Special Communication

Change In The British National Health Service

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Abstract: **The most dramatic changes in the British National Health Service since its inception are underway. These changes place new responsibilities on general practice and create new opportunities to expand and develop general practice. Market strategies are important in these changes and could result in a system that adopts aspects of the US health care system. There is disagreement within the United Kingdon about the need for and wisdom of these changes. This paper partially describes these changes for hospitals and general practice. Family physicians in the United States can learn valuable lessons by monitoring the progress of this grand social experiment. (J Am Board Fam Pract 1992; 5:75-80.)**

The changes underway in the British National Health Service (NHS) are unprecedented. General practice is envisioned to play a central role in an improved health service where value is obtained for money. The foundation document for these reforms is *Working for Patients*,[1] presented in 1989 with an ambitious time line. Whereas not every action proposed has been achieved, much has; and the implementation of fund-holding general practices was initiated as forecast on 1 April 1991. Thus, family physicians and other primary care providers in the United States have another opportunity to learn from the strategies and experiences of the British as they proceed to remodel the NHS.

The Changes

The Government's intentions have been plainly stated. In the Foreword to *Working for Patients*, then Prime Minister Thatcher stated, "Taken together, the proposals represent the most far-reaching reform of the National Health Service in its 40-year history." She declared that the NHS will continue to be available to all regardless of income, financed mainly out of general taxation and that the changes would apply to the whole of the UK. She concluded with, "The patient's needs will always be paramount."

Although there is disagreement about why these changes are occurring now, the principal objectives of the revision are twofold: (1) give patients, wherever they live in the UK, better health care and greater choice of the services available; and (2) provide greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences. To accomplish these objectives, the Government is proceeding to do the following:

1. Delegate as much power and responsibility as possible to the local level (to make the health service more responsive to the needs of patients).
2. Allow hospitals to become self-governing *trusts* to stimulate a better service to patients (have fuller responsibility for their own affairs, earn revenue from their services, set pay rates for their own staff, borrow money).
3. Allow money to cross administrative boundaries (a hospital can offer services to private sector enterprises or any health authority—not just its own district).
4. Create 100 new consultant posts (to reduce waiting times, allow reliable appointments for patients, relieve long hours worked by junior doctors).
5. Allow large general practices to have their own budget to use to purchase defined services from hospitals (to encourage general practitioners [GPs] to offer a better service

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and compete for patients while making it easier for patients to choose and change their GP).
6. Revise regional, district, and family practitioner management bodies to reduce size, clarify roles, and enhance accountability (to make management effective).
7. Audit rigorously the use of resources available to meet the needs of patients (seeking value for money, best quality).

Among the most important aims behind these changes is a desire to secure a clearer distinction at the national level between policy responsibilities of ministers and operational responsibilities of top management. The Government also aims to improve information available to local managers enabling timely budgeting and monitoring, to involve hospital consultants in managing hospitals, and to contract out functions that do not have to be undertaken by health authority staff and can be provided more cost-effectively by the private sector. Also, the Government hopes to keep drug-prescribing costs within reasonable limits.

Implementation

Putting these aims into effect is proceeding largely as proposed in three main phases, with new legislation being introduced when necessary.

Phase 1: 1989

1. A new NHS policy board is established.
2. First hospitals to become self-governing trusts are identified.
3. GP budgets and drug budgets are prepared.
4. Regulations to make it easier for patients to change their GP are introduced.
5. New consultant posts are created, job descriptions for consultants are established, and the framework for audit is implemented.
6. The Audit Commission begins work in the NHS.

Phase 2: 1990

1. Operational changes near completion throughout the hospital service.
2. "Shadow" boards for first NHS Hospital Trusts start to work.
3. Regional Health Authorities (RHAs), District Health Authorities (DHAs), and Family Practitioner Committees (FPCs) are reconstituted.
4. FPCs become accountable to RHAs.
5. Regions begin to pay directly for work they do for each other.

Phase 3: 1991

1. First NHS Hospital Trusts are established.
2. First GP practice fund-holders begin buying services for their patients.
3. Indicative drug budget scheme is implemented.
4. DHAs begin to pay directly for work they do for each other.

Funding

Specific statements in *Working for Patients* concerning the financing of these reforms indicate the Government will make provision for costs of preparing for reforms. This document further states, "The total provision for spending on health will take account of progress made in implementing reforms and be considered as part of annual public expenditure surveys."[p 101] There is the explicit claim that over time any extra costs should be offset by the improved efficiency that will stem from the reforms. Overall, there is a relative silence concerning additional funds for the NHS.

Implications

The following sample quotations from *Working for Patients* show the breadth and depth of what is envisioned for hospitals and the organization of the NHS:

Funding Hospitals

The present system of funding offers only limited incentives for hospitals to satisfy the needs and preferences of patients or to take on additional work by improving productivity. In the future, each DHA's duty will be to buy the best service it can from its own hospitals, from other authorities' hospitals, from self-governing hospitals, or from the private sector. Hospitals for their part will have to satisfy Districts that they are delivering the best and most efficient service. They will be free to offer their services to different health authorities. . . .[p 33]

The Government believes that the primary task of each DHA should be to secure the best and most cost effective services it can for its patients, whether or not those services are provided by the District's own hospitals. This in turn implies that health authorities should

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be funded for the population they serve, and not for the services they provide. . . .[p 30]

Offering choice to patients means involving GPs far more in key decisions. . . .[p 36]

The emergency services provided by a hospital will of course always be available immediately, without any question as to where the money is coming from.[p 34,35]

Managing the NHS

If the NHS is to provide the best service it can for its patients, it must make the best use of the resources available to it. The quest for value for money must be an essential element in its work. . . .[p 7]

The Government will expect authorities to provide themselves with the medical and nursing advice they will need if they are to undertake these tasks effectively. . . .[p 15]

The NHS has made considerable progress in developing better information systems in hospitals, but there remain some important limitations. In particular, there is at present only a limited capacity to link information about the diagnoses of patients and the costs of treatment.[p 16]

Public and Private Sectors

The NHS and the independent health sector should be able to learn from each other, to support each other, and to provide services for each other. Anyone needing treatment can only benefit from such a development. People who choose to buy health care outside the Health Service benefit the community by taking pressure off the Service and add to the diversity of provision and choice. The Government expects to see further increases in the number of people wishing to make private provision for health care. . . .[p 8,9]

Self-Governing Hospitals (Trusts)

Hospitals will have to meet only a few essential conditions to achieve self-governing status. There will be two main criteria. First, management must have demonstrated the skills and capacity to run the hospital. . . . Second, senior professional staff, especially consultants, must be involved in the management of the hospital. . . . NHS Hospital Trusts must also continue to provide essential core services to the local population, including accident and emergency facilities, where no alternative provision exists. . . . As more and more proposals for establishing NHS Hospital Trusts come forward, RHAs will need to consider the viability of existing DHAs and the possibility of sensible mergers with neighboring Districts. Larger Districts might eventually become candidates for mergers with Family Practitioner Committees. . . . The NHS must not be obliged to retain hospitals which are redundant to its needs.[p 27,28]

Accountability

The responsibilities of the Audit Commission will cover the full range of organizations within the NHS as they develop, including the proposed NHS Hospital Trusts and GP practice budgets. It will provide an independent source of advice to Ministers. Its reports will be published under the authority of the Secretaries of State for Health and for Wales, and will be made available to Parliament and the public.[p 21]

Distinction Awards for Consultants

Distinction Awards are intended to reward clinical excellence and are payable until retirement. Some 35% of consultants currently receive a distinction award. . . . The Government proposes . . . to modify the criteria for (entry level) awards so that in the future consultants must demonstrate not only their clinical skills but also a commitment to the management and development of the service . . . and to restrict progression (to higher paying awards) to those consultants who have earned entry-level awards.[p 43,44]

The NHS Training Directorate offered courses throughout 1991 that focused on problems precipitated by these reforms. The courses suggested how people can be prepared for change (especially those who resist or are apathetic) and how teams can be developed to provide services to the public. Other seminars focused on specific challenges, such as dealing with the impact of new legislation, e.g., the loss of Crown immunity on the NHS Estate.

Other quotations from *Working for Patients* show what is envisioned for general practice:

The GP—acting on behalf of patients—is the gatekeeper to the NHS as a whole.[p 47]

The relationships which GPs have with both patients and hospitals make them uniquely placed to improve patients' choice of good quality services. . . . Hospitals and consultants need a stronger incentive to look on GPs as people whose confidence they must gain if patients are to be referred to them. . . . GPs themselves lack incentives to offer their patients a choice of hospital. . . . To help tackle these problems in a way that builds on the strong foundations of the family doctor service, the Government will introduce a new scheme for enabling money to flow with the patient from the GP practice itself. Both GPs and hospitals will have a real incentive to put patients first. The Government believes that this reform will deliver better care for patients, shorter waiting times, and a better value for money. . . . General practice will become a still more satisfying job.[p 48]

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GP practices with lists of at least 11,000 patients will be free to apply for their own NHS budgets for a defined range of hospital services [outpatient services including diagnostic and treatment costs, a group of inpatient and day case treatments, such as hip replacements and cataract removals, and diagnostic tests done at the request of the GP, such as x-ray examinations and pathology tests].[p 49]

In addition, the Government intends the scheme to cover three important aspects of the services provided by GPs themselves: the 70% of practice team staff costs which is directly reimbursed to GP practices at present . . . improvements to practice premises . . . and prescribing costs. . . . GPs within the practice budget scheme will have their own drug budgets.[p 49,50]

The drug bill is the largest single element—more than a third—of total expenditures on the family practitioner services.[p 57]

Each practice's budget will include a fee to cover the management and other costs, including start-up costs, of participating in the scheme. . . . [Selection of practices by RHAs and FPCs to hold a budget will be based on the following two main factors:] The ability of the practice to manage its budget effectively, for example its practice management capacity, its technology and its access to hospital information; and the GPs' commitment to, and policies for, taking individual decisions within a collective budget.[p 53]

It will be possible for the FPC to agree with its GPs that they should aim for expenditure lower than the drug budget which the RHA had given to the FPC. . . . Where the target is achieved, half the saving will be retained by the FPC and spent on schemes of improvement in primary health care in their areas as agreed with their GPs. For the first time, this will give the medical profession positive incentive, linked to their interest in improving primary health care, to encourage cost-effective and prudent prescribing.[p 59]

The Government now intends to make FPCs accountable to RHAs as are DHAs. This change will bring responsibility for primary health care and hospital services together at a strategic level. It will then be easier to plan and monitor effectively comprehensive policy initiatives spanning both services, for example in the field of health promotion and disease prevention.[p 62]

Patients should be quite free to choose and change their doctor without any hindrance at all.[p 55]

Practices which have joined the scheme will be free to leave it again if they wish, after giving due notice.[p 50]

The organization of medical audit will be less straightforward than in hospitals. Care is delivered in more places; periods of treatment are less well defined; medical records are usually less detailed. But the Government is confident that these are difficulties which can be overcome.[p 56]

The patients in the NHS will have many levels of potential influence on the health service. They will have the option to express to their GP preferences about where services are provided, and they will be able to change doctors more easily, seeking or avoiding particular doctors or arrangements. The revisions of the managing authorities assure representation and competence from a spectrum of interests, including medical schools. Local communities can continue to channel their concerns to health authorities and FPCs through Community Health Councils.

The initial fund-holding practices, NHS managers, and academic units of general practice are being called upon to conduct seminars to prepare additional fund-holders and to help implement specific requirements, such as audit procedures and practice budgets.

Comment

The current reform of the British National Health Service may be the largest social experiment in human history. It has been launched quickly, without the support of the medical profession, with scant financial analysis and modeling, and with little pilot testing. Because there was little evidence of public dissatisfaction with the old NHS, it seems likely that the prime motivation to take these actions grew from the government's concern about the continuing affordability of the NHS in the UK.

Such major initiatives have, of course, provoked varied and intense responses. The British Medical Association has articulated the concerns of its constituency and called Government representatives to task on the issues.[2] There is a range of opinion among British GPs about the wisdom of establishing a market within the NHS; some see an opportunity to develop generalism in medicine and the role of the general practitioner, and others fear the emergence of a two-class system of care in which money moves a patient to the head of the queue.

The 1990 James Mackenzie Lecture by Jarman[3] was devoted to the meaning of these changes for hospitals and general practices. Dr. Jarman concluded with an optimistic view of the

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GP "at center of the stage in the new NHS," but he also delineated problems with the NHS reforms that mistakenly view health services as a normal market commodity in the same way as a profit-making industry. He noted conflict between the old methods of allocation in which professionally decided measures of need prompted hospital budgets and GP capitation and new methods that move to funding by demand, relying on market forces and responding to patients' perceptions. Such changes could breed a new GP who is resource-oriented rather than patient-oriented. Dr. Jarman also drew attention to the need to measure the underprivileged, not only to allow increased weighting of resources toward those with most need but also to measure and cope with small-area variations. He wondered whether the UK is proceeding down a path that could repeat the failures of the US system, in which access is limited and costs are high.

The cover story of the February 1991 issue of *Medeconomics* was titled, "Are GP Fundholders Leaving You Behind?" [4] and it included a checklist for "Get Ready for April." On the eve of implementation of phase 3, the *British Medical Journal* published a thoughtful review of how one group of GPs approached becoming a budget-holding practice[5] and an editorial acknowledging that calling for a return to the old ways would not do and suggesting it would be "better to go forwards than backwards." [6]

In the weeks immediately following the initiation of the third phase of reform, vigorous commentary continued, for example, pointing out that the purchaser-provider separation proposed as an internal market is a myth.[7] British newspapers were filled with NHS headlines: "Ministers retreat in NHS Row" and "Reform that Will End in Tiers" (*Guardian* [Manchester and London]) and "Major: Hospital Savings Go to NHS" and "Pity the NHS: It's Too Sick to be Cured" (*Times* [London]). The newspapers also carried paid advertisements for private insurance, one in the *Times*[8 p 7] stating: "The best health care that money can buy is now closer than you think." And in smaller print the same advertisement explained:

> To keep premiums low, we have excluded cover for any initial visit to a consultant. And for the more everyday out-patient treatments. But rest assured. All in-patient hospital care is fully covered, as are serious out-patient treatments, like radiotherapy and chemotherapy.

A counter-advertisement pictured a premature baby girl who "desperately needs an incubator. Unfortunately, so does the hospital." It continued to claim, "Instead of investing enough in our health service, the Government is turning it into a market place. Surely saving lives is more important than saving money?" [9 p 9]

By midsummer 1991 many GPs seemed demoralized, some thinking of early retirement. Among those working to adapt, there was often a sense of fatigue and frustration, e.g., with the inability of hospitals to send them bills. NHS managers were contending with an extraordinary array of issues. The purchasing structure of the NHS needed to be rationalized to improve coverage and use of resources in primary care, avoiding duplication and striking a balance between primary and tertiary care. The independence of GPs and their resistance to being managed had to be addressed. The variation in the quality among GPs had to be accommodated and standards established from within the profession. The interface between medical services and community and social services needed redefining.

Within these reforms are conflicts probably more apparent to US physicians than UK physicians. It takes a lot of work to operate a small- or medium-sized business, and it is additional to clinical work. Whether British general practice becomes a still more satisfying job by adopting additional management responsibilities remains to be seen. Acting on behalf of patients as a gatekeeper changes the doctor-patient relationship, with money entering the equation in a way that can pit doctor against patient, an unfamiliar circumstance for British GPs. Furthermore, the gatekeeper role as now defined for the GPs is weak at two critical, often expensive junctures: the emergency department and consultant decision making.

A partner with expensive practice habits in a fund-holding practice can preclude the practice from benefiting from new incentives. Thus, British GPs have another, large opportunity for intrapractice conflict. There are also new risks outside the practice for adverse exposures through public reports of the Audit Commission. Managed improperly, the published results of the

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Commission could lead to widespread erosion of the key to general practice—trust between doctors and patients.

All of this needs to be seen in the context of the Government's program of privatization. Since 1977 the British Government has sold British Petroleum, British Steel, Rolls-Royce, British Gas, British Aerospace, British Airways, British Airports Authority, National Freight, and Water Authorities. According to a summary article published 4 June 1991 by the *Guardian*[10]:

> The Government believes privatization is helping to build a nation of shareholders. . . . According to supporters of privatization, state industries are bound to be inefficient and costly. They are run in the interests of their workers, not in the interests of the public. Costs rise because such industries are not under the same pressures as private-sector businesses to respond to market pressures. And any losses will be covered by the Government using taxpayers' money. . . . But opponents have argued that the privatized industries have put profit before serving the public.

The loyal opposition (Labor) trounced the Government in local spring elections, and no one contested the assertion that the NHS reforms as perceived by people hurt the Government (Tory) candidates. There is virtually no dissent voiced that the changes do little to increase the flow of capital from the Government into an underfunded NHS. A cynical view could reduce this entire process to the off-loading of the Government's financial risk for an undercapitalized and inadequately equipped health service to others, including British GPs, who could be positioned to accept the blame for not doing well enough with what used to be enough.

Change is usually accompanied by both risk and opportunity. It seems prudent to be cautious and to look for opportunities that now exist for general practice in the UK as a result of these reforms. The entire scheme acknowledges the centrality of general practice in an effective health care system and actually further institutionalizes general practice. The strategy to fund health authorities for the population they serve, and not the services they provide, may offer practical opportunities to unite what too often has been divided—personal health services and public health services. The funding opportunities for budget-holding practices provide a reliable mechanism to finance improvements in practice facilities, acquisition of new equipment, expansion of services within the practice, and the addition of staff. A particularly exciting opportunity is the Government's commitment to fund the development of adequate information systems to capture and link clinical and business information. Should British GPs be inclined, they appear to have been provided with a source of capital to develop further office-based information systems that interface throughout the health care delivery system, and this opportunity is certainly not trivial.

It was indeed ironic in 1991 to witness a system that had embraced its entire population into its health care system, at just greater than 6 percent of its gross national product, move toward strategies that resemble those of the United States, where access for all remains elusive despite twice the expenditure. Perhaps in a few years we Americans and the British will meet in the mid-Atlantic, having modified our health care systems toward each other.

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