Lessons Learned from the United Kingdom National Health Service (NHS)

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I have no relevant disclosures

History of the NHS

• Before 1948 all health care in the UK was the responsibility of private individuals
• Charities and churches did often help with the costs
• Government did pay medical costs for the military
5 Stages Towards the NHS

• Pre World War I
  • 1911 National Health Insurance Scheme introduced by a reforming Liberal government
    Workers were forced to contribute to a special fund that would help pay if they got sick or were unable to work.
    Although only available to workers Not their wives or children

5 Stages towards the NHS

• World War One
  • The government had to massively expand hospitals and medical care for the millions of soldiers mobilised
  • Soldiers were promised a “Country fit for heroes” to thank them for their sacrifice
    However, there was little money spare after the costs of war were accounted for.
5 Stages towards the NHS

• Inter War Years
  • The development of the Labour Movement
    • Socialist ideology wanted to help working class people
    • It believed in sharing out the resources of the country in an equitable way
  • The Labour party gradually gathered strength throughout the 1920s and 1930s
  • The Great Depression of the 1930s showed how vulnerable the poor could be

5 Stages towards the NHS

• World War Two
  • Blitz brought the casualties to the civilian population
    • Not just soldiers getting injured this time around.
  • Coalition government of Labour, Liberals and Conservatives all working together for victory.
  • 1942 Beveridge Report
    • Britain would benefit from a “Cradle to Grave” social security system
    • Healthy citizens would be needed to rebuild Britain after the war.
    • The report was popular with soldiers fighting and the civilians at home.

5 Stages towards the NHS

- Post World War Two
  - Labour Party elected with a huge majority in 1945
  - 1946, they proposed creating a National Health Service available to all paid for through national taxation.
  - July 5th 1948 the NHS is created!

SOURCE 10. From a speech made by Nye Bevan in 1945:

"Medical treatment should be made available to rich and poor alike in accordance with medical need and no other criteria. Worry about money in a time of sickness is a serious hindrance to recovery apart from its unnecessary cruelty. The records show that it is the mother in the average family who suffers most from the absence of a full health service. In trying to balance her budget she pays her own needs last... The essence of a satisfactory health service is that the rich and the poor are treated alike, that poverty is not a disability, and wealth is not advantaged."
Opposition to the NHS

- Opposition came from the Conservatives who believed that the free market was the best way of allocating resources. They were mostly worried about the cost.
- Many GPs and doctors were also against the idea of standardised contracts.
- Local authorities were not keen to lose control over local health provision.

Opposition to the NHS

- Bevan conceded generous contracts to win over the British Medical Association.
- Hospital Specialists guaranteed good salaries and allowed to treat private patients in NHS hospitals.

British NHS

- National Health Service, first comprehensive, nationalized healthcare program.
- Highly centralized management and finance.
- Providers can have public & private practices.
Principles of the NHS

- Universal coverage
- Free of direct charge
- General taxation source of finance for NHS
- Pooling of financial risk at centre
- Collective provision
- Promotion of advances in medical science

What does the NHS actually do?

- Hospital services
- Medicines made available by prescription
- Dental services
- Family doctor Service
- Ante-Natal services
- Post-Natal services
- Vaccinations & Immunisations
- Physiotherapy
- Mental Health facilities
- Training of doctors and nurses
- Conducts research
- Screening
- Health Education
  - Health warnings
  - Family Planning

UK: OECD 2013

- Population: 61.7 million in 2011
- Life Expectancy: 78.6 male/ 82.6 female
- Infant Mortality: 4.2 per 1000 (2010)
- Population over 65: 16.2%
- GDP for healthcare: 8% (2010)
- Total health expenditure per capita per annum: $3405
Health Services Workforce
More than 1 million employees, largest single employer in Europe
- MD’s: 2.8 per 1000 pop (OECD 2011)
- General Practitioners (GPs):
  - 60% of NHS workforce
  - Approximately 35,000 GPs in 9,000 practices
- GPs handle 90% of episodic care; gatekeepers
- GPs paid by mix of capitation, salary, fees

Health Services Workforce
- Specialists are hospital based, called "Consultants."
- Specialists/Hospitalists are salaried
- All MD’s can have public and private practices
- Nurses largest group within NHS staff
  - 40% of NHS budget
- Work closely with GPs in the community

Hospitals
- More than 2000 public or NHS trust hospitals
  - NHS Trusts
  - NHS Foundation Trusts
- About 300 private/surgical procedure facilities
NHS Trusts (Hospitals)

- Hospitals in the NHS are managed by NHS Trusts
- Their wide-ranging services are commissioned – or purchased - on behalf of patients by Primary Care Trusts (PCTs)
- NHS Trusts employ most of the NHS workforce
- Hospital treatment is arranged through a GP, except emergencies
- Appointments and treatment at NHS hospitals are free

NHS Foundation Trusts

- New type of NHS hospital run by local managers, staff and members of the public
- Only the highest performing hospitals can apply to become NHS Foundation Trusts – a status which gives them much more freedom and autonomy in running their services than other NHS Trusts
- However, Foundation Trusts remain firmly within the NHS and its framework of standards

Private Market

- 12% of Britons have Supplementary Insurance
- Doctors & hospitals treat both public and private patients
- Private insurance pays for treatment in private hospitals as well as dental, vision, some prescription drugs
Economic Factors

- **Revenues**
  - 83% NHS funding from taxes
  - 13% from employer-employee contributions
  - 4% User fees

- **Expenditures**
  - NHS accounts for 88% of health expenditures
  - Private Insurance 4% of expenditures
  - 3/4 of NHS budget goes to workforce salaries
  - 1/10th of NHS budget goes for drugs

NHS Expenditure Early 2000s

Although the United Kingdom spends considerably less on health care than the United States, by most measures of mortality and morbidity the UK does about as well.
How does the United Kingdom keep its health care expenditures this much lower while providing universal access to health care?

Though patients have relatively easy access to primary and emergency care, specialty care is rationed through long waiting lists and a limit on the availability of new technologies.

• A system such as the NHS depends on queuing (waiting lists) for access to care, as well as postponing, or simply not providing, certain services.
• The NHS devotes considerable resources to high-return services as prenatal and infant care.
• To the populations served, and to the larger public concerned with equitable provision of care, the universal nature of the service is beneficial.

• Despite universal access to care in the United Kingdom, historically there have been considerable regional disparities in funding and in the use of health care.
• Evidence shows that upper-class patients have received substantially more care for a given illness than have lower-class patients.
Current Challenges in the NHS

- Aging population
- High cost of advanced technology and its impact on tight budgets
- Increased incidence of serious and expensive to treat diseases (cancer, HIV/AIDS)
- Recognition that the UK was lagging behind similar countries with lower cancer survival
- On-going problems with long queues and rationing

Motivations for Reform

- Control rising cost of medical care, reflected in increasing health shares of GDP, driven by ageing populations and technological progress
- Improvement in access to medical care and reductions in health inequalities
- Improvement of quality of medical care
- Reductions in inefficiencies, duplication in the medical system
- Improvements in health outcomes (survival rates, raising life expectancy)
- Reducing public dissatisfaction with medical care and increasing patients' choice of treatment
Objectives of Health Reforms in the UK

- Control cost of medical care
- Improve efficiency so that health spending has greater impact
- Reduce bureaucracy, strengthen purchaser-provider split, increase competition
- Devolve decision making and resource allocation to General Practitioners
- Give patients greater choice of treatment paths

NHS Developments and Reforms: 1948-1980s

- Substantial growth of NHS and quantities of services provided
- Significant increase in medical technology in NHS and in quality of care
- Continuing increase in the cost of the NHS (HE % GDP rises from 3.5 % to 8%)
- Improvements in almost all measures of health outcomes (e.g. life expectancy)
- But shortages, queuing, rationing
- Reforms introduced to improve performance

Health Reform Waves: 1990-2000s

- Early 1990s: Introduce market-style mechanisms, greater competition, purchaser-provider split
- Mid 1990s: Criticism of market mechanisms, unclear impact on efficiency but worse equity and access
- 2000s: Emphasis on quality of care and patients’ rights. Patients in NHS can choose provider and funds follow
Health Reforms in the UK in the 1990s

- 1991 Introduction of the “internal market”. Purchaser-provider split. Purchasers were District Health Authorities or fund holding General Practices
- 1994 Total Purchasing Pilot Scheme allows GP fund holders to commission (purchase) all services

Purchaser-Provider Arrangements in the NHS in the 1990s
Developments of Health in the UK in the 2000s

• 1997 GP fund holders abolished in favour of Primary Care Trusts (PCT) that maintain Purchaser-Provider split
• In 2002 Phasing out of Health Authorities, move to 152 PCTs with average population of 300,000 and responsibility for £80b (80% NHS)

Primary Care Trusts

The center of the NHS, control 80% of the total NHS budget
PCTs are responsible for:
• Assessing the health needs of the local community.
• Commissioning the right services, for instance from GP practices, hospitals and dentists.
• Improving the overall health of their local communities.
• Ensuring access to services
• Monitor interaction of social and healthcare organizations.
• Annual assessment of GP practices in their area.
• Buy and monitor services

Primary Care Trusts

• Primary Care Trusts are the center of the NHS, control 80% of the total NHS budget
• Assumed responsibility from district health authorities of commissioning (purchasing) of community, secondary care and tertiary/specialised services
• Primary Care Trusts are subordinate to the Strategic Health Authority
Role of Strategic Health Authorities

- Strategic Health Authorities manage the NHS locally and are a key link between the Department of Health and the NHS
- Local health service planning
- Monitoring quality
- Increasing the capacity of local health services
NHS Trusts and Foundation Trusts

- NHS Hospital Trusts
  - Hospital trusts subordinate to Strategic Health Authorities and need to satisfy annual accountability agreements
  - More freedom of activities than previously
  - Provide services to PCTs
  - Must satisfy standards set by Care Quality Commission

- Foundation Trusts
  - NHS Trusts that are promoted by Monitor because they satisfy stringent criteria concerning financial viability
  - Greater autonomy in medical and financial activities
  - Provide medical services to PCTs in accordance with contracts
  - Must satisfy Monitor and Care Quality Commission

Parliamentary Report on Commissioning (Purchasing) in the UK NHS in March 2010

Conclusions from House of Commons March 2010 Report on Commissioning

- Expensive: rise in share of NHS administration from 5% pre-reform to 14% (lack of transparency)
- PCTs lack necessary skills (analysis, clinical knowledge, management), do ineffective job in commissioning
- Weaknesses of PCTs force them to make extensive use of expensive outside consultants
- PCTs remain weak relative to providers and do not insist on hospitals using evidence-based procedures
- Adversarial system without benefits. "After 20 years of costly failure, the purchaser/provider split may need to be abolished."
Parliamentary Election, July 2010 White Paper, December 2010 Health Reform Bill

- May 2010 parliamentary elections in UK. A government formed from a coalition of Conservative and Liberal Democrat parties.
- Neither party had radical reform of the NHS in its election manifesto
- July 2010 government published White Paper on Equity and Excellence: Liberating the NHS
- Proposes radical reforms to organisation and functioning of the NHS

Health and Social Care Bill: January 2011

- Abolish all 150 Primary Care Trusts and 10 Strategic Health Authorities
- Establish GP Commissioning Consortia
  - GP practices to continue to offer community based services as independent contractors
  - But groups of GPs to form Commissioning Consortia that will be NHS organisations and to be given £70-80 billion to purchase services
- Create new NHS Commissioning Board
- All NHS Hospital Trusts will become Foundation Trusts

White Paper and Parliament Bill Proposals for 2013 NHS Governance
US versus UK Healthcare System

• The per capita cost of health care in the United States is about twice that of the UK
• In 2010, health care consumed 17.6% of the US gross domestic product (GDP)
• An important component of the high cost base is the continuing expansion of medical services that depend on increasingly costly diagnostic tools, new drugs, and surgical procedures

US versus UK Healthcare System

• This focus on high-cost technology is linked to the country’s high proportion of specialists, who tend to rely on the delivery of increasingly expensive and technically complex care to maintain their income.
• Salary differentials between specialists and primary care physicians in the United States contribute to the relative dearth of general practitioners in the country

US versus UK Healthcare System

• The NHS provides taxation based universal health coverage that provides free care at the point of delivery
• The British government
  • Determines how expenses are reimbursed,
  • Negotiates salaries and contracts with its 1.4 million NHS employees
  • Limits the availability of expensive technology through the National Institute for Health and Clinical Excellence (NICE).
US versus UK Healthcare System

• When the Labour government came to power in 1997, it recognized that healthcare spending was inappropriate low
• Britain’s total expenditure on health was 6.6% of its GDP, as compared with 13.4% in the United States at that time
• In the intervening decade, Britain has made major investments in its health care system, raising the total expenditure to 8.4% of the GDP in 2010, as compared with 17.6% in the United States.

US versus UK Healthcare System

These funds doubled NHS spending, from $75 billion to $159 billion per year, used to
• Build new hospitals,
• Hire more nurses and doctors,
• Provide an improved base for physicians’ salaries linked loosely to productivity
• Enhance the research infrastructure in order to generate a stronger evidence base for clinical care guidelines

US versus UK Healthcare System

• There have been massive improvements in waiting times and patient satisfaction with the NHS
• Real improvements in outcomes
  fewer deaths from cardiac causes
  fewer deaths from cancer
So what can the United States learn from the NHS?

- The jewel in the NHS crown is the strength of its primary care and its General Practitioners
- These highly trained physicians contribute to Britain's health by focusing on the health of the whole person, rather than on a single organ
- Emphasizing prevention and health screening, which should reduce the life-expectancy gap between rich and poor

The British General Practitioner

- Act as gatekeepers who control costs by referring only patients who truly require a specialist's opinion, since 86% of medical needs can be managed in the community
- Provide continuity and coordination of care and being patients' constant companions in the domain of health care

Patient Contacts in NHS
The British General Practitioner

As a result, NHS patients have great trust in their own doctors, which allows general practitioners to absorb diagnostic risk and so reduce hospitalizations, excessive investigations, and inappropriate prescribing, as well as to enhance anticipatory care and improve patient satisfaction and health outcomes.

Primary Care in the US

• In the United States, by contrast, primary care is an area of relative weakness that must be addressed if the current proposals for health care reform are to be sustainable
• In 2012, for the 15th straight year, the number of graduating U.S. medical students choosing primary care continued to decline

Factors contributing to PCP Shortage

• First, primary care physicians earn far lower incomes than procedural specialists, reducing career attractiveness for medical students with high debt burdens
• Second, the work-related stresses felt by primary care physicians tags primary care as the career with more work at less pay
• Third, medical education favors training in non–primary care fields.
• Rescuing primary care requires national policies that address all three issues.
Evolution of General Practice in the UK
• In the early days of the NHS, general practice in Britain was in a similar state of weakness.
• With the establishment of the Royal College of General Practitioners in 1952, a unified approach was taken to developing the discipline.

Evolution of General Practice in the UK
• Professionalization of GP training
• Embracing of undergraduate teaching
• Recognition and description of the importance of the doctor–patient relationship as part of the therapeutic process
• Development of a quality agenda for the management of chronic conditions
• Establishment of methods for building partnerships with patients

Evolution of General Practice in the UK
This approach has lent a validity and respectability to the discipline, which, along with the rewards of long-term relationships with patients, has made general practice a positive career choice for many young doctors.
A second key lesson might be learned from the role of NICE

- This organization was initially established to end regional differences in access to medical care or what has been called a "postal-code lottery of prescribing."
- Because of localized decision making in the NHS, one patient might be granted access to an expensive procedure while another patient living in a neighboring region with a different administrative health authority might be denied access
- Such differential treatment was arbitrary — driven by geography and contrary to the concept of a truly national health service.

The National Institute for Health and Clinical Excellence (NICE)

NICE is the independent organisation, established in 1999, responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.
The Institute encourages cost effective practice by issuing guidance in three areas

- **Public health** – guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector
- **Health technologies** – guidance on the use of new and existing medicines, treatments and procedures within the NHS including interventional procedures, diagnostics and devices
- **Clinical practice** – guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS.

Core principles underpinning NICE guidance

- Comprehensive evidence base
- Expert input
- Patient and carer involvement
- Independent advisory committees
- Genuine consultation
- Regular review
- Open and transparent process
Better outcomes for patients

Knowledge for professionals and patients

Effective use of NHS resources

Access to the NHS market

Purpose of NICE is to improve the quality and productivity of clinical practice, public health and social care.

Independence, objectivity and transparency.

Not so NICE

- The other mandate of the agency, which was to provide guidance on technology appraisal, has proved to be more controversial.
- It has provided a means for the NHS to ensure “value for money” by using the evidence base to weigh the benefits and costs of any new drug or medical procedure.

Value Based Pricing

The UK Government view:

“We need a system that encourages the development of breakthrough drugs addressing areas of significant unmet need. And we need a much closer link between the price the NHS pays and the value a new medicine delivers, sending a powerful signal about the areas that the pharmaceutical industry should target for development.”

“Over the next three years we will be moving towards a new system of pricing for medicines, where the price of a drug will be determined by its assessed value.”
"What is the most difficult ethical dilemma facing society and science today?"

"How far do you go to preserve individual human life? I mean, what are we to do with the NHS? How can you put a value in pounds, shillings and pence on an individual's life? There was a case with a bowel cancer drug – if you gave that drug, which costs several thousand pounds, it continued life for six weeks. How can you make that decision?"

Sir David Attenborough, Naturalist
• It is generally accepted that the statistical methods and appraisal process established by NICE are logical and transparent and invite participation from clinical experts, industry, and patients.
• Most of the debate centers on the concept of cost per quality-adjusted life-year gained and on where the funding cutoff is set.
• Is an extra month of life for a patient with cancer worth $1,000, $10,000, or $100,000?
• Empowers decision makers in low and middle-income countries by identifying and helping them to act on their own policy priorities
• Focuses on institutional structure, longer-term capacity building and system governance
• Offers collaborative problem-solving and hands-on support, drawing on people and experience, from the UK and abroad, to adapt evidence and policies to countries’ local context

• The sorts of questions that NICE decides are at the heart of the debate over U.S. health care reform
  • Can we automatically fund any advance in health care, regardless of how marginal the benefit might be?
  • Is it possible to introduce a transparent, rule-based, evidentiary form of health care rationing?

• At the moment, health care rationing in the United States is based on the exclusion of the poorest people, through a health care system that runs on perverse incentives for physicians and increasingly transforms their profession into a business that is driven by an unsustainable proportion of the nation’s GDP
Conclusions

- National Health Service is a centralized, publicly financed system which provides cradle-to-grave care for all citizens, free at point of delivery
- The NHS has been performing well over past several decades given tight financial constraints
- NHS has been subjected to many reforms, not all of which have been successful

Summary

- The experience of the NHS in the area of cost containment is fairly clear.
- Rationed care cuts costs, and even with increased expenditures from the healthcare reforms, total U.K. expenditures are expected to be well below the United States.
- A wait list of 1 million is a shortcoming of UK system.
- 45 million uninsured is a limitation of the US system.

Conclusions

- New radical health reforms promise to reduce bureaucracy, improving efficiency and quality of care, providing more choice for patients
- The NHS is far from perfect, but the UK health care system is not the evil being painted by some opponents of U.S. health care reform
- Important and relevant lessons could and should be learned from it