Agonies of reform: changes in the British National Health Service

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Genesis of the NHS reforms

The British National Health Service (NHS) of today has its origins in the NHS Act of 1946, passed in Parliament by the post-World War II Labour Government of Clement Atlee. The Act very explicitly set out the objectives of the NHS: to provide an adequate and comprehensive healthcare system, available to all citizens, funded from taxation, and free at the point of delivery. Aneurin Bevan, the Health Minister at the time, proceeded to set up an NHS that, over the years, succeeded in achieving those goals to a very large extent, and became a model aspired to by many developing nations.

However, the cost to the exchequer of providing such a service was considerable, and by 1987 the perception began to grow that the discrepancy between NHS cash supply and demand had reached crisis proportions (annual government expenditure on the NHS for 1987-88 was £ 20 billion). The Conservative Government of Margaret Thatcher responded by setting up a cabinet committee to study ways of reducing costs in the NHS, and their findings led to the publication in 1989 of a white paper called "Working for patients"[1]. At the time, the management structure of the NHS - to put it very briefly - consisted of the Department of Health (i.e. the central ministry or DOH) at the apex and District Health Author-i ties (DHAs) and Family Health Service Authorities (FHSAs) at the ground level. The DHAs and FHSAs were responsible for the provision of hospital-based care and primary health care for the residents of that district. To this end, they received an annual sum from the DOH (determined, among other things, by the number of people resident in that district) which was then disbursed among the hospitals, general practitioners (GPs) and other providers of medical care in that district. Salaries of hospital staff (doctors, nurses, paramedics) and GPs were paid by the DHAs from these funds, according to uniform pay scales that applied nation-wide, and to all specialities.

The principal change proposed by the white paper related to separating the purchasers from the providers within the NHS. It was envisaged that the DOH (the funder) would disburse funds to individual Regional Health Authorities (larger bodies, created by amalgamation of the old DHAs and FHSAs), and entrust them with the task of purchasing health care for the population of that area (i.e. they would be the purchasers). The RHAs would then have the freedom to purchase from whichever providers they felt could provide a good and economical service. The providers within each area, particularly the hospitals, would be expected to bid for these contracts. The hospitals could no longer complacently expect that all patients in their respective catchment areas would inevitably be referred to them for all ailments. It was felt that creation of such an internal market would reduce costs, improve quality, and increase responsiveness of the providers to the needs of the patients. As a corollary, NHS hospitals were to be encouraged to opt out from the governing ambit of the Region, and become self-contained, self-managing Hospital Trusts responsible for their own finances and own resources. The other major group of providers, the GPs, were to also see significant changes. GPs with sufficiently large practices were to be given the option of becoming fund-holder GPs, i.e. they could receive funds directly from the DOH, and use that budget to provide primary care for their patients, as well as purchase hospital health care for their patients as required from local providers. They would, in other words, fulfil dual roles as purchasers and providers, and Hospital Trusts would have to enter into contracts not only with the RHAs but also with individual fund-holder GPs in the region. Other important proposals in the white paper included suggestions for incorporating some independent (i.e. private) hospitals amongst the providers, and the creation of indicative drug budgets.

The ideologic drive behind the reforms proposed by the white paper are thought to have come from the writings of Alan Enthoven, an American health-care economist[2]. Further inputs, particularly relevant to London, were to come in three years' time, from the report submitted by Sir Bernard Tomlinson in 1992, urging changes in London's healthcare, education and research infrastructure'.

Effects of the reforms

Implementation of the reforms commenced from 1991, amidst a lot of sound and fury. The government pressed ahead despite loud protestations from professional organisations representing doctors, nurses and other healthcare workers, large sections of the lay press, patient-interest groups and the opposition benches. The effects of the reforms have been too far-reaching to be grasped in their entirety as yet, but certain effects are quite apparent already from the viewpoint of a hospital doctor.

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Effects on medical infrastructure: The overwhelming majority (perhaps all) of the large NHS hospitals in this country are now independent Trusts, and have unprecedented financial autonomy. While many have managed to balance their books and therefore not had to make significant cuts in services, many others are in the red. These Trusts have been forced into economising by cutting down on what they perceive as non-essential services. Closure of wards and in some instances casualty departments has led to increasing demands on the existing beds and facilities, with longer waiting times for patients. Recent newspaper reports state that over the past 3 years, 28 out of 60 casualty units in London have been closed down, and there are warnings of bed shortage crises over the winter months. In some instances, amalgamation of two or more hospitals has led to the creation of large Trusts, which have then proposed concentrating all their resources at one site and closing down the other sites entirely. The bitter struggles that two of London's leading teaching hospitals - St Bartholomew's and Guy's - have had to fight to avoid complete closure are prominent examples. A frequently quoted reason for slashing hospital funding is that the money may be better spent on bolstering care in the community, but this does not seem to be happening either. Facilities for geriatric and psychiatric care within the community are a growing area of concern. Therefore, while the cuts may make financial sense, and may lead in the long term to fewer, leaner but better-equipped units, in the short term they are being perceived by NHS staff and lay people as a cynical means of further slashing the already stretched services, and are widely unpopular.

Effect on human-power and morale: Hospitals have also sought to downsize their workforce as a means of economising. This has led to job losses, and those who have retained their jobs are left with increasing workloads, a severe crisis in morale and a growing sense of insecurity. Doctors in the NHS get paid less than what bankers, lawyers, managers or accountants may earn in the private sector. The possibility of pay scales being set locally by the Trusts (as opposed to national pay scales) has generated fears that already low salaries may be slashed even further. One of the assets of the old NHS was a zealous and committed workforce that was willing to accept modest salaries and poor working conditions because of the satisfaction they derived from their jobs. That ethos is rapidly disappearing. The Trusts have also been recruiting more managers at the same time that they have been shedding medical and nursing staff. They have - in all fairness - been forced into this, because the reforms have unleashed a whole new plethora of managerial problems and mountains of paperwork (having to negotiate contracts with each individual fund-holder GP in the region is a case in point). But the growing number of well-paid "men in grey suits" has helped demoralise the diminishing medical and paramedical staff even further. Working from cramped offices with poor secretarial support, they cannot help noticing that the newly appointed managers work from smart offices and draw attractive perks. There has been a not-so-subtle shift in power within the hospitals, from the doctors to the managers, and doctors are certainly not happy about it.

Effect on medical practice. With cash shortages and bed closures, there have been instances where medical care has been compromised, Patients having to wait for long times in casualty departments before they can be seen or before a bed can be found for them on a ward, is a commonly-quoted example (though this particular problem is not an entirely new phenomenon). There have been instances of cash-strapped Trusts refusing to offer certain cosmetic operations, fertility-enhancing treatments or very expensive drugs. Trusts that have run out of funds midway through a financial year resort to healthcare rationing in various forms: stopping all elective operations till further funding comes through (thereby leading to longer waiting lists) is typical. In one recent well-publicised instance, a hospital refused to admit any patients above the age of 75 years! The issue was resolved only after extra cash was provided from other sources. The creation of fund-holding GP practices and the perceived need for the hospitals to keep such GPs happy (or else they may send their patients to another hospital), has led to concerns about a two-tier system, wherein patients referred by fund-holding GPs will be given priority on non-mecical grounds. On the positive side, there have certainly been changes in clinical practice which have led to more efficient utilisation of beds and resources. In the surgical disciplines for example, the turnover of cases is much more rapid. Patients for elective surgery frequently have their entire pre-operative work-up done on an out-patient basis. After surgery too, they spend less time in hospital and are discharged into the community as soon as it deemed safe. Day surgery is getting increasingly popular. Groin hernias and laparoscopic cholecystectomies are routinely being done as 24-hour admissions. Doctors have become more conscious of the cost of the therapies they prescribe. Units throughout the country are engaged in clinical audit to ensure that their results measure up to acceptable standards. Doctors have also become more aware that treatments prescribed by them should be justifiable on the basis of the best available information in the medical literature - "Evidence-based medicine" is the new catch phrase. However, official efforts to quantify medical performance using industrial rating standards can also extend to the ridiculous -attempts to grade hospitals with a l-star to S-star system (as for hotels) or create league tables on the basis of overall mortality figures are cases in point.

Patients' expectations: Along with the health reforms, the Government has also attempted to raise the patients' awareness of their rights, by publishing a Patients' Charter, which outlines for example the maximum permissible time one can expect to wait to be seen in a casualty department [illegible] imum time period one

can spend on a waiting list for an elective operation. Hospitals have by and large attempted to meet these performance standards, leading to an impressive cut-down on surgical waiting lists in many instances. But the heightened expectations of the patients has also led to a remarkable increase in the number of complaints received against NHS hospitals from aggrieved "customers". In fact, one of the deplorable consequences (I think) of the prevailing managerial ethos in hospitals has been the tendency to perceive patients as customers and refer to them as such.

Effect *on research:* Usually, research funding is one of the first casualties of healthcare penny-pinching. This was predicted, and has already begun to happen. The demoralisation in the ranks of research personnel has been further compounded - at least in London - by the turmoil resulting from the reorganisation of medical schools and their affiliated hospitals and research institutions, as recommended by the Tomlinson report'. Some remedial efforts are under way, however. A committee headed by the health economist Professor Tony Culyer proposed in 1994 that a levy be imposed on all healthcare purchasers, and the proceeds be used for research funding. This has been taken on board by the NHS Executive.

Fears of privatisation. The general attitude of this Conservative government towards all public utilities (they have already privatised all water, gas and electrical supplies, and much of the railway system) has led to growing fears that the hidden agenda behind these health reforms is to gradually impoverish the NHS to such an extent that increasing numbers of people turn to private healthcare, and then sell off the depleted remnants to private buyers. Already there is talk of several hospitals being renovated under the 'Private Finance Initiative' which will invite private companies to invest in these projects. The Government of course denies these accusations of backdoor privatisation vociferously, and as evidence of its commitment to the health sector points to the fact by 1994-95 its annual spending on the NHS has increased to £ 39 billion. Whether there is any truth to these allegations may be revealed in the fullness of time if the Tories get elected to another term in office. However, even the Labour Party, which vehemently opposed the reforms when they were introduced -now acknowledges that the changes have been far too extensive for them to consider a total reversal if they come to power.

The role of the doctors

The medical fraternity in the UK are represented in most official fora by the British Medical Association (BMA). While it does command considerable clout and public respect, the BMA has a poor record when it comes to standing up to a determined Government. In 1946, the BMA was at first fiercely opposed to the creation of an NHS, but ultimately caved in to Aneurin Bevan. This time too, when Mrs Thatcher's ministers opted to bring in such wide-ranging reforms with little prior consultation with the BMA, and with total disregard for pleas that the reforms be initially tested in a pilot area or in pilot institutions, the BMA was unable to defend its position strongly enough or mobilise public opinion effectively in its support. Doctors now have accepted the reforms and decided to "get on 'with it". Many are still disgruntled, but their responses are muted. As one who grew up in the strident militancy of junior-doctor politics in India, I have in turn been impressed by how civilised their forms of protest are, and been stunned by how ineffective they were in the long run.

Some observations

Britain is not alone in suffering these difficulties. Several other countries, including Australia, New Zealand and Finland are in the process of implementing healthcare reforms which involve the creation of a similar purchaser-provider split, and they all have had their successes and their problems [4]. The difficulties of introducing free-market concepts into what was so far a state-run venture on 'command economy' principles may strike a familiar chord with Indian observers, who are after all seeing the same happen with their national economy. If health workers and health planners in India wish to incorporate some of the principles of the British NHS into their own healthcare systems, then they would be well advised to watch how things unfold here, and perhaps learn how to do and how not to do certain things. Health services cannot be run purely like a business. A demoralised workforce of health workers and a disgruntled population who view their NHS in a poor light cannot be reassured by the utterances of a paternalistic government, or by the sight of growing numbers of managers grappling with unbalanceable budgets.

These NHS reforms have been extremely wide-ranging in their scope, and there have been - not surprisingly - problems associated with their implementation. Inevitably, such changes are bound to generate a lot of angst. There have no-doubt been some obvious benefits, but by and large, the lay public and health workers 'are not yet persuaded that things will change for the better. Time will tell. In the meanwhile, we live in hope.

(The author has worked in London hospitals for six years from 1989 to the present. The author would like to emphasise that the opinions presented here are entirely his personal views, and have not been expressed in any official capacity.)

References:

1 Secretaries of State for Health, Wales, Northern Ireland and Scotland: *Working for Patients.* London: HMSO, 1989

2 Enthoven AC: *Reflections on the management of the National Health Service.* London: Nuffield Provincial Hospitals Trust, 1985

3 Tomlinson B: *Report of the inquiry into London's Health service, Medical Education and Research.* London: HMSO, 1992

4 Mason A, Morgan K: Purchaser-provider: the international dimension. *British Medical Journal* 1995;310:23 *l-235*