The Past, Present and Future of the National Health Service

Professor ROBERT ARNOTT

Green Templeton College
Management in Medicine Workshop
25 September 2017
What we shall look at....

- The birth of the NHS
- Before that - how healthcare was originally managed and operated
- Successive changes since 1948
- How it is managed today
As well as…

- The future of the NHS in the twenty first century
- The challenges it currently faces

Don’t try and keep up making notes. This presentation will very soon be available on the Management in Medicine website.
THE PAST
The National Health Service came into being on the 5 July 1948 as the result of the National Health Service Act 1946.
Before the NHS was created, patients were usually required to pay for their health care. Free treatment was sometimes available from teaching and charity hospitals, such as the former Radcliffe Infirmary next door.
Some local authorities operated local hospitals (Municipal Hospitals) for its ratepayers, under a system originating with the Elizabethan Poor Law.

At the time of the Second World War, many hospitals were former workhouse infirmaries.
Systems of health insurance usually consisted of private schemes such as those of Friendly Societies.

Under the National Insurance Act 1911, the brainchild of Liberal Chancellor of the Exchequer David Lloyd George, a small amount was deducted from weekly wages, with added contributions from the employer and the Government.

In return for the record of contributions, the workman was entitled to medical care (as well as some retirement and unemployment benefits) but not necessarily for the medicines prescribed.
To obtain medical care, a workman registered with a GP. Each doctor who participated in the scheme thus had a 'panel' of insured patients and was paid a capitation grant.

This imperfect scheme only covered certain trades and occupations; many, particularly in casual work, were unable to obtain treatment.

Did not include occasional or female workers, wives or families.
During the Second World War, a new centralised state-run Emergency Medical Service (EMS) employed doctors and nurses to care for those injured by enemy action and arrange for their treatment in whichever hospital was available.
Soon the EMS took over the management of most hospitals. The very existence of the EMS made voluntary (and some municipal) hospitals to become totally dependent on the Government.

There was now a growing recognition that many of these hospitals would be in huge financial trouble, once peace arrived.

On the basis of this experience, an expectation of free and standardised treatment was now growing and being demanded.
The need to do something to guarantee the future of voluntary hospitals helped drive the impetus for change.

A Medical Planning Commission set up by the BMA and the Medical Royal Colleges went one stage further in June 1942 by (in an interim report) proposing a National Health Service with General Practitioners working through health centres and hospitals run by regional bodies.

There was a growing expectation of social change, proven by the eventual Labour Party landslide of the 1945 General Election.

The Beveridge Report of 1944 also proposed a National Health Service.
The NHS is born

- Developing the idea proved difficult. Although the wartime Cabinet endorsed the subsequent White Paper, published in 1944, proposing the NHS, the Minister of Health set about trying to assuage the doctors, a job taken over by Aneurin Bevan in the new Labour Government, which was totally committed to an NHS
Bevan encountered considerable resistance from the BMA who voted in May 1948 not to support the new service. But he won! He bought off the consultants.

Winston Churchill and the Conservative Party were strongly against it – but were outvoted by Labour’s huge parliamentary majority.
Discussions after the Second World War on what form should the new NHS take?

There were three possible models -

- **The Bismarckian System** – a mixed insurance based and government financed system (e.g. Germany before and after the war)

- **Shemashko System** – centrally controlled (e.g. Soviet Union) or modified as a Taxation-based and centrally controlled

- **Market System** (USA) – quickly discarded
Dr Nikolai Shemashko
1874-1949

- Early Bolshevik
- People’s Commissar for Health, 1918-1930
- Later responsible for Child Health on the Presidium of the Supreme Soviet of the USSR
- Founder of the Soviet Health System
What system was selected?

The early reports were contradictory about how an NHS should be funded.

The Labour Government of 1945 was open to influences from within the wider Labour Movement.

Influence on the Labour Party on the form of the NHS and that it be based on the Shemashko System, came from the Socialist Medical Association, particularly Communist Party members within it, organised in the British Sigerist Society, which included Richard and Joan Doll, Julian Tudor-Hart and others.

The Founding Principles of the National Health Service

- Services are provided free at the point of delivery

- Services paid for out of central taxation, not National Insurance

- Everyone is eligible for care (subsequently and subtly changed to care for everyone eligible)
How was it first organised?

Following the 1945 General Election, the structure of the NHS in England and Wales was established by the National Health Service Act 1946, which came into being on 5 July 1948.
Services would henceforth be provided by the same doctors and the same hospitals as before, but they were now managed by the state.

There was a huge rush for treatment.

This covered England and Wales. Scotland and Northern Ireland had their own structures.

The original organisational structure of the NHS in England and Wales had three aspects, known as the *Tripartite System*.
Hospital Services

- Fourteen Regional Hospital Boards were created in England and Wales to administer the majority of hospital services. Beneath these were 377 Hospital Management Committees which administered hospitals.

- The thirty four teaching hospitals (such as the Radcliffe Infirmary) had different arrangements and were organised under Boards of Governors and managed in partnership with university medical and dental schools.
Primary Care

- GPs were independent contractors (that is they were not salaried employees) and would be paid for each person on their list. Dentists, optometrists, opticians and community pharmacists also provided services as independent contractors.

- Executive Councils were formed to administer contracts and payments to the contractor professions as well as maintaining lists of local practitioners and dealing with patient issues.
Community Services

- The Medical Officer of Health, Maternity and Child Welfare clinics, School Nurses (the “Nit Nurse”), health visitors, midwives, health education, vaccination and immunisation and ambulance services together with environmental health services were now the responsibility of local authorities, sometimes with the help of charities (as in *Call the Midwife*).

- This was a continuation of the role local government had held under the Elizabethan Poor Law and nineteenth century public health legislation.
The 1950s

- By the 1950s, spending on the NHS was exceeding what had been expected, leading to the introduction by Hugh Gaitskell in 1951 of a 1/- charge for prescriptions and a 20/- charge for dental treatment.

- This cut across the principle of the NHS being free at the point of use and led to Cabinet resignations by Nye Bevan and Harold Wilson, who was later to become Prime Minister.
The 1950s also saw the beginning of the planning of hospital services, dealing in part with some of the gaps and duplications that existed across England and Wales.

The period also saw growth in the number of medical staff and a more even distribution of them with the development of hospital outpatient services.

It also witnessed a major hospital building programme and the welcome influx of overseas doctors, especially from the Indian Sub-Continent.
The Swinging 60s…

- The 1960s have been characterised as a period of NHS growth
- Prescription charges were abolished in 1964, but reintroduced in 1968 after a financial crisis
- New drugs and procedures came on to the market improving healthcare, including polio vaccine, dialysis for chronic renal failure. Chemotherapy for certain cancers were developed, all adding to costs
The 1970s also witnessed an end to the economic optimism which had characterised the previous decade.

There were increasing pressures coming to bear to reduce the amount of money spent on public services and to ensure increased efficiency for the money spent.
But it was becoming clear that the NHS would never get the resources necessary to provide unlimited access to the latest medical treatments, especially in the context of an ageing population.

However, in 1978, an additional £101 million was provided by the Callaghan Government to the NHS.

It was the beginning of a process of change, starting around 1980, which is still continuing today.
1974 Reorganisation

The NHS in England was reorganised in 1974 by the Heath Government to bring together services provided by hospitals and services provided by local authorities under the umbrella of Regional Health Authorities.

- Probably quite unnecessary and very certainly unpopular and expensive.

- The 1974-79 Labour Government did nothing to change the structure but increased expenditure to pay for new medical technology and drugs.
Figure 2.2 Outline Organisation Structure of English NHS; 1974.
The 80s

- Margaret Thatcher’s government was now in office
- Other than its dreadful pop music and dress sense, the 1980s witnessed the introduction of modern management methods (General Management) in the NHS to replace the previous system of consensus management
- It didn’t always work
The Griffiths Report of 1983, recommended the appointment of General Managers in the NHS with whom complete responsibility should lie.

The report also recommended that clinicians be more fully involved in management.

But financial pressures continued to place a huge strain on the NHS.
Approaching the Future

- In 1988, after nine years in office, having left the NHS largely untouched, Prime Minister Margaret Thatcher announced a major review.

- In 1989, the white paper *Working for Patients* was produced and changes proposed and introduced.
Some change was necessary...

- The priority after the Second World War was fighting infectious disease, like TB, diphtheria and poliomyelitis and malnutrition brought on by poverty.

- Now approaching 70% of all healthcare expenditure was on treating long-term conditions like cancer, heart disease, growing problems of obesity, diabetes and dementia – and we needed to adapt to this new reality. But did we?
NHS Structure in 1984: How the 1974 structure evolved
Enter “The Market”…

- More importantly, the reports outlined the introduction of what was termed the *internal market*

- It was to shape the structure and organisation of health services for the next forty years
Consequences

- In spite of intensive opposition from the BMA, who wanted a pilot study or the "reforms" in one region, the untried and untested internal market was introduced.

- An ideological war on the future of the NHS now broke out.
In 1990, the National Health Service and Community Care Act (in England and Wales) defined this internal market, whereby Health Authorities ceased to run hospitals but ‘purchased’ care from their own or other authorities' hospitals.
Certain GPs became "fund holders" and were able to purchase care for their patients.

The "providers" became NHS Trusts (some later to be Foundation Trusts), which encouraged competition, but also increased local differences (or the post code lottery for treatment).
Reforms also included:
- The laying down of detailed service standards
- Strict financial budgeting
- Revised job specifications
- Emphasis on rigorous clinical and corporate governance

Whilst leaving services free at point of use, the government now encouraged outsourcing of medical services and support to the private sector
These innovations, especially the "fund holder" option, were condemned at the time by the Labour Party, the TUC and NHS trades unions, the BMA and all the Medical Royal Colleges.

Opposition to what was claimed to be the Conservative intention to privatise the NHS became a major feature of Labour's election campaigns.

The “Save our NHS” campaign was born.
and there was the white paper and subsequent legislation entitled *Caring for People* that produced the disaster of *Care in the Community*, still described by some as at best a folly and at worst, criminal
The Labour Years, 1997-2010

- The new Blair Government in 1997 provided additional funding and in thirteen years expenditure rose from £45 billion to £100 billion.

- There was no new re-organisation and GP fundholding was curtailed, but there was the onward march of “the market” contributed to by the Labour Government’s introduction of PFIs (Public Finance Initiatives).

- The damage done by Care in the Community could not be reversed.
The structure of the NHS before the 2010 Coalition Government
THE PRESENT
(from 2010)
What are the major challenges to the NHS and its finances, compared with say fifteen to twenty years ago?

- Cost of drugs and new technology
- Aging population
- Higher real incomes and a better educated population (and greater expectations)
- Being undermined on purpose politically and economically
The Finances of Health

Unhealthy outlook
Departmental current spending, 2015-16 (% of total)

- Health: 35%
- Other departmental spending: 49%
- International development: 3%
- Schools

NHS spending (£bn)

- Forecasts
- NHS spending on historic trends
- Actual NHS budget

Sources: HM Treasury; SMF
GDP in current US$ prices, 1970-2014

Source: World Bank
2010 Changes

- In 2010 the country elected a Conservative and Liberal Democrat Coalition Government led by David Cameron and Nick Clegg

- This Government promised to help and preserve the NHS, but soon it faced the prospect of funding cuts and massive change
One of their first initiatives of the new Conservative and Liberal Democrat Coalition Government was the Health and Social Care Bill, which became Health and Social Care Act 2012.

It was and is one of the biggest upheavals for the National Health Service since it was formed nearly 70 years ago.
Controversy

The changes contained in the Act were some of the Coalition Government's most controversial.

This is partly because they were not proposed during the 2010 General Election campaign and were not contained in the 20 May 2010 Conservative – Liberal Democrat coalition agreement which stated that the government would “...stop the top-down reorganisations of the NHS that have got in the way of patient care“ .... So what did they then do?
Passed in 2012, the Act created the most extensive reorganisation of the structure of the National Health Service in England ever seen.

It has cost £3 billion to implement.
- It abolished NHS Primary Care Trusts and Strategic Health Authorities

- £80 billion of "commissioning" of health care funds, were transferred from the abolished PCTs to Clinical Commissioning Groups, partly controlled by general practitioners
There was now an NHS Independent Commissioning Board to oversee GP-led Clinical Commissioning Groups.

The CCGs would buy care for their patients from "any qualified provider" which is jargon for an NHS organisation or a private company, a charity or a voluntary organisation.

Aim is that all NHS Trusts to eventually become Foundation Trusts.

Public Heath to be returned to Local Authorities (with Health and Well Being Boards).

New role for NHS Improvement (policeman for Trusts) now Monitor and the Care Quality Commission.
The New Structure

Parliament
→
Department of Health

NHS Commissioning Board
→ Monitor (economic regulator)

Care Quality Commission
→ Providers

Local authorities
→ GP commissioning consortia

Local HealthWatch
→ accountability for results

Patients and public
→ licensing

Funding Accountability

Local partnership
→ contract

accountability for results
→ contract

accountability for results
→ contract
What it all means...

- When the white paper was presented to Parliament, the Secretary of State for Health, Andrew Lansley MP, told Parliament about three key principles of the legislation:
  - Patients to be at the centre of the NHS
  - Changing the emphasis of measurement to clinical outcomes
  - Empowering health professionals, in particular GPs
Privatisation

The **duty** on the Government to provide a National Health Service has been lost now that the Act has become law.

It replaces a “duty to provide” with a “duty to promote”

*Any Qualified Provider* - this is a battleground

Some say that the vultures are circling above… and many (including the BMA) believe it was a victory of dogma over patient care and common sense.
Ion 2012, Mark Britnell, the Head of Health Policy at KPMG, has said:

- In future, the NHS will be a state insurance provider not a state deliverer
- He emphasised the role of the Act in making this possible.
- The NHS will be shown no mercy and the best time to take advantage of this will be in the next couple of years
Fears the public and medical profession have about the Health and Social Care Act 2012 have been possibly justified as it contained "insufficient safeguards" against private companies exploiting the NHS.

Many are worried about changing one of the founding pillars of the NHS to read ‘any qualified provider’ rather than the current language guaranteeing a needed service exclusively via the NHS and its direct affiliates and partners.

Many believe that it allows the Government to promote privatisation.

Increased privatisation is all around us.
Any qualified 'provider' allows private sector providers to have a potentially major say inside the NHS, potentially introducing private-sector operations and pricing within the NHS.

Fears are that it could also open up local NHS operations to the possibility of forced closure because the private industry could out-compete them and corral the NHS services into bankruptcy.
In the year 2009-2010, 4.4% (£ 4.3 billion) of spending by NHS England went to the private sector.

£16 billion in clinical contracts have been awarded through the internal market since April 2013 and by the end of this financial year, it is expected to be much more.
Dangers in the new structure?

- Forcing commissioners of care (mostly CCGs) to tender contracts to any qualified provider, including commercial companies, could destabilise local health economies and fragment care for patients.

- Adding price competition into the mix could also allow large commercial companies to enter the NHS market and chase the most profitable contracts, using their size to undercut on price, which could ultimately damage local services.
The biggest danger?

- Does it make it too easy to place profit before care and that services will be closed because they are not financially viable, even if they are needed?

- Ignorance by the profession – how many GPs do not know what has really happened and how it has affected themselves and their patients?

- How many CCGs have simply handed-over their management and finance to the private sector?
Where do we go from here – like many of us, I owe the NHS a great deal

Many will fight to stop it to be destroyed or changed
THE FUTURE
- The NHS is facing a major crisis, not entirely related to financial, social and clinical pressures

- Many believe it is a crisis prompted by politics and the actions of those who want the NHS to fail
Finance

The budget for NHS England is rising higher than the rate of inflation. In 2016-2017, the budget stands at £107 billion, with an overall real-term increase of only 0.1%.
Currently a large number of NHS trusts have deficits from which they can’t escape, with missed cancer waiting times up 56% and no chance of restoring the four-hour A&E waiting time limit.

Capital funds needed for overcrowded and clapped-out buildings are being diverted to day-to-day treatment. The NHS’s £1.8 billion Transformation and Sustainability Fund, supposed to be invested in joining up NHS and social care is being used up on basic services.
Before the election earlier this year, the Government promised the NHS a further £10 billion

On the other hand, they were looking in the same period to make £22 billion in “efficient savings” – a **net cut** of £12 billion. Some have said these savings are unachievable.
Jeremy Hunt is unable to properly confront NHS underfunding, preferring to “name and shame” inadequate care.

He has never properly taken up the case of public health and social care cuts in local councils, causing the filling up hospital beds (bed-blocking) with the elderly and frail, estimated at costing £6 billion per year.
There is a staff shortage - more staff are urgently needed. We are failing to train enough, and we are still scouring the globe for nurses and doctors. After Brexit, the fear is that many here already may depart. The NHS Executive publicly begs for “early reassurance to international NHS employees about their continued welcome in this country”, but the Government refuses as yet.

The British Red Cross have stated that there is a “humanitarian crisis” with repeated closure of maternity units and there is a failure to hit targets for cancer treatment more and more patients are waiting sixty-four days plus or more for treatment.
The NHS funding is now back to the year 2000 as a share of GDP; think back to how it was then. There were eighteen month waits, many fewer nurses and doctors, lower pay, winter crises, no NICE and CQC minimum standards.

Portraying the NHS as failing when many believe it is being systematically undermined by government policies in order to bring in the private sector is unacceptable.

Approaching its 70th birthday, the NHS has the lowest funding increase ever, with worse to come in the next two years.

Some say the NHS is at a “tipping point”
NHS trusts end-of-year financial results

£ millions

Source: Department of Health
Sustainability and Transformation Plans

- Without legislation or publicity, the Government has divided all English NHS Trusts, CCGs and local authorities into 44 ‘Footprints’ each of which has been ordered to develop a Sustainability and Transformation Plan (STP).

- These plans were initially kept secret from patients and the public – despite a Department of Health proposal to consult patients.
These unaccountable bodies are to plan future NHS and social care funding across England with local authorities - but with massively reduced budgets. The core component of STPs is a financial one, where local authorities and NHS Trusts are being compelled to tailor provision to meet the demand for cuts and budget deficits to be reduced to zero. The STPs aim to shift core elements of health provision from hospitals to the community. With local authority cuts, this is both unlikely and will result in lower health care standards for many.

Core NHS functions are to be handed over to Accountable Care Partnerships or Organisations which may lead to further privatisation in the NHS and over which local authorities will have no control.
The role of community hospitals is being questioned and the number of mental health inpatient sites could be reduced.

NHS England prefer to call it “transformation” and they plan to go forward with consultation with local communities. The Government want to implement them soon.

I believe it is about finding the Treasury’s £22 billion, not about healthcare improvement or rationalisation.

What the NHS needs is a £350 million injection.
Immediate Challenges

- Finance
- Seven Day Working
- Privatisation
- Primary Care
- Accident and Emergency Services
- Staffing Shortages and Brexit
- Staff Pay and Morale
- Whole Person Care – the Social Care Issue
- Obesity, sedentary living and Health Prevention (it costs £50 to install a grabrail, but up to £14,000 to mend a hip)
- PFI – future costs
- De-professionalisation
Are there solutions?

- Must be based on Social Determinants
- Integration of Health and Social Care?
- No immediate changes to NHS structure?
- We must deliver a modern service that remains free at the point of use and is fully publicly provided and fully publicly funded
- Repeal of the Health and Social Care Act 2012?
- End PFIs and the Internal Market?
- Better provision for mental health
- Reverse government plans to replace publicly-funded bursaries for nurse, midwife and other healthcare professional training with student loans?
- What else?
None of it is helped by these unbelievable nonsenses
There is hope and there are people put there telling the Government they are wrong.

Stephen Hawking has repeatedly warned that underfunding and cuts, privatising services, the pay cap, the junior doctors pay settlement and the removal of nursing student bursaries are all part of a failed management. To make matters worse, failure of privatised social care places an additional burden on the NHS.

Jeremy Hunt has no answer.
Final thoughts....

- The NHS was established on 5 July 1948. It was the climax of a plan to set up the welfare state after the Second World War, tackling what Sir William Beveridge called the five giants: disease, ignorance, squalor, idleness and want.

- In the nearly seventy years since the NHS was founded and its basic need and principles have not changed.
Since then, the NHS has grown into the world's most respected free healthcare system and one of the world's largest employers - along with the Chinese People's Liberation Army, Indian Railways and the Wal-Mart supermarket chain.

US Commonwealth Fund (a think tank) in 2017 again put the NHS first amongst the healthcare systems of the G7 countries for effective, safe, co-ordinated and patient-centred care, access and efficiency. The US came last. This assessment has not changed on the basis of fairness and value for money, even with the UK lagging behind its G7 partners in % of GDP spent on healthcare.
Staff across the NHS are in contact with more than 1.5 million patients and their families every day. Men and women now live an average of 10 years longer than they did before the NHS was set up.

This is something of which we can be proud.
However….

- Do we want the NHS to simply stay the same?
- Do we accept that the challenges of the twenty-first century are different to those of 1948 – but do the basic principles need to change?
- Is the funding model (general taxation) the right one?
- Who should manage the NHS – National Government or Local Government? Should healthcare be above politics?
Back in the USA…

- But our problems pale into insignificance compared with attempts in the USA to create something that goes only 10% towards what we have in the UK through Obamacare and now the recent proposals in the Senate by Bernie Sanders and complicated by total opposition from Donald Trump
QUESTIONS FOR DISCUSSION

- Do we want the NHS to be a universal service or a service of last resort?
- How should it be paid for?
- Is there any role for the private sector?
- What should be its priorities?
- What is the role of doctors and other healthcare staff in helping to get this right?