

The 1991 National Health Service reforms and their implications for patients, doctors and medical students

The problems facing health care in Britain in 1991 are not new—but some of the proposed solutions are. In the 1820s the Board of the Middlesex Hospital was told that more expensive drugs were being dispensed than was proper for a charitable institution and the use of leeches had risen to about one hundred a day. As leeches cost 16 shillings a hundred it was suggested that each be used twice! By the end of the century, civil servants saw the solution with a clarity even Mrs Thatcher would have admired. 'The object of the hospitals', wrote Sir H. C. Burdett in 1893, 'is to cure with the smallest number of beds the greatest number of patients in the quickest possible time'.

Fifty years later a broader, kinder concept of health care for the nation was stirring in the corridors of power. In 1943, Sir John Hawton, permanent secretary at the Ministry of Health, made the revolutionary statement:

The British Government have announced that they intend to establish a comprehensive Health Service for everyone in the country. They want to ensure that in future every man, woman and child can rely on getting all the advice, treatment and care which they may need . . . that what they get will be the best medicine and other facilities available; that their getting them shall not depend on whether they can pay for them, or on any factor irrelevant to the real need to bring the Country's full resources to bear upon reducing ill-health and promoting good health for all its citizens.

This statement was not rabid socialism but the pronouncement of a national coalition government under the premiership of Winston Churchill. Admittedly by the time the NHS bill reached parliament the war was over and the government was socialist but the template was set long before.

Forty years on, the NHS has become the largest industry in the country and one of the largest in the world, with over one million employees. Costs have been escalating for all manner of reasons although they still only amount to about 6% of GNP in Britain. Greater accountability had become imperative if the

NHS supertanker were to remain afloat and controllable. This accountability was managerial, financial and medical.

The American professor Alain Enthoven, who advised the British government on its current NHS reforms, recently emphasised that there were two major alternative approaches to achieving greater accountability. The first he described as the 'Honda method', a process of rigorous quality control at each stage of the process; success is measured as value for money. The second was an internal market with rigorous financial control, success being measured by solvency or even by profit. He said that, 'being American', he had recommended the latter approach for an experimental, limited trial. He completely dissociated himself from its across the board, precipitate adoption.

The internal market involves three principles: explicit purchasing (with separation of purchaser and provider functions), capitation funding (a standard unit of resource on the head of each member of the population) and contract-led resource allocation by purchasers with competition between providers on price and, if it can be defined, quality of service.

Explicit purchasing has the merit that costs of service have to be identified and can theoretically be compared, although the methods for their derivation at present seem diverse. It may also help local health authorities to be more discriminating in purchasing what the community thinks it needs—but the community may or may not be sensible in its priorities. On the other side of the coin, it becomes almost impossible to plan a coherent National Health Service out of a diverse, uncoordinated series of parish-pump operations.

Capitation funding has the merit of moving away from historical patterns of distributing resources which many would perceive as unfair, inappropriate, or both. On the other hand, demands on health care are legitimately very different in different parts of the country, especially in relation to poverty, mobility of population, age structure, sufficiency of social services and adequacy of general practitioner services. Unless these special factors are properly recognised and capitation appropriately compensated, deprived populations will suffer. Inner city hospitals will be at grave commercial disadvantage not only as they cope with those higher service demands but also as some have national responsibility for coordinating medical education and spear-heading clinical research in a multidis-

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ciplinary university setting. The internal market was not designed for, nor is it an appropriate means of, deciding which long-term coupling of NHS and university resources should continue to provide national leadership into the twenty-first century.

Contract-led direction of resources has the superficial merit that resources accompany work. But instead of resources following the decisions of patients and their GPs, patients in fact are required to follow contracts, and GPs, unless budget-holders, have effectively lost their professional freedom to tailor-make referrals. Extra contractual work for the rootless and homeless may break the bank. Inner city hospitals may find themselves in an analogous position to one of the University of California hospitals facing a large deficit, not because it was inefficient but because it had only 5% of the facilities and served 60% of the indigent patients. Under the reforms other questions arise, including what work will be done and how it will be funded when and if the contractual work has been completed before the year's end. Costs continue but income will cease even if, as is likely, work remains to be done.

The medical profession was and substantially remains concerned, not just out of pique that such far reaching changes were decided without consultation and debate, but at the blanket introduction of such fundamental change without experimental trial. It also appeared that a vast investment was to be made in bureaucracy and information systems which, if not recouped in more than commensurate efficiency, could only become a charge on patient care. Currently only about 5% of NHS resources is spent on administration; if it rises towards the American figure of 15–20% a major increase in efficiency must result if patient services are not to diminish. Is such an increase in efficiency a realistic expectation? Further, the profession is worried about loss of its ability to guide patients in their choice and in elements of a two-tier service in response to competitive contracting. And fears remain that the internal market will damage the university centres of teaching and research.

There can be no doubt that the government did not intend NHS reforms to damage the education of students and doctors, nor that it should harm clinical research. The White Paper itself, titled *Working for patients* (as if politicians did and doctors had not), stated: 'The Government is firmly committed to maintaining the quality of medical education and research'. A few months later the Secretary of State for Health went further, saying:

The comprehensive and high quality Health Service which will be needed to face the demands and challenges of tomorrow's world will depend crucially on the standard of medical education we provide, and on the range and quality of the nation's medical research programmes. Both are an intrinsic part of our commitment to the NHS.

To compensate university hospitals for the service costs associated with undergraduate medical education, the government continued the provision of a health service resource called the Service Increment for Teaching (SIFT) but in return for a 5% increase in resource it also redefined SIFT so that it would also be expected to defray service costs of clinical research; 'and Research' was added to the designation of SIFT which now became known as SIFTR. Much work will be needed to identify this resource in current expenditure and to find a way of extracting it so that it can be specifically re-injected to promote both teaching and research.

One potential advantage of the NHS reforms is the incentive to target the use of SIFTR in specific support of teaching and research and the quid pro quo of a contract for teaching which encourages greater accountability and a clear educational strategy. The professionalisation of teaching is enhanced, moving on from a marginal, grace-and-favour activity, albeit performed conscientiously and effectively by the great majority of consultants and junior staff, to a more clearly stated task.

Nonetheless, universities remain concerned that the ability of main university teaching hospitals to continue as leaders in service, education and research will inadvertently be undermined. Where teaching medical students is concerned, the inspiration students derive from learning everyday clinical practice, scientifically, humanely and critically from men and women at the frontiers of their subjects will be lost because patients with common conditions will be diverted to less expensive or more local hospitals on grounds either of cost or of parochial institutional self-interest. The leaked and undenied prediction of the Department of Health that the internal market will reduce hospital services in inner London by 20–30%, with insolvency of at least one major university hospital, strongly suggests that concern is well-founded. The problem is not confined to London but it is greater there.

Does it matter if the teaching of basic clinical skills is farmed out to busy practitioners at peripheral hospitals—indeed is apprenticeship not the name of the game? Should clinical academics at the main university hospitals not be left to win Nobel prizes unencumbered by undergraduate students? Of course there is and should be a balance of teaching and experience in these different settings and indeed in the community, and a balance between personal and population medicine. But learning today's practice is insufficient preparation for what the Secretary of State for Health referred to as 'the demands and challenges of tomorrow's world'. We all face a bewilderingly rapid succession of tomorrows in our professional lifetime.

It is an old argument, formulated by Abraham Flexner, the American professor who reported on medical education in London shortly before the First World War:

The family doctor being what is called a practical man, it is urged that he is best trained in an unambitious institution where he is taught by experienced practitioners what to do in definite emergencies he will encounter. Such medical teaching regards itself as preparing the student to be a higher sort of artisan. As against it one may urge that medicine is in the strict sense a profession—a profession being definable as an activity in which practice and progress are closely interwoven and constantly reacting on each other. The more isolated the doctor is apt to be, practising in the country or in a remote village, the more important that a medical training which thoroughly rouses his intelligence should send him further with a momentum that may carry him further every day of his life.

The university must have students at their most formative moments in order to inspire, rouse the intelligence and to generate momentum for life. This is the task of an interdisciplinary team working for patients

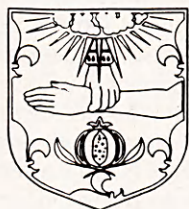
through service and research at the frontiers of knowledge while at the same time teaching medical students high standards of care of patients with common conditions.

Finally, what do patients make of the NHS reforms? In short, they are bewildered and uncertain. Those organisations concerned with patients' interests seem far from sanguine. To take just one example, Fedelma Winkler, Director of the Greater London Association, was quoted as saying:

the shift of power to managers and the consequent weakening of professional power does not enhance the status of patients.

This article is based on a paper given at a conference of the American College of Physicians held in New Orleans in April 1991.

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