4

Editorial

Reforms in the British Health Service

Extract of speech delivered by HE Miss L J Duffield at the Inauguration Ceremony of the 33rd Annual Academic Sessions of the Ceylon College of Physicians on 28 September 2000

Linda Duffield*

Journal of the Ceylon College of Physicians, 2001, **34**, 4-6

The National Health Service in Britain is now in its fifty-second year of existence. Over this time, the approach taken to ensuring good performance of services has gradually evolved from one which was largely based on implicit assumptions about maintaining standards to a managed system in which there is much greater clarity about what is expected and more explicit accountability for achieving results.

Healthcare, in the UK and Sri Lanka, is no longer the cosy domain of professionals. Patients are demanding a greater say in what services are provided and in their own treatment regimes. The media focus relentlessly on national and local standards and are quick to highlight any shortfalls. Health care costs have rocketed whilst public expectations go on rising too. Clinical performance is coming under closer scrutiny. Today in Britain, the National Health Service has moved to the top of the political agenda.

I should like in this brief article, to outline some of the changes which are taking place in the UK and identify some of the issues under discussion within the British health service.

Last year the British government announced a major new National Health Service Plan, accompanied by a substantive injection of new money. This included the establishment of new regulatory bodies for the professions, tough new targets for service delivery in the primary care sector as well as the hospital sector; and changes to the roles of health care professionals, particularly the role of nurses.

Why another Plan for the NHS? The NHS has been through many changes since it was set up in 1948, from the periods of cost containment in the 1970s and 1980s, and into the era of health system reform of the early 1990s as concepts and methods of quality in health care underwent a quiet revolution. But today in Britain there is a sense that the NHS is in crisis. There are widespread concerns about delays in treatment and patchy standards of care. About why health funding has not kept pace with other comparable countries. And these concerns, in turn, have fed fears about the very survival of the NHS, as a public funded service, in the 21st century.

The two key problems we have to face are – chronic under-funding and the shortcomings of a system designed really to meet the health needs and conditions of 1948. Most patients, and probably most clinicians too, would acknowledge that, for the resources provided, the NHS still delivers high quality care at low cost. We spend far less on health care (NHS and private sector) than most of our European partners and certainly far less than the United States. In the UK it is about 5.8% of GDP as compared to just under 14% in the US and 9 – 10% in France and Germany. And whilst there is, and always has been, a thriving private health care sector in the UK, the vast majority of those resources (96%) are channelled through the NHS, providing a service which is still largely free at the point of delivery – holding true to the founding principal of the NHS which is that need, not ability to pay, should determine access to health care.

On the whole I continue to believe it is a cost-effective way to provide health care. The fact that it is publicly financed puts a cap on expenditure. That may limit research funding and access to certain new and expensive forms of treatment. It certainly involves clinicians and others making choices about different types of intervention. But when it comes to emergency medical care and life-threatening treatments the NHS continues to match the standards of care in most parts of the world. Whilst I won't pretend the emergency medical sector has all the resources it needs, the chronic under-funding to which I referred tends to be felt more in non-emergency elective surgery (we see that in the long waiting lists for hip

* *British High Commissioner in Sri Lanka.*

replacements or cataracts) and in the non-acute sector (geriatrics still remains under-funded and short of consultants; our services for the mentally ill are less than satisfactory in places).

But past lack of investment is not to blame for all the shortcomings in the health Service. It does not explain, for instance, why services in one hospital are so much better than those in another hospital in the same town. Why the cost of a hernia operation varies so widely from one hospital to another. Why the length of stay for some operations differs widely between consultants even in the same hospital. Why waiting lists for some treatments are coming down in one hospital but still rising in another. Sometimes the debate about shortages of money masks other serious failures in the organisation of the NHS.

That is why the British Government's recently announced National Plan for the NHS tries to address both challenges – funding and reform.

The Government has pledged an average real terms increase in spending of 6%. Over five years the NHS will grow by a third in real terms, the largest sustained increase in its funding since 1948.

The Plan involves significant investment in NHS facilities and staff. New facilities include:

- 7000 extra beds in hospitals and intermediate care
- over 100 new hospitals by 2010 and 500 new "one stop" primary care centres
- over 3000 GP premises modernised and 250 new scanners
- modern IT systems in every hospital and GP surgery

and on staffing:

- 7500 more consultants and 2000 more GPs
- 2000 extra nurses and 6500 extra therapists
- 2000 more medical school places

This is an ambitious programme but to succeed it needs to be accompanied by equally radical reforms in the way in which health care is delivered. Doctors probably sighed with relief to hear Ministers acknowledge that local hospitals cannot be run from Whitehall. They are right. There has to be a new relationship between the Department of Health and the NHS. A new system of devolved power with greater authority at local level. The Department of Health will continue to set national standards, matched by regular inspection of all local health bodies by an independent inspectorate. But local NHS organisations that are performing well will get more freedom to run their own affairs. Conversely, the government will intervene more rapidly in those parts of the NHS that fail their patients.

Clinical governance is a powerful, new and comprehensive mechanism for ensuring that high standards of clinical care are maintained throughout the NHS and quality of services is continuously improved. In the primary care sector, as in the hospital sector, poor professional practice needs to be tackled. To do that requires a new management culture, a greater emphasis on continuing professional development, clinical audit and appraisal of clinicians' performance. Two new national bodies – the National Institute for Clinical Excellence which will set standards and the Commission for Health Improvement which will inspect local clinical governance systems and investigate where services appear to be failing – will play a key role in this.

There will be new contracts for both GPs and hospital doctors working in the NHS. The system dating back to 1948 when doctors contracted to work full time for the NHS whilst still maintaining a sizeable – and at times conflicting – private practice is expected to change. The Government has proposed replacing the merit awards system with extra payments for consultants who work exclusively for the NHS. And newly qualified consultants will not be able to undertake private work for a certain period. These are some of the radical changes, which I expect will continued to be hotly debated by the medical profession in Britain in the months to come.

As part of the NHS reforms we also want to remove unnecessary barriers between professions. The idea is that nurses and other staff should have greater opportunity to extend their roles through specialised training. By 2004 over half of them will be able to supply medicines. The number of nurse consultants is expected to increase to 1000 and a new role of consultant therapist will be introduced. Perhaps, most popular with patients, we shall see the return of modern matrons with the authority to get the basics right on the ward.

Another key objective behind the reforms is to give patients more say in the NHS and in their treatment. One very specific proposal is that if operations are cancelled on the day they are due to take place, the patient will be able to choose another date within 28 days or the hospital will pay for the operation to be carried out at another hospital of the patient's choosing.

There will also be a new concordat with the private sector to enable the NHS to make better use of facilities in private hospitals, where this provides value for money and maintains standards of patient care. But NHS care will remain free at the point of delivery, whoever provides it.

At the heart of these reforms is the idea of redesigning the system round the patient. By 2005 booked appointments will take the place of old waiting lists for all inpatient care. All patients will have the right to have a GP appointment within 48 hours. And the maximum waiting time for an outpatient appointment is set at 3 months and for an inpatient 6 months. The hope is that average waiting times will also come down: from 7 weeks to 5 for outpatients and 3 months to 7 weeks for operations.

These are ambitious targets. They cannot be achieved without extra staff and extra beds. And staff need time to be trained and new hospitals take time to build. That is why the reforms are "front loaded" with a large increase of funds now for new training places, for staff recruitment and for hospital expansion. But to work it also needs a new understanding between Government and health care workers.

British people are attached to a publicly funded National Health Service in a way they are to almost no other institution. The funding system we have in the UK, and which the Sri Lankan model follows in part, is a remarkably efficient way of financing health services. It's global budgeting controls healthcare inflation. Its low transaction costs means resources reach the frontline. And the GP "gatekeeper" role, which controls access, ensures that care is clinically managed. But we have to ensure it is organised efficiently to deliver the maximum health gain without generating undue economic burdens. And, secondly, to ensure it is organised so that it delivers preventative services and not just sickness services – intervening upstream as well as downstream. That is what the new NHS Plan aims to do.

I hope that this brief account of the reforms planned for the British health service will be of interest to your readers too in relation to health care provision in Sri Lanka.