A National Health Service - the UK experience

by Rachel Jewkes and Anthony Zwi

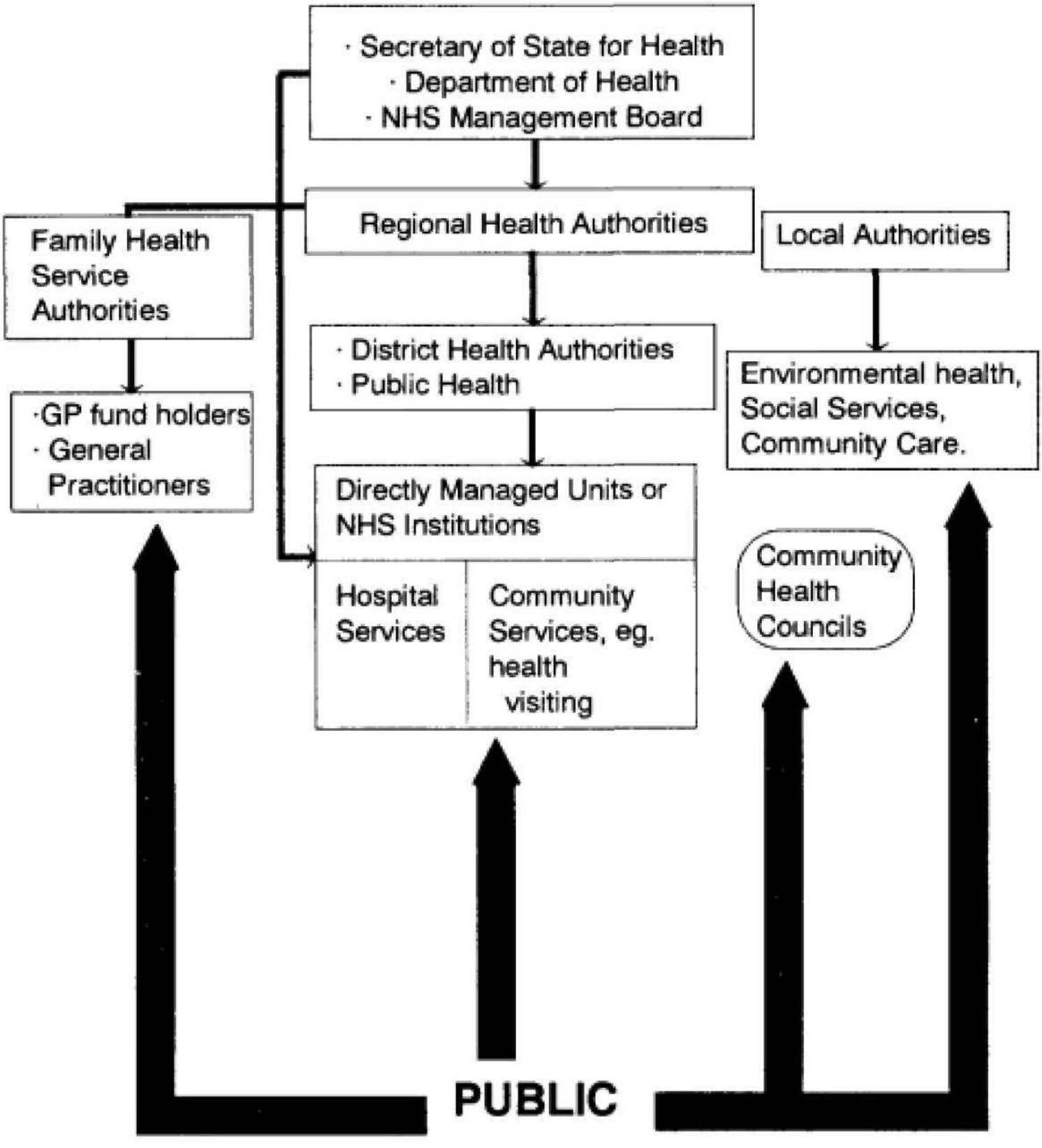
This article provides a broad overview of the British National Health Service. It describes the structures of control, as well as the role of Community Health Councils, Directors of Public Health and General Practitioners. The article briefly examines "the NHS reforms" introduced by the Conservative Party government to create an "internal market" within the NHS. Positive and negative aspects of the NHS are assessed and the author concludes by suggesting what some of the lessons of the British experience have been.

The British National Health Service (NHS) was established by the Labour Party government in 1948 as part of the programme of national reconstruction following World War II. Its aim was to provide "a comprehensive health service designed to secure improvement in the physical and mental health of people in England and Wales by prevention, diagnosis and treatment" (Ministry of Health, 1946).

Before the War the health care delivery system was fragmented (partly private for profit, partly charitable, partly local authority, and partly insurance scheme), and haphazard, and excluded many people from access to appropriate treatment (Morgan, et al; 1985, p.178). The NHS provides high quality care across the broadest range of services and is free at the point of delivery, available to all on the basis of need, and of one standard for rich and poor alike.

Structure of the NHS

(arrows indicate lines of responsibility & access to services)



Structure of the NHS

Regional Health Authorities and District Health Authorities

The NHS is an hierarchical organisation ultimately accountable to the Secretary of State for Health. The national controlling body for the NHS is the Department of Health. Powers for administration and running of the service are delegated to the 14 regional health authorities (RHAs) and 189 district health authorities (DHAs).

RHAs cover populations of 2-5 million people; DHAs serve a population of about quarter to half a million. Both types of health authority are composed of executive (employees) and non-executive (lay) members; they are not elected and may therefore be appointed on a political basis and are not accountable to the local communities (Ham, 1991).

Community Health Councils

Community Health Councils (CHCs) were set up in 1974 to represent the views of consumers of health services. Their members are nominated by voluntary organisations, local authorities and the RHA. They too are not elected. The Secretary of the CHC is a paid employee of the RHA. They have access to public information, the right to visit hospitals, access to senior managers and, prior to the latest NHS reorganisation, had rights of attendance at health authority meetings. They have few formal powers and in practice do not amount to real community participation (Doyal, 1979 p.185).

Directors of Public Health

Each district has a Director of Public Health who is the chief medical advisor to the DHA. The role of the Director includes determining the health status of the local population and the factors influencing it, assessing the health care needs of the population, monitoring the effectiveness and efficiency of services, providing public health advice to local agencies, communicable disease control and health promotion.

General Practitioners (GPs)

General practitioners (GPs) are independent practitioners who contract with Family Health Service Authorities (previously called Family Practitioner Committees). They undertake to provide primary health care (PHC) to 2 000 - 3 500 people who are on

their "list". Everybody in Britain is entitled to be "on the list" of a GP and receive care from him/her; about 98% of the population are.

GPs are paid from the Family Health Service Authorities according to their list size, items-of-service, preventive activities like immunisation and health promotion. Historically, they have not had to worry about the costs of treatment or prescribing, although this is now changing.

Some of the large general practices (group practices with more than 9 000 patients) are given a budget from the RHA from which to purchase hospital care and drugs, except for emergency care, for their patients.

The distribution of GPs is controlled centrally to ensure that all areas of the country are served; some incentives are provided to encourage GPs to work in under-served and more needy communities. GPs are the gate-keepers to secondary care in the NHS and can refer patients on for treatment to the hospitals with which the local district health authority (or in the case of fund-holding practices, they themselves) have contracts. There are some private GPs but their numbers are so small as to be negligible.

The NHS Reforms

Prior to 1 April 1991 the acute care hospitals (with the exception of a few specialist hospitals) were all managed and funded directly by DHAs. After the introduction of the latest reforms, the NHS was split into those who purchase health care and those who provide it, in an attempt to introduce a competitive "internal market" in health care.

"Providers"

In most cases the "providers" are the same hospitals units (now called "directly managed units") that have been delivering health care for years. The most notable differences are that they are no longer directly funded and all the resources they need to provide a service come through winning contracts from the "purchasers".

Some hospitals have taken an option of "self-governing" status. These remain broadly within the framework of the NHS but are accountable to the Secretary of State for Health and not the health authorities, they are run by a board of directors, and can establish their own management structure, employ their own staff and set their own terms of employment. In all these respects they differ from the directly managed units. They can also choose to provide the services they wish and find most profitable.

"Purchasers"

There are two types of purchasers in the new system. The main purchasers are the DHAs. They have a budget provided by the RHAs from which they are expected to purchase the health care needed by their communities. They can purchase from directly managed units, self-governing trusts or private hospitals (of which there are very few) depending on where they can get the quality they require at the lowest price.

Fund-holding GP practices make their own contracts with providers, and account for approximately 10% of purchasing power.

Finance

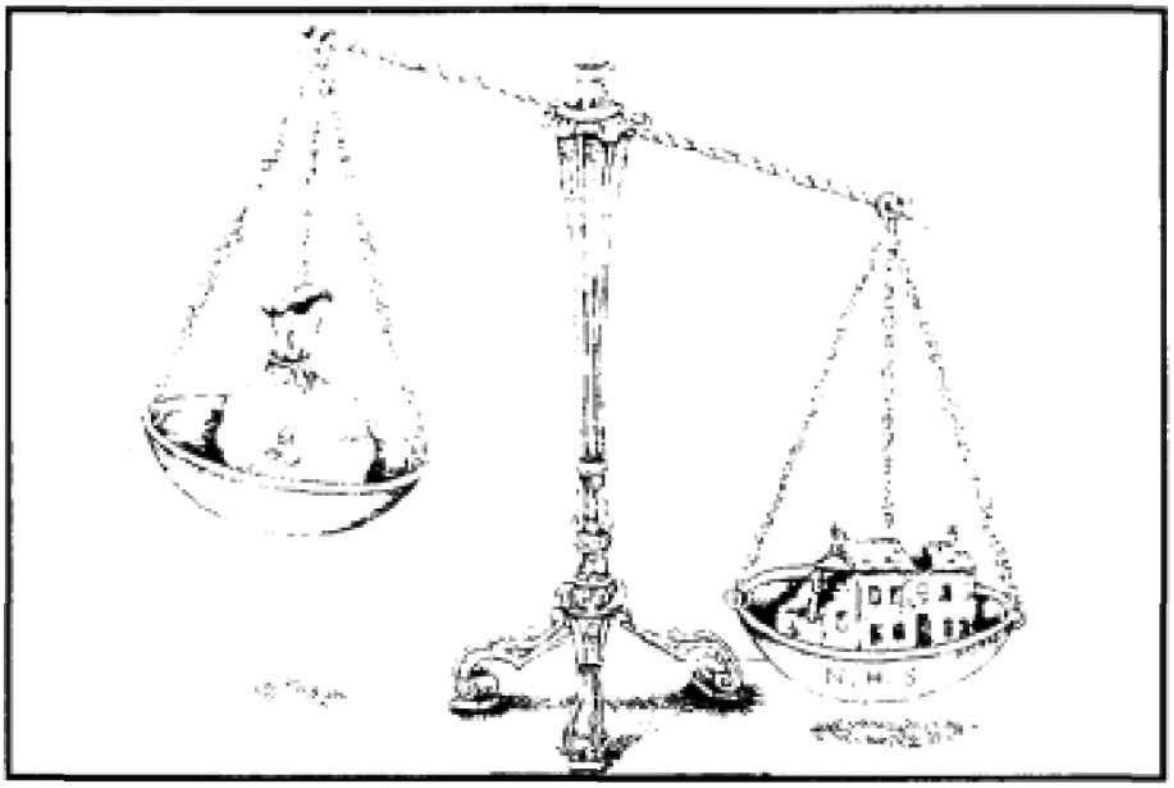
The NHS is 96% funded from central government revenue. Of this 81% is from general taxation and 15% from National Insurance contributions which are deducted from employee salaries with an employer contribution. The remaining 4% of NHS funding is from direct charges for prescriptions (a flat rate per item paid only by the employed, currently 3 pounds), dentists and opticians (Ham, 1991).

Some Positive Features

A high standard of health care is available to all. Access to hospitals is either through GP referral or through casualty departments.

· The NHS encourages health promotion activities, although most activity is treatment orientated. Community services, such as community nursing and psychiatric services, also form an important part of available care supporting and maintaining people in their homes: some complimentary services are provided by local authorities.

· Although the NHS is frequently criticised for being inefficient, only 6% of the Gross Domestic Product is spent on health care compared to 9% in Sweden and nearly 12% in the USA (1987 figures) (Ham, 1991). Services provided are acknowledged to be as good as or better than those in similar countries. Pharmaceuticals are purchased at centrally-agreed prices which are lower than in other countries. Until the latest NHS reforms, all staff where employed on a nationally agreed basis which meant that the salaries of the most skilled professionals were kept much lower than those of colleagues in comparable countries.



Underfunding is always a problem. (Source unknown)

· Administration in the NHS is very efficient. Until the NHS reforms were introduced only 5% of the NHS budget was spent on management (Donaldson and Donaldson, 1988). Resources intended for health care were not wasted on invoicing and charging.

· National coordination is relatively easy in the NHS. Health policy issues, such as drug policies, can be decided nationally and implemented locally. Prior to the latest NHS reforms, services were centrally planned and there were attempts to ensure that resources were allocated and services available nationwide according to need.

· The NHS is supported by most of its staff, even those who are politically Conservative. Much of the success of the NHS has been due to its ability to harness this support as well pride in the service amongst local communities.

· Private practice is kept to a minimum. Only 200-300 doctors work solely in the private sector (Griffiths et al, 1987). Over 90% of consultants work at least 80% of their week for the NHS and use their NHS practice as a "shop-window" for their private practice (DHSS Annual Census, 1985). Although there are important criticisms to be made about private practice in Britain, consultants in the UK work many more hours in the state sector than they do in many comparable countries.

Unfortunately most of the above features are threatened or directly undermined by the latest NHS reforms and attempts to subject health care to market forces. A critique of these reforms is not provided here.

Some Negative Features

· Community participation and control is insufficient. With no local accountability, the system is vulnerable to party political manipulation.
· There has been too much professional autonomy. Prior to the NHS reforms consultants were not accountable and they had unlimited budgets for the introduction of new, often untested, technologies leading to escalating health care costs (Morgan et al, 1985, p.189). One positive feature of the NHS reforms is that they attempt to limit the power of professional and make them accountable. Consultants are being made to account for expenditure in their departments; they must agree to timetables with their managers and must account for their clinical practice through medical audit.
· In reality there is still overwhelming hospital dominance of the system. Health promotion and prevention of disease is severely underfunded.
· The NHS suffers from chronic underfunding, which has resulted in dissatisfaction with some areas of the service, notably the long waiting lists for surgery.

Lessons Learned

· Restricting the power of doctors is essential if any new health system is to avoid some of the mistakes of the British NHS. Clinical practice must be subject to peer review and appropriate clinical audit.
· The availability of free primary health care and health promotion is possible through the general GP system. This is by far the greatest strength of the NHS and is the key to the service being cheap, comprehensive, acceptable, and accessible to the total population.
· Communities should have real power over local health services, although this should be balanced by a strong central policy and overall health strategy.
· New technology, new drugs and new treatment should be introduced only after proper evaluation.
· Staff support is essential and real problems such as poor wages of less skilled staff grades should be addressed. Junior doctors should not have working conditions which other workers and their unions would not accept. Career planning and training should be available, to make the best use of junior medical staff.
· NHS experience of minimum private practice indicates that private practice should be controlled so that the state sector does not lose the benefit of these doctors training and skills.
· Equality has to be worked at. Access to services is not made uniform by simply removing tariffs. Certain disadvantaged groups, such as minority ethnic groups, the

elderly, women, the unemployed and unskilled, and the homeless have specific needs which have to be addressed first. These needs include interpreters and advocates, help with transport, play areas for children, appropriate clinic hours, and information about services and health in general.

· There are limitations to any health care system. A national health service does not solve a country's health problems on its own. Despite 40 years of the NHS in Britain wide class-based and geographical-based inequalities in health persist (Townsend and Davidson, 1982). Radical changes are needed in society tackling the social determinants of ill health before radical improvements in health will be seen.

Conclusion

The NHS has provided an excellent service to the people of Britain, which unfortunately is now declining due to years of underfunding and recent moves by the government. Although clearly the NHS system cannot be transferred directly to South Africa, many features of the service may be relevant to those planning a future health system and there are many important lessons to learn.

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