Jeremy J. Ramsden
Hon. Professor of Nanotechnology,
University of Buckingham

The Criminological Dimensions of the National Health Service

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The most basic function of government is to provide law and order, including defence, thereby preserving the essential features of a national civilisation. Individual freedom of thought, belief, opinion, work and leisure is the root of civilisation; yet it is not immediately obvious why the provision of health services should be a state duty rather than an individual one. Healthcare is, however, commonly listed among state responsibilities alongside education, scientific research and the alleviation of indigence. Mid-20th-century Britain formalised this view: the Beveridge Report sought to abolish five perceived great evils – want, disease, ignorance, squalor and idleness – on the argument that ill health, ignorance and want render individual freedoms nugatory. Acceptance of Beveridge's recommendations marked the birth of the welfare state through measures such as the Education Act 1944 and the National Health Service Act 1946; this reframing placed the state as guarantor of population health and organiser of collective medical provision.

State involvement in scientific research predated these reforms. The Department of Scientific and Industrial Research (1923) followed continental precedents, notably Germany's

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Kaiser Wilhelm Gesellschaft (1911), which aligned science with national economic aims and demonstrated how state patronage of research can be mobilised to serve public policy objectives. Seen criminologically, the state's expansion into health creates new regulatory instruments – compulsory obligations, taxation, administrative exclusion and surveillance – which, while intended to protect, can also discipline or criminalise behaviour.

Peter Kropotkin's early 20th-century observation that medical interventions among the poorest are often ineffectual because ill health in such populations stems from inadequate nutrition and poor living conditions remains salient. Where social determinants (housing, sanitation, income) produce disease, clinical medicine alone cannot secure health; remedial structural measures are required. Over the past century, some forms of poverty have declined, yet new morbidity profiles have emerged: obesity, type 2 diabetes, sedentary-related conditions and growing burdens of mental ill-health have increased in many high-income countries alongside the expansion of formal health services. These shifts have invited policy responses that combine incentivisation, fiscal instruments and regulation – what might be termed preventive paternalism – and they raise difficult questions about responsibility, stigma and coercion.

The state now pursues population health by means both punitive and permissive: fiscal "sticks" (taxation on alcohol, tobacco and sugary drinks) and behavioural "carrots" (nudge-based interventions and information campaigns). These instruments are justified by collective externalities and market failure: individual choices about consumption and risk impose system-wide costs and reduce aggregate welfare. Yet fiscal or administrative sanctions implicitly attribute responsibility to individuals and can impose disproportionate burdens on the poor,

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thereby entangling public-health policy with moral judgement and social control.

The UK Soft Drinks Industry Levy (sugar tax), implemented in 2018, exemplifies both intended population-level effects (manufacturers reformulating products to reduce sugar) and distributional concerns: while average sugar content in marketed beverages fell, the fiscal burden can be regressive unless offset by revenue recycling into targeted health programmes. Comparable fiscal measures on tobacco and alcohol have reduced consumption but have also prompted debate about criminalisation of supply, illicit markets and enforcement costs.

All health systems face finite resources and therefore must make choices about allocation. Criminological analysis highlights how scarcity is converted into exclusion: policy vocabularies – "priority," "low clinical benefit," "backlogs" – do not merely describe constraints but instantiate categories of deserving and undeserving patients. The rise of explicit cost-effectiveness thresholds (for example, quality-adjusted life years, QALYs) operationalises distributive judgements and embeds normative choices in bureaucratic decision rules.

The backlog of elective care generated by the COVID-19 pandemic demonstrates, operationally, how scarcity produces exclusion. Analyses of NHS waiting-time data reveal substantial increases in referral-to-treatment times and growing inequities in access by socioeconomic status and region, with consequential effects on morbidity and quality of life. Where explicit fees are politically infeasible, implicit rationing – waiting lists, prioritisation algorithms and the denial of certain interventions – functions analogously to punitive restrictions on entitlements.

Comparative systems reveal how financing design embeds distinct regimes of obligation and sanction. The Swiss transition to compulsory insurance (post-1994 reforms culminating in

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implementation in the 1990s) sought to pool risk across the population but generated rising premiums and intensified insurer cost-containment practices that sometimes limited access to recommended treatments. The US model, with point-of-service payments and a multiplicity of insurers, produces financial barriers and fragmented care; high per-capita spending coexists with poorer population health outcomes on several measures, a state of affairs often attributed to market incentives, administrative complexity and litigation pressures.

By contrast, universal tax-funded provision concentrates discretion in the state and professional bureaucracy. Centralised gatekeeping may reduce transaction costs and extend equitable access, but it also relocates coercive capacity to administrative and clinical decision points – triage, clinical guidelines and commissioning decisions – which can act as instruments of exclusion.

The Covid-19 pandemic crystallised the criminological potential of health governance. Emergency powers, mandatory isolation, contact tracing, quarantine enforcement and mass vaccination transformed therapeutic activity into matters of public order. The NHS's rapid conversion into a National Covid Vaccination Service reallocated workforce and infrastructure and, in many cases, curtailed routine services; that shift illustrates how care can be redeployed for regulatory ends.

Cross-national comparisons indicate that large-scale vaccination campaigns carried complex opportunity costs. In England, modelling and administrative analyses found that the rapid redeployment of staff and facilities for testing and vaccination displaced elective work and stretched primary-care capacity, contributing to waiting-list growth and to reductions in preventive services in certain localities. Jurisdictional responses to non-vaccination – such as Singapore's policy to limit hospital fee

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Volume 4, Issue 8
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subsidies for unvaccinated Covid patients in specified circumstances – have reignited debate over conditionality in care, blame attribution and the ethics of denying treatment on behavioural grounds.

Operational reforms intended to improve effectiveness – automation, centralised patient records, remote monitoring and AI-driven decision support – offer clear clinical benefits but also expand capacities for surveillance and classification. Centralised databases that log adherence, outcomes and behaviour are valuable for care coordination and epidemiology, yet they also permit the extension of administrative oversight into domains that might be used punitively: eligibility checks, enforcement of conditional entitlements and predictive risk assessments that influence access.

Pilot projects using remote monitoring (for example, pulse oximetry home monitoring for Covid patients) have reduced admissions and improved early detection of deterioration in selected cohorts, but algorithmic triage and risk-scoring systems have provoked concerns about bias, transparency and effective appeal processes for those denied services. Data-linkage exercises that correlate adherence to preventive programmes with eligibility for enhanced services raise legal and ethical questions about consent, proportionality and the repurposing of health data.

Professional judgement has historically provided a buffer against crude administrative coercion. Comparative histories show divergent trajectories: Soviet deprofessionalisation in favour of bureaucratic control; Bismarckian corporatism, which reinforced professional associations; and the NHS's original aspiration to protect clinical autonomy. Erosion of professional autonomy through managerialism, audit culture and cost-containment increases reliance on protocols and guideline

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enforcement that resemble penal codes, thereby subjecting clinicians and patients to bureaucratic sanction.

Empirical studies of performance management in the NHS document how target-driven incentives reshape clinical priorities and generate perverse behaviours – for example, the gaming of waiting-time statistics or conservative coding to avoid meeting penal thresholds – practices that in turn influence patient pathways and access to care.

Prevention versus cure remains the central ethical tension and a persistent social determinant. The NHS has long been criticised for privileging curative interventions over upstream prevention. Prevention can be more cost-effective and socially redistributive, but it also entails normative judgements about acceptable intrusions on liberty and the proper reach of state power. Skrabanek's critique of preventionism warns against supplanting the maxim "first, do no harm" with an aggressive prophylactic ethic that may be used to justify coercive measures.

Large population-level prevention interventions (screening, taxation, behavioural nudges) can reduce disease incidence but may produce substitution effects or stigmatise particular groups. For example, smoking-cessation programmes have reduced prevalence in many demographics but have simultaneously concentrated smoking in more deprived populations, thereby entrenching health inequalities unless accompanied by broader social interventions.

A criminological reframing foregrounds questions typically absent from technocratic debate: Who is responsible for ill health and on what normative grounds? When does public-health policy become punitive? Conditionality proposals – denying or deprioritising treatment for those judged causally responsible for their conditions (for example, repeated refusal of vaccination, persistent smoking that leads to lung disease, obesity-related

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complications) – revive historical precedents for conditional welfare and provoke serious ethical and legal concerns.

Survey evidence indicates public support for some forms of conditionality (for example, higher premiums or lower priority for perceived self-inflicted conditions), yet empirical trials of such policies frequently encounter equity, legal and practical obstacles. In organ transplantation, some systems apply behavioural criteria (for instance, requirements for smoking cessation before listing), demonstrating how conditionality can be operationalised in bounded clinical contexts while remaining controversial when generalised.

Physical lesions provide objective markers for many conditions, but mental-health challenges complicate diagnostic and normative boundaries. The history of psychiatric classification and ongoing debates (Szasz, Canguilhem) underscore that mental distress often occupies a hybrid category: partly medical, partly social, and partly normative. Policies that criminalise behaviours associated with mental distress (for example, punitive approaches to substance dependence or compulsory treatment regimes) show how health governance can intersect with penal systems, frequently to the detriment of vulnerable groups.

Programs that divert people with mental illness away from criminal courts and into health or social services have produced mixed outcomes: some reduce reoffending and improve engagement with care, while others fail without adequate investment in community support – a reminder of the limits of medicalisation in the absence of social remedy.

Practical reforms can reduce the criminogenic potential of health administration while improving effectiveness:

- Prioritise prevention that addresses social determinants: invest in housing, nutrition, education and community services to reduce health burdens upstream.

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- Reduce administrative burdens on clinicians: automate routine record-keeping, deploy intermediaries for non-clinical tasks, and streamline contracting to free clinical capacity for patient care.
- Strengthen transparent, participatory priority-setting: make rationing criteria explicit, subject them to public and ethical review, and provide clear appeal mechanisms.
- Adopt distributive impact assessments for fiscal public-health measures to avoid regressive outcomes.
- Limit surveillance uses of health data by codifying purposes, retention limits and independent oversight to prevent repurposing for punitive conditionality.
- Preserve professional judgement: involve clinicians centrally in guideline development and resist over-reliance on rigid protocols in complex cases.

Reframing the NHS as both a welfare instrument and a regulatory space exposes enduring tensions between care and control: financing architectures, administrative practices and preventive strategies can inadvertently criminalise vulnerability and moralise illness. Empirical investigation – ethnographies of triage, statistical analysis of administrative data and comparative policy evaluation – is required to map how decisions are reached at the bedside and in commissioning boards. Normative scrutiny must clarify the limits of conditionality, preserve professional autonomy and set lawful boundaries for surveillance.

If the NHS is to remain humane, reform must extend beyond increases in funding to address structural determinants of health, to design financing and prioritisation systems that minimise exclusion, and to build governance safeguards that prevent the conversion of health policy into a mechanism of punishment. Only by recognising and resisting the criminogenic

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tendencies embedded within health systems can public provision fulfil its founding commitment to protect both freedom and health.

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ჯერემი ჯ. რამსდენი
საპატიო პროფესორი,
ბაკინგემის უნივერსიტეტი

ბრიტანული ჯანდაცვის სისტემის კრიმინოლოგიური განზომილებანი

(ანოტაცია)

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რომ ჯანმრთელობის პრობლემები, უმეცრება და სიღარიბე ინდივიდუალურ თავისუფლებას აუტანელს ხდის. ბევრიჯის რეკომენდაციების გათვალისწინებით, სოციალური სახელმწიფო დაიბადა ისეთი ზომების ცხოვრებაში გატარებით, როგორიცაა 1944 წლის კანონი განათლების შესახებ და 1946 წლის კანონი ჯანდაცვის ეროვნული სამსახურის შესახებ. ამგვარ ცვლილებათა შედეგად, სახელმწიფო მოსახლეობის ჯანმრთელობის გარანტად და კოლექტიური სამედიცინო უზრუნველყოფის ორგანიზატორად იქცა.

ამ რეფორმებს წინ უსწრებდა სახელმწიფოს მონაწილეობა სამეცნიერო კვლევაში. სამეცნიერო და სამრეწველო კვლევების დეპარტამენტი (1923) კონტინენტური ევროპის პრეცედენტებს მიჰყვა. კერძოდ, გერმანიის კაიზერ ვილჰელმ გეზელშაფტის (1911) მაგალითს, რომელმაც მეცნიერება ეროვნულ ეკონომიკურ მიზნებს შეუსაბამა და აჩვენა, თუ როგორ შეიძლება საჯარო პოლიტიკის მიზნების მისაღწევად სახელმწიფო მფარველობის კვლევებზე მობილიზება.

სახელმწიფოს კრიმინოლოგიურად გააზრებული მონაწილეობა ჯანდაცვაში ახალ მარეგულირებელ ინსტრუმენტებს ქმნის: სავალდებულო მოვალეობებს, დაბეგვრას, ადმინისტრაციულ გარიყვას და მეთვალყურეობას. ეს ყოველივე, მიუხედავად იმისა რომ დაცვისკენაა მიმართული, შესაძლოა, ქცევის დისციპლინირების ან კრიმინალიზაციის ინსტრუმენტადაც იქცეს.

კვლავ სახეზეა პიტერ კროპოტკინის დაკვირვება XX საუკუნის დასაწყისში, რომ უღარიბესთა ცხოვრებაში სა-

BRAMS 2023 May
Volume 4, Issue 8
ISSN 2667-9299 (print)
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მედიცინო ჩარევები ხშირად არაეფექტურია, ვინაიდან ასეთ პოპულაციებში ჯანმრთელობის პრობლემებს იწვევს არასაკმარისი და არაჯანსაღი კვება, ცუდი საცხოვრებელი პირობები და მისთ. იქ, სადაც მოუგვარებელი სოციალური ფაქტორები (სანიტარული პირობები, საცხოვრებელი, შემოსავალი) იწვევს დაავადებებს, მხოლოდ კლინიკური მედიცინა ბევრს ვერაფერს შეძლებს.

XX საუკუნეში სიღარიბის ზოგიერთი ფორმა შემცირდა, თუმცა, ჯანდაცვის სერვისების გაფართოებასთან ერთად, გაჩნდა ახალ დაავადებათა პრეცედენტები მრავალ მაღალშემოსავლიან, უზრუნველყოფილ ქვეყანაში: სიმსუქნე, მე-2 ტიპის დიაბეტი, უმოძრაო ცხოვრების წესი (ჰიპოდინამია) და ფსიქიკური ჯანმრთელობის მზარდი მაჩვენებელი. ამ ცვლილებებმა გამოიწვია პოლიტიკური რეაქციები, რაც აერთიანებს სტიმულებს, ფისკალურ ინსტრუმენტებსა და რეგულირებას, რასაც შეიძლება პრევენციული პატერნალიზმი ვუწოდოთ. ეს ყოველივე რთულ კითხვებს აჩენს პასუხისმგებლობის, სტიგმისა და იძულების თაობაზე.

კოვიდ-19-ით გამოწვეული პანდემიის შედეგად ჯანდაცვის მმართველობის კრიმინოლოგიური პოტენციალი გამოვლინდა. საგანგებო სიტუაციით განპირობებულმა უფლებამოსილებებმა, სავალდებულო იზოლაციამ, კონტაქტების მონიტორინგმა, კარანტინის დაძალებამ და მასობრივმა ვაქცინაციამ თერაპიული საქმიანობა საზოგადოებრივი წესრიგის საკითხებად აქცია.

ბრიტანული ეროვნული ჯანდაცვის სისტემის (NHS) სწრაფმა გარდაქმნამ კოვიდ-19-ის ვაქცინაციის ეროვნულ

BRAMS 2023 May
Volume 4, Issue 8
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ISSN 2960-9348 (online)

სამსახურად, სამუშაო ძალა და ინფრასტრუქტურა განსხვავებულად გადაანაწილა და, ბევრ შემთხვევაში, ჩვეული მომსახურება შეამცირა. ეს ცვლილება ასახავს, თუ როგორ შეიძლება მზრუნველობის გადანაწილება მარეგულირებელი მიზნებისათვის.

კრიმინოლოგიური თვალთახედვა წინა პლანზე წამოსწევს კითხვებს, რომლებიც, როგორც წესი, ტექნოკრატიულ დებატებში არ არსებობს: ვინ და რა სამართლებრივ საფუძველზე აგებს პასუხს ჯანმრთელობის პრობლემებთან დაკავშირებით? როდის ხდება საზოგადოებრივი ჯანდაცვის პოლიტიკა სადამსჯელო? პირობითობის წინადადებები, როგორიცაა იმ პირთა მკურნალობაზე უარის თქმა ან პრიორიტეტის შემცირება, რომლებიც საკუთარი ავადობის გამომწვევად ან მასზე პასუხისმგებლად მიიჩნევიან (მაგ.: ვაქცინაციაზე განმეორებითი უარის, ფილტვების დაავადების გამომწვევი თამბაქოს მოხმარების, სიმსუქნით გამოწვეული გართულებების შემთხვევაში), აბრუნებს პირობითი კეთილდღეობის ისტორიულ პრეცედენტებს, რაც სერიოზულ ეთიკურ თუ სამართლებრივ შეშფოთებას იწვევს.

პრევენცია თუ განკურნება? ეს დაპირისპირება კვლავ მთავარ ეთიკურ დილემად და მუდმივ სოციალურ დეტერმინანტად რჩება. საიმისოდ, რომ ჯანდაცვის ეროვნული სისტემა ჰუმანური დარჩეს, საჭიროა რეფორმა გასცდეს მხოლოდ დაფინანსების ზრდის მოთხოვნას, მოგვარდეს ჯანმრთელობის განმსაზღვრელი სტრუქტურული ფაქტორები, შეიქმნას დაფინანსებისა და პრიორიტეტების სისტემები, რომლებიც მინიმუმამდე დაიყვანს გარიყულო-

BRAMS 2023 May
Volume 4, Issue 8
ISSN 2667-9299 (print)
ISSN 2960-9348 (online)

ბას; შეიქმნას მმართველობის დამცავი მექანიზმები, რომლებიც ხელს შეუშლის ჯანდაცვის პოლიტიკის დასჯის მექანიზმად გადაქცევას.

მხოლოდ ჯანდაცვის სისტემებში ჩადებული კრიმინოგენული ტენდენციების აღიარებითა და მათთვის წინააღმდეგობის გაწევით შეძლებს საჯარო უზრუნველყოფა თავისი ფუნდამენტური ვალდებულების შესრულებას: დაიცვას როგორც მოქალაქეთა თავისუფლება, ასევე, მათი ჯანმრთელობა.

BRAMS 2023 May
Volume 4, Issue 8
ISSN 2667-9299 (print)
ISSN 2960-9348 (online)