

The English NHS: Key attributes and challenges

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The English NHS is one of the archetypes of health system, known worldwide as the “Beveridge,” or national health service, alternative to Germany’s “Bismarck” model of social insurance. Together, Bismarck and Beveridge, or NHS and SHI, are the two ideal-types of health system referenced in global conversations. Discussions of their relative merits and flaws have influenced health reform politics in almost every country. There are six key things to know about the English NHS.

First, it is funded out of general taxation, rather than social insurance. The UK government determines the budget each year. Conservatives systematically spend less than Labour, so changes in its funding tend to follow party politics rather than need. As a result, the NHS tends to exist in a situation of feast or famine. Labour governments in good economies spend a great deal, and generally see better health care quality and satisfaction as a result. Conservative governments and Labour governments under financial pressure typically impose austerity on the NHS, and over time this translates into understaffing, deteriorating physical infrastructure, and public discontent.

Being funded out of general taxation also means that the NHS is very effectively redistributive. Ill health is correlated with poverty while the wealthy pay more taxes. Simply by being financed out of general taxation and then doing its job of treating the sick, the NHS is redistributing from richer to poorer parts of the population. Even if this point is rarely articulated, we can imagine that it might explain the relatively weaker support for the NHS at the top of the income spectrum.

Second, the NHS is run by the government and its professionals are government employees or contractors. Hospital doctors are employed by the NHS directly. General practitioners, who are the heart of primary care, are organized into independent businesses, but their independence is something of a fiction as their only client is the NHS. Professional autonomy, over how to treat individual patients, is very strong, but doctors do not control the management.

As a result, the NHS is easy to reorganize- too easy, in fact. Many governments find it too easy and agreeable to reorganize the NHS rather than deal with the more detailed problems of quality and investment that actually improve health care. One can have some sympathy for them. The English NHS is the world’s fifth largest organization, with approximately 1.1 million staff, many of them professionals who regard managers as interlopers in their professional domains. But the often fantastically complex

organizational designs that result are frequently costly, confusing, and unworkable. That is the case for the current system created by David Cameron's Coalition government.

When we put these first two facts together, we can see the third fact: the state of the NHS depends on government decisions. The English are right to hold their governments accountable for their health care. Since the government owns and can organize the NHS as it sees fit, it is actually reasonable and legitimate for individual patients to hold national politicians to account for their treatment. Politicians will try to lay the blame for problems on unspecified managers, but there is a clear public view that the reason for long waits for treatment is mismanagement and inadequate finance from the politicians. The argument that the NHS is somehow unaffordable and should be privatized, or converted to social insurance, has been marginal for decades and looks likely to remain so. There have also been proposals for more local accountability and more of a role for local government in health for the whole history of the NHS, since there are obvious problems with having national political accountability for local problems. These proposals have rarely had much impact either, in part because of an ingrained English distrust of local government. The NHS is, as its name suggests, still a fundamentally national service.

Fourth, the NHS is a very good health system. International comparative research, such as the ongoing quality surveys conducted by the Commonwealth Fund¹ shows that the English NHS is extremely high quality for the money spent on it. When the Blair government spent more money on it, quality improved as well.

The problem is that "health care quality" encompasses many things, from "hotel" services such as comfortable beds and quick appointments, to reliable execution of procedures for problems such as hernias or cataracts, to preventative medicine that avoids future ill health, to daring operations at the technological frontier that by nature often end in failure. Each of these different indicators of quality has different measures of different sophistication. But the problem is that patients, above all, see and rate the quality of hotel services: were the staff nice, did my appointment happen on time, do I feel like I have a personal doctor, could I choose my doctor, could I call in a second doctor involved for a second opinion, did I have a long wait for a procedure, did I have to share my room, was the food good, could I sleep well? These are exactly the kinds of problems that a highly efficient service will often address poorly. In the English NHS, the answer to all these questions is frequently no. NHS patient satisfaction suffers in all but the best times, and its efficiency is underpinned by policies such as limited choice of doctor, no ability to refer oneself to a specialist, or rationing by waiting times for non-urgent procedures. There are systems in Europe with higher patient satisfaction that on any other measure are delivering worse overall care measured by metrics such as avoidable mortality, financial cost to patients, excessive prescriptions or medical errors.

Governments, responsive to these concerns, have accordingly focused on increasing patient choice and cutting waits. Obviously, a shorter wait for a debilitating condition that is not life threatening (such as optical cataracts) is a good thing. But frequently we find that raising patient satisfaction actually reduces the efficiency, however measured, of the

¹ www.cmwf.org

system. When funding is tight, the NHS can survive for years maintaining clinical quality at the price of diminishing patient satisfaction.

Since 2010 Conservative funding policies have increased waiting times and limited choice simply by reducing the amount of money going into the NHS relative to need for health care. As of 2018 the results are becoming visible. Patient satisfaction started to drop after a few years of austerity as people found themselves waiting longer for appointments or noticing their carers seemed overworked². Now, clinical quality is being endangered. The NHS is, for example, using hospital beds at a very high occupancy rate. Not only does this mean that a predictable influx of patients, such as we see during influenza season, can lead to cancellations of elective operations such as cataract surgery and justifiably angry patients. It also means that keeping hospitals clean and managing healthcare acquired infections becomes harder. A hospital with more than about four-fifths of its beds occupied is a hospital risking an outbreak of infection and by 2018 almost every facility in England was above that occupancy rate. This creates the “winter beds crisis” which is a recurrent feature of the NHS and is becoming longer and more serious every year. Likewise, at first cutting nursing slots and not hiring doctors produces poor patient satisfaction, but after a while it starts to endanger the quality of care. Finally, reducing the public health budget, which has also happened dramatically since 2010, also leads to worse health- a cut in smoking cessation service funding in 2010 can easily mean an increase in (more expensive) heart disease ten years later.

In short: the NHS is a remarkably good health system, arguably the best quality care at the lowest price of any health system. It often maintains this high quality medicine at a low price at the price of patient satisfaction. And ultimately efficiency is no substitute for inadequate funding, and by almost any standard NHS funding since 2010 has been flatly inadequate. This is not the first time we have seen this. The Conservatives tried hard to keep NHS funding down in the 1980s and 1990s, and reorganized it multiple times in the hopes that different management structures could squeeze more out of its funding. By the mid 1990s the quality of the system, measured by patient satisfaction or clinical outcomes, was deteriorating rapidly- and the Conservatives faced the consequences in the 1996 election that gave Labour a landslide on a promise to “save the NHS.”

Fifth, much of the reason for the resilient quality and efficiency of the NHS is in its basic structure, which is highly integrated and has strong primary care. Primary care can be very efficient. For many patients, a short interaction with a primary care practitioner, who need not be a doctor, is all they need (most health problems go away pretty quickly, remember). This is the basis of “gatekeeping” which is the single biggest reason that the NHS systems can provide good quality care efficiently. There are basically two ways to access NHS care: via the gatekeeping general practitioner (GP) or in a serious emergency via an ambulance or hospital accident and emergency (A&E) department. Before anybody is referred to a specialist for non-emergency care, therefore, they have seen and often been treated at the primary care level, and at far lower cost than a specialist or hospital care.

Meanwhile, for the increasing number of patients who have multiple health conditions, the problem is managing low-key treatments such as medicines regimes over

² Follow the Kings' Fund surveys: <https://www.kingsfund.org.uk/projects/public-satisfaction-nhs>

the years, and a local primary care provider is well equipped to do that with greater effectiveness and at lower cost than a specialist doctor. Primary care also avoids the fragmentation of care that can arise when a patient is being treated by multiple specialists who might not coordinate.

Sixth and finally, the English NHS is not the only NHS. In 1998, Northern Ireland, Scotland, and Wales each gained autonomous elected governments with great authority over their NHS systems. As a result, the different systems began to diverge. Over time, the three “devolved” systems of Northern Ireland, Scotland, and Wales all began to converge anew on a similar structure, albeit with different names and formal justifications. In this model, the health service is organized into integrated territorial boards that are responsible for most of the health care in their area, with only a few issues such as public health or ambulances organized by specialist organizations. This is administratively simple and reduces barriers to innovation and integration by giving the board incentives to opt for the most efficient way to deliver health care in any given situation. It reduces the number of managers and complexity that England’s various experiments require, with no identifiable loss of efficiency or quality.

In terms of outcomes, Scotland’s NHS is cheaper and more egalitarian, while systems of Wales and Northern Ireland also have different models and priorities and do not seem to deliver care that is overall quite as good as England and Scotland. By some standards, such as low administrative costs, the Scottish NHS is one of the best health care systems in the world, even better than England. Like the other devolved systems it has failed to compensate for the generally poor health of its population. Overall, though, there is no clear difference in the quality of the four health systems- England and Scotland probably deliver better quality care in most circumstances, but the data do not justify saying much more.

The advantages and disadvantages of the NHS system stem from these characteristics. It is redistributive because the rich pay higher taxes and the poor have worse health. It is far better at care integration and far more efficient than systems with more autonomy for doctors and patients, and it is especially good at prioritizing and using evidence to inform care. It is vulnerable to political interference and politics determines its budgets and priorities. It is less good at patient satisfaction- but the promise of free care to anybody ordinarily resident in England when they need it, in egalitarian settings, makes it so much loved that it has been called the real church of England. That explains what might seem so striking about the NHS, which is the combination of constant public complaint about it and deep public support for it.

What challenges face the NHS? The NHS systems face the challenges of every European health system: an ageing society and an increase in noncommunicable diseases attributable mostly to obesity and sedentary lifestyles as well as the increasing risks of disasters and outbreaks attributable to climate change. In England, as elsewhere, it is common to speculate that ageing and the rise of noncommunicable diseases will bloat health care costs and make the system unaffordable. There is no particular evidence of that in general- it is the end of life rather than an old age of chronic conditions that is expensive. For most people in rich countries, their last six months will be by far the most expensive health care, and that is true whether they die at eighty or eighteen years old. Better medical treatment turns what used to be acute and quickly fatal illnesses, such as

cancer, AIDS, and diabetes, into long-term chronic diseases that require different management techniques. What is required instead is a reallocation of resources to manage chronic conditions over decades. The NHS systems are well positioned to handle these changes for two reasons. First, they are run on less expenditure per capita than most comparable systems so simply getting to the average expenditure of Germany or France would constitute a major increase. Second, the integration of services and strong primary care that mark the NHS are both better suited to managing long-term chronic conditions than more fragmented and competitive systems.

The Brexit vote shows how much the public values the NHS, even if it creates the real and distinctive challenge for the NHS. A campaign bus used in the Brexit campaign famously, and mendaciously, had this claim painted on it: "We send the EU £50 million a day. Let's fund our NHS instead." It even, illegally, used the NHS logo. Public opinion research shows that this claim was one of the most effective that Brexit campaigners made. It was also both wrong on its own terms, and disguised the threat that Brexit poses to the NHS. First of all, it is almost inconceivable that Brexit will improve the UK's economy, so there will be less money to spend across the public sector (the *Financial Times* estimate is that Brexit will cost the UK economy almost exactly £50 million a day, or £350 million a week- a painful irony for those who remember the slogan on the bus). Second, the NHS is heavily reliant on EU citizens at all levels from specialist consultant doctors to porters in hospitals. Uncertainty about their future status and discomfort with life in Brexit Britain has already led to an outflow of EU citizens in professions such as nursing. The NHS, already under a regime of low salary increases and little new hiring, is being cut off from sources of cheap skilled labor from the EU. Third, until the ink is dry on every agreement there is a risk that UK citizens, especially pensioners of no great wealth, who have settled elsewhere in the EU will need to return to the UK and receive health care in the UK rather than Spain or some other EU member state.

The result is likely to be negative-sum: the UK has been a labor market of last resort for overqualified people from many EU countries, and therefore could get away with underpaying staff because it offered more interesting work and in many cases more meritocratic hiring procedures. The UK, profiting from this situation, underinvested in professional education and training. Now, a UK that is structurally unequipped to train enough people to staff the NHS is losing access to the EU labor market while well trained Europeans who could not find sufficiently interesting or lucrative work in their home systems will lose the opportunity to work in the UK. A UK political system entirely engrossed in Brexit thinking, and an NHS with no spare policy or managerial capacity, are unable to remedy this problem. A false claim about the NHS might have decided the referendum in favor of Brexit but it has created the greatest challenge the NHS has faced in a long time.

In conclusion, the NHS model, as implemented around the UK offers a great deal: high quality, high efficiency, made possible by strong primary care and integration across services. As Scotland shows, its management and administration costs can be extremely low. In addition to good quality clinical health care, and often strong prevention through its public health and primary care arms, the NHS systems are redistributive from rich to poor and sustain one of the world's largest and most sophisticated biomedical research establishments. Facing a system with these advantages, governments have funded the system to promote satisfaction, or tried to see how long they can avoid increasing funding

without being punished at the polls. They have reorganized the management. But no serious British politician advocates replacing the NHS with something else, since from their perspective every other broad type of system is less egalitarian, more complex, less efficient and probably lower quality. It is no wonder, then, that the NHS systems are popular with the public and that the claim about funding the NHS probably tipped Brexit into success. What British politicians do not always do is recognize that efficient use of resources is ultimately no substitute for the resources themselves. That is a lesson that British governments tend to learn the hard way -when the electorate teaches them.

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