Free healthcare should be a reality on both sides of the pond

John Timmons

I recently spent a week in Florida observing the fun and frivolous side of America that is Walt Disney World. As is always the case on holiday, I met a fellow clinician — an epidemiologist who couldn't help but expound upon his fear for the USA if Hillary Clinton were to become president and introduce free healthcare. On deeper questioning I discovered that his real fear was that his tax dollars would be spent on those less fortunate than himself. This man assured me that there were many things which the NHS could not provide that could only be available in a privately-funded healthcare system. I asked him to name one, but he was suddenly unable to expand on this! I came away with a renewed belief that the NHS in the UK is to be celebrated, not berated. Yes there are some problems and funding will always be an issue, but the essence of free care for all at the point of delivery still, thankfully, remains the central tenet of the service.

This year could be a year of great changes in tissue viability some of which are explained in this month's guest editorial on page 10. As a former colleague of the director of Health Protection Scotland (HPS) Dr Jacqui Reilly, I am not surprised that she is now in that post. She is one of the most motivated, driven and affable nurses I have met. Her seminal work on the monitoring of surgical site infections and the subsequent recommendations created an essential link between audit, practice and the implementation of change in order to improve patient care.

The latest audit of healthcare-acquired infection by HPS indicates that a high number of those with pressure ulcers have a soft tissue infection. Tissue viability specialists have always been aware of this link, however, it has not received the attention it deserves. As a result of the audit, in Scotland, the chief nurse has been keen to strengthen ties with the National Association of Tissue Viability Nurses Scotland (NATVNS), in order to address the problems associated with pressure ulcer development in our older patients. This is pioneering work and represents a change in attitude at government level. There is a chance for tissue viability to push this agenda forward in order to ensure there is sufficient funding and services available to prevent and manage pressure ulceration and to reduce the chance of infection. It has never been more important to audit practice and treatment outcomes in order to demonstrate the effectiveness of our services.

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2008 has to be the year that we prove beyond doubt that tissue viability services are essential in order to provide the highest quality patient care, cost-effective care, reduction in infection as well as improving healing times and reducing length of hospital stays. Without tissue viability services patients and their relatives will not be receiving optimum care. They are at risk of pressure ulcer development and infection — and potentially sepsis. Surely health boards and trusts can no longer ignore this link?

There is some evidence that wound care specialists are beginning to get the recognition they deserve. Richard White gave his inaugural lecture as Professor of tissue viability at the University of Worcester in January this year. His appointment is a hugely positive step for the recognition of tissue viability as a specialty in an academic setting. Wound care was also recognised in the New Years' honours list when Mary Jones was awarded an MBE for her work with maggot therapy (read her reflections on her career on p.102–3).

While some Americans worry about 'Hillary Care' becoming a reality, the NHS continues to do an incredible job regardless of costs. My fear for America is not for the wealthy who have no financial worry about becoming ill, but for those on the breadline, for whom illness means a choice between eating or having treatment. This is not a choice I would like Britons to be forced to make. WUK

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