

Editorials

Market Reform Of The British National Health Service: Competition For Better Or For Worse

Ask Americans to say what comes to mind when they hear the words "British National Health Service," and you are likely to get the response "rationing" and "socialized medicine." US perceptions of the National Health Service have been dominated by images of patients denied hemodialysis or other tertiary care services and of unresponsive government bureaucrats overseeing indentured physician civil servants. Not only are these images largely lacking in verisimilitude, but the tendency of Americans to use access to tertiary care services as a litmus test of health system performance and to have an almost allergic reaction to all things labeled government has inhibited appreciation of many of the National Health Service's admirable accomplishments, particularly in the area of primary care.

For nearly 50 years the National Health Service (known to persons in the United Kingdom as "the NHS") has served as a model of how to structure a system to provide universal access to care within a framework emphasizing the foundation of good primary care.¹ Under the tax-financed NHS, everyone in the UK is entitled to health services free at the point of service. The NHS requires individuals to register with the general practitioner of their choosing and to route all their care needs, with the exception of major emergencies, through their general practitioner. Long before the term *gatekeeping* entered the lexicon of US managed care, the principle of general practitioners serving as the caregiver of first contact and helping to guide patients judiciously through the medical jungle was a basic tenet of the NHS. Approximately two-thirds of physicians in the UK are general practitioners, twice the proportion of generalists in the US.

The NHS has traditionally paid general practitioners through a mix of capitation, block grants for practice overhead, and fee for service for such selected items as preventive care. A good way to offend British general practitioners is to call them government employees. General practitioners consider themselves independent contractors working in privately owned premises in the context of a publicly financed system of payment. Specialist physicians in the UK are based at hospitals, serving as consultants for outpatient services and providing care to hospitalized patients. The NHS pays hospitals according to line-item budgets. Specialist physicians are paid a salary drawn from funds included in the hospital budget.

On many scores the NHS has performed extremely well. It has provided universal coverage for a broad array of health care services, has oriented the system toward provision of primary care and community-based services, and by and large has been quite a bargain in a world of high-priced health care systems. Health care expenditures in 1991 in the UK were 6.6 percent of the gross domestic product compared with US costs of 13.2 percent.² The difference is even more dramatic when compared on a "real dollar" basis. In 1991 the UK spent \$1043 per capita for health care, about one-third the US expenditure of \$2868 per capita. Despite the much lower level of spending, the UK has more physician visits and days of hospital care per capita than the US.² The NHS operates at an extremely low level of administrative overhead — lower even than that of the Canadian system.³

To be sure, the NHS has not been without its problems. The most visible and politicized manifestation of its shortcomings has been the queues for certain elective procedures, such as hip replacement and cardiac surgery. To critics within and outside of the UK, these waiting lists have become emblematic of a system that is perceived to be insufficiently responsive to patient needs. As public concern about waiting lists grew in the UK in the 1980s, the Thatcher government came

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under increasing pressure to address the "health care crisis."⁴ (The health care crisis is an epidemic of international proportions.)

Several different tacks could have been taken to improve services in the NHS. For one, funding levels could have been increased to bring UK spending more in line with that in other European nations. Measures also could have been taken to resolve a major destabilizing factor for the NHS — the parallel system of private insurance that exists in the UK. Approximately 10 percent of British citizens buy private insurance, mainly to allow them to "queue jump" and receive elective procedures at private facilities. Who provides the medical care at these private facilities? NHS specialists, who supplement their income by working additional hours at private hospitals. Many observers believe that long NHS waiting lists serve the economic interests of specialists by encouraging greater use of privately insured services, giving specialists no incentive to improve productivity within the NHS.

Neither increased NHS funding nor curtailment of private insurance was ideologically in tune, however, with the Thatcher administration's defining theme of privatization and scaling back the British welfare state. Mrs. Thatcher instead proposed that the NHS produce better value for the money under existing levels of spending. Ferreting out inefficiency was to be accomplished by introducing competitive markets within the NHS. The Thatcher reforms created two types of "internal markets" within the NHS, one aimed at hospitals and one at general practitioners. Hospitals are no longer assured global budgets under the NHS, but must now market their services to local NHS district health agencies. These agencies have taken on the role of purchasers of hospital services for the populations in their district. District agencies have considerable power to negotiate contracts with different hospitals in an attempt to obtain the best level of service at the best price. The assumption is that hospitals will have to improve their responsiveness to patients, such as reducing waiting times for consultations and procedures or risk losing contracts and the attendant revenue.

The second internal market is directed at general practitioners and is the subject of the article by Garvie in this issue of *JABFP*.⁵ The fundamental element in the restructuring of general prac-

tice is the creation of an option for "fund-holding." Fund-holding is in essence an expansion of the scope of services falling under the general practitioner capitation contract. As noted above, general practitioners in the NHS traditionally received capitation payments to pay for services directly provided by the general practitioners; payments for specialist consultations, laboratory and diagnostic testing, and hospitalization occurred through the separate funding process of hospital budgeting. Under the new fund-holding option, general practitioners can elect for a more inclusive capitation payment that folds in outpatient prescriptions and a number of hospital-based services. In this arrangement, the general practitioners use the capitation fund to purchase elective hospital services. As in the case of the hospital competitive market, the goal is to make hospital administrators and hospital-based consultants more responsive to general practitioners (and the patients of general practitioners) to be awarded contracts from general practitioners. The fund-holding arrangement might have a familiar ring for many US family physicians: fund-holding is the British version of the independent practice association style of managed care common in the US.

Based on his review of some of the preliminary literature evaluating the impact of the recent NHS reforms, Garvie concludes that fund-holding has resulted in a "shift in the balance of power from the hospital specialist and administrator to the general practitioner acting on behalf of his patients." Garvie also mentions some of the less desirable outcomes: the development of a two-tiered system in which patients in fund-holding practices are given preferential treatment by hospitals and consultants (adding to the tiering effect already produced by private insurance), the increased administrative burdens and expenses required of contracting, and the potential for general practitioners to place their financial interests ahead of patient needs when deciding whether to refer.

A recent comprehensive evaluation of the NHS reforms by an independent British policy institute found little tangible evidence for improved quality or accessibility of services.⁶ The report did bear out many of Garvie's concerns, however. The number of senior managers had increased threefold, and hospital administrative costs had burgeoned, in some facilities rising from less than

5 percent to 18 percent of total hospital costs. The report warned that in the new competitive environment "the will to succeed financially, or even just survive, has overridden the concern to ensure everyone has access to the same high standard of [care]." A *Lancet* writer commenting on the report asked whether a "new wedge of doubt has been inserted between patient and doctors: are they refusing to send patients to hospitals to earn bigger surpluses?"⁶

Whether the Thatcher reforms will thaw the bureaucratic freeze in British health care and produce a more flexible, efficient, and responsive NHS remains to be seen. The optimistic scenario has been sketched by Alain Enthoven,⁷ America's father of "managed competition" and a principal consultant to the Thatcher administration. Another American policy analyst and overseas consultant, Donald Light,^{8,9} has predicted a less satisfactory outcome for competition in the UK and offered an alternative approach to reforming the NHS. What appears more certain is that competitive reforms are already visiting upon the NHS the problems (well known in the US) of administrative inefficiency, erosion of public trust, and commercialism of a public service. To admirers of the "classic" British NHS (of whom I confess I am one), the injection of a competitive, managed-care modus operandi into the NHS elicits the same emotions as discovering the Golden Arches in the vicinity of Buckingham Palace. British cuisine, however, never had so much to lose to American commercialism as does British health care.

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Children's Health: Priorities, Responsibilities, And Health Policy

The persistent lack of a national commitment to improve the health of children in the United States is evident in our health statistics. Infant mortality rates in the US, mostly attributable to low birth weight, are higher than in most industrialized nations. Infant death rates for African-Americans are twice those for whites.¹ Unintentional injuries (motor vehicle accidents, drowning, falls, poisonings) are now the leading causes of death for children aged 1 to 14 years.² Homicide, suicide, abuse and neglect, developmental problems, and lead poisoning are also major preventable problems in this age group.

Lack of access to basic health services and pervasive social problems, including poverty, poor nutrition, substance abuse, inadequate housing, and unemployment, have been major impediments to improving child health in this country.³ Almost 1 of every 5 children in the US lives in poverty. The present and future costs of these problems to society are incalculable. The federal response to this problem has largely been to expand Medicaid eligibility for women and children. Proposals to increase funding for the maternal and child health block grant program, community and migrant health centers, the WIC (women, infants, and children) nutrition program (a supplemental food program funded by the

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