

Rodney and Pearl Burnham appraise the National Health Service

The NHS at 60

Aneurin Bevan visits 'the first NHS patient'.

key points

In their 2008 Rendle Short Lecture, the authors review the origins of the NHS and identify problems almost from its beginning of finance, rationing, organisation, models of delivery, and training and staffing.

Inequalities in health are not 'the fault of the NHS' but inequities of provision may be. Rationing, competition, and other models of delivery are considered. The authors recommend 'integrated care' delivered by 'teams without walls'.

Urging CMF to have a wider ethical focus, they remind us of the challenge to Christian health professionals to show God's love in the way we deliver care in the NHS and elsewhere.

The NHS has endured buffetings but has also been a blessing to many. Nick Land is astute in considering the NHS as common grace, minimising the effects of the Fall.¹

Paul Corrigan said that the most important word in the title was the word 'National' because the NHS should provide equivalent care wherever in the UK one lived.²

The word 'Health' has been criticised, as the NHS is an 'illness' service rather than one with an emphasis on prevention. However, caring for the sick was an instruction from the Great Physician, so taking resources from a service for the ill in order to use it for prevention may be short sighted, especially if we still do not do the simple things, like fortifying flour with folate that could prevent 400 cases of spina bifida each year.

The late Alan Johnson (publishing anonymously at the time) said the most important word was 'Service'.³ His words still challenge all of us, whether we are at the beginning or end of our medical career.

The NHS in England

In 1942 Sir William Beveridge identified a national health service as one of three essential elements of a social security system.⁴ Aneurin Bevan steered legislation through the House of Commons in 1946 and after a two year battle with the BMA, agreement was reached. Services were comprehensive, free at the point of need, and intended to promote good health as well as treat sickness and disease. The NHS became operational on 5 July 1948. This article will mainly deal with NHS England, where most

Recurring issues - 1948 to 2008

- Financing
- Provision of comprehensive service or rationed service
- Organisation
- Models of health care delivery
- Training and staffing

change has occurred.

Looking back over the history of the NHS, one is surprised how the same issues have recurred over the past 60 years (see box above).

Finance

The original calculation of the annual cost of the NHS was £276 million; this year it is £90 billion. Enoch Powell in his detailed analysis in 1975 found it impossible to reconcile the combination of unlimited demand and limited resources provided free.⁵ Sir Derek Wanless argued in 2001 that continuing to fund the health service through general taxation was the most cost effective and fairest system for the future.⁶

In 2000, the Labour Government produced a strategy⁷ for reform of the NHS, coupled with investment (from £35 billion per year to £90 billion in ten years). National targets were introduced with variable success, the aim being to manage a comprehensive service more efficiently using central controls. However, even additional resources did not solve the problems and rationing in some form was required.

All supported a comprehensive service in 1948, yet Bevan said in the years that followed that expectation would always exceed capacity.⁸

A few years after it began, the NHS began to charge for some items and continues to do so.

Inequality, inequity and rationing

There are significant inequalities in health: income, unemployment, environment, education, housing, transport and life style all play important roles.^{9,10} These are not the fault of the NHS.

However, inequity of provision may be. The elderly, the mentally ill and ethnic minorities do badly on such assessments.¹¹ Access depends on skill in managing the system, and the better educated are more likely to do this effectively. Rationing (demand management) is achieved by limiting funding and delegating decisions locally to Primary Care Trusts. The financially well off can opt out by going private or by co-payments.

The National Institute for Health Care and Clinical Excellence (NICE) provides objective, evidence-based guidelines and guidance to the NHS about medicines and technologies that should be provided, but special interest groups may try to undermine this process.

Some GPs find themselves limited by restrictions on referrals to specialists, leading to surreptitious telephone and corridor consultations to obtain expert advice. Rationing also tries to by-pass 'choice' by referrals to 'GPs with a Special Interest' or others rather than fully trained hospital specialists, which may not improve quality.

Competition

Does competition have a role to play? Some authorities believe it will not produce a perfect system, but make the system better through self-interest that benefits society.¹² Do we believe in financial incentives? What happened to Christian vocation? The Quality and Outcomes Framework targets have proved financially advantageous to GPs, increasing GP pay by £23,000 pa, but is payment for performance a desirable motivation?

A logical consequence of competition is that some hospitals may close. Manual workers are more supportive of choice than professionals who have it already, and it is believed choice is an incentive for providers to improve.¹³ Thus entrepreneurial Foundation Trusts and Independent Sector Treatment Centres (ISTCs) were created to encourage choice and competition.

However, funding ISTCs in advance means that resources (including emergency services) are denied to the NHS even when it provides a good service, and ISTCs prioritise elective surgery above services for those with long-term conditions. For this to work, money has to follow the patient through 'demand side reform'. The government has tried to replicate the workings of the market by Practice Based Commissioning (PBC) and Payment by Results (PbR). PBC is not popular with GPs; PbR is payment by activity and may produce perverse incentives discouraging care outside hospital.

A better way to organise the NHS?

There is a tension between public expectation and what it is possible to achieve in a transparent and democratic way. The system cannot respond well to competing priorities. An independent NHS has been suggested.¹⁴ A national debate on NHS values and an NHS Constitution could set clear objectives endorsed by the public. However, strategic and operational decisions within the NHS cannot be separated from their political context. An NHS constitution could either be 'motherhood and apple pie' or a restrictive legalistic document. A 'public value approach' may help to balance organisational efficiency, better outcomes, and trust and legitimacy.

What people would give up, perhaps more taxes or another service, in order to obtain another more desirable benefit, could be explored as in Canada. With more clinical and patient involvement, 'World Class Commissioning' could become a reality. Appointments to the commissioning body could follow the model for appointment of lay magistrates.

In a mandatory insurance model introduced in Holland in 2006, health insurers, who may operate for profit, are required to compete on premiums, types of health plan and service levels. The government compensates insurers for big differences in the health profile of clients.

In the USA, rising costs and the large number of the uninsured are unsustainable. The argument against competition is that the insurers do not try to improve things for patients, but try to increase income, shift costs to somewhere else in the system, and restrict services. Competition between institutions in all areas, discrete services, and local markets has been described as 'the wrong kind of competition' but competition on value (outcomes) relates to the whole cycle of health care rather than just interventions.¹⁵

Outcomes

Avoidance of Health Care Acquired Infections (HCAI) could be one outcome quality indicator for hospitals. The Health Care Commission found many trusts had difficulty reconciling the prevention or management of HCAs with national targets, whether waiting-time or financial.¹⁶ As Christian doctors, we can show our love for our fellows by being less dignified, removing our jackets, ties and wrist watches and washing our hands rather than their feet.

Workforce and Training

Over the last 60 years, there have been many attempts to improve training for NHS workers and to increase their numbers. The decisions at the turn of this century to increase the number of medical students, and later to reorganise postgraduate medical training, came together last year to produce a disastrous situation that will not be easily resolved. Even if the government accepts all the recommendations of Sir John Tooke in his report on



Top: The first babies born in the NHS
Above: Aneurin Bevan

As Christian doctors, we can be salt and light in the NHS

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the Modernising Medical Careers/Medical Training Application Service disaster, it may not undo the damage to morale and patient care.

The impact of the European Working Time Directive will have an effect on the provision of services in hospitals. The data show the UK has fewer doctors per head of population than other developed countries and that there is a growing number of female physicians. Part time working may increase, and thus make shifts for trained staff more likely. This in turn may further decrease continuity of care.

Increased numbers of UK graduates, the continuing presence of International Medical Graduates, and an open door for European Union graduates make future medical workforce planning difficult. A shortfall of 15,000 training places is predicted for future graduates, raising the spectre of medical unemployment.¹⁷

Ethical issues

CMF has been strong on some ethical issues such as euthanasia and termination of pregnancy, but less prominent in others. We would like to see a balance. For example, there is a real danger in our experience of some doctors force-feeding patients and prolonging the dying process, with consequent lack of dignity and potentially great suffering. CMF should speak out against this, as we do against euthanasia.

What about health inequalities in the UK as well as overseas, or alcohol excess, or honesty in practice and research? What about co-payments – top up of NHS care by paying extra? BUPA has suggested that GP visits could be funded by co-payments. We believe this is unethical because it encourages health inequality. What about organ donation? Have we compared presumed consent with mandated choice? We have mentioned workforce numbers, also an ethical issue. Should CMF consider a wider ethical focus than now?

Integrated care – collaboration not competition

When we completed training, there was a partnership between GP and consultant. The introduction of the internal market and the purchaser-provider split damaged this and developing the private sector has not always helped. We would like to encourage you to support the adoption of 'integrated care'.

Clinical integration can deliver prevention and care for long-term conditions, and improve efficiency. Lord Darzi's Review aims to involve local clinicians in the next stages of reform. Collaboration between generalists, specialists and other health care professionals would offer similar advantages to those provided by Kaiser Permanente in northern California. There, high levels of performance are

achieved by allowing multi-specialty medical groups control over capitated budgets, to keep patients healthy and minimise future health expenditure.

Teams without Walls,¹⁸ a document from three medical Royal Colleges, outlines and supports these ideas as a way forward. As a Christian couple we think it is appropriate for us to encourage 'team' (the old English word can mean 'family') working as we show how Jesus cared for others.

The provision of more care closer to home, in an integrated system, from specialists in harmony with generalists is possible because of a large number of new doctors to be produced in the future. By managing care outside hospital, capital costs are minimised and this will allow the employment of the doctors and health care professionals who will be available. Clinical integration may enable us to provide personal care most effectively, and in the future, consultants will deliver care rather than directing it.

To achieve this, doctors need to be engaged in the organisation and management of the service. As Christian doctors, we can be salt and light in the NHS and follow in a long line of distinguished Christian physicians and surgeons. We urge you to engage with this process.

Conclusion

At this 60th anniversary, the NHS faces significant challenges due to financial, organisational, workforce, medical and ethical factors. Although there are more buffetings ahead, we must remember that God is in charge (Acts 4:28). Christian doctors should live out the teachings of Jesus Christ in response to these challenges.

Morale has been damaged but we would like to repeat some words of Arthur Rendle Short at a Missionary Study Circle conference in 1912.¹⁹ Speaking on Colossians 4:17, he reminded his listeners that this command – 'See to it that you complete the work you have received in the Lord' – was personal and encouraged perseverance. We should follow this advice, as we show God's love in the way we deliver care in the NHS and elsewhere.

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