Perspectives in NHS Management

Are there lessons from abroad for the NHS?

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The National Health Service is constantly under attack for alleged wastefulness and poor efficiency. At the same time the service is being changed and reorganised. Whether the NHS is as bad as sometimes portrayed and whether it is better or worse than the ways in which other countries provice medical care is hard to judge because reliable measures of health care are notoriously hard to establish. Certainly, much of the criticism is ill founded because people do not understand the service and how it differs from other systems. All advanced industrialised countries share similar and serious problems in providing medical care: what is interesting is how different countries have attempted to cope with these. Are there lessons for the NHS in how other countries provide their medical services?

One of the distinctive characteristics of the NHS is the separation between primary and secondary care. This originated in the 19th century, was institutionalised by Lloyd George in 1911, was reinforced when the NHS was launched in 1948, and has had a lasting effect on medical care in Britain. The administrative and financial arrangements for general practice established by the 1911 National Health Insurance Act have preserved general practice in Britain while in most other countries it has declined. Now some countries such as Sweden and the United States are trying to re-establish their primary care and are looking to Britain with its well developed primary care system.

Most illnesses (as measured by patient contacts) are dealt with by general practitioners, and relatively few patients pass through this "filter" and become inpatients in Britain, resulting in a low inpatient rate compared with other similar countries. The admission rate to general hospitals in England and Wales in 1974 was just over half that in the United States and Sweden and three quarters that in West Germany.[1] This has kept costs down and helped to make medical care in Britain relatively cheap. In 1977—the latest year for which international figures are available—Britain spent about 5·2% of its gross national product on medical care compared with 8·8% in the United States, 9·2% in West Germany, and 9·8% in Sweden.[1]

Equity in the provision of health care, free access to the service, and improved effectiveness in providing care were and have remained the guiding principles of the NHS. Unfortunately, these objectives often prove mutually conflicting, which helps to explain many of the difficulties of and complaints about the NHS. In Britain state medical care covers primary and secondary care as well as community services, with local authorities providing personal social services. In the United States health insurance cover concentrates on hospital care and physician services, and the development of other services has been largely neglected. Care in the United Kingdom is (almost) free at the time of consumption. The principles of the 1946 NHS Act was to "divorce the health care need from personal means." Need is measured not by capacity to pay as in many other systems but by health care professionals such as general practitioners. This open ended system meant that governments soon found that the NHS cost much more than was expected, and in 1951 the then Labour government sought to reduce costs by introducing charges to cover items such as prescriptions, dental care, glasses, etc. Even today, after they have been sharply increased in the past four years, charges cover only about 4% of total NHS costs.

Medical care is also "free" at the time of consumption in other countries—for instance, to those in America who are covered by Medicare or who are "veterans." For most Germans who are covered by social insurance funds medical care is almost free, though there are small charges for inpatient care. Medical care is nearly free to most of the French, who pay for it when they receive it but can then reclaim most of the charge (75% for doctors' and dentists' fees) from the government's social insurance scheme. Most French people insure to cover the cost not covered by social insurance. The difference is that medical care in Britain is not only comprehensive but is also available free to all residents; there is no question about qualifying. Indeed, the NHS was the first health service in Western society to offer free comprehensive care to the entire population, though visitors are now expected to pay.

Who pays?

Free it may be to the individual patient, but the NHS still has to be paid for and overwhelmingly the money comes from public expenditure. Part of the cost (about 10%) comes from National Insurance (really a form of taxation). General taxation covers about 87% of the cost, whereas in France and Germany health care is financed by social insurance and so is paid for as a proportion of income only by those in employment, and income from private individuals' investments is not tapped. Payment out of general taxation has the advantage of being progressive so that the biggest burden is borne by the rich.

The French and German systems are expensive to administer. It is estimated that 4% of the premiums collected by German social insurance funds are used to pay the costs of collecting the premiums and paying the bills. In the United States administrative costs are much higher, in some instances up to 45% for individual medical insurance policies. The provident associations in Britain also pay substantial administrative costs. As the funds for the NHS are mainly collected as part of general taxation there is no need for separate machinery and the costs are estimated at about 2%. That means a big saving over other methods of financing on a total budget of £17 000 million.

Payment out of government funds does, however, suffer the disadvantage that every year expenditure on health care has to be dragged through the budget process and so becomes a political issue. Governments in other countries do not have this stark annual decision to make of how much to spend on medical care. Even so, most medical care systems have to be subsidised by the

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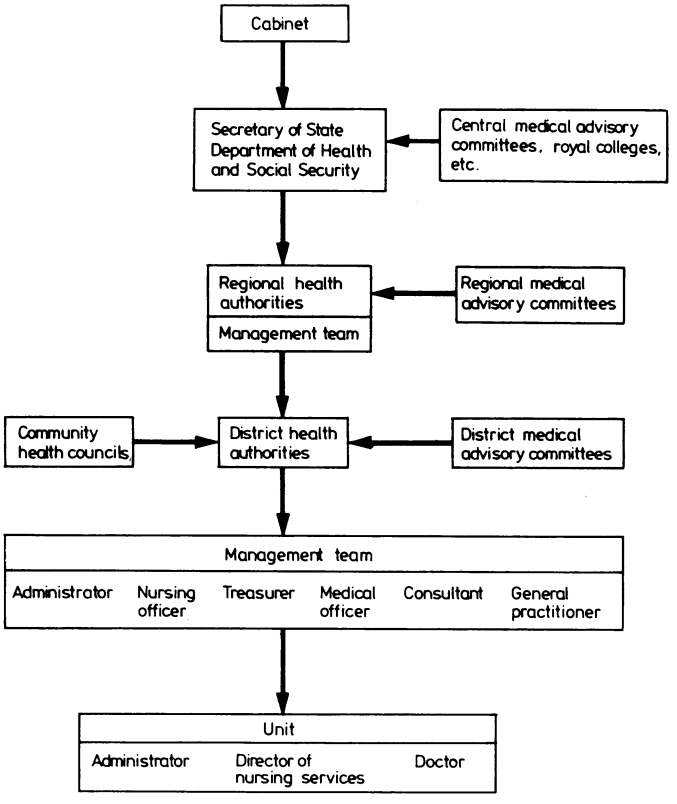
state in one way or another and so other governments do have to decide how much to spend on subsidies, and this becomes a political issue. As the Royal Commission on the National Health Service said, health care costs are too large to be left alone by any government.[2]

Development of the NHS structure

If a service receives government finance in Britain government accountability is a constitutional requirement, and a hierarchy of control has been developed from the Secretary of State for



Structure of the NHS.

Social Services and the Department of Health and Social Security to those working on the shop floor. The nature of control changes from time to time and some people believe that the present system is too centralised—it may become even more so when the Griffiths proposals for management reform are introduced.[3] In practice, however, the system of control of medical care provision is much more highly developed in Britain than in other countries. The Secretary of State and the DHSS cannot maintain detailed control of all the people working in the NHS, so various public bodies have been created to act as the Secretary of State's agents.

The major structural change produced by the 1946 Act was that most voluntary hospitals and all local authority hospitals were nationalised. This was done because the main alternative, local authority control, was unacceptable to many NHS staff, particularly doctors. The Minister of Health, Aneurin Bevan, had to set up new bodies to administer the hospitals and created regional hospital boards and below them hospital management committees to act as his agents. In 1948 the local insurance committees, which had been established by the 1911 Act to administer the Act locally, were renamed local executive councils, and these supervised most of what we now call the family practitioner services. The local authorities were responsible for the provision of community services (maternity and child welfare services, health visitors, home nursing, etc), which they had developed over the previous 50 years or so. This tripartite structure was much criticised later because of poor coordination, criticism that eventually prompted the 1974 reorganisation.

Until 1974 the emphasis in NHS planning was on hospital care. Since then an attempt has been made to plan medical care comprehensively by drawing in the primary care and local authority services. One of the aims of the 1974 reorganisation was to create a system that could provide continuity of care for patients—particularly of maternity, psychiatric, and geriatric patients—once they had left hospital. To this end the 1974 reorganisation created area health authorities, which covered the same areas (conterminous) as local authorities, so services could be more easily coordinated. In some places these areas were so large that they needed to be further subdivided into districts. This created an additional administrative tier, which soon led to complaints about excessive bureaucracy, and the tier was subsequently removed in the 1982 reorganisation.

The 1982 reorganisation, aimed to improve decision making by cutting bureaucracy and bringing effective decision making closer to the patient. As well as doing away with multi-district areas and creating districts, each district was divided into several units, each unit being a patient group, such as psychiatric patients, or a geographical unit, such as a hospital. Each unit was to be administered by a troika—an administrator, a nurse, and a medical representative (see figure). This arrangement will be superceded by the recommendations in the Griffiths report to create a general manager who will have overall responsibility for management performance at each level—DHSS, region, district, and unit.[3]

Who provides medical care?

Medical care everywhere is provided by a mixture of public and private institutions. Little health care provision is private in the sense of profit making, and little is public in the sense of being government managed. Britain is the exception in the Western world in that the institutions are owned and managed by the government. Most medical organisations elsewhere are voluntary and non-profit making. The country with the biggest profit making sector is, of course, the United States, but even there that sector accounts for only 30% of hospital care expenditure. In Germany the profit making sector accounts for about 5%. In the United Kingdom it accounts for less.[4] How much of this private medical care in the United Kingdom is extra resources as opposed to resources transferred from the NHS and how much is overprovision and would not have been provided by the NHS has never been determined, though a recent report, *Health Care UK 1984*, has taken a welcome initiative in trying to estimate the total costs of health in Britain.[5]

The important difference between the NHS and other systems of medical care is that not only is most of the cost of medical care paid from government taxation but the government also owns the facilities and employs (directly or indirectly) the health professionals. It is this combination of public finance and public ownership and management of medical care that distinguishes the NHS from medical care systems in other Western countries. State expenditure on health in Britain is determined by the government's public expenditure survey exercise, where competing demands for public money are, in the end, resolved by the Cabinet. This allows the British government precise control over total expenditure on medical care, while other countries are desperately trying to develop measures to regulate medical care costs.

Health costs in France, for example, increased by seven times between 1950 and 1977 while Britain's increased about 2·6 times. Even the French admit that there is no evidence that the health of the British is inferior to that of the French. In 1979 the French government put a tithe on doctors and dentists, and it has tried other ways of controlling costs.[6] The German govern-

ment has tried to contain costs by removing cover for some illnesses and cures, and German hospitals can now receive public grants for building only if the development complies with the state hospital plan.

The NHS has a structure that makes it easier for the government to tackle the uneven distribution of resources and inefficiency. As Rudolf Klein has noted, "The NHS seems a remarkably successful instrument for making the rationing of scarce resources socially and politically acceptable."[7] Other advanced countries have similar financial and organisational problems, but they have to rely on medical care planning by prohibition of development, subsidised loans, and similar schemes to try and regulate the development of medical care systems. Furthermore, Britain does not have the expense of monitoring the quality of medical care, which other countries such as the Americans with their professional standards review organisations have to incur to protect their citizens. Even if it is still true that the NHS responds more rapidly to innovations in medical care than to changes in size and structure of populations —and, as Klein notes, "state provision tends to institutionalise rigidities through organised lobbies for maintaining the status quo"—the structure of the NHS is a more direct, though far from precise, means of control of the provision of medical care.

Cost of doctors

It is generally accepted that British doctors are paid less than their colleagues in Western Europe or North America, but to make any sort of comparison allowances would have to be made for pension rights and their cost, the cost to doctors of their training, and the length of time before a doctor's maximum income was reached—British hospital doctors spend about twice as long in the training grades as those on the continent. Allowance must also be made for any income from private practice. NHS general practitioners earn relatively little from private practice, but about half of NHS consultants work part time. Up to date information on consultants' earnings from private practice is not available, but figures for 1971-2 showed that part time consultants on average derived about one third of their income from private practice.[2] Since then there has been a considerable expansion of private practice with the three non-profit making provident associations paying out £70 million in 1982 in surgeons' and anaesthetists' fees.[8] Furthermore, about a half of all consultants receive distinction awards during their life, with about a third of consultants holding awards at any time.

Allowance also has to be made for differences in costs of protection against legal suits for medical negligence. The cost of protection in the United Kingdom, though rising, is still much less than that in the United States because lawyers are not paid by results and British courts have adopted general principles that set fair criteria to be applied to judging medical negligence suits but that discourage volume litigation against doctors.[9] Finally, living standards generally are higher abroad, with Americans about 50% richer than the British, the Germans about 25%, and the French 20%. Nevertheless, though it is difficult to make valid international comparisons on doctors' incomes, doctors in Britain are among the best paid and have one of the highest living standards of any group in the country.

Despite the fact that most of their income comes from the state financed NHS doctors have a surprising degree of clinical freedom. Much of the literature on the health service, including the Griffiths report,[3] emphasises the importance of delegating decision making to the lowest level: to doctors and nurses who make the decisions about the consumption of resources as opposed to the commitment of resources, which is done by health authorities and NHS officers. Health authorities and management teams decide on the level of provision of resources but it is up to doctors and nurses how these resources are used. As Professor Cummings says, "the prescribing authority in the health service lies solely in the hands of the clinician—not only of drugs but to all expenditure."[10] In the United States it has been estimated that doctors determine 60-70% of health costs.[11] But because of the different system of paying physicians in the United States—and other market sensitive health care systems—there is a tendency to admit more patients for operation than is the case in the United Kingdom, where doctors do not benefit financially from admitting more patients to NHS beds. Furthermore, in the NHS general practitioners act as a gateway to the specialist services, thus exerting some control over the flow of patients to hospitals.

As Professor Klein said earlier in this series, "Clinicians are free to determine whom they select for treatment and how they treat them. District health authorities cannot actually take any decisions about the delivery of services."[12] Consultants generally have to take patients who are referred to them from general practitioners. They can, however, influence the number and types of patients who are referred to them by giving some types of patients preference. This allows them greater freedom. It is these decisions that determine how resources are consumed, and, to quote Klein again, doctors' freedom to make decisions is constrained by the availability of resources but is very real and "sufficient to frustrate the decisions of policy makers at the top of the administrative hierarchy."

The commitment of resources is not independent of consumption, for if resources are not consumed they are likely to be withdrawn by the health authority—or at least not allocated again. Similarly, if resources are all consumed early in the financial year further demands are likely to be made. So here is further opportunity for doctors to distort the strategic plans of the DHSS and district health authorities.[13] A recent development—the annual reviews, which monitor how NHS funds are being used—will, however, reduce doctors' freedom to some extent. But British hospitals are some way from adopting the strict peer review procedures that operate in many North American institutions, where accredited specialists who stray too far from the norm may lose their hospital access privileges.

Doctors in the NHS are not trained to think in terms of money and of how treating one patient will affect the treatment of others, and some people believe that they need such training.[14] Unfortunately, little information is available to doctors (or anybody else) to help them make decisions about the costs of alternative treatments or selecting particular patients for treatment, though this is the area of clinical budgeting that is now being developed.[15]

The amount of control that most NHS consultants have of their expenditure depends largely on the type of expenditure. For instance, there is little control on expenditure of drugs: providing the drug is in stock the doctor can use what and as much as he thinks necessary for a patient. On the other hand, his expenditure on *x* ray examinations and pathology laboratory tests or his use of operating theatres is limited by the availability of the service. Such rationing imposes some control on consultants' expenditure though it is of an arbitrary kind. The objectives of developing clinical budgets is both to limit expenditure and to increase efficiency by allowing the budget holder to use the money available as he believes most suitable. Although it may sometimes be difficult to identify precisely any direct financial savings from the use of clinical budgeting, its greatest benefit is probably that it changes the management style, drawing more doctors directly into the management of the health service.[16] This responsibility for budgets is something that is familiar to doctors practising in health care systems that are more sensitive to market forces: it should also help to improve management efficiency in the NHS.

Conclusion

It is difficult in a short article to provide comprehensive comparisons with other countries, but while Britain has something to learn from abroad its health care system has lessons

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Armed forces doctors' pay

The review body on armed forces pay has announced its recommendations for doctors in the armed forces for 1984-5. In the supplement to the 13th report 1984 (Cmnd 9301) the review body has based its judgment on the actual levels of remuneration for general medical practitioners resulting from the government's decision to phase the award recommended by the doctors' and dentists' review body. Service doctors will receive staged increases in their pay of 3% from 1 April 1984 and from 5·2% to 7·5% from 1 November 1984, with an average for the year of 4·6%.

In assessing the pay analogue the armed forces review body has used the average net remuneration of NHS general medical practitioners as its starting point. The analogue, however, has increased by 6·2% whereas NHS general practitioners had an increase of 6·8%.

On manning, the review body reports that the Royal Navy had a surplus of medical officers and that the overall position had improved in the Royal Air Force. Although the strength has increased in the army, it is not up to establishment. Recruitment for the Royal Navy and the army is higher than their targets.

The allowance for general practice trainers has been increased from £700 to £1000 from 1 April 1984.

The total cost of the review body's recommendations, which include awards for dentists, are estimated at £1·48 million.

New scales

The new scales range from £5405 for a cadet on appointment (£5535 from 1 November) to £27 555 (£28 600 from 1 November) for a brigadier (or equivalent rank). A preregistration service doctor will receive £11 016 (£11 271 from 1 November); on appointment a captain's salary will be £14 257 (£14 456 from 1 November); a major's £17 491 (£17 896 from 1 November); a lieutenant colonel's £21 772 (£22 499 from 1 November); and a colonel's £24 765 (£25 649 from 1 November). After eight years in post a colonel will receive £26 557 (£27 711 from 1 November).

Increased fees for police and other local authority work

An agreement has been reached between the BMA and local authorities on increased police surgeons' fees, fees paid to medical referees at crematoria, and fees for other local authority work. The implementation date is normally 1 August or 1 November in the case of police surgeons.

Fees for professional witnesses in court have been increased with effect from 23 July. The minimum attendance fee has increased to £28 and the maximum daily rate has been increased by £3 to £84.

Members may obtain details of the new fees by sending to the BMA secretary or regional offices a stamped addressed envelope and quoting their current membership number. For police and local authority work the reference is "Fees 71." For professional witnesses in court the reference is "Fees 9."

New GMSC chairman

Dr Michael Wilson, a general practitioner in Huntington, York, has been elected unopposed as chairman of the General Medical Services Committee for 1984-5. At the meeting on 19 July Dr Wilson paid tribute to his predecessor, Dr John Ball. Much of the day was spent electing members to committees for the new session.

The following members were elected to the negotiating team: Dr Peter Enoch, Dr Peter Kielty, Dr J A Riddell, and Dr W G A Riddle. Dr Wilson is a member ex officio.

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for other countries. Britain seems to be the only country that has a firm grip on health care expenditure, and the government has helped Britain to spend relatively little on health care, yet the health of the population, as measured by life expectancy, perinatal mortality, etc, compares well with that of other countries that spend more—and some much more—than Britain does.

Other countries have similar problems of containing total costs, while consumers complain that not enough is provided. The problem for the NHS is how to provide a government financed personal service: people as patients want a good service while as tax payers they want to keep costs down. It may be that Britain's present system of financing medical care means that the NHS will never match the community's expectations. People have to wait for care, hospital and surgery environments are sometimes unsatisfactory, and doctors' salaries are lower than in other countries. It may be that people would be willing to pay more for medical care. But if medical care were to be wholly or even partly financed through either private insurance or social insurance it would cost much more, some medical care provided would be wasted, and the detailed control of how money is spent would be sacrificed. Furthermore, we would face the practical and moral difficulties of restricting access as some patients would not be able to afford medical care and the gain in health of the population as a result of the increased expenditure would be questionable. The outcome would probably be medical care that was both less efficient and less equitable. Even a Conservative government committed to "market force" policies decided after studying alternative methods of financing the NHS that it was not worth changing the present system.

All institutions reflect the society from which they come, and the NHS is no exception. It is a social institution that reflects the compassion of the British, but, internationally speaking, Britain is not a wealthy country and there are limits to what it can afford. So the development of the NHS will continue to be permeated by the twin concerns of caring for all but on a limited budget.

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