Navigating the seas of change

John Roberts

British and American medicine are like two ships crossing the Atlantic towards the other's shores. Both are curious what the other holds. The questions are: Will they meet and inspect one another? Will they quietly pass by each other? or Will they collide and both sink? At the same time, Europe's biggest employer, the NHS, prepares to join the European Community. And at home the government has set about restructuring how Britons will give and receive medical care. Doctors seem adrift in change.

John Roberts, an American internist, toured England and Scotland for six weeks, interviewing general practitioners, nurses, consultants, students, house officers, patients, politicians, and people on the street. Here, and for the next few weeks, he reports how doctors in Britain have adapted to the constant political, economic, and technological changes placed before them.

The British practise medical minimalism, spending far less on medical care than any other Western country. So it amazes visitors that Britons are so loyal to their National Health Service. Public opinion polls consistently show that more than 75% of the population support the NHS. Among those who have used a doctor recently support runs higher than 90%.¹ In travelling about England and Scotland for six weeks, I heard no one offer to trade the NHS in for an American, Canadian, or any other model of medical care.

Yet if not ready to trade the whole thing in, the government is certainly ready to overhaul the NHS. The basic ideology of Mrs Margaret Thatcher—still Prime Minister when I visited Britain—was that private enterprise is better than public works. This ideology, combined with a decade of doctors pleading for more money, has grown into a plan that many doctors and patients believe will lead to the end of the NHS.

Doctors in Britain are used to politics and change. The relationship between politicians and doctors dates all the way back to Henry VIII, when he shut down the hospitals during the Reformation. British doctors proved they could survive that; they have survived four major changes in health policy since 1976; and most agree they will survive the current reforms.

An American comparison

To most Americans who have heard of it the NHS is a symbol of the kind of place they believe Britain has become—a poor welfare state in retreat from the grand days of the Empire. The NHS is seen as a bastion of inefficiency, a place where elderly people with uraemia cannot get dialysis, where medical care is directed by the state, and where doctors are trade unionists, rather than professionals. It is the epitome of “socialised medicine,” a term not far removed from “communist” in the American public vocabulary.

Few British doctors deny that the NHS is inefficient. A London surgeon described a 79 year old woman with osteoarthritis of the hip who has waited more than a year to see an orthopaedic surgeon, who then will place her on a waiting list for a hip prosthesis, where she will wait at least another year. At present, more than

1 million Britons are waiting for some medical procedure.²

The NHS is an austere system. The average patient gets seven minutes with the general practitioner; his American counterpart will get 15-20. The odds are he will not get a physical examination beyond a blood pressure check. He will certainly get fewer laboratory tests and x ray examinations than the American, and he probably will get less explanation of his diagnosis and treatment.³ Surgery is more sparse as well. Britons, whose death rate from coronary artery disease is nearly twice that of Americans, get one sixth as many bypass operations.⁴ Many large British hospitals have no computed tomography scanner; many American radiologists have such scanners in their consulting offices, and no large United States hospital would be without a magnetic resonance imaging scanner as well. British hospitals are old, inefficient places, nearly a quarter more than 100 years old.⁵ America's hospitals tend to be newer, and as one United States physician said of his hospital, “This place is so efficient that sometimes my patients get sent for tests before I think of them.” British medicine is regimented. If a Briton needs a specialist, his general practitioner will decide it for him and will dictate whom he will see. An American can choose specialists from the telephone book and see them at his leisure.

British medicine is paternalistic. In Britain a doctor is required to tell a patient only what any “reasonable doctor” would tell.⁶ In America the courts have said that patients are informed consumers, and so doctors must tell at least what a “reasonable patient” would want to know.

Finally, British medicine is cheap. America's most certainly is not. The United States spends three times as much per person as Britain, even though 15% of Americans have no medical care.

But this austere, inefficient system is fair. Everyone gets a doctor free of charge, and nearly everyone stands in the same queues. British doctors claim it is a safe system: financial constraints mean that needless tests are avoided, often because the tests simply are not available nearby. A young philosophy professor in London, who has lived in America, said, “In the United States doctors are paid to do more; in England they are paid to do less. I feel safer in England.”

Even the austerity is seen as positive by Britons, who often say that the NHS is a system where doctors, nurses, and patients “pull together” to get by under hard conditions.

Democracy in the NHS

Hard conditions, of course, built the NHS, and made “pulling together” the centre of it. It was hard conditions in the poor houses and the coal mines that prompted David Lloyd George to draft the first national health insurance laws in 1911. It was hard conditions during the world wars that injected medical egalitarianism into class oriented Britain. Doctors were drafted and were put on army salaries. Aristocratic young men served as soldiers alongside working class boys. And both fell together into the doctors' hands after battlefield injuries. One story describes an upper

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Austere, inefficient—but fair

class soldier reporting ill to the company doctor, who said, "Look here, my man, you wouldn't come to my surgery with a trivial complaint like this." To which the private retorted: "Of course not sir, I should send for you."

The second world war especially created a movement towards a national service, both in the United Kingdom and in the United States. Numerous historians have found it difficult to explain why the two countries' medical roads diverged. After the war health minister Aneurin Bevan had to fight the British Medical Association, just as President Harry Truman faced the American Medical Association. Bevan may have won because the bombs that fell on London created a communal attitude: Britons learnt to pull together. As an old woman in Devon told me, "What separates us from you is that we Brits learned how to suffer. You Americans never have—yet." "Pulling together" is a theme that runs up and down the NHS. Several patients expressed thoughts similar to a Nottingham man just discharged from hospital: "The staff cared, and I knew they cared because I know they get nothing extra by giving me attention. They're just the kind of people who care." Indeed, British patients put up with delays, dirty wards, and staffing shortages. Rarely does one hear patients complain about their doctors or nurses. Instead, the inconveniences are placed at the door of Downing Street. Mrs Thatcher was not the only tenant to have got fed up with shouldering the blame, but her solution was the most radical.

The new NHS

During the 1980s health care demands in the United Kingdom, as everywhere, were rising rapidly, mostly due to the costs of new technologies and new medicines and an older population. By 1987 the pressure on the government to spend more was intense. The media was reporting that children were dying because hospitals did not have the money to provide their heart repair surgery, the three major royal colleges were meeting with health ministers to demand more money, and junior doctors were threatening strikes. The common demand of all groups was "More money."

The government of Mrs Thatcher had had enough. In early 1989 Mrs Thatcher responded not with money but with radical NHS reforms—the infamous white paper. In her forward to the paper, *Working for Patients*, Mrs Thatcher declared that the NHS "at its best is without equal," then added, "We believe that a National Health Service that is run better will be a National Health Service that can care better."⁸

Her plan—written without the advice of the medical profession, which opposed any move toward "privatisation"—was pushed swiftly through parliament by the Conservative majority. The brief white paper (and its follow up working papers) said nothing about infusing more money. Instead, it drew on writings from American economists to create an NHS in which various groups within it compete against one another for business—the internal market. The government, mostly through its then Secretary of State for Health and Social Services, Kenneth Clarke, said the fundamental change was that money would follow the patient. For doctors, hospitals, and health authorities each patient now presents an opportunity for profit rather than a cost.

Basically, the white paper has four elements: self governing hospitals, fund holding general practices, targets for general practitioners, and audit.

Creation of self governing hospitals—Instead of receiving directives and budgets from districts, regions, and Whitehall, hospitals will be able to venture into a market system, where they will sell services to districts, general practitioners, and perhaps others. For the hospital the biggest incentive to becoming a self governing trust will be that it can build cash reserves from year to year. Of course, the risk will be failure and closure. Critics, who point to the United States, are concerned that self governing hospitals will be able to develop lucrative, high technology programmes (such as cardiothoracic surgery) at the expense of costlier emergency and geriatrics departments. The government has said that it will not allow hospitals to close "essential services," though it concedes that patients will probably travel further to distant referral hospitals for certain procedures.

Fund holding—Large groups of general practitioners can become fund holders, which means that the general practitioners become buyers of specialist, hospital, and some nursing services. Essentially, general practitioners will be informed surrogate consumers for their patients. As with the hospitals, general practitioners will take on some financial risk, though the government promises to protect their existence if their schemes fail.

Health targets have been set for general practitioners. At present the government's targets are fairly simple preventive measures: health visits, vaccinations, and cervical smears. For example, if a general practitioner vaccinates 90% of the 2 year olds on his list he gets £1800; if he reaches 70% he gets £600; less than 70% garners nothing. Since the announcement of the general practitioner's targets, the health ministry has added that it plans similar targets for consultants, including cutting death rates from heart diseases, cancer, and asthma.

Audit will be required in all areas of medicine. The government defines audit as "the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient."

Many other changes in the NHS lie inside and beyond the white paper: drug budgets for general practice, massive investment in information technology, more extensive public health targets, new roles for district health authorities (which will become buyers and sellers of services rather than providers). But underlying all these changes, according to the government, is the aim of creating a system where patients and general practitioners become informed consumers in a medical marketplace, thus rewarding excellence in medical care.

Many doctors would place quotation marks around "reforms." Most I interviewed accused the government of trying to "Americanise" medical care in the United

Kingdom. ("Americanisation" has the same evil connotation among British doctors as "socialised medicine" carries with American doctors.)

Medicine is politics

But the fact that the government takes a position at all is exactly what makes medicine in the United Kingdom so different from that in America. The United States government avoids dealing with medical care as much as possible, recognising that whatever policies are instituted some major constituency will be offended, be it the American Medical Association (the richest lobby in Washington) or the American Association of Retired Persons (not far behind in contributions to candidates). In the last United States presidential election neither George Bush nor Michael Dukakis offered a specific statement on health care.

The great gap is not between Americanisation and socialised medicine. It is between a system run by business versus one run by politics, by the standards of the free market versus those of public discourse. As distressed as British doctors seem to be about the state of affairs of the NHS in 1991, they still seem more optimistic than their American colleagues, who see themselves as besieged by hundreds of different insurance corporations, competition among themselves, and bureaucracy from one federal and 50 state governments. As a United States internist said, "We have been so damned worried that government was sneaking up over our left shoulder that we didn't see businessmen coming up on our right. Now we're pinned in by both."

"In America, medicine is a business, and American patients are commodities," said a British consultant who has studied in Boston and who fears contagion of that attitude into Britain.

In the United Kingdom medicine is politics. Decisions, from the top down, come from political debate. The health service competes in the Treasury against education, defence, transportation, housing, and other programmes. At some point each year, someone must say, "This is how much we can spend, and this is how we can spend it."

From Downing Street to the Treasury to the health minister, down through the regions, the districts and all their hospitals, someone is accountable for how much will be spent and for what. And ultimately, at the ballot box, the voters decide if they like what has been done. And they do think about their health service at balloting time. Polls repeatedly show the NHS as No 2 or No 3 on voters' agendas.¹

The Labour Party enjoys its current popularity mainly because of Tory discussion on the NHS. A poll in September in the *Guardian* showed that 68% believed the NHS to be "unsafe in the hands of Mrs Thatcher."¹⁰ Although the new Prime Minister, Mr John Major, has declared himself a supporter (and user) of the NHS, it is not yet clear whether the change at the top will translate into a change in policy in the NHS. So far the signs are that it will not. Though Mr Clarke's successor at health, Mr William Waldegrave, is a more emollient character, he approved almost all of the first wave of applicants for self governing trust status.

While Tories and Labourites have jousting for 43 years over the NHS, the political process has kept health care spending down to about 6% of the gross domestic product. In every other developed country medical costs have outstripped inflation year by year. The politics of health have meant constant change: government reports, green papers, white papers, and four major reforms in 16 years. In contrast with their American colleagues, doctors in Britain seem inured to change, welcoming what they like and trying to adapt

to what they do not, often adopting a fatalistic tone. A cardiologist told me, "We'll take Mrs Thatcher's 'reforms.' We'll just keep our heads down and keep working and taking care of patients. Then we'll look around in a year to see how things work."

By and large, things have worked out well for doctors, even if they have opposed many of the major changes. In reviewing all the reforms of the twentieth century, one cannot help but note that doctors' organisations have opposed every major change—1911, 1946, and 1990. But in the earlier two doctors and patients were definitely better off after the government got its way. One wonders if doctors shouldn't hope their organisations should "lose" more debates with government.

But however the winds of politics in Britain have blown, the NHS's course has been certain: every citizen can receive arguably excellent medical care free of charge.

Lessons from America

What Britain wonders in 1991 is: Can the course be held? Each month pressures grow stronger either to spend more or to deliver less. Like all developed nations, the United Kingdom faces an aging population and more expensive drugs and technologies. Creating efficient markets may temporarily relieve those pressures, but they will return, as Americans have painfully learnt.

Another lesson America offers is the result of patients becoming "informed consumers." Already, full page advertisements in British newspapers extol private insurance as consumer choice for patients. Consumer choice in the United States has led to a multipayer bureaucratic medical system that spends up to 25% on administrative costs, that rations by ability to pay, and that fosters an attitude of doctor-patient distrust and more lawsuits.

No one knows how much the new, reformed NHS will cost, but, according to the Department of Health, the point has never been cost. It has been efficiency and public health. In that regard, several points stand out.

Firstly, clinical audit has the potential to measure whether doctors can do what they claim to do: improve health, or at least decrease suffering. The potential for learning about the effectiveness of various treatments is awesome in a closed medical system such as the NHS, especially with the information technology the government has pushed and that general practitioners are adopting. The cost, however, will be great, especially in the first few years. The costs of administering audit programmes, especially in hospitals and other centres away from the general practitioner's surgery, will be great, perhaps going from an estimated 8% at present toward the United States estimate of 25% of total medical costs. Mr Clarke believed that the costs would be offset in the long term by improved efficiency in care.

Secondly, prevention of disease is a major focus of the general practitioner's contract and the targets. However laudable a goal that may be, the Americans have again discovered, painfully, that "prevention" often means finding disease earlier—before symptoms occur—which often increases the cost of caring for the person. In addition, some observers, such as Ivan Illich, have suggested that prevention leads to a perverse medicalisation of society, which he claims is a social problem in America.¹⁰

Thirdly, any marketplace, internal or otherwise, requires that certain risks should be taken to survive. For hospitals the risks of competition will be closure. "The real test for Mrs Thatcher's plan," said a rural consultant in the midlands, "will be when a little district general hospital goes broke, and the local MP

knocks at Downing Street to save it. Her answer then will tell all." Though Mrs Thatcher is no longer around to give the answer, the point remains.

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Understanding Benefits

Means tested benefits

Simon Ennals

Contributory benefits

Retirement pension
Widow's benefit
Unemployment benefit
Sickness benefit
Invalidity benefit
Maternity allowance

Non-contributory benefits

Child benefit
One parent benefit
Attendance allowance
Invalid care allowance
Mobility allowance
Severe disablement allowance
Industrial injury benefit
Statutory sick pay and maternity pay

Means tested benefits

Income support
Housing benefit
Community charge benefit
Family credit
Social fund

Although means tested benefits were intended for only relatively small numbers of people, they have grown in importance and complexity so that by 1988 over five million people were claiming housing benefit and over four million income support. As a result a large number of patients depend on means tested benefits. These include income support, the main benefit for those not in full time work; housing and community charge benefit, which provide help with rent and poll tax; family credit, for people bringing up children on low wages; and the various forms of help with NHS charges.

One of the problems that have always plagued means tested benefits has been that of low take up by those entitled to them. People are put off by the complexity of the claim forms; worried about the stigma attached to claiming what many still regard as "charity"; or not aware that they may be entitled to benefits.

The claim forms are complicated, and for those with poor eyesight or literacy skills this can be an insurmountable barrier. Help and encouragement with completing the forms can make all the difference. Many elderly patients in particular associate means tested benefits with charity and may need reassurance. These are benefits that people have a right to, paid for out of the taxes that they have paid throughout their working life and continue to pay through value added tax and other excise duties. Many people struggle to survive on incomes significantly below the qualifying level for these benefits, and health workers are in a good position to point out to people their possible entitlements—perhaps making use of the Lisson Grove computer program*—and help them to make their claims.

Income support

Income support replaced supplementary benefit in the reforms of April 1988 as the main benefit for people not in full time work. The principle of how it works is straightforward, even if the detail is often obscure. The calculation compares the amount each family is deemed to need to live on (the "applicable amount") with whatever income they already have. Income support tops up their existing income to the level of the applicable amount.

The applicable amount varies with the family's size and circumstances. It consists of a personal allowance for a single person of £36.70 (if aged 25 or more), £28.80 for an 18-24 year old, or £57.60 for a couple, plus allowances for any dependent children under 19 still in full time education (£12.35 for those aged

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under 11, £18.25 for 11-15 year olds, £21.90 for those aged 16-17, and £28.80 for 18 year olds). Certain patient groups then qualify for additional fixed rate "premiums" to reflect their additional needs. Premiums are awarded to families with children, lone parents, the long term sick or disabled, pensioners, and carers. For owner occupiers allowance is also made for the interest on any mortgage or home improvement loan. This figure is then set against whatever income there already is, such as retirement pension, child benefit, etc. While most income is counted in full, attendance allowance and mobility allowance are ignored completely, making them especially valuable to look out for. Some other types of income are partially disregarded.

To claim income support several basic conditions of entitlement have to be satisfied.

(1) The claimant and any partner must have less than £8000 capital between them. This includes shares, unit trusts, National Savings Certificates, as well as more obvious bank or building society accounts. If they have less than £3000 of capital it is ignored. For capital of £3000 to £8000 an assumed interest rate of £1 a week for each £250 is added to the claimant's income.

(2) The claimant must be at least 18. The removal of benefit rights from most 16 and 17 year olds has been the subject of much controversy. But it is important to be aware that some 16 and 17 year olds can still receive income support, including those who are disabled, covered by a sickness certificate, lone parents, pregnant with a baby due within 11 weeks, or any other case where there is a risk of severe hardship. Girls in earlier stages of pregnancy may qualify if they are incapable of work because of the pregnancy. A letter from a doctor confirming a young person's ill health, or the risk of severe hardship, can be the key to them receiving any income at all.

(3) The claimant, and any partner, must not be in paid work of 24 hours a week or more. There is an exception to this rule for some disabled people with reduced earning capacity, for people caring for severely disabled people, and for childminders.

(4) In many cases people have to be available for work to claim income support and have to satisfy the Department of Employment that they are actively seeking work. This rule does not apply to a number of specific groups, however, including those incapable of work and covered by a sickness certificate; people over 60; those caring for severely disabled people receiving attendance allowance; pregnant women less than 11 weeks before the birth and within six weeks after the birth; lone parents; and the registered blind.

(5) In most cases people under 60 must not be in full time education. The main exceptions are lone parents and those with disabilities.

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