

The British National Health Service

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INTRODUCTION

We are a pragmatic race. We make things work even when they seem, by theory, to be unworkable. We shall probably do the same with our health services.

—Lord Horder (1939)

In a number of ways, the United Kingdom's National Health Service (NHS) is a unique experiment, springing from the fusion at the end of World War II of a number of synergistic elements: a powerful desire for social change; a determination on the part of the populace not to repeat the experience of the broken promises after World War I; the presence on the table in 1945 of a plan for social service reform, including health care, a plan made, remarkably, in the middle of the war; and the arrival on the scene of a single-minded, charismatic politician who saw the establishment of a national health service as his mission [1,2].

Health care provision the world over is in difficulty as inflation in this sector exceeds inflation in economies in general, as a result in turn of new technological innovation running at a startling pace, demographic change, and increasing expectations [3,4]. The latter, whatever the existing structure for provision, introduce or increase political pressure for change. In no country does there appear to be a consensus on what changes, fundamental or marginal, should be made to improve delivery of health care. The United Kingdom is no exception in this, except perhaps in one important respect. It may be said with some confidence that though there are, as there always have been, some dissenters, there is a consensus that the basic philosophy represented by the NHS of a "cradle to grave, free at the point of use, essentially paid for out of taxation, no small print exclusion clauses system" should stand without significant dilution.

This appears to be deeply embedded

in the British psyche. This is a consensus that even inhibited Margaret Thatcher, who, it was said, could not contemplate any "institution" without hitting it with her handbag. Yet even she was forced to issue a reassurance to an anxious electorate that "the Health Service is safe with us."

This is absolutely not to say that the British are uncritical of the NHS. On the contrary, they criticize it constantly for its waiting lists for routine scheduled surgery, for example; the tabloid press, largely on the political right in the United Kingdom, love an NHS failure story. However, only a small proportion of the U.K. population uses private health care, with a total expenditure of some 1.1% of the gross domestic product (GDP), as compared with 6.8% of the GDP for the NHS [5]. All opinion surveys reveal a desire that it be improved by greater expenditure, there being a general feeling that it has always been underfunded; but of course, similar surveys reveal a simultaneous resistance to paying more taxes, a universal phenomenon [6,7].

The United Kingdom expends only 6.8% of its GDP on health care. This is the lowest figure in Western Europe and, of course, only half the U.S. figure [5,8]. This tells us that U.K. health care is, by the standards of other developed nations, either inadequate or efficient; the truth is that it is both. Some indication of the efficiency is that although the United Kingdom provides the whole nation with a comprehensive health care system on 6.8% of its GDP, the United States spends a similar amount to deliver only Medicare and Medicaid [8].

The NHS may be seen as a unique experiment in the social and political sphere, an experiment that continues today, more than 50 years after its initiation. Given that government in the United Kingdom has been in the hands of the Conservative Party for a greater proportion of the time than the Labour

Party, and given that in general matters, the political climate has changed and swung in the United Kingdom as much as anywhere else in the democratic world, it seems reasonable to say that the NHS can hardly have been a complete failure.

THE ORIGINS OF THE NHS

After World War I, that "war to end all wars," the homecoming troops and demobilized home-front workforce were promised a "land fit for heroes to live in." What they got was years of recession and poverty. Britain was still one of the richest countries in the world, but its wealth was built on its leadership in the industrial revolution and on, it must be admitted, a significant element of exploitation of an empire. Britain was, with good cause, described as "the workshop of the world." However, it is no revolutionary Marxist analysis but a simple fact of history that the wealth of the nation was inequitably distributed on a monumental scale; the workers of those "workshops" took little share of the wealth they produced.

World War II came only two decades after the end of World War I, and the broken promises following that war were still a lived-with reality, not an historical memory. During World War II, the country had in Winston Churchill a charismatic war leader who was politically "hard right." His deputy throughout the war in a coalition government had been Clement Attlee, leader of the Labour Party, a quiet, rather diffident figure, lacking in political and personal charisma, we would say today. He was, incidentally, like almost all leaders of the British Labour Party, not a working-class "hero" but an Oxford-educated, middle-class man. Remarkably, even in the depths of a war that it was by no means clear Britain would survive, a plan for the social reform of the country in a postwar world was commissioned (the Beveridge Plan). More remarkable yet were the

scale and scope of the plan, including that portion devoted to health care provision.

The war was a searing experience for the British, but it was something else too; it was something of a social leveler, a period during which, at home and abroad, the different classes in a class-ridden society were thrown together in a common cause. The widely accepted historical-social analysis is that this factor, combined with a determination that this time, there would be no broken promises, led to a cataclysmic political event.

When the war ended in Europe and normal political activities were resumed, the uncharismatic Clement Attlee led his Labour Party to a landslide victory against the great war leader, Winston Churchill, a landslide on a scale not seen before or since in British politics. To what degree the British people had voted for socialism is unclear, but that they had voted for a radical change of society cannot be in doubt.

The new Labour government picked up the Beveridge Plan and ran with it, introducing even at a time of postwar austerity and rationing wholesale social security reformation. The proposals for an NHS were put in the hands of the new secretary of state for health, Aneurin Bevan, a fiery Welsh politician not known for his political subtlety but with considerable abilities and determination. He set out with bravura to replace the ramshackle and largely uncoordinated structure of health care provision. This included turning the chaotic mix of voluntary (charitable) and local government-run (municipal) hospitals and general practice arrangements ("family practice" in U.S. terminology) run on a basic insurance scheme called "the panel" into a coherent system funded by taxation and free at the point of use. Prescription drugs, optician services, and dentistry were to be included. The original Beveridge Plan called for the hospitals in the new scheme to be run by local governments. Bevan finessed all the political problems and negotiation difficulties that might be involved by simply nationalizing the hospitals. It is important to

say here that health care itself was not nationalized. No restrictions on private medicine were, or to this day have been, implemented, but private medicine was in effect consigned to a marginal role.

Ever since the publication of the Beveridge Plan, in the middle of the war, the doctors, led by their representative professional body, the British Medical Association (BMA), had mounted a campaign against the formation of a national health service. They acted much more as a militant trade union than as a professional body. The reasons were complex. Not all doctors at this time by any means had high and reliable incomes to protect. Hospital-based specialists such as radiologists realized that self-employment was no option and that there was a need for teamwork in well-organized and well-funded modern settings, which, it seemed at that point, only the state was likely to provide. Thus, the BMA was mainly representing general practitioners. It has been said, in fact, that the campaign against the NHS lasted for longer than the war itself (from 1942 to 1948). The fears of some in the 1940s became the near-hysteria of 1948.

Bevan's approach to physicians' resistance was brutal but simple. He persuaded most of the necessary political constituencies by remaining firm on the central issues but compromising on details that would allow him to build a coalition. He saw this as a means of buying in to the NHS those consultants with established and lucrative interests in private medical practice. As Bevan put it in his inimitable way, "I stuffed their mouths with gold." Then, rather than arguing with the doctors' leaders, he bypassed them, framing his NHS bill and getting it passed in Parliament against, it should be said, bitter Conservative Party opposition led by Winston Churchill. The bill became law, and the NHS was in legal terms a fact. Bevan then turned his powerful bulldozer personality to the last bastion of resistance, the implacable enemy: general practitioners. He gave in to more of their demands than anyone previously had. He let them be inde-

pendent contractors paid on a capitation basis (i.e., according to number of patients registered, whether seen or not). Primary care (general practice) was to become something of a success, but it could have been so much more than it became.

In the end, the headline disagreements between the BMA and the government seemed trivial but were probably metaphors for real issues of underlying anxiety and principle. Whatever the truth, in 1948, doctors finally relented and signed on to the NHS.

Bevan launched the enterprise with this:

I regret that this great act to which every party has made its contribution, in which every section of the community is vitally interested, should have had so stormy a birth. I should have thought, and we all hoped, the doctors would have realised that we are setting their feet on a new path entirely, that we ought to take pride in the fact that, despite our financial and economic anxieties, we are still able to do the most civilised thing in the world—put the welfare of the sick in front of every other consideration.

Bevan personified the NHS and was happy to promote himself as its father. He persuaded the mild Attlee, who planned a radio speech hailing the NHS as a national triumph, to declare it instead a Labour triumph and to attack the Tories for opposing it. Thereby began the politicization of the NHS. In fact, having opposed it, the conservatives quickly reverted to their previous wartime position and accepted it. The simple fact is that both parties were then indistinguishable in their approach to the NHS until the later part of the Thatcher era (see below): both neglected and underfunded it. Later, Bevan was to resign from the government when small charges for prescriptions were imposed by the government in what he portrayed as a betrayal of fundamental principle. The NHS was well on the way to becoming a political football.

WHAT WAS THIS NHS?

The new NHS consisted of public hospitals, with a proportion in each of pri-

vate beds—Bevan’s famous concession to the doctors—and a national network of general practitioners dispensing first-line family medicine, all funded by taxation and with the special arrangement for the general practitioners that they were not salaried employees but independent contractors paid largely on the basis of how many patients they had on their books.

There is no space here, and no fundamental necessity, to discuss the precise administrative structures at the national, regional, and local levels through which the NHS was run. These have varied frequently as governments have tinkered. It is enough to say here that such structures to diffuse power and responsibility from the center to the grass roots have always been in place. The NHS has never been a heavily centralized bureaucracy. However, there is no avoiding the fact that ultimate central political control has always been an inescapable fact. Indeed, critics of the NHS have made the point (no one seems to know if it is literally true) that the NHS is a larger employer than the Red Army. This jibe cleverly combines the hint of overmanning, heavy bureaucratization, and socialist menace!

In effect, the United Kingdom’s Treasury acted as a single insurance company. The downside of this may be seen immediately: the premiums charged and the benefits (NHS expenditure) are to be decided by government, thereby inevitably politicizing the system. On the upside is the intrinsic efficiency of such a system: no multitude of insurance companies driven by a need for a profit margin, no armies of accountants in hospitals, no lawyers on both sides, and no billing departments. The “Red Army” jibe notwithstanding, the NHS was a lean and rather efficient organization with low management overhead costs.

HAS IT BEEN AND IS IT A SUCCESS?

For Americans in particular, who sometimes struggle to understand all this, it is important to explain that mainstream European political thought

still lies well to the left of its American counterpart. What many Americans would consider “socialized” often passes for the desirable public service norm in Europe. Suffice it to say that the survival of the NHS for more than half a century is, as suggested earlier, clear proof that it has been at least something of a success, if not an unmitigated one. Public support continues to this day. The system has continued to work, and the basic principles on which it was originally based appear still to be very widely supported.

Doctors themselves in great majority came to admire the NHS, and for many years they and other NHS workers maintained an element of idealism and good will toward it. The quality of health care remained strong, as represented by Chief Medical Officer Sir George Godber in 1972:

Having been at the centre since the earliest planning day, I am well aware of the many occasions on which mistakes have been made and yet, not withstanding considerable knowledge of comparable services of other countries, in a time of need for myself or my family I would now rather take my chance at random in the British National Health Service than in any other service I know.

And as one-time secretary of state for health in the 1960s, something of a legend himself in Labour politics, Richard Crossman once remarked, if you were seriously ill, the United Kingdom was as good a place to be as anywhere; the problem, he admitted, could be if you were not seriously ill but still in need of some more routine attention, such as minor surgery. There remains some truth to this analysis today.

WHAT WENT WRONG?

In a fundamental sense, very little went wrong. Or to be more precise, what went wrong was what has gone wrong to a greater or lesser extent with other health care systems, however organized, namely, a failure of investment and expenditure to cope with increasing demands and expectations in a world of new drugs, technologies, and treatments, particularly of an ever growing and articulate middle class. In

spite of its undoubted problems and shortcomings, there is much continuing interest in the NHS in such diverse countries as Australia, New Zealand, and the Scandinavian nations.

The impact of new drugs and technologies has been particularly great in very recent years. The fabric of the NHS was never purpose built but was provided by the original, often Victorian, buildings of its predecessor municipal and voluntary hospital providers taken over by Bevan. Its replacement and renewal have been slow. Visitors are often surprised at the poor fabric of some of our world-famous institutions even today. For 20 years or more, there were few complaints. The population was grateful for what it perceived, rightly or wrongly, as the best system in the world, and notwithstanding early vigorous opposition, there was enormous good will on the part of medical staff members. Over the next quarter century or so, and ever more so today, people are less tolerant of any shortcomings such as having to wait months for routine surgery in some parts of the country; even in a small country, the uniformity of provision is not easy to achieve. The fact that similar budgetary increases appear not to go as far as they did in the past has led to a perception of the deterioration of services, of their availability if not their quality. Thus, defenders of Margaret Thatcher may point to the many extra billions injected into the system during her long period in office, but others respond by pointing out that allowing for inflation, these massive sums represented a reduction in real terms in funding, especially when regard is paid to the greater inflation in the NHS than in the general economy pointed to earlier. Then, there is the matter of the diversion into management of a considerable proportion of new money under her market reforms to weigh in the balance.

THE THATCHER MARKET REFORMS

In the late 1980s, after nearly a decade of power during which she attempted

no fundamental change in the NHS, Mrs. Thatcher was presented with a small political crisis. She was concerned at bad publicity, particularly in the tabloid press, concerning alleged delays in surgery on neonates with congenital cardiac disease in one region of the United Kingdom. Two broad analyses of the problem seemed possible: that the NHS was underfunded and that this was but one manifestation of the fact or that it was adequately funded but inefficiently run. Most informed observers would have adopted a hybrid analysis but with emphasis on the former. Mrs. Thatcher opted for the second diagnosis. Using her bombastic secretary of state for health, Kenneth Clark, she launched a series of market reforms with a “purchaser-provider” split. New commissioning bodies would purchase health care (e.g., 3000 hip replacements) for the citizenry of their regions from one or more of the local hospitals. The hospitals, which in turn became “trusts,” had to create new bureaucracies to bid for the contracts in competition with other hospitals. At the same time, the general modern management philosophy was leading to the privatization of various services, such as food catering and cleaning, and to the creation of markets within hospitals with “cost centers” cross-charging one another for services. The flaw was immediately apparent: in effect, IOUs for public money were being circulated within and between hospitals and commissioning bodies, and the only real money involved was being used to fund the costs of operating the system. For the true believers in “the market,” it was a step in the right direction but a very modest and timid one. The iron lady had blinked in the face of British political reality. The great irony was that the NHS was set on the road to becoming what it actually had not been to that time, that is, a weighty bureaucracy [9].

The government decided on wholesale national change and resisted calls for pilot studies in limited administrative regions: doctors were quick to point out that in different circumstances, they would be criticized for imposing universally some new treat-

ment that had not been subject to clinical trials. For his part, Kenneth Clark, a politician in some ways not entirely dissimilar in style to Bevan, remarked to BMA leaders, “We’re not going to have pilot schemes because you lot would bugger it up!” This was certainly a vintage Bevanesque remark. Perhaps he was a student of history and knew of the doctors’ previous resistance to change.

Much of the new money coming into the NHS was diverted to the new management structures and systems, and in real terms, health spending proper fell. As these reforms failed to deliver improvements on the ground, in terms of the reduction of waiting lists or the improvement of fabric, disillusion set in.

After a few years of this in the early 1990s, the Tories were tired and a spent force. They were to hang on a few years more under a new leader, John Major, but were not to produce further change in the NHS—mercifully, most working in it would say. There was a sense of a caretaking role, and the opposition Labour Party, the government in waiting, stood ready with a simplistic slogan to “save the NHS.” This was a slogan the public at least *wanted* to believe in. Again, if not quite as in 1945, the nation was overwhelmingly ready to embrace change, and the NHS was high on the agenda politically.

During the 1997 election campaign, the Labour Party did not hesitate to play the NHS card, and with a week or so to election day, its campaign slogan of the day was “7 days to save the NHS.” As in 1945, the Labour Party won with a considerable landslide, and great expectations were invested in Prime Minister Blair, but he had no one but himself to blame for this, having himself raised those expectations. It would be fair to say that in the NHS, the country still awaits its savior. It has of course limped along, but with regard to investment, the new government, anxious to establish credentials for financial caution and anxious to avoid being labeled a tax-and-spend government, decided to stick to the outgoing government’s tax and spend plans, including, broadly, those for the NHS.

They left themselves little room for maneuver as a consequence.

Under pressure, the government advanced several tranches of new funding. The release of substantial sums into public services in general had to wait for the second Blair term of office and was initiated only a year or so ago, and its effects are yet to be felt and assessed. But there are anxieties— anxieties that much of the money may again be spent on administration; anxieties that though the sums are very large indeed, they may represent little more than a catching up exercise, especially given the accelerating effects of new drugs, technology, and procedures, and given the fact that, under the Blair government, the numbers of managers have continued to grow in spite of promises to reduce them; and there are anxieties even that after years of restraint on public spending, government departments have actually forgotten how to spend money.

A broader political problem for Labour is that it appears to have embraced what it despised in opposition, an approach dubbed the “private finance initiative,” a scheme to have the private sector build and run hospitals and lease them to the state for high rates over long periods, at the end of which they will not be owned by the state—like, some critics have said, paying a large mortgage for 30 years and then finding at the end that you don’t own the house. The government claims that it is the only realistic way to bring large amounts of capital investment to the NHS and renew its fabric; critics counterclaim that it is expensive money, and the cheapest money is available from the Treasury.

And it has launched a scheme, the details of which are still emerging and evolving but that, in brief, will allow some hospitals, and eventually perhaps all, to opt out of central “control” to some extent. Such hospitals will be called, somewhat mysteriously, “foundation hospitals.” These two schemes together, it is feared by many, herald the eventual privatization of the NHS.

The attitude of doctors and staff members in general at the moment is a cynical, world-weary one. After the

years of never-ending change without obvious improvement, they feel less valued and feel, with certainly considerable justification, that they have been expected to shoulder greater and greater clinical burdens and greater and greater administrative burdens (see below). Much of the long-standing good will and dedication have evaporated. Recent tortuous and at times farcical and amateurish negotiations conducted with the Department of Health by the BMA on behalf of the doctors yielded a confusing and apparently “family-unfriendly” new draft consultant contract that was overwhelmingly rejected at ballot. The doctors are now cynical about both the government and the BMA. Compounding all attempts at improvement is a severe shortage—a worldwide phenomenon—of doctors, nurses, radiographers, and several other key staff members. Morale is not what it was.

THE GROWTH OF BUREAUCRACY AND MANAGERIALISM

This appears to be a worldwide phenomenon that probably has its roots in the corporate America of the 1960s [10]. Management techniques, management theory, management courses, and management consultancies all began to flourish in that period and continue to grow in strength. It is important to stress that this is not a public-sector phenomenon, but the public sector has certainly also fallen prey to its influence. The managerialism that now besets the NHS does not spring from any bureaucratic, statist, socialist roots but, ironically, has been grafted on to it by marketers wishing to increase its efficiency when, most would have argued, its real needs are for money. In the United Kingdom specifically, other drivers have contributed to a growth in what amounts to big government’s direct engagement in the NHS, supposedly for the common good.

We have seen the establishment of formal structures for monitoring the performance of doctors and other staff members: annual “appraisal,” “clinical

governance,” “audits,” and so on. It is absolutely not that any one of these things is undesirable or of no use but rather that each has become something of an industry, and enormous amounts of time, which could be usefully used by an overstretched profession for clinical care, are now devoted to these new activities.

At the national level, we have a proliferation of statutory bodies monitoring performance and activities in a variety of ways: the Commission for Health Improvement, which inspects hospitals or departments; the National Institute for Clinical Excellence, which pronounces on which new drugs and treatments are proven and acceptable; the National Clinical Assessment Authority, which examines the competence of individual doctors when a complaint is made; the National Patient Safety Agency, which looks for disturbing trends; and so on, and so on, all well-meaning and intended to prevent patient harm but all indicating that the mood is for more external rather than self-regulation.

At the local level, every hospital has its clinical governance and “modernization” teams. Again, there is little wrong with looking for new approaches and sensible changes in working practices, but the whole exercise betokens the fact that in government, the persisting diagnosis is that the NHS has failed to meet expectations because of its inefficiencies or because of the Luddite tendencies of doctors and others. This is a convenient diagnosis because it absolves politicians from having to admit that they have spent more than a decade administering the wrong treatments.

CONCLUDING THOUGHTS

Consider these comments from two people intimately involved with the NHS:

[I like]...that it is there. I was a child of the thirties and have vivid memories of pre-NHS life for the poor (we lived in the east-end of London). I had no professional care at all in spite of having TB at some point as a routine chest X-ray later showed when I started in my nursing career....So for

me long may the NHS flourish...[I dislike]...the political vulnerability. Despite being the most important political achievement of this century (any century?), politicians find it easy to starve it, misconstrue its values, kick it, complain about its costs. If ever there was a construct that has a value far in excess of its cost, it is the NHS. Yet too many of the well-heeled who don’t need it as much as the majority regard it as a merely political object. (Clare Rayner, chairwoman of the Patients’ Association, 1998)

I love the whole concept of the NHS—a system in which everybody has an automatic right to treatment and where treatment does not involve financial negotiations with the care giver. I cannot imagine a system that is more efficient or more egalitarian. [I dislike]. . .the fact that it is underfunded, that there are those who would wish to dismantle it, that it is sometimes slow to embrace advances, and that I have to spend time defending it. (Dr. Joe Collier, St. George’s Hospital Medical School, London)

Yet we now face in the United Kingdom a tragicomic situation: the NHS is widely deemed to be something of a success in a world where health care systems everywhere are in considerable difficulties. It has survived for more than half a century under governments of varying political colors. But from its inception it was, by general consensus, underresourced, taking up a mere 6% of the GDP; it consequently failed to meet all, particularly modern, expectations, particularly fast-growing late-20th-century and early-21st-century public demands; so it was given more managers and a pseudomarket structure rather than the extra funding it needed—indeed, what extra funding it did actually receive went largely into structures and management; predictably, this did not deliver the goods; when, finally, it was given genuine new money, in substantial headline amounts, this was probably no more than would be required to catch up on even recent years of underfunding; and in fact, much of it is again being diverted to growing managerialism. Not surprisingly, we may be yet again at the point of failure to meet expectations and at the point at which some will say, “we’ve tried everything, believe us, but

it won't work—we'll have to try a different way.”

Politicians are unlikely to make the diagnosis that they got it wrong throughout and have been administering the wrong, expensive treatments for years. The danger is that they may now carry more of a frustrated public with them in throwing it all away. It would indeed be a savage irony if this were to happen at a time when all other health care systems are in at least as serious difficulties and are actually casting a new eye on the positive achievements of the British NHS model.

I might conclude with the thoughts of Sir Humphrey Davy Rolleston, physician to King George V: “Medicine is a noble profession but a damned bad business.”

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