of the women's health movement in Britain. International Journal of Health Services 15(3), 373-87.

4. Doyal L and Elston MA. (1986). Women, Health and Medicine, in V Beechley and E Whitelegg (eds.) Women in Britain Today. Open University Press.