

Reforms of the UK' s NHS

T. Hitiris
University of York, UK

1. Introduction

The UK' NHS was established by the National Health Act (1946) and started operating from 5 July 1948. The main characteristics of the NHS were:

- Tripartite division: Central Government - Regional Authorities - Local Authorities (see Figure 1).
- The Minister of Health was made personally responsible to Parliament for the provision of all hospitals and specialist services on a national basis.
- All hospitals were nationalized under 15 Regional Boards for England and Wales, while Scotland and Northern Ireland formed separate NHS departments.
- Local Authorities remained responsible for community services.
- The British Medical Association (BMS) only agreed to take part only after two concessions were granted: i. Family practitioners (GPs), dentists, pharmacists and opticians were left as independent contractors; ii. Salaried hospital doctors were allowed to undertake private work outside their NHS contract.
- The financing of the NHS was provided by the Government from funds raised by general taxation. Patients were not charged.

But the cost of the NHS very quickly became a financial problem to the Labour Government which encountered numerous spending demands for both capital investment and current expenditure for two main reasons:

1. The NHS was the first national health service in the world. Hence, nobody could have predicted the ever-increasing rise in demand under zero pricing.
2. The NHS inherited old and war-damaged hospital buildings and medical equipment.

An unexpected consequence of these problems was the formation of queues by lengthy waiting time for non-urgent treatment. Under budgetary pressures, the key principle of a free service was first breached in 1951 with the introduction of charges to some people for spectacles and dentures. A year later, the new Conservative

government introduced charges for medicines which (excluding an interval of three years under a Labour government, 1965-68) continue today. Subsequent administrations prepared many plans for reform of the NHS which were not implemented fully mostly because of the estimated political costs and the frequent changes in governments. The first major administrative reorganization took place in 1974 by the Labour government which, attempting to decentralize the NHS, introduced a fourth level of management in the form of 90 area health authorities (AHAs) and district management teams (DMTs). But after a few years, it became clear that this reorganization increased the bureaucracy of the NHS without solving its problems. The next extensive reorganization was undertaken by the Conservative government which took office in 1990.

2. The 'internal market' 1990 reforms

The National Health Service and Community Care Act (1990) implemented new reforms that were the most radical since the inception of the NHS. They comprised a major part of Thatcher government's reappraisal of the public sector and the welfare state. Although the Conservatives had given assurances about the future of the NHS, they found themselves under continuing financial problems that resulted in cuts in services. At the core of these problems were the growing public expectations, advances in costly medical technology and an ageing population. The government believed that the NHS would benefit from less government intervention and that the problems would be solved by subjecting the NHS to the disciplines of the market (Enthoven, 1985). NHS spending could be checked by more rigorous cost controls and by encouraging those who could afford it to pay more towards their care (Box 1). This meant enabling private practice to develop and forcing more elderly people to independent private nursing homes, where they had to pay from own resources until their money ran out.

The government had two main objectives:

1. To improve its ability to control the NHS financially. The first priority was to separate 'health' from 'social' care. The former was free if provided by the NHS staff. The latter were 'means tested'. 'Free' but controlled NHS in practice meant making doctors more accountable to government. This required restricting the clinical autonomy of doctors which, since the foundation of the NHS, had made it difficult for the government to set performance targets or to restrict the excessive use of medicines and other health services.

2. To increase the efficiency of the NHS. This involved improving both productive efficiency and allocative efficiency¹.

Foundation of the 'internal market' entailed the introduction of competition by establishing more and smaller provider-units created by breaking up the large health districts and replacing the power of the health professionals by specialist managers. Competition between providers of health care was expected not only to improve patient choice but also to supply health authorities and individual hospitals with incentives to work efficiently. But this was opposed by doctors and nurses, who claimed that managers and accountants were given too much power at the expense of the patients interests. The public were inclined to support the professionals' view but the government unperturbed went ahead with the new arrangements, separating the health authorities (the purchasers of health care) from the providers (the newly created Trusts).

| |
|--|
| Box 1: Working for Patients, 1990 |
|--|

¹Productive efficiency requires the NHS to produce the maximum possible health care from the resources allocated to it. This meant using resources to produce existing treatments as efficiently as possible and switching resources to new more efficient treatments as they become available (= technical efficiency). Allocative efficiency involves making sure that the NHS is producing the type of health care - treatments, operations or medicines - which consumers want and at the quantities they want them.

<Introduction of the 'internal market' by separating 'purchasing' and 'providing' functions.
 <Creation of NHS trusts with greater freedom to set pay levels and to borrow for capital projects.
 <New corporate boards of management at Regional, Health Authority and Trust levels with joint executive and non-executive membership.
 <Fundholding for larger GP practices allowing them to purchase certain patient services direct from providers.
 <Consultants' contracts held by Trusts (previously held by Regions).
 <Family health services authorities to replace family practitioner committees.
 <Tax relief on private medical insurance for elderly people.
 <Extension of medical audit.
 <Extension of hospital clinical budgeting.
 <'Indicative prescribing' to contain GP drug costs.

3. The 1990 reforms in practice

The reforms of the NHS were very controversial. The British Medical Association (BMA) claimed that a 'two tier' health service was being created, with the patients of fundholding GPs jumping queues for treatment, and that "patients are no longer being treated on the basis of clinical need". Were the reforms successful? This has been judged (by Le Grand et al., 1998) on the basis of five criteria:

- Efficiency: Overall efficiency in the NHS appeared to have increased¹.
- Equity: Two major equity issues were examined: 1. Whether the internal market would lead to "the deliberate selection of patients both by hospitals and by fundholding practices who were easier or less costly to treat in order to protect budgets".
 2. Whether the reforms would lead to a two-tier system.
 No evidence was found that either had occurred.
- Quality: This was measured by looking at the range of services offered, the lengths of waiting lists, and surveys of the public's attitude to the NHS. The overall conclusion was that the introduction of Trusts had not led to any improvement in quality but that fundholders had obtained quicker admission for their patients to hospitals and a greater provision of services in the community (i.e. in or near patients' own homes).²

¹To measure efficiency we need information about health care outcomes yet there is remarkably little information about the effectiveness or otherwise of different treatments.

²Waiting lists continued to grow in length during the 1990s (from 948,000 in 1991 to 1,262,300 by 1997) but the

- Choice and responsiveness: No evidence was found that choice for patients had increased.
- Accountability: There is no evidence that Trusts had become more accountable to their local populations, and that "the decision making of either Health Authorities or Trusts had become more transparent to the public".

The separation of functions between purchasers-providers was judged to have been successful and was retained by the incoming Labour government in 1997. But the problem of 'too many managers' in the system was not resolved. Instead, its requirements forced a further increase in their number with fundholding GPs appointing more managers or turning themselves into managers. Overall, the internal market failed because the people involved in the NHS did not behave in the kind of self-interested way that market theory demands. But the general conclusion reached must be that "the Thatcher-Clarke reforms - GP fundholding, the quasi market - are neither pernicious nor notably efficacious" (*The Independent*, 25 February 1997).

The partial abrogation of government from national health care in favour of privatization also meant that the NHS fell well behind similar organizations in other European countries, Figure 2. Thus while in 1998 Germany directed 10.3 % of GDP to health care, the UK spent only 6.8% (comprising 5.7% spent publicly and 1.1% privately), far below the 15 EU countries' unweighted average of 8% (or 8.9% weighted by national income across the EU countries³). As a result, the numbers of doctors⁴, nurses, therapists and hospital beds were insufficient to match the increasing demand and, therefore, the waiting times for treatment lengthened.

4. The 'new' NHS

Following Labour's victory in the 1997 general election, after 18 years in opposition, it rapidly became clear that the new government intended to revise the internal market by launching its own plan, the 'new' NHS, a "ten-year

waiting times had tended to fall. The British Social Attitudes Survey showed that the public's level of dissatisfaction with the NHS rose from 25% in 1983 to 47% in 1990. From 1990 to 1993 levels fell to 38% but then started to rise again and by 1996 had reached 50%, its highest ever level.

³ Only Ireland and Luxembourg spend less on health than the UK.

⁴People per doctor in 1990: Germany=332, UK=560.

vision for the modernisation of the health care system to be based on co-operation, not competition" (Department of Health, 2000). This was considered necessary since 'in part the NHS is failing to deliver because over many years it has been underfunded' by the lengthy Conservative administration during which important changes had taken place in health needs, medical advances and public expectations. The 'internal market' was replaced by 'integrated care' which reinstated planning into the NHS. But the reforms maintained many of the features of the previous administration, such as fundholding in the form of Primary Care Groups or Trusts (PCGs/PCTs) which took over many of the functions previously exercised by health authorities. The emphasis on efficiency and quality continued with the creation of the National Institute of Clinical Excellence (NICE) and the Commission for Health Improvement (CHI), (see Box 2, and Figure 3 for the managerial structure of the 'new' NHS). Through time, the 'new' NHS acquired more features of the internal market. For example, a major change to the way funds flow to the NHS was to reintroduce competition by rewarding hospitals by result. To assist 'consumer choice' patients are given information on waiting times and options for treatment, and those who have been waiting the longest can choose to be treated in another hospital (often in a private hospital or overseas). This innovation meant that spare capacity in one hospital can be used to shorten queues at another, speeding treatment for patients and making more efficient use of resources. Hospitals that fail to deliver lose money calculated according to the number of cases by which they have fallen short. Those that treat additional patients are paid extra on a cost per case (capitation) basis. Thus, the price competition of the 'internal market' has been replaced by 'volume and quality' competition at prices of treatment set by benchmarks based on international health care standards.

One problem the reforms had to deal with urgently was the lengthening queues which were one of the consequences of the restrictions on health care expenditure inflicted by the previous administrations⁵. After five years of planning and deliberating, the government decided in the 2002 Budget to 'drag the NHS into the 21st century' by pouring billions of extra funding into the health infrastructure, increasing the NHS real expenditure between 1996-7 and 2007-8 by 255 per cent (from £41.3bn to £105.6bn, see Figure 4). This will raise the

⁵The Wanless Report (2002) argued that many of the NHS's current problems stemmed from "a history of under-investment over 50 years and a long-term lack of capacity". The Report estimated that the healthcare workforce must increase by nearly 350,000 over the next 20 years, including 62,000 doctors, 108,000 nurses, 45,000 therapists and scientists, 74,000 health care assistants. The number of GPs would need to double from 26,000 in 2000 to 55,000 by 2020.

proportion of GDP spent on health from 7.7% to 9.4%, moving the UK above the current average EU levels. The funds will be raised by direct taxation in the form of higher national insurance contributions paid for by employers and employees.

5. Problem issues

5.1. Elderly people

The largest single category of patients is the elderly: at any time, over half the hospital beds are occupied by people aged over 65. The proportion of elderly in the population is currently about 18% and is expected to increase over the next decade, with the number of the very old (those over 75) predicted to rise the fastest. Although the UK does not expect a ‘demographic time-bomb’ similar to that of some other countries (such as Japan and Italy), health care

expenditure on the elderly will certainly rise. According to a recent Nuffield Report⁶, the ageing UK population, coupled with a shrinking working tax base, will have a significant effect on the dynamics of UK health services over both the medium and the long term. The Report identified several key trends responsible for this:

- The ageing UK population (15.8% of population aged 60-74 and 7.8% aged 75+ by 2015).

⁶ Nuffield Trust website: www.nuffieldtrust.org.uk

- Increasing life expectancy (to 77 for men and 82 for women by 2015 compared with current 75 and 80 respectively¹).
- Increasing the dependency ratio of the old (308 per 1,000 people by 2015 compared to the current 294 per 1,000) and the rising cost of long-term care (current cost estimated at £12 billion, projected to be £34.5 billion by 2030).

However, the Wanless Report (2002), which is the base of much of the government's planning, states that the biggest sources of pressure on the NHS over the next decade will come from technological innovation and increasing public expectation rather than the aged. The Report played down fears that an ageing population will adversely impact on the health service, arguing that the pressure will not be as high as expected: "It is possible the effect of an ageing population will be to postpone rather than increase health service costs." It is, however, very unwise to dismiss lightly the significance of ageing population from the future problems of the NHS which will derive from all three equally important sources:

- Advances in medical technology;
- Patients' demand for treatment by new and costly medical technology;
- Ageing population.

5.2. Financing the NHS

The Wanless Report (2002) stated that the NHS will face growing financial pressures in the coming 10-20 years but it should continue to be funded by general taxation, albeit at higher levels, which is the most cost-effective and fairest system for the future: "There is no evidence that any alternative financing method to the UK's would

¹ But life expectancy for the population of non-manual classes is longer than for the manual classes. For example, between 1997 and 1999, for women 2.4 years and for men 2.6 years.

deliver a given quality of healthcare at a lower cost to the economy. Nor do alternative balances of funding appear to offer scope to increase equity." It suggested, however, that "more self-care" by patients encouraged to stay at home rather than relying on their GPs or a local hospital, could help to reduce financial pressure on the health service. It added that "better use of information and communication technology, which is currently 'poor', could improve efficiency and therefore cut costs".

But the tax revenue for financing the NHS as well as patients' self-care will depend on the rate of economic growth, which is one of the unknowns in the equation, and on the demand of competing government expenditures (such as defence, education and pensions) on the UK Treasury's resources. Therefore, the debate on whether the NHS should be exclusively funded by general taxes and national insurance contributions or instead adopt some form of social health insurance entailing higher spending by individuals is continuing¹. The proponents of modernization argue that the NHS needs for funds would be better served by the social insurance system which allows spending levels to rise according to demand². The opponents counter that the most important issue in a health care system is the distribution of costs and benefits among the population, and that the main advantage of funding from general taxation is that it recognises that those whose needs are greatest are least able to pay for care. Although the UK government remains at the moment in the latter camp, new ideas have lately started to creep into the NHS system. The Government's 'modernists' argue that the vast size of the NHS means that it cannot be directed effectively from the centre. The solution is to give more autonomy to hospitals that perform well, so that they become self-governing public interest foundations allowed to borrow in the capital markets, invest and expand rapidly, thus improving the overall NHS performance. The 'traditionalists' argue that the borrowing of these 'foundation hospitals' will not be 'private' but 'public' debt, therefore, their formation will undermine the government's control over public debt, at the same time resulting in the partial 'privatization' of the NHS.

At the beginning of October 2002, the dispute was settled in favour of the modernists. In one of the

¹ See, e.g., the debate in *British Medical Journal (BMJ)*, 31 August 2002.

² The World Health Organization ranked countries according to the responsiveness of their health systems to needs: Switzerland, Luxembourg, Germany, and the Netherlands (all with social insurance systems) ranked second, third, fifth, and ninth in the world. Of the tax-based systems in western Europe, only Denmark (with tax funding) achieved rank fourth. The UK was twenty sixth (WHO, 2000) . See also OECD, 2000.

biggest changes to the NHS since it was founded in 1948, the top-performing hospitals become independent, no longer own or run by the NHS but primarily dedicated to the free treatment of NHS patients. They will also gain the right to borrow privately to improve services but at the expense of other NHS funds. Eventually, after the 2007-08 NHS expenditure, if they prove their excellence they will gain greater borrowing freedom and be allowed to set their own pay and conditions. The opponents warned that this innovation creates “a two-tier NHS, undermining patient confidence and draining staff and resources from neighbouring NHS trusts to the disadvantage of the British public”.

6. Conclusions

The UK's NHS is a vast administrative organization of a million employees absorbing a large share of UK's national budget. As such, it has become an important political issue which each incoming government feels obliged to reform in order to meet the public's demand and to win votes. However, what the public want is a better health service provided somebody else is paying the bill. Therefore, governments face an unsolved problem: How to provide more funds for the NHS to please the public without raising taxes to displease the public and lose votes. Hence all the ambitious plans for reform of the NHS in practice end up making no more than a marginal change. “Progress in health will always cost more. The question is: are you willing to pay more? Not the government, but the citizens. Are the British citizens ready to pay more? If you approach health care as a matter of economy, it can't work”³.

References

Department of Health (2000), *The NHS Plan: a plan for investment, a plan for reform*, The Stationary Office, London.

³ Bernard Kouchner, France's health minister, in *New Statesman*, p.28, 28 October 2001.

Enthoven, A. (1985), *Reflections on the Management of the NHS*, Occasional Paper 5,

Nuffield Provincial Hospital Trust (NHPT), London.

Le Grand, J. E. M., Mays, N. and Mulligan, J. A. (1998), *Learning from the NHS Internal*

Market: a review of the evidence, Kings Fund, London.

OECD (2000), *World Health Report 2000 - Health Systems*, OECD, Paris.

Wanless, D. (2002), *Securing Our Future Health: Taking a Long-Term View*, (The Wanless

Report), HM Treasury, London.

World Health Organization (2000), *World Health Report 2000*, WHO, Geneva.

Figure 1 The National Health Service 1948-74

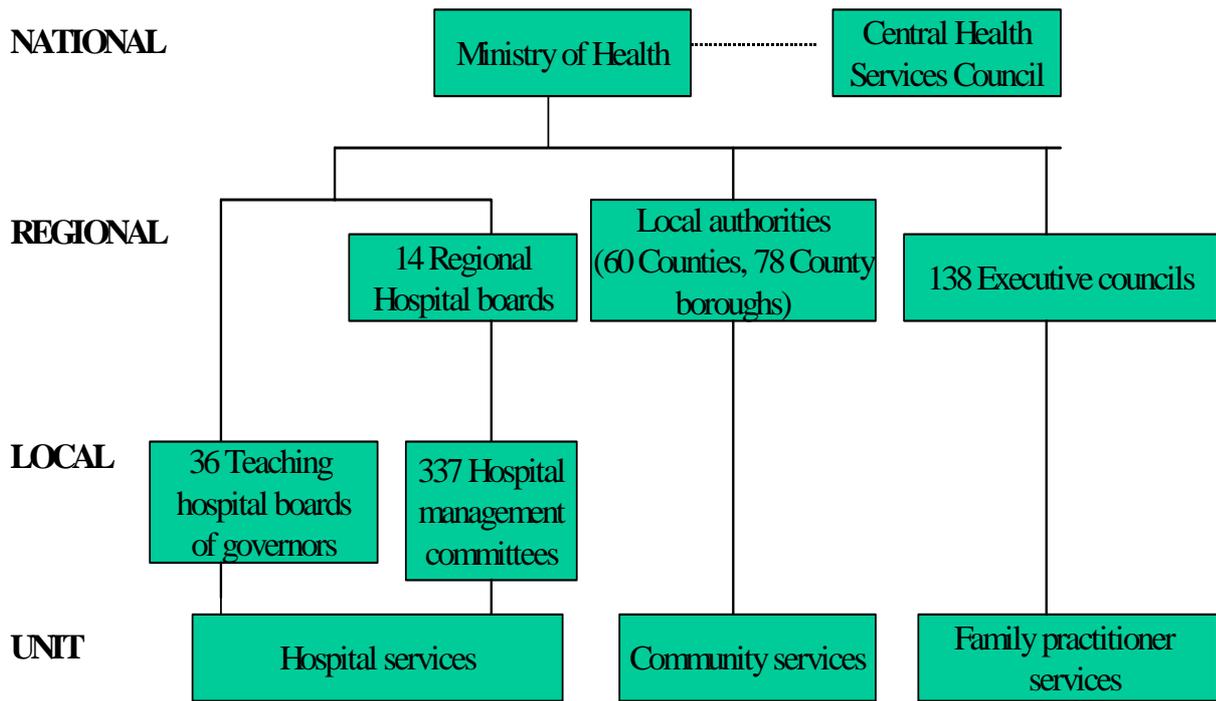
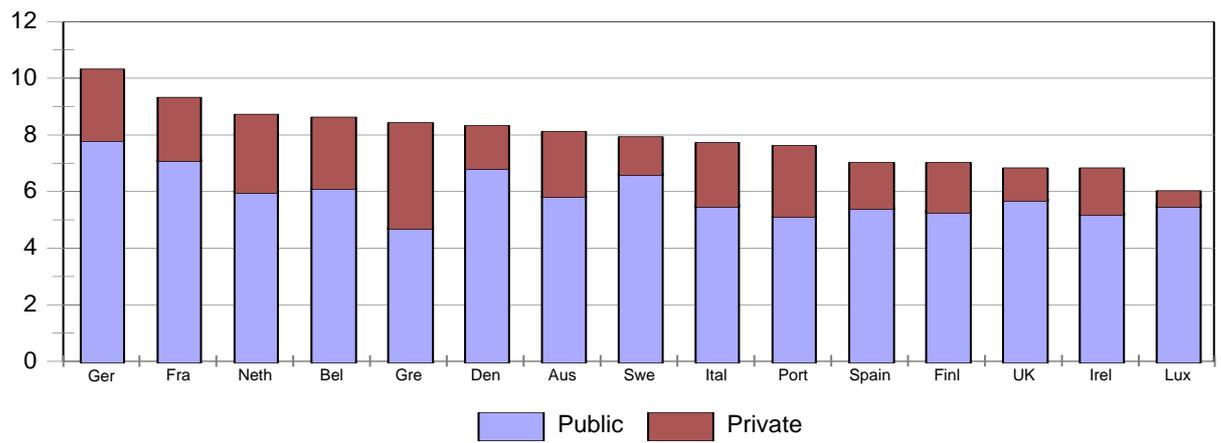
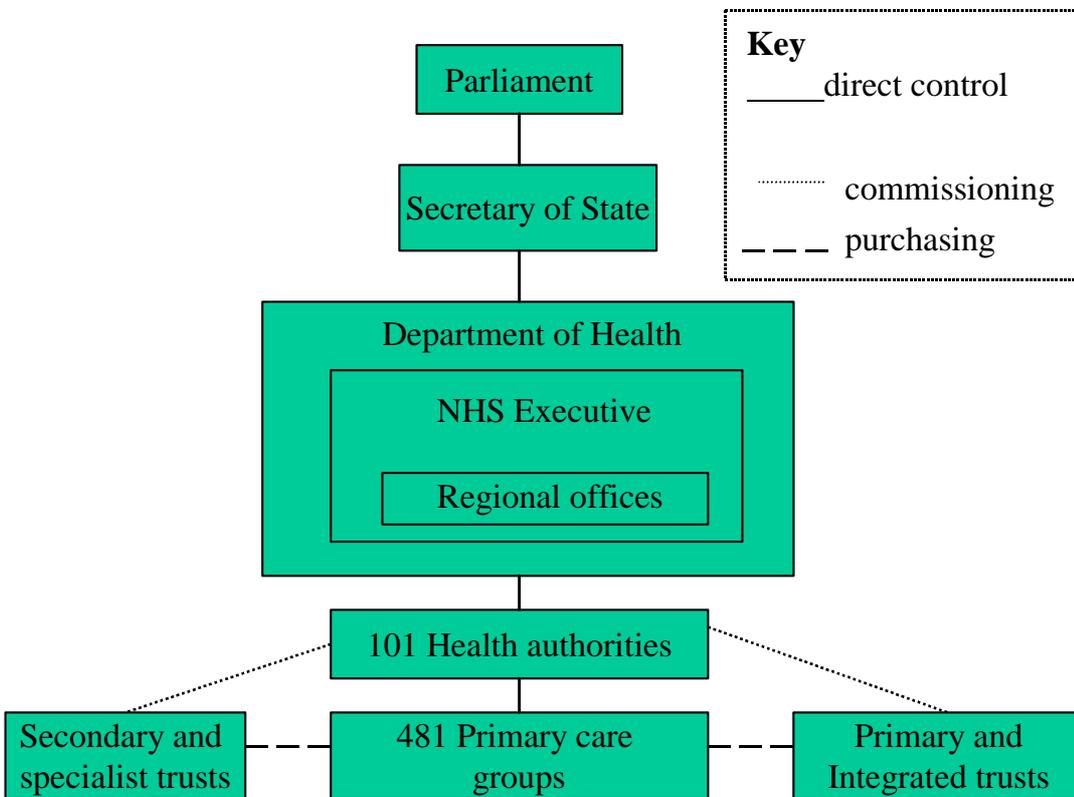


Figure 2. **Public and private health expenditure as percentage on national income across the 15 EU Member States, 1998.**



Source: *OECD Health Data 2001: A Comparative Analysis of 29 Countries*, CD-ROM..

Figure 3. The organization of the NHS, 1999



Box 2: The new NHS

- ☐ 'Integrated care replaced internal market.
- ☐ Health authorities plan services for given populations in partnership with other public authorities.
- ☐ Primary Care Groups (PCGs) covering whole population replaced fundholding and are responsible for purchasing services.
- ☐ New National Institute of Clinical Excellence (NICE) and Commission for Health Improvement (CHI) set up.
- ☐ Curb on management costs continue.

The Plan provides for:

- 7,000 extra beds in hospitals and intermediate care
- over 100 new hospitals by 2010 and 500 new one-stop primary care centres
- over 3,000 GP premises modernised and 250 new scanners.

Figure 4. NHS spending (£bn): government net expenditure 1996-7 to 2007-8

