



The History and Development of
The UK National Health Service
1948 - 1999

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The toolkit is a revision of an earlier document published in 1997.

Target audience: This publication is aimed at anyone trying to get a better understanding of the development of the UK NHS including policy makers and managers in low and middle income countries.

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Glossary

A & E	Accident and Emergency
BMA	British Medical Association
CHI	Commission for Health Improvement
DHA	District Health Authority
DMU	Directly Managed Unit
DPH	Director of Public health
FHSA	Family Health Service Authority
GP	General Practitioner
GPFH	GP Fundholder
HA	Health Authority
HImp	Health Improvement Programme
HoN	The Health of the Nation
NHS	National Health Service
NICE	National Institute for Clinical Effectiveness
OHN	Our Healthier Nation
PAM	Profession Allied to Medicine
PCG	Primary Care Group
PCT	Primary Care Trust
R & D	Research and Development
RAWP	Resource Allocation Working party

1. Introduction

Since 1991, the UK National Health Service (NHS) has undergone some of the most radical reforms since its creation as a comprehensive public service in 1948. Despite their scale, the reforms have preserved the principle of health care free at the point of use. However, as demands and costs have risen, the comprehensiveness of the service is increasingly coming into question. In order to understand why the successive reforms took place, what has been learnt from them and how current plans may take shape, this document provides a brief history of the NHS. **Figure 1** below summarises the key dates.

Figure 1 Key dates in the NHS

1946	The National health Service Act
1948	NHS begins, July 5th
1967	GP Charter
1974	Major reorganisation: "Area" tier created (Region, Area, District). Public health responsibilities transferred from Local Government to NHS
1976	RAWP begins - lasted until 1991 (RAWP applied mortality data to weighted regional populations to obtain a fair-share funding target)
1982	Area tier abolished
1984	General management introduced
1987	New payment systems for GPs to encourage more health promotion/ prevention activities
1988	Major review of the role of public health medicine
1989	"Working for Patients" describes major reforms to introduce an internal market for UK health care. "Caring for Patients" promotes community-based care
1991	Implementation of 'Working for Patient' reforms begins. "Patient's Charter" issued. "Health of the Nation" published
1992	Tomlinson Report on health care in London
1996	DHAs and FHSAs merge formally; Regional Health Authorities abolished
1998	"The new NHS: Modern-Dependable" outlines proposals for further reforms "A First Class Service: Quality in the new NHS" published, outlining a framework for improving the quality of care provided
1999	"Saving Lives; Our Healthier Nation" while paper published, the new national strategy for health.

2. Origins and Formation of the NHS

There has been some form of state-funded provision of health and social care in England for 400 years. Historically, the poor, infirm and elderly received care from religious orders, in particular the monasteries. However, in order to legitimise his second marriage to Anne Boleyn, King Henry VIII established himself as head of a newly created Church of England in 1543. England was subsequently excommunicated from the Catholic Church and, in return, the King dissolved the monasteries, simultaneously removing the main source of care for vulnerable people.

Over the next 50 years, various measures were introduced to ensure that some form of support was available to the most needy. In 1601, under Queen Elizabeth 1, these were brought together under the first **Poor Law**. This established almshouses to care for the poor and sick, and a system of "outdoor relief", providing benefits in kind to support the poor at home.

This remained the main source of state-sponsored care until the 19th Century. By then, attitudes towards the poor had changed and the care provided by almshouses was thought to be too benevolent. Outdoor relief was abolished and austere **workhouses** were established, providing accommodation for the poor, orphans and the elderly.

Although the different groups were supposed to be looked after separately, in practice this rarely happened and everyone was housed in single, large institutions. Towards the end of the century, annexes were added to house the sick. Care was rudimentary, often provided by untrained volunteers and Florence Nightingale, amongst others, commented on the atrocious conditions.

As the anatomical/pathological basis of disease became better understood, health care was increasingly provided by other bodies. Local and Municipal Authorities established hospitals for **infectious diseases**, and separate institutions for people with **mental illnesses and handicap**. Additionally, many **voluntary hospitals** were established, run by boards of Governors. Medical care was provided by visiting specialists who would, invariably, have lucrative private practices elsewhere. For economic reasons, such hospitals tended to focus on people with relatively acute problems who did not require long-term care.

Meanwhile, primary and community care services evolved quite separately from the hospitals. Community care, including domiciliary services, plus environmental and public health services, had always been the responsibilities of local authorities. In contrast, at the start of the 20th Century, the developing family doctor service was funded (and provided) through insurance schemes. In 1911, the Government, under Lloyd George, extended the scheme to all working men whereby they could choose a GP from a "panel" of local doctors. This "**panel system**", although not providing cover to family members or their dependents, made a considerable difference to a large proportion of the poor entitling them to free, government funded health care.

The first step in creating a nationalised health service was in 1938. The imminent war obliged the Government to establish an **Emergency Medical Service**. All the various types of hospitals were registered and run centrally to anticipate large numbers of expected casualties.

By the end of World War II, the concept of an integrated, state-funded hospital service had become established and, in 1948, the newly-elected Labour (socialist) government created a **National Health Service (NHS)** as none of a series of welfare reforms designed to guarantee basic levels of personal and social security. For the first time, a UK government assumed responsibility for the provision of a comprehensive preventive and curative service for the whole population.

The fundamental principles underlying the NHS were, and still largely are, that services would be funded predominantly from general taxation and that they would in general be free at the point of use, comprehensive and available to all, regardless of means to pay. A small but significant privately-funded health care systems has always existed alongside the NHS, expanding and contracting in line with the country's broader economic state. However, for nearly fifty years, British people have received almost all their health care without paying directly for it.

The structure of the new service reflected its disparate origins and artificial divisions between different elements persisted for many years. There were three main strands¹:

- **State owned (nationalised) hospitals**

Hospitals that had previously been run by voluntary charitable organisations and local government became the responsibility of Regional Hospitals Boards, with local responsibility delegated to Hospitals Management Committees. Acute specialities retained their traditional high status in comparison with the relatively low profile services for the elderly or the mentally ill. Until the early 1990s long-term care was provided in large, impersonal institutions and it is only relatively recently that acute services for the elderly and mentally ill have been integrated with other types of hospital care.

- **A national network of general practitioners**

A network of General Practitioners (GPs or family doctors) replaced the panel system. They were responsible for personal primary health care and received fees which were set and paid nationally. They were also the gatekeepers to other health services, referring patients on (e.g. to hospital services) as they thought appropriate. Executive Councils, which received money directly from the Ministry of Health, administered the family practitioner services.

- **Community and domiciliary health services**

Services such as home nurses, public and environmental health and health prevention/promotion continued to be run by separate, elected Local (municipal Authorities or Councils, which were also responsible for housing, roads and education.

The three strands were financed centrally but managed separately. Throughout the history of the NHS, this initial division of functions between separate statutory organisations created problems in the provision of comprehensive and co-ordinated services. It is only recently that all three strands of direct health care have been provided within, and commissioned by, the NHS. Nonetheless, functions such as personal social services, long term care for most elderly people and responsibility for the environment, housing, roads education and employment (which are of fundamental importance to overall health) remain the preserve of local and central government. Periodic attempts to create a more cohesive approach to social policy in general, and health in particular, have not been very successful.

The new government (which came into power in May 1997) has launched a major programme of what is termed "joined up government". In health this means co-ordinated action on the part of all those bodies whose activities have an impact on health and who provide health care.

The creation of the NHS divided the medical profession into salaried employees (hospital specialists and hospital doctors in training) and independent contractors (GPs and most dentists). Hospital consultants were also free to work in the private sector by having part time contracts with the NHS. Again, this distinction has remained significant over time-at best it makes efficient use of skills of different medical practitioners, at worst it creates a battlefield for power and control.

3. 1950s: Command & Control

Having created an enormous nationalised health industry, the various government of the day began to look critically at how the services could be managed efficiently. The prevailing management style for hospitals was "command and control", reflecting the practise of the war years, with central instructions being passed down a chain of authority from central government to local hospital boards. The same was partly true of the community services but with the differences that these services were under the management of elected local government. In contrast, GPs were independent contractors and could not be 'managed' in this sense but were influenced through a centrally agreed national contract for services. Because of these differences, the emphasis for change was on hospitals, where the most direct influence could be exerted.

Three-way professional hospital management had broadly persisted since 1948, with various combinations of medical, nursing and lay administration². In 1948 hospitals were managed by a medical superintendent, a matron and a lay administrator. Lay administration was then about enabling hospitals to function in clean, well-supplied and well-maintained buildings. It was not necessarily the job of administrators to ensure that the hospitals functioned efficiently, nor to question medical or nursing practise unless something went wrong.

A report published in 1956³ expressed early concern about many issues which are still familiar in the 1990s. These included:

- Changing trends in health and illness.
- The importance of prevention of illness.
- The needs for GPs and hospitals to work closely together.
- The need to make adequate provision for the care of old people in their own homes.
- Whether the NHS would in practice be able to meet every demand justifiable on medical grounds.

Despite these concerns - which were all variations on the danger of demand out-stripping the ability to supply health care - a national resource allocation formula was rejected. In other words, the allocation of funds amongst the regions was not determined centrally. Instead, hospitals were funded on the basis of historical budgets (ie. What had been spent the previous year), regardless of use or need. It was to be another 20 years before the problem of historical budgeting was seriously addressed.

4. 1960s: Expansion

The 1960s was a decade of fast expansion in new buildings and technology and the health service benefited with a boom in the building of new hospitals. Health planning concentrated on capital schemes. A "Hospital Plan for England and Wales"⁴ specified 'norms' - number of beds per 1000 population served, using the 14 Regional Health Authorities as a basis for planning and building new hospitals.

Definitions were also produced centrally for those services which should be provided in District General Hospitals, all with Accident and Emergency Departments and Outpatient clinics feeding a range of general medical and surgical specialists⁵. Services for the elderly and mentally ill were included, and single speciality hospitals went out of favour.

Underlying the concept of a District General Hospital was the objective of providing services to a local population in a comprehensive, well-organised way. Only those people requiring relatively specialised care needed to travel further to Regional Hospitals where specialities such as cardiac and neurosurgery were based. In practice these Regional centres developed around existing teaching and postgraduate hospitals distorting the distribution of specialities particularly in London and the larger cities.

Although the first signs of a population-based approach to health care provision were now apparent, the following obstacles remained:

- hospital funding was still based on the previous year's expenditures and was not linked to population size;
- GPs could in theory refer patients anywhere;
- Community services were still managed by Local Authorities.

The second major theme of the 1960s was the development of hospital consultant (specialist) career structures and medical advice to management⁶. Consultants were encouraged to group into divisions of related specialities and to involve themselves in the planning of services, including the co-ordination of hospital work with community services. This initiative can be seen as a forerunner of the current trend for clinical management - see "The 1980s".

The third and arguably the most important theme of the 1960s was the development of personal care services. The quality of general practice was extremely variable. It was seen as a second class career for those doctors who did not become specialists. GPs were poorly paid and overworked and there was no post-graduate training. Anyone could go into general practice after their one year post-graduation internship. After much negotiation a charter was agreed between the government and the BMA on behalf of the profession agreeing a new funding formula for GPs - a mixture of capitation and fee per item of service - combined with plans to improve the quality of general practice. These plans included the recognition of general practice as a specialty with post graduate training and funding for the improvement of premises and ancillary staff.

5. 1970s: Consensus Management

The 1970s were characterised by "corporate" approaches to the management of health. The move towards a population based funding system continued but relations between management and staff deteriorated under powerful and largely disaffected trade unions. Partly this deterioration was a result of managers beginning to tackle inefficiencies (including what can now be seen as the beginning of the hospital rationalisation programme as lengths of stay fell) but it was also partly a result of demands to rectify historically low pay which proved impossible to meet.

In order to tackle poor service co-ordination a major reorganisation of the NHS took place in 1974. This followed a long period of research and consultation^{7,8,9} initiated by the Conservative Government which was in power in the early 1970s. The Labour Government which took over in 1974 went ahead with the proposals. The 1974 reorganisation tackled two of the NHS's long-standing problems by:

1. Taking the NHS a step population-based funding.
2. Bringing together hospital and community services and the public health function

The 1974 reorganisation happened at a time when the capital boom was tailing off and planning began to emphasise services, rather than building. There was an emphasis on

co-ordination and management of services within clear geographical boundaries. The 14 Regional Health Boards became strategic planning authorities with operational authority delegated to new Area Health Authorities. Both these tiers were managed by boards of primarily lay members, appointed by the Secretary of State for Health. Certain places were prescribed for professional members such as doctors and nurses, local authority members and trade unionists. However, none of these positions could be held by individuals who were also employees of the boards, that is, what we might now call "Executive Directors".

Area Health Authority had responsibility for populations of between 500,000 and 1,000,000. They were sub-divided into health districts with populations of 200,000 or so which had no lay representation but were managed by multi-disciplinary management teams working by consensus and who were responsible for day to day operational management. The employing authorities were Area Health Authorities except for consultants who, with the exception of those working in teaching hospitals, continued to be employed by the Regions.

Local authorities retained responsibility for broad-based public health measures related to food hygiene and environmental health, while personal preventive programmes become the responsibility of the NHS. The 1974 reforms established Joint Committees between the NHS and Local Authorities, which provided social services, housing and education. Despite initial confusion, the 1974 re-organisation made progress in the key area of breaking down divisions between different parts of the services. Management teams brought representatives from hospitals, general practice (in an advisory capacity) and public health around the same table.

In spite of these innovations, historical year-on-year funding of services remained the basic allocation method through the Regional Health Authorities to the Area Health Authorities. Although staff were employed at the Area Authority level, contracts were based on national terms and conditions of service with national grades and pay scales.

The 1974 reorganisation attempted to improve clarity of delegation and accountability but encountered three fundamental problems:

- It produced a rigid organisation with too many layers of decision making. The reorganisation did not take sufficient account of the many layers of management existing within hospitals and community services. For the nurse practising at ward level, there could be as many as four layers of management before reaching even the local sector or unit level. To many people working within it, the service felt top-heavy with managers. The 1974 changes were widely disliked and many parts were dismantled in the early 1980s to reduce excess bureaucracy.
- The arrangements were inflexible and management structures and posts were dictated on a uniform basis by a central manual.
- Management decisions were to be arrived at by consensus, with teams of six senior managers and professionals agreeing on a way forward but with no general manager or chief executive providing leadership. Whilst this seemed attractive in theory (in terms of equality between the professions), it often led to poor or even non-existent decision making in practice.

A subsequent innovation arising out of the tight central planning of the 1970s was the move to redistributed resources away from historical supply-driven funding which enshrined geographical inequalities¹⁰. A national formula called RAWP (named after the Resource Allocation Working Party that produced it) applied mortality data to weighted regional populations in order to obtain a fair-share funding target. RAWP aimed to channel more funds to Regions which were more deprived but which had received

relatively less funding in the past. RAWP produced gradual but hotly-contested reductions in some regions and increases in others between 1976 and its abolition in 1991.

A second significant change of thinking during the 1970s was that of the relative priority of different services¹¹. In particular, services for people with a mental illness or a mental handicap were felt to be in need to reform because:

- standards of service were poor and there had been a number of highly-publicised scandals;
- buildings were often isolated and unsuitable;
- many older residents had been admitted under outdated medical criteria (eg. having a child out of marriage)

There was a need to reform the services to deliver appropriate care and to ensure that past mistakes were not repeated. Services for elderly people were also re-examined, and from these initiatives, new models of Community Care were drawn up. The aim was to put new investment in non-acute services wherever possible.

6. 1980s: General Management

Two major reallocations of financial resources were under way by the beginning of the 1980s:

- from one geographical area to another to address historical inequalities (RAWP);
- towards non-acute services.

The foundations were being laid for the later move to population-based funding for hospital and community services. In the meantime, there was work to be done in dismantling the excess bureaucracy of the 1974 reforms¹². The first (Conservative) Thatcher government came to power in 1979 with an agenda of radical change in the public sector. The area tier of management was removed in 1982 and management costs were generally targeted for reduction.

New District Authorities were formed, with elected Local Government members forming part of the membership¹³. The need was recognised for Districts, as the "natural" planning and service-managing organisations for populations of between 200,000 and 500,000, to develop flexible, local arrangements. Regions, as the supervising tier of management, were to stand back from day to day operations and concentrate on recurrent and capital resource allocation.

The Royal Commission¹² which recommended these changes had itself explicitly rejected the idea of introducing general (as opposed to consensus) management into the NHS. This was contradicted only two years later in an influential government-sponsored report by a leading businessman, Sir Roy Griffiths¹⁴. General management was consequently introduced in 1984, encouraging:

- one individual at every level of the organisation being responsible and having authority and accountability for planning and implementing decisions;
- more flexibility in team structures;
- greater emphasis on clear leadership;

- explicit decision-making.

Clinical and professional staff (except consultants) became responsible to managers. This caused particular trouble with the nursing profession, as consultants remained accountable to their employing authority (Region or District), though the District or Regional Medical Officer.

Changes took place in the central Ministry of Health (Department of Health). A policy board chaired by the Minister was created to set policy and remove the Minister from day-to-day involvement in the service. This became the responsibility of an NHS Management Executive, later renamed the NHS Executive. The NHS Management Executive was still within the civil service but distinct and separate from the Department of Health which retained responsibility for policy.

Other significant and linked changes came with the Griffiths' report. Consistent with general management, operational units within districts (eg. hospitals, community health services) were set budgets for the entirety of their operations instead of budgets divided into functions (such as supplies, catering, nursing). This was aided by the increasing availability of financial information systems which allocated costs to clinical activities.

Since doctors made the clinical decisions that actually spent the budgets on patient care, each unit was encouraged to involve clinicians closely in management. Following rather difficult pilot projects, clinical budgeting systems were gradually introduced. They are still being developed but usually allow costs to be allocated to specialty level, enabling the specialty to become the unit of management - often called the clinical directorate - with responsibility for managing resources.

Emphasis was put on investment in management information systems in order to improve the quality of decision-making by managers¹⁵. These changes sent clear signals that a "business-like" approach was expected in the provision of hospital services. The development of clinically-based information systems was not easy and had many pitfalls. Because the NHS did not, historically, bill patients it had no need to cost the treatment of individuals. Management information systems were based on managing staff and materials and the costs were low. The technology and costs involved in moving to clinically-based management systems were often underestimated and this is a particularly useful area for study for countries moving in the same direction.

Comparable developments were taking place in public health and primary care. In 1987 the government reviewed payments systems for GPs in order to encourage more health promotion activities and to emphasise the importance of prevention^{16,17}. The speciality of public health medicine was the subject of special study in 1988. Many public health specialists had become very involved in management and planning to the detriment of communicable disease control and population based chronic disease prevention programmes. Recommendations for the expansion of the specialty were made and its role clarified.

A particular recommendation was to ensure that every District had a Director of Public Health (DPH) with responsibility for the health status of the local population. The DPH had to produce an annual report to reflect this, reinforcing the growing awareness of the need to look at resource use in the NHS in terms of "investing" in health and population-based prioritisation of need¹⁸.

The changes which took place in the 1980s set the scene for the health reforms of 1989¹⁹. Despite management streamlining and the emphasis on health promotion and prevention, pressure on resources had steadily mounted over the preceding ten years. Closure of hospitals and hospital wards were attracting media attention and causing public anxiety.

The government was concerned that incentives to reward well run, popular hospitals did not exist in the current system. District Health Authorities - which managed hospitals and community health services - were cash limited themselves and allocated funding by Regions on an historical basis (adjusted marginally for RAWP). Budgets were subsequently allocated to the hospital and community units that they managed, again on the basis of historical patterns of use.

The proposals were set out in a White Paper "Working for Patients" in 1989¹⁹. Reaction within the NHS was divided. Some welcomed the business ethos underpinning the creation of Trusts and the promotion of competition in contrast to the inflexible and prescriptive structures of the 1974 reorganisation. Critics of the reforms were worried that the proposals were a back-door route to privatisation and the end of co-operation between NHS institutions. Some also saw the technicalities of contracting as ending the freedom of referrals for GPs to the hospital of their patient's choice. This led some GPs to choose fund-holding as a means of preserving clinical freedom.

White Paper status meant these proposals were not for discussion and an implementation date of April 1991 was set. They were introduced nationally without any piloting. Many people, particularly professionals and academics felt that the timescale was too short. Senior managers felt differently. They felt the service was in trouble, with resources and demand out of phase. The proposals at least offered a possible solution and the concept of the freedom offered to Trusts was attractive. In any case, whilst the trust and fundholder options were voluntary, the fundamental purchaser/provider split was mandatory and the timetable was clear. The NHS Management Executive took on responsibility for implementation and, with considerable input from management consultants, both the centre and the Districts met the target date.

7. 1990s: The Internal Market

"Working for Patients" introduced wide-ranging proposals setting out the most radical changes in the NHS since its creation and in the process ending the post-war consensus about the management of the NHS. **Figure 2** lists the seven major recommendations of "Working for Patients".

Figure 2 The 1989 reforms - "Working with Patients"

	Recommendation	Objectives
1	The introduction of an "internal market" through the separation of providing services from purchasing (or commissioning) them.	To reward efficient and popular providers; to create competition to improve the standards of service.
2	The establishment of stand-alone Trusts to manage the provision of hospital and community services. Trusts directly accountable to central government.	To delegate responsibility for decisions about services to as near the patient as possible. To remove from service providers the need to consult higher levels, particularly in the management of finance and staff conditions.
3		
4	The voluntary creation of fund-holding GPs to enable them to buy hospital services directly-mainly outpatient services, elective operations care and diagnostic procedures.	To improve standards in hospitals through competition for GP budgets; to make GPs more influential in decisions about hospital.
	The use of non-legal "contracts" for payment for services between purchasers and providers for defined	To establish clarity about the volume and standards of services to be provided; to improve the quality of services and to

5	workloads. GPs to be consulted on where District Health Authorities should place big contracts.	enable purchasers to make clear choices between providers.
6	The change to a capitation (weighted population) basis for purchasing services for a given population in place of direct funding of services provided on an historical basis.	To promote resource equity between different parts of the country; to encourage services to be tailored to meet local needs rather than vested medical interests.
7	Introduction of capital charges for buildings/ equipment	To increase the accountability of hospital doctors, including their clinical performance.
	The promotion of medical audit and job plans for consultants.	To encourage efficient use of land and other capital assets.

The most far-reaching change was the introduction of an "internal market" for health care. Within this, Health Authorities became responsible for assessing the health status of their resident population and for purchasing the services needed to meet identified needs from the public or, in theory, the private sector. Conversely, NHS providers, established as "self governing" organisations, could focus on delivering services efficiently.

Rather than allocating resources directly to providers based on historical patterns, budgets were calculated for Health Authorities on a capitation basis related to population size, age structure and deprivation with which they could purchase health care. The intention was that, since money would not automatically flow to providers, they would have to compete for funds from purchasers by offering higher quality, more responsive and efficient services.

As well as establishing Health Authorities as purchasers, the Government introduced a voluntary scheme whereby certain GPs (known as fundholders) could hold a devolved budget to purchase a restricted range of services. The objectives were:

- i To establish alternative purchasers of healthcare in place of Health Authorities, based on detailed knowledge of patients' needs.
- ii To breach the strict financial division between primary care and DHA-managed hospital / community health services.
- iii To improve the quality of secondary care by virtue of the direct relationship between GP and hospital, as opposed to the vicarious position of Health Authorities which did not themselves generate referrals. GPs would know where waiting lists were shortest, how efficient hospitals were at sending them test or other results, and in hearing first hand about the experiences of the patient.

Fundholding budgets were calculated on the basis of historical activity and were subtracted from the host HA within which they were located. Initially only larger practices with lists of at least 11,000 could apply to be fundholders and their budgets covered just elective surgery, outpatient and diagnostic services plus prescribing and practise staff costs (about £1 million, depending on the practise size). These restrictions reflected concerns that smaller practices would not be able to predict how much care to purchase and that they would have inadequate technical expertise about rarer, more specialised, conditions. It was expected that fundholders would inject dynamism and a desirable level of competition into the managed market.

In parallel with the development of purchasing, the reforms enabled individual providers to apply to become NHS trusts. Trusts were intended to be semi-autonomous organisations, run in a more business-like manner than the Directly Managed Units (DMUs) that they replaced. These would promote greater efficiency and quality whilst increasing accountability to, and choice for, purchasers.

Although they were non-profit organisations, trusts were free to raise income from other sources such as private beds or commercial activities and were responsible for employing their own staff. For NHS contracts, their prices were supposed to be based on actual costs. In practice this proved problematic.

Community services providers were encouraged to establish themselves as separate Trusts from acute providers, thereby promoting a shift of care towards community and primary services and preventing the more powerful acute hospitals taking money away from them. Trusts were established in several waves, with the selection of suitable organisations being guided by their proposed business plans and long-term viability. **Figure 3** outlines the roles of health authorities, GP fundholders and trusts.

The reforms were intended to lead to improvements in five key areas: efficiency, quality, equity, choice/responsiveness and accountability. Taken as a whole, they were expected to shift the NHS from a passive bureaucracy still largely driven by historical budgeting to a responsive organisation where money was channelled towards meeting patient's needs.

Figure 3 The roles of purchasers and providers

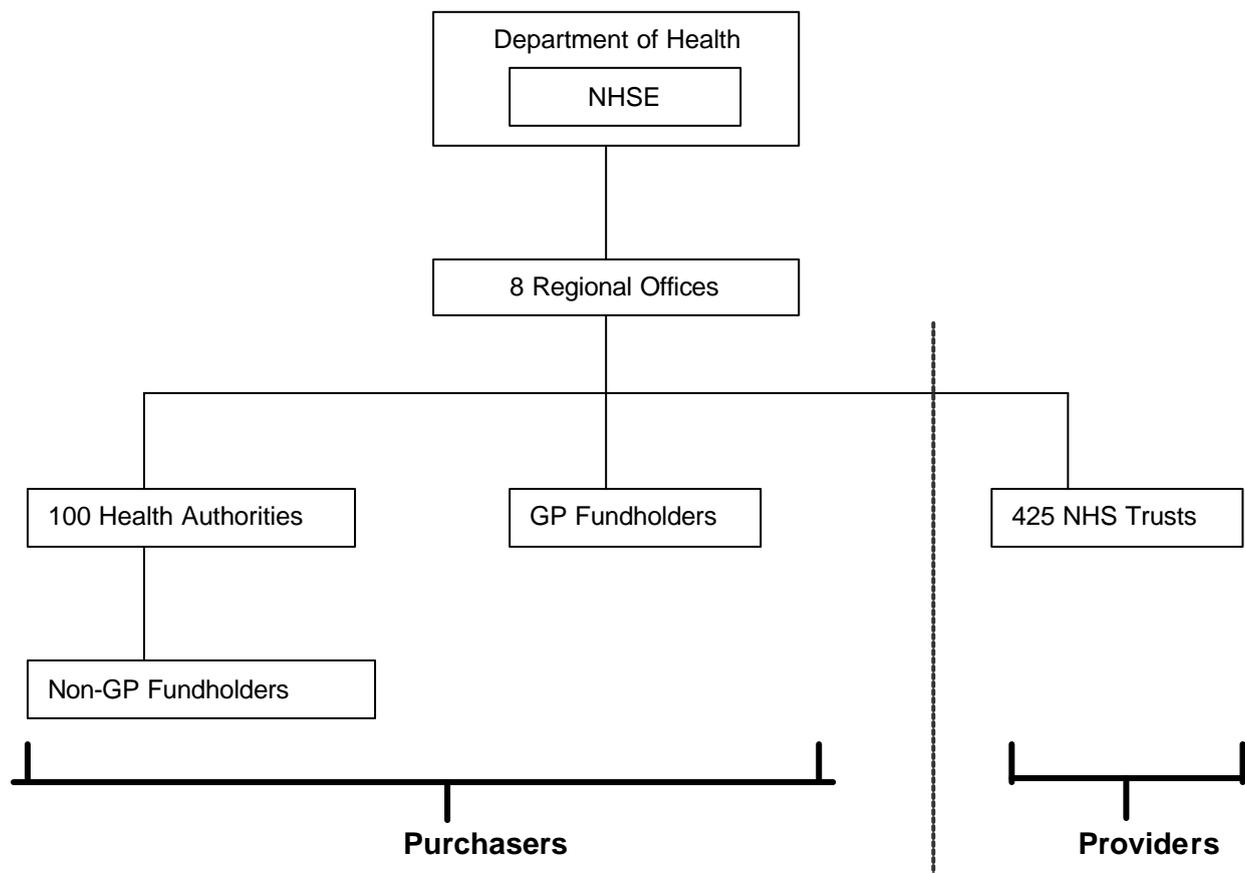
	Purchasers		Provider
	Health Authority (HA)	GP Fundholder	Trust
Accountable to			
Has predetermined budget for	NHS Executive through an objective-led performance management process	NHS Executive for their purchasing role	NHS Executive for financial performance; Purchasers for service delivery through contracts
	Purchasing health care for the resident population on behalf of non-fundholding GP's plus care not covered by GPFH contracts	Prescribing and practice staff. Range of elective, emergency, outpatient and community services dependent on type of fundholding	Staff and non staff costs involved in running its services.
	NHS Executive	Health Authorities	Contracts won from HAs and GPFHs
	Trust, private sector	Trusts, Private sector	HAs and GPFHs
	Identifying need, setting priorities, ascertaining views of residents and health services users. Purchasing care for the population. Contract monitoring. Liaison with other bodies	Purchasing care for patients. Contract monitoring including the quality of service delivery	Providing high quality care in accordance with the contracts
	Decide what health care its budget will purchase and from whom	Re-invest savings in the practice or spend on providing more care	Raise money for capital development. Set terms and conditions for staff
	Yes	Yes	Yes

Reflecting this philosophy, the structures and functions of the Department of Health and of Health Authorities changed as decision making was devolved to local level. At the inception of the reforms, Family Practitioner Committees, responsible for administering primary care services, were renamed Family Health Service Authorities (FHSAs) and both they and District Health Authorities (DHAs) were successively realigned to make them co-terminous.

Regional Health Authorities became responsible for the financial probity of NHS Trusts and GP Fundholders. They also, initially, purchased a range of specialised services (for rare or highly technical conditions such as plastic surgery, bone marrow transplantation or kidney dialysis). However, in 1996, this function was devolved to DHAs and RHAs were abolished as statutory health authorities. In practise, driven by the difficulties of assessing need for such services for their own relatively small populations, HAs within each region grouped together to commission specialist services, nominating a lead authorities on their behalf.

RHAs were replaced by newly created Regional Offices of the NHS Executive, part of the civil service and with newly clarified functions such as performance management of trusts, health authorities and GP fundholders, strategic resource allocation, workforce planning and research and development. Simultaneously, DHAs and FHSAs were merged into unified Health Authorities, finally integrating the commissioning of hospital, community and primary care services into one structure. **Figure 4** illustrates the structure of the NHS in April 1996.

Figure 4 Structure of NHS in England, 1996



The 1989 proposals were founded on clear principles. At the same time, implementation details were deliberately slight²⁰ in order to encourage the active involvement of NHS managers in their development. As the reforms were implemented, the details were filled in and the pace of change accelerated, reflecting the enormous shift in culture which was taking place. Involvement of a wide range of field managers in national working groups, set up to work through the practical detail for implementation, paid dividends, spreading knowledge and enthusiasm widely throughout the service. Within six years all providers had been converted into trusts and over half the populations was registered with fundholding GP practices. New models of fundholding were introduced and the original "standard" fundholding system was opened up to progressively smaller practices with populations of just 5,000. A more restricted form of "community fundholding" was introduced, enabling the smallest practices with lists of 3,000 people to purchase non-hospital services. "Extended Fundholding", conversely, expanded the range of services that larger practices could buy.

Some groups of fundholders formed "multifunds" to share resources and offering a more robust basis for planning services. By 1997, there were over 50 multifunds in existence, covering over 3 million people. In 1997, 80 "total purchasing pilots" were established from groups of standard fundholders, responsible for purchasing all hospital and community care. Meanwhile, other GPs, often ideologically opposed to fundholding, formed co-operatives which acted as advisory bodies to Health Authorities, but without introducing separate commissioning arrangements with their associated high costs.

Although often considered equivalent to Health Authorities, fundholders had considerable advantages. Firstly, they could invest savings generated by the scheme in their own practices, for example by employing new staff or improving premises. Health Authorities prevented from doing this. Secondly, fundholders demonstrated the potential to be more effective purchasers than HAs despite the greater purchasing power of HAs. Being relatively small, fundholders could shift contracts between providers without destabilising them. They could also, in theory, choose to provide some diagnostic secondary care services themselves, thus improving patient responsiveness and retaining any financial surpluses.

The motivations for becoming a fundholding practice varied. Some GPs chose to become fund-holders in order to protect their local providers by continuing to contract with them. Others wanted to improve hospital practice as soon as possible and had no scruples about making immediate changes. Those providers (mainly acute hospitals) which failed to secure fund-holder contracts and referrals experienced the first effects of real competition in the new internal market.

Fundholders were sometimes perceived to hold disproportionately high budgets. This was because more detailed data (procedure level) was used to set their budgets than that used by Health Authorities (aggregate specialty level). Before the reforms, hospitals had traditionally under-recorded activity as there had been little incentive to count in accurately. In some regions, fundholders were allowed to count their own hospitals activity in order to set their budget, often recording much higher levels than those captured by the hospitals and the HAs. Anomalies occurred when this translated through to real budgets, top-sliced from cash limited HA funds. This perception of fundholders as unfairly privileged was widespread within the NHS and never fully shaken off in many places, prejudicing some trusts and HAs against the scheme in principle. In retrospect, it was evident that a single contract currency used across all parties might have avoided some of these problems. (Other lessons learned about allocative equity below HA level were later used to good effect in establishing PCG allocations as part of the current (1999) wave of reforms).

The 1989 reforms provoked huge controversy when first introduced largely because of cultural mistrust of introducing business principles and overt competition into a public

service, and fears about service fragmentation through the quasi-autonomous status of trusts. As the internal market took shape and developed, even the most vocal opponents accepted that some of the changes had brought benefits. The purchaser-provider split offered a means for more rational planning of services. Hospital management had improved with greater flexibility and the adoption of innovative working practices in some trusts.

Most significantly, however, the internal market was not really a market at all. It was heavily managed from the centre and its impact was modified by political considerations. Hence, purchasers were restricted from making sudden shifts in contracts, there was little use of the private sector and few trusts closed. In many parts of the country true competition between providers was neither possible nor expected, and they and their purchasers settled into a system of "bilateral monopolies" but supported by more rigorous and explicit specifications of activity, price and standards than had previously been the case.

Nonetheless, real concerns remained. First, there was a perception of increasing inequity of access to care. This reflected the fact that responsibility for priority setting (or rationing) had been devolved to health authorities, and different decisions about eligibility for care were being introduced in different districts.

Secondly, the costs of administering the internal market were high. 10,000 new managers were appointed in the first three years of the internal market, although this figure included a large number of existing clinicians taking on part-time management roles. A similar increase had occurred before the internal market was even proposed, and there were believed to be real efficiency gains. Even so, the increase was seen as reducing resources available for front-line care and successive Secretaries of State for Health set targets for reductions in management costs.

The question as to whether or not management costs are high has to be set against the relatively low proportion of the NHS budget spent on management (3%) when compared with similar businesses and industries. Some believed that the NHS had long been undermanaged, especially in view of its rapidly changing agenda. The reform processes perhaps brought it nearer to a realistic level. However, perceptions of managers as bureaucrats were, and sometimes still are, deeply embedded in medical culture. Some of the populist media exploited this on occasion, fuelling public mistrust about NHS funds being 'diverted' to management. This perception clearly brings political ramifications with it. On the other hand, the introduction of clinical management in recent years has helped to change the culture towards one of broader inclusion and ownership of management issues.

When the Labour Party won the General Election of May 1997, its manifesto included an intention to abolish the internal market. Interim guidelines were issued instructing Trusts and Health Authorities to co-operate more fully rather than to compete. Discussions about a new wave of reforms started, culminating in the White Paper "The new NHS. Modern - Dependable"²¹. Like its predecessor in 1989, there was a formidable timetable for implementation. The Key features of capitation based allocations to Health Authorities, devolved powers for NHS trusts and the purchaser/provider split were retained. The one major change was that GP fundholding was abolished from March 1999 and a new form of primary care co-operative, the Primary Care Group, established. Targets were set for management cost savings of £100 million per year from simplifying the contracting process and pooling resources. The savings were to be invested in patient care.

8. Purchasing and Contracts

The introduction of the internal market in 1991 meant that district health authorities, freed from operational management, could adopt a population and planning focus to provision of healthcare. A new discipline of purchasing developed, based on a cycle of assessing population need, specifying services to meet that need, contracting, monitoring and evaluating those services and ultimately engaging in a new cycle of needs assessment.

Applying this simple process to an existing (and entrenched) system of health proved difficult. Purchasers could not always initiate radical changes because central government frequently intervened to protect hospitals for practical reasons (such as maintaining a service for other purchasers) or for political reasons (such as avoiding unpopular hospital closures).

Purchasers were also unsure where to start with needs-based assessment. Theoretical possibilities were disaggregation by age and sex, disease or care group, or geographical area. In practice, each purchaser tended to look at the most obvious known problems, such as pressures faced by acute mental health services or long orthopaedic waiting lists. Whilst this was a sensible use of scarce purchasing skills, it left the problem of how purchasers were to discover health problems about which they did not already know.

Many purchasers quickly encountered problems with trusts claiming they had fulfilled or exceeded contracts early in the year and needed more money. There were two principal reasons why this happened. First, many clinicians believed that if they fulfilled their elective activity commitments early, money would be found for them to carry on operating. Although the government's investment in the NHS outstripped inflation, an unprecedented real growth in activity (particularly in emergency workload) and demand maintained pressure on resources.

Second, the powerful new incentive to count patient activity quickly remedied earlier under-recording. There were obvious means by which trusts could inflate activity, for example by counting outpatient minor procedures as day cases. Whilst there was a great deal of concern about the accuracy of financial and activity data, many believed that it would only be improved by using the data to make real decisions.

Contractual funding meant that all providers, not only trusts, were involved with the internal market. All managers became engaged in the design of local contracting systems, using skeletal central guidance and the basic financial and activity data available at the time. There was substantial bottom-up innovation, with managers devising systems on the ground and sharing them with others informally or formally through centrally funded initiatives.

In the absence of a national standard contract, most purchasers pooled their experiences and developed broadly similar processes. Most contracts were broken down into a number of schedules covering different aspects, usually money and activity-specific standards for service delivery and general terms and conditions.

There were three basic types of contract: block, cost and volume and cost per case. Most Health Authorities contracts, particularly at the start of the reforms, were on a block basis, giving access to all services offered by a provider for a set price. In contrast, cost and volume contracts specify levels of expected activity within each specialty at the outset. Cost per case contracts are much more detailed agreements where remuneration is directly linked to activity and can accommodate marginal as well as average costs of care.

Block contracts are relatively straightforward ways of managing large amounts of money for high volume activities but the system sometimes lack sensitivity in handling individual specialities. Conversely, other models are more detailed but produce situations where individual purchasers and providers have to manage multiple contracts of various sizes,

each specifying the services that are and are not included, the volume to be provided, the cost, the standards required and the business rules and controlling the contract.

There is a tension between the view of contracts as vehicles to specify everything (requiring the negotiation and monitoring of huge volumes of paperwork on a regular basis) compared with a view of them as instruments for effecting priority changes only. Some contracts contain 10-20 specifications for different specialities. Other contracts are more ad hoc, with general quality standards (waiting times, discharges arrangements, respect for culture and religions, etc) set out in one schedule.

The detailed approach runs the danger of over-specifications. If something is not explicitly written into the contract, it can be argued that it need not to be provided. Over-specifications also blurs the distinction between purchasers and providers when purchasers feel they must monitor the contract on a line-by-line, highly detailed basis. The second, broader-brush approach is more economical in terms of skills and resources but has the drawback that, when things do go wrong, a purchaser may be open to criticism for not having made provision for that eventuality in the contract.

The introduction of contracting brought in its wake some undesirable pseudo-business behaviour, with negotiators sometimes forgetting that they were working within a public service, and dealing with colleagues, not opponents. High level intervention was sometimes needed to remind people that the purpose of contracting was to secure benefits to patients, rather than win at all costs. It was a lesson which the incoming Labour government had noted and were quick to tackle; that the process should not overwhelm the purpose.

9. Towards 2000: The "New" NHS

"The new NHS. Modern. Dependable" was published in December 1997. In many respects it represented an evolution, rather than revolution, in the management of the NHS initiated by "Working for Patient". Despite a rejection of the competitive ethos of the internal market, the fundamental purchaser-provider split, which separated planning of health care from its delivery, is retained, and the move towards a primary care led NHS reinforced. Board responsibilities for financial performance are now complemented by equally explicit board-led responsibilities for the quality of care. A renewed emphasis has been placed on co-operation between the various partners in local health economics rather than competition. Performance management includes an expanded set of indicators and benchmarks. Some key features of the reforms are listed in **figure 5**.

Six principles underpin the proposals:

- 1 To renew and improve the NHS as a national service.
- 2 To make delivery of health care a local responsibility.
- 3 To focus on quality of care.
- 4 To work in partnership.
- 5 To drive efficiency and performance.
- 6 To rebuild public confidence.

Three pre-existing strands of activity are consolidated and given a new emphasis: the developing role of primary care (through Primary Care Groups); attempts to link NHS activity into the broader national strategy for health; and an explicit emphasis on quality and standards.

Primary Care Groups

Under the proposals, all general practices are obliged to be part of a Primary Care Group (PCG) operational from April 1999. Each includes about 50 GPs and their practice staff, serving a population of about 100,000 people. They cover defined geographical areas and each is run by a board with a natural majority of GPs, plus representatives of practice nurses, community groups and the Health Authority. PCGs will undertake both provider and commissioner roles.

PCGs, as both providers of primary care and purchasers of secondary care, will be funded on a deprivation-weighted capitation basis by their Health Authority. Thus, for the first time, primary and secondary care will be delivered within a single, unified (and cash limited) budget. This will make it much easier to effect shifts between primary and secondary care or social services, but it introduces a cap on GP prescribing for the first time.

PCGs will be expected to progress through four levels, reflecting their degree of autonomy. The most basic Level 1 PCGs will merely advise the HA on commissioning decisions. The most developed (Level 3 and 4) PCGs will hold fully-devolved budgets to provide and commission almost all care. Most radically, level 4 Groups will be able to merge with community Trusts as free-standing Primary Care Trusts. It is not clear whether GPs will be employed by such a Trust, and if not, what their contractual relationship will be.

Unlike the Fundholding scheme which was always voluntary (albeit with considerable financial incentives to encourage individuals to join) every general practice has had to join a PCG. In addition, whereas Fundholding concerned the role of GPs as commissioners, the new arrangements impact on them as providers of care as well. Although GPs retain their existing contracts and their status as independent practitioners, they will be obliged to take corporate responsibility for the use of resources and the quality of care that they provide. In a major cultural shift, GPs within their designated PCG are therefore being expected to monitor their peers' clinical performance and address variations in the quality of care.

Figure 5 The 1997 reforms: "The new NHS. Modern. Dependable"

	Proposal	Objective
1	The abolition of the internal market	Reduced transaction costs, more co-operation between Trusts, Primary care, Health Authorities and Social Services
2	The introduction of Primary care Groups (PCGs), each responsible for commissioning health care for populations of about 100,000 people, and the abolition of Fundholding	Abolish inequity between patients registered with fundholding and non-fundholding practices. Reduce commissioning costs. Single budget for primary care including prescribing.
3	Health Authorities to assume a strategic role by developing three-yearly Health Improvement Programmes (HimPs) in conjunction with the local NHS, PCGs and Local Authorities.	Co-operative, longer-term approach to planning services. Delivery of health (and social) care embedded within a broader strategy for health
4	The introduction of Clinical Governance , imposing a statutory upon Trust Chief Executives for the quality of care delivered	Placing quality at the heart of NHS activity and closer monitoring of clinical practice
5	A new Performance Management Framework to assess six factors: the outcome of, access to, patient and carer views of, the effectiveness and efficiency of and general health improvement due to health care	Broader performance indicators to reduce perverse financial incentives

6	The establishment of two new bodies. A National Institute for Clinical Excellent (NICE) to develop National Service Frameworks for care delivery.	Improve and monitor quality and effectiveness of care using national standards
7	A Commission for Health Improvement (CHImp) to evaluate clinical care against these and other standards Investment in information technology, eg: a nation-wide patient information telephone line (NHS Direct) and expanding the NHS intranet to connect all general practices	More appropriate care delivery, better inter-sectoral communications

Strategic approach to commissioning

Although the ultimate function of Health Authorities is to improve the health of their population, they have traditionally focused on planning and commissioning health services. The New NHS enables HAs to concentrate on strategic planning, leaving PCGs to negotiate standards of care and the way in which it is provided locally.

HAs will be required to produce three-yearly **Health Improvement Programmes** (HImps), the starting point of which will be the Director of Public Health's Annual Report. Programmes will need to be developed as joint exercises with local partners to reflect national **Saving Lives: Our Healthier Nation** priorities and local issues. HAs will be responsible for ensuring that all local stakeholders (PCGs, Trust, Local Authorities, Community groups) are involved in developing, and are subsequently signed up to the programme, which is expected to provide a framework for all health and social care locally.

The intention is to produce a less combative commissioning process and more co-operative relationships between different parts of the NHS and with non-NHS bodies (particularly local authorities, voluntary groups and local commercial/business groups) whose activities have a major impact on health. The role of the NHS within a broader health strategy should also be more explicit.

The new emphasis on co-operation has been reinforced by various other developments obliging providers to offer 24 hour, consultant-led care across all sub-specialities. Such developments include:

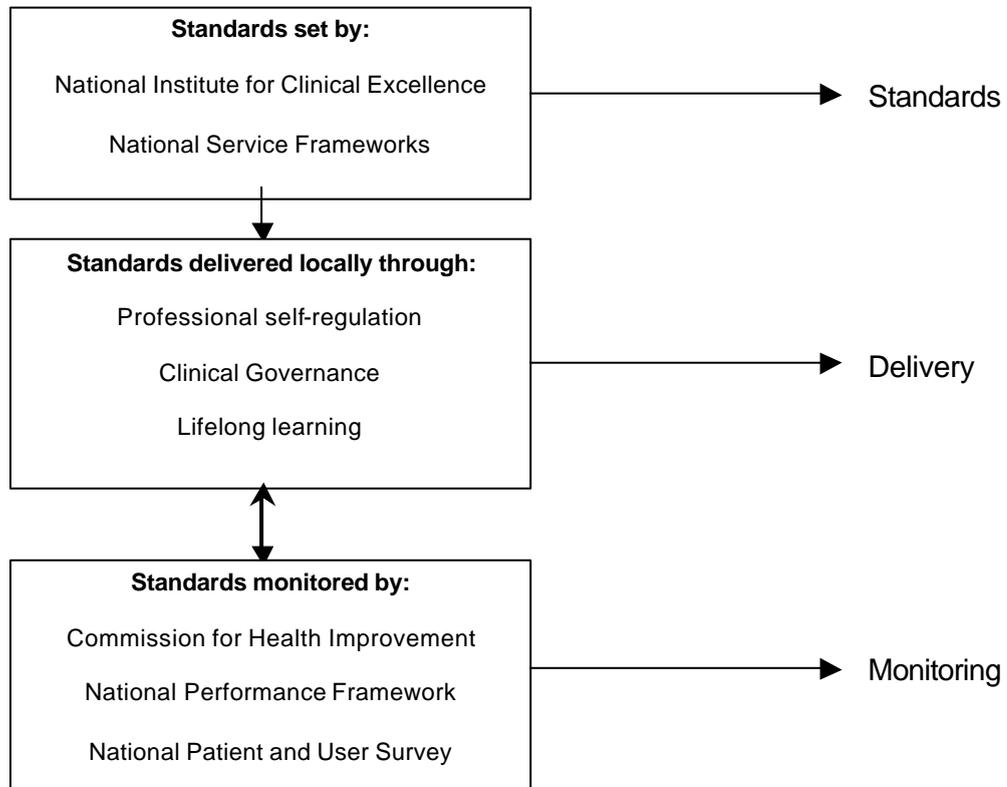
- The government's consideration of European Union directives restricting the working hours of junior (non-consultant) doctors in training.
- The Calman Reforms of medical postgraduate training introducing shorter, more intensive training programmes.
- Consultants being required to take a more active role in training their juniors reducing the time available for treating patients.
- Patients increasingly demanding more consultant-led care.
- Greater specialisations within the medical disciplines requiring new arrangements to ensure that hospitals have appropriate medical cover 24 hourly.

Quality

In June 1998, the Government published proposals to put quality "at the heart of healthcare"²². There are three components to the strategy: setting clear standards,

developing local systems for achieving them, and monitoring whether this has been achieved. The links between the three are illustrated in **figure 6**.

Figure 6 **Setting, delivering, monitoring standards**
(taken from "A First Class Service. Quality in the new NHS")



Setting standards

The **National Institute for Clinical Excellence** (NICE) will be a Special Health Authority, taking over the role of a number of existing organisations which produce information and guidelines on effective health care. It will be responsible for "horizon scanning" to identify health interventions that are likely to have significant impact on the NHS as well as examine current practice, develop and disseminate guidance on the most cost-effectiveness use of those interventions, and advise on appropriate means of implementation.

In particular, NICE will oversee the production of "**National Service Frameworks**" concerning major areas of health policy. Initially, these will set standards for the management of cancer, coronary heart disease and mental health. Subsequently, it is intended that one disease/condition framework will be produced, supplemented by 30-50 appraisals of specific interventions, annually.

NICE will also take responsibility for the four existing **National Confidential Enquiries** that examine perioperative deaths, still births and infant deaths, maternal deaths and cases of suicide and homicide by people with mental illness.

Delivering the standards

One of the more radical aspects of the reforms is the introduction of **clinical Governance** into acute and community trusts, PCGs and HAs. Clinical Governance is akin to Corporate Governance and places a statutory responsibility for the quality of care upon Trust and HA Chief Executive (and, for the interim, a nominated individual with PCGs).

It incorporates quality assurance, clinical audit, risk management and staff development and training. It means that, for the first time, clinicians (in particular consultants) are accountable to managers for the quality of the care that they provide.

Trusts have had to develop systems rapidly to meet these requirements, for example by establishing committees responsible for clinical governance, reporting on a monthly basis to the main Trust board. In contrast, PCGs (whose members have not previously worked within an institutional framework) have been advised to identify a limited number of specific priority areas for review. It is likely that they will progressively strengthen their systems of clinical governance as they develop.

Other mechanisms to deliver high standards of care build on existing mechanisms of self-regulation and the concept of life-long learning. Self regulation has come under close scrutiny following a series of highly publicised medical negligence cases. The resultant public concern has forced the GMC and Medical Royal Colleges to consider far more rigorous systems for re-accrediting and regulating specialities. Public confidence in doctors has been badly dented, and the medical profession is under considerable pressure to facilitate the introduction of clinical governance despite the potential restrictions on clinical autonomy that it could result in.

Monitoring standards

Whilst NICE is expected to "tell doctors what to do", the **new Commission for Health Improvement (CHI)** will "make sure that they do it". CHI will be a new statutory body overseeing a rolling programme of reviews and visiting every NHS Trust (acute, community and primary care) every 3-4 years. It will be responsible for reviewing clinical governance arrangements, the implementation of National Service Frameworks, other guidance issued by NICE and general performance as indicated by the new performance management arrangements and National Patient Surveys. Like NICE, CHI will be funded from existing resources, primarily those used to support the existing Clinical Standards Advisory Group.

CHI will disseminate examples of good practice and make recommendations to tackle shortcomings. Regional Offices, Health Authorities and service providers will be able to invite CHI to investigate particular problems, although local organisations will be primarily responsible for follow-up. CHI will also be able to refer clinicians to the GMC and other regulatory bodies if it feels that there are problems with their individual performance.

These changes represent a fundamental change in the relationship between the clinical professions, managers, purchasers and Government. Whilst a focus on standards and accountability is overdue, it is essential that it does not compromise the doctor-patient relationship which depends on the ability of the clinician to act in the patient's best interests.

Equally, it will be important to avoid the creation of perverse incentives through the inappropriate use of unreliable performance indicators, particularly when presented as "league tables". For example, clinicians may be reluctant to perform surgery on people with very poor prognoses, since the outcomes would reflect badly on their practice (although it can be argued that this is merely an efficient use of resources). Similarly, patient satisfaction surveys need to measure appropriate quality indicators if providers are to be encouraged to invest in clinical, rather than "hotel" services.

However, in many respects the changes merely formalise and extend existing arrangements, albeit more systematically. Both NICE and CHI will incorporate the functions of existing bodies but neither will receive extra resources despite the scale of the tasks facing them. There is, therefore, some concern that they will not have the capacity to make a significant impact on clinical practice. In the USA, the Agency for Health Care Policy and Research (similar to NICE) was unable to meet its commitments

to deliver its functions and its remit has been reduced. Likewise, CHI will need huge resources to review 450 NHS Trusts, and a similar number of Primary Care Trusts, every three to four years.

10. Research and Development (R & D)

Background

The NHS has always been a unique resource for undertaking research and introducing the findings into clinical practice. Until the introduction of the internal market, the costs of such work were largely subsumed within the overall health service budget. Since funding followed historical patterns, most research and development (R&D) took place in a relatively small number of teaching and academic units.

In the absence of any national strategy for R&D, the main research themes reflected the personal interests of researchers and the priorities of external funders (largely charities and private companies). These favoured high profile conditions and services, often neglecting the common causes of illness handled by the NHS in community and primary care settings. Nurses and the other "professions allied to medicine" (PAMs) undertook very little R&D and there were few studies into how the findings of research could be incorporated into routine practice. In effect, the NHS did not benefit as much as it could from the large volume of research being undertaken by its staff in its facilities.

In 1989, the Government appointed the first National Director R&D. Despite this high level appointment and the introduction of a national strategy to set research priorities, there were concerns that R&D would be jeopardised by the internal market. Since clinical research depends on patient involvement, much R&D was being subsidised through NHS contracts. Despite long standing mechanisms for direct central funding of the additional costs of teaching and research (the Service Increment for Teaching and Research), over the years it had become almost impossible to separate the true costs of patient based teaching and research from direct patient care. Most designated teaching hospitals (where the vast majority of teaching and research had traditionally taken place) could only estimate these costs and their contract prices often appeared unduly high. The explicit costing of episodes of care introduced through contracting gave a new impetus to remove teaching and research costs from the equation so that purchasers could make true comparisons between providers. Some feared that research would be squeezed out, particularly where hospitals were engaged in long term research of relevance to the NHS as a whole but of apparently little relevance to an individual institution working to survive and prosper in a competitive environment.

The Culyer Reforms

Hence, in 1993, the Government established a task force led by Professor Anthony Culyer to review the funding arrangements for R&D. The group reported within one year²³. NHS R&D was defined as work which was clearly-defined, peer-reviewed, well-managed and that provided new knowledge which would be widely available and generalisable outside the locality where the research had been undertaken. This excluded service development per se and reinforced the principle that R&D supported by the NHS is not the property of individual organisations but is for the "common good".

To support these principles, the Culyer Reforms proposed that all NHS R&D should be financed from a "levy" top-sliced from the annual allocations made to each Health Authority. The value of this single funding stream was initially calculated from providers' own estimates, and replaced an equivalent level of funding that they received from a large number of existing service and academic sources.

Setting priorities for R&D

The national strategy is determined by a revamped "Central Research & Development Council" headed by the Director of R&D and comprising representatives of the NHS,

academic and charitable bodies and private companies. This enables major external funders of research within the NHS to clarify the level of support that their plans will require. Alongside this national body, Regional Directors of R&D act as the focal point for determining research funding allocations within their own region, and for setting local priorities to complement the national strategy.

The strategy is informed by various sub-groups with responsibility for major areas of R&D. The largest is the Health and Technology Assessment Programme which commissions work to evaluate the effectiveness of new drugs and interventions, and makes recommendations about their implementation. Within this, the National Screening Committee oversees the introduction of all new screening programmes, according to revised criteria originally developed in the 1960s by Wilson and Jungner²⁴. Thus, screening for prostate cancer in asymptomatic people has been rejected, but pilots for colonic cancer and abdominal aortic aneurysms are to be introduced in 1999.

Funding mechanisms

The costs of R&D are considered within three categories:

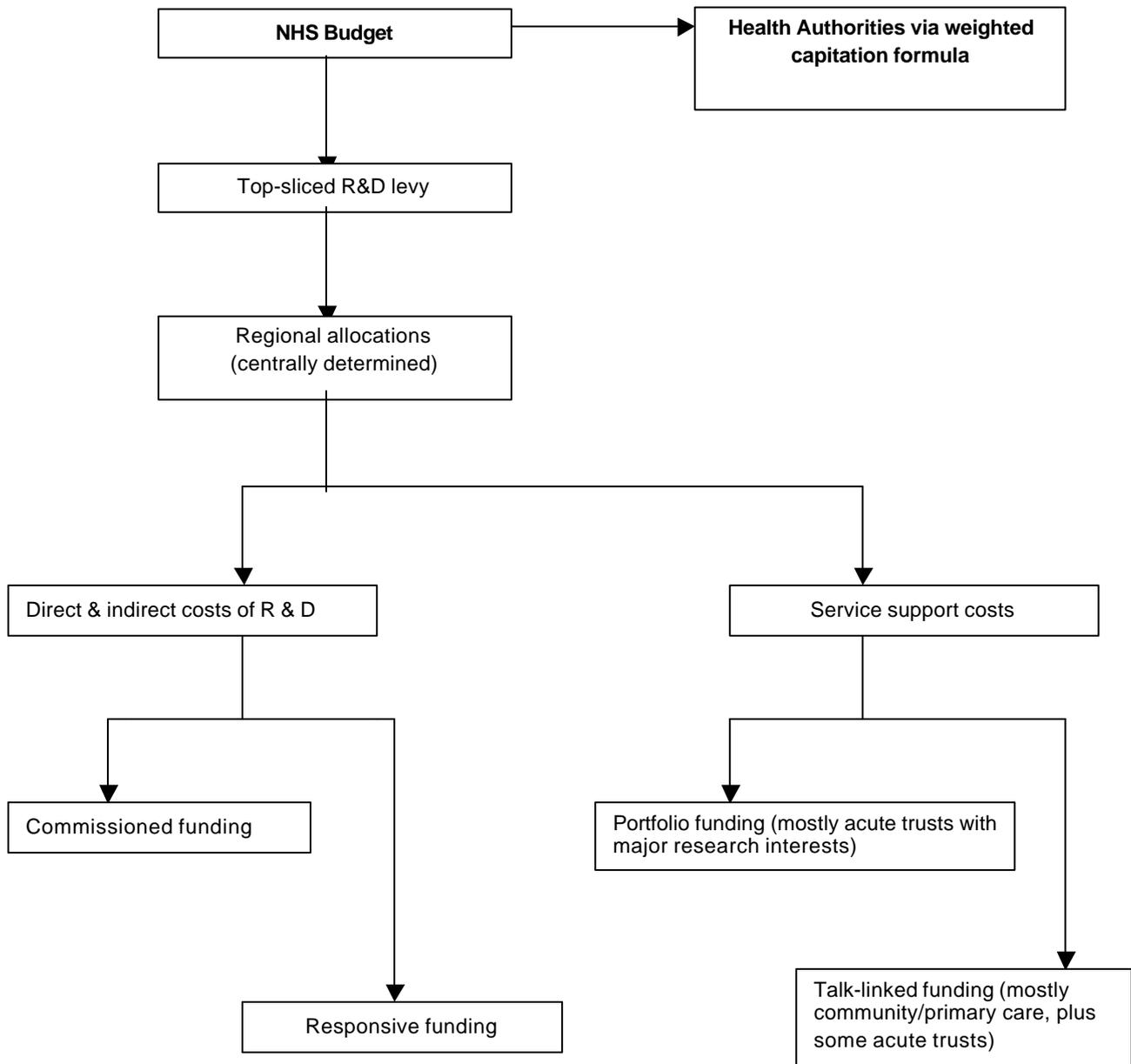
- Direct and indirect costs. This includes the costs of staff, equipment, drugs and data processing.
- Service support costs. This is the marginal cost of supporting individual R&D projects, including overheads for research space, extra outpatient appointments and the extra overheads incurred by routine services such as radiology or pathology laboratories.
- Costs of research facilities. These are the costs of maintaining institutions which conduct large volumes of R&D, but which cannot be attributed to specific programmes.

The latter two categories are funded on a four-yearly basis, based on submissions by providers and newly introduced research assessments which complement similar academic assessments. Providers planning to undertake small volumes of R&D, and new entrants into the field, can apply for "Task-linked" funding. Larger institutions (research facilities) are eligible for "Portfolio Funding" which carries additional responsibilities for in-house financial and quality assurance.

The direct and indirect costs of R&D are allocated predominantly within a "commissioned" programme, whose priorities reflect the national strategy for R&D. A parallel "responsive funding" stream exists to fund approved projects that fall outside the commissioned programme. This retains an element of flexibility within the system, and enables "blue sky" research to be continued and local needs to be met. In addition, local purchasers and providers are free to commission and undertake research on their own behalf.

Figure 7 illustrates the funding flows for R&D within this strategic framework.

Figures 7 Funding flows for NHS R&D



11. Health Strategies

The Health of the Nation

In 1991, the year of the introduction of the internal market, the Government published its first strategy for health, rather than health services. "The Health of the Nation" (HoN)^{25,26} highlighted the responsibilities of health authorities for the health of their resident population, rather than simply purchasing treatment for them. It specifically encouraged the new purchasers to concentrate on cost-effective strategies for dealing with major causes of ill-health but emphasised the actions that individuals could take to safeguard their own health.

Broad targets were set for the improvement of health in the population over a four year period. Five key areas were presented together as a coherent health - as opposed to illness-strategy. These areas (which represented the most common preventable causes of serious illness and death in England and Wales) were:

- cancers;
- coronary heart disease and strokes;
- accidents;
- HIV/AIDS and sexual health;
- mental illness, including suicides.

Population screening and health promotion programmes designed to change personal behaviour (eg. smoking, sexual practices) were agreed for district populations and linked to explicit, measurable improvements against agreed baselines. However, within each key area there were multiple targets and critics noted that, in general, these were simply extrapolations of existing trends. In addition, the reluctance by the Government to acknowledge social, environmental and economic factors (particularly inequality and poverty) as major causes of ill-health limited the potential of the strategy.

District Health Authorities, charged with the lead role to drive the strategies locally, formed multi-disciplinary groups to prepare and implement action. The massive change agenda facing Health Authorities, plus financial pressures facing local councils, probably lessened their impact but much good work was done, and some innovative schemes, crossing traditional inter-sectoral and professional barriers, were established.

By 1996, although progress had been made in achieving some targets, there were notable exceptions, especially the facts that more teenagers were smoking and more adults were overweight or frankly obese.

Saving Lives: Our Healthier Nation

One of the first acts by the new Labour Government in 1997 was to appoint the Country's first Minister for Public Health, reporting to the Secretary of State. A draft policy document, "Our Healthier Nation" (OHN)²⁷ was subsequently published in to replace HoN. At the time of writing, the White Paper resulting from consultation on Our Healthier Nation ("Saving Lives") has just been published, setting a national target of 300,000 lives saved over the next decade with specific focus on four areas; cancers, coronary heart diseases and stroke; accidents; and mental illness.

Saving Lives: Our Healthier Nation differs from HoN in some important respects. Most fundamentally, it acknowledges the association between inequality, poverty and ill health. There is a marked shift from HoN's focus on individual responsibility to improve health to a recognition that this can only occur within a broader framework of change which empowers individuals. Hence, the strategy proposes "national contracts for health" for each of the four areas, within which three groups (Government, Local Authorities/community groups and individuals) should accept certain responsibilities. The strategy also identifies three settings where action should be focused. The key features of the new strategy are summarised in **figure 8**.

Figure 8 Saving Lives: Our Healthier Nation: Key points

Aims	
1	Increased quantity and quality of life in general
2	Improved health for most deprived and reduced health inequalities
Settings	
1	Healthy School (children)
2	Healthy workplaces (adults)
3	Healthy neighbourhoods (elderly)
Targets (by 2010)	
1	Heart disease and stroke: reduce deaths by two fifths (people <75 years)
2	Accidents: reduce accidents by one fifth and serious inquiry by one tenth
3	Cancer: reduce deaths by one fifth (people <75 years)
4	Mental health: reduce deaths from suicide by at least one fifth

The main criticism of the proposals is that, as with HoN, there are no targets for narrowing the inequalities observed. The consultation process resulted in a significant change to the draft targets; they now encompass the 65 to 75 age group following criticism that the elderly were effectively excluded from the strategy. The targets proposed for the four key areas are very narrow indicators of health (for example, using suicide rates as proxies for mental health). The Health of the Nation had faced similar problems in restricting its focus to a few key areas, and prioritising a small number of targets to monitor it. Saving Lives; Our Healthier Nation has reduced the scope even more, and although presented as separate Government strategies, levels of smoking, alcohol and illicit drug use, and indicators of sexual health are not included within the specific targets set.

The new strategy has been given a much higher profile within Health Authorities than HoN. It details clearer mechanisms and responsibilities for translating the strategy into action at a local level, primarily by using it as a basis for Health Authority three-yearly **Health Improvement Programmes (HimP)**. These define the framework within which Primary Care Groups and the NHS in general, Local Authorities, community and voluntary groups will act to improve health locally. The new responsibilities of primary care groups and trusts explicitly cover public health.

To complement this new approach, the Government plans to place a new duty on Local Authorities to promote the economics, social and environmental well-being of their areas. They have been instructed to adopt **Agenda 21** action plans for sustainable development, as endorsed at the 1992 UN "Earth Summit" held in Rio de Janeiro. In addition, a number of **Health Action Zones** have been established (through a competitive tendering process).

Their purpose is to engage Health and Local Authorities, the NHS, community and voluntary groups, and local private companies in long-term programmes to improve health in general. Considerable resources for joint working between the partners have been made available to support each zone, and they are seen as pilots to inform HImPs about successful ways of working together.

Similarly, Saving Lives proposes establishing a network of **Healthy Living Centres** across the country. They are intended to be resource centres, providing a focus for local health improvement activities. Funding of £300 million has been earmarked from the National Lottery. Standards and quality of the public health function will be overseen by a new **Health Development Agency**, and other initiatives will support the development of Public health information and research. New measures will tackle the education and training of the multidisciplinary public health workforce, significantly raising the status of non-medical public health professionals. Special attention will be given to the public health potential of the roles of nurses, midwives and health visitors.

12. Consumerism and the Patient's Charters

In 1991, John Major, Margaret Thatcher's successor as Prime Minister, proposed publishing a series of "*Citizen's Charter*". These were seen as a way of making state-run organisations more responsive to individuals by defining the standards of service that could be expected. The "**Patient's Charter**" set out some of the basic standards which users of the NHS could expect to receive. Some services were set out as rights²⁸ and league tables were initiated which directly compared the performance of different providers. This form of public accountability was intended to raise very basic standards of service delivery in the most explicit way possible.

Some commentators welcomed the clear messages that standards of service to the individual patient should improve (and be seen to be improving). However, many criticised the charter for concentrating on basic process issues - not clinical outcomes. For examples, maximum waiting times for routine in-patient and day-case treatments and for outpatient appointments were specified. The standards were widely perceived as irrelevant yet threatening, encouraging patients to complain about conditions over which NHS staff had little control. Similarly, many patients thought that the standards were unrealistic and bore little resemblance to the actual quality of care received.

In 1997, the Labour Government asked Greg Dyke, a former TV Executive, to develop proposals for a revised charter. A report was published in 1998²⁹ proposing a new charter based on a core set of minimum national standards, augmented locally to reflect staff and community concerns. The hope was that staff and patients would perceive the standards as more relevant, meaningful and achievable than their predecessors. However, there were concerns about the development of local standards when one of the Government's major policy objectives was to reduce or eliminate variations in care across the country. The final shape of the revised charter remains to be agreed.

13. Community Care

1989 saw the publication of "**Caring for People**", a set of proposals advocating care in the community rather than in large institutions, for the mentally ill, mentally handicapped, the elderly and the physically disabled³⁰. The proposals promoted individually designed care packages of hospital and community services, overseen by a care manager nominated for an individual patient.

People were encouraged to live in their own homes for as long as possible, with services brought to their homes. The individual consumer would be at the heart of a network of services provided by a number of agencies - local government (providing social services), health services and the voluntary, not-for-profit sector. In addition to promoting the centrality of the needs of individuals, the proposals were intended to promote rational planning and the funding of services across organisations. "Caring for people" was a consumer-centred response to the problem which was as old as the NHS itself - the split of responsibility between the NHS and other agencies.

A considerable process of change occurred to implement the plans. Most of the long-stay mental hospitals were closed down and their residents transferred into smaller residential units in the community. Similarly, hospital care for elderly people started to resemble that provided by other specialties with much shorter admissions for acute problems only. Residential and nursing homes, mostly run by private companies, rapidly expanded to provide long-term care and rehabilitation.

Not surprisingly, the introduction of these changes did little to promote new ways cross-organisational working, nor novel approaches to manage budget together. This partly reflected the different cultures of the NHS and social services but also bureaucratic barriers to joint working or budget pooling.

Hence, the general perception of community psychiatric care was of a series of episodes in which the care of individuals broke down because of lack of continuity between different members of multi-disciplinary teams. There were a number of high profile incidents in which people with mental illnesses harmed either themselves or others, and public confidence was shaken. In fact, the proportion of homicides committed by the mentally ill dropped steadily from the 1950s and throughout the 1990s.

Long-term care of the elderly was also subject to funding problems. Whilst nursing care is funded by the NHS, those people requiring long-term social care because of frailty or dementia are means tested and required to dispose of most of their assets before they are entitled to state funding. This artificial distinction between health and social care is widely regarded as inequitable and unfair. A Royal Commission on long term care has proposed that the state should fund all "hands on" care, whether nursing or social care³¹. The government has yet to make its position clear. However, the financial consequences are enormous and, irrespective of the arrangements made for today's elderly population, it is almost inevitable that younger people will have to make provision for their own future care.

The most recent NHS reforms offer new mechanisms to co-ordinate care across different agencies, with the potential to improve the efficiency, coherence and sensitivity of services in meeting the varied needs of individuals users across a network of organisation. The new role of Health Authorities to develop Health Improvement Plans with other NHS organisations and Local Authorities should produce common strategies for the development and supply of care between health and social services. Similarly, Health and Local Authorities will be able to pool greater proportions of their budgets and to nominate one organisation to take the lead on managing particular services. Despite these new flexibilities, it is highly unlikely that the funding gap will be closed, or barriers totally removed.

14. The Rationalisation of Acute Services - the London Example

This section draws specifically from experience in London. Similar rationalisations of services have been taking place in other major conurbation within England. Wales and Scotland have also developed whole country plans for mergers and service reorganisation.

All share the same drivers for change, a combination of rapid technological developments; shorter lengths of stay; shift towards ambulatory and out-of-hospital modalities of care; shortage of manpower in some clinical areas; and the dispersal of teaching and research into primary care and general acute settings.

The introduction of the internal market in 1991 and the shift to capitation funding channeled through purchasers threatened the viability of several prestigious teaching hospitals, especially in London. There were several reasons for this:

- The reforms exposed the high costs of services, including the value of capital assets
- Capitation funding generally moved funds away from big cities (relatively fewer people actually lived in cities than in the past; there had been substantial migration to peri-urban areas).
- The large teaching hospitals attracted patients from all over the country, with geographically distant purchasers referring perhaps only one or two patients per year. Such small flows of cases did not fit into the block contract system, and were subject to special arrangements requiring prior authorisation. However, such cases are often necessary for teaching and research, and the big teaching hospitals stood to lose large amounts of money if they failed to recoup the costs of this work.
- World-wide, hospitals faced a changing role, as increased day surgery, shorter lengths of stay and new technologies all pointed towards new styles of work.

Particularly concerned about London, the government asked a non-London based medical academic, Sir Bernard Tomlinson, to look at the Capital's health services. The main points of his 1992 findings were that ³² :

- The standards of primary care (in particular general practice) were generally worse in London than in the rest of the country.
- London was over-provided with inappropriate used acute hospital beds
- The effect of capitation funding moving money away from inner London and the high cost of London teaching hospitals indicated closures or mergers.
- Undergraduate medical schools should pool their resources around fewer campuses.
- Highly specialist services (eg renal care, the single-specialty postgraduate hospitals) were in urgent need of review on the basis that there were too many small departments ³³.
- Whilst the report confirmed what the government had expected, it stirred up considerable controversy. In its own formal response to Professor Tomlinson's report ³⁴, the government took the following steps:

- Establishment of a special funding mechanism to improve primary care in London which was used to enable purchasers to set up new schemes, to be funded after five years by transferring existing resources from acute care.
- A plan for mergers and closures, including several world-famous hospitals (St. Bartholomew's, the Hammersmith and even Guys which had been lauded as the "flagship" of the Trust movement).
- Rationalising undergraduate medical schools.
- A review of specialist services, which itself proposed a further set of mergers between departments following the lines of the overall teaching hospital mergers.
- 'Transitional' funding for hospitals whose running costs exceeded their contract income in order to maintain stability whilst the changes took place

Critics argued against the plans for London on the grounds of both logic and tradition. The idea that London has too many acute beds seemed incomprehensible to doctors - GPs and consultants - trying to admit patients to hospitals. Studies have since shown that London's relative position depends on what is counted. If beds for the elderly, super-specialties and maternity are excluded, London has fewer acute general medical and surgical beds per population base than other parts of the country. Critics also claimed that improved primary care would stimulate demands for more hospital care.

The total cost of the mergers would have run into hundreds of millions of pounds and some questioned the wisdom of rapidly closing down hospitals which had themselves received substantial recent investment, sometimes raised through public appeals. The emotional arguments were powerful; defenders of tradition and centres of excellence found the prospect of closing world famous hospitals distressing and distasteful.

In opposition, the Labour Party committed itself to reconsider the proposals, and hence one of the first acts of the new Government was to establish a second review of London's health services under Sir Leslie Turnberg in June 1997³⁵.

The proposals, accepted by the Government, included:

- Establishing a single London Regional Office to replace the two existing authorities.
- Additional investment in primary, mental health and community care services.
- A greater focus on providing "intermediate" facilities such as rehabilitation and respite care beds.
- Specialised services to be organised within five sectors, corresponding to the five University medical schools in the capital.
- Increasing the number of GPs in the capital.
- Putting a halt to any further bed closures on the basis that London did not have an excess compared to other parts of the country.
- Restrictions on the further closure of A & E departments.
- Recommendations about individual hospital development or closure plans. These included suggestions to review specific A & E or hospital closures.

London's problem (other than those of the medical schools) are common to most large cities. Most people now agree that change should take place in the UK's large cities - but at a sensible, measured pace which preserves good medical practice. The London debate highlighted many of the problems faced in large cities. The approach to tackling these problems has reflected the wider NHS context, moving from the market-driven philosophy of the early 1990s to the current, more centralist and planned health economy.

15. Human Resources and Employment

Historically NHS staff had been employed locally but on national terms and conditions. These were negotiated and agreed centrally and included procedures for resolving disputes. In certain cases this included the right of appeal against local decisions to the Secretary of State for Health. There was a national contributory pension scheme. Employment was seen as being permanent unless the employee decided to leave or transfer elsewhere within the NHS. When the latter occurred, existing rights, including seniority and pension, transferred with him or her.

The introduction of local pay bargaining was a feature of the reform of the UK public sector in the 1980s and the NHS was to be no exception. As in other countries, salaries account for between 70% and 75% of costs and local managers felt that unless they could control them they could not truly manage their assets. Following the introduction of general management in 1985 the various grades for administrators and

managers were replaced by some local flexibility in which staff were placed. A performance related common pay spine for senior managers was also introduced - a national scheme administered locally.

One of the aims of *Working for Patients* was to break the NHS into smaller units for pay bargaining purposes. With its introduction, NHS Trusts became the employers of the majority of staff with the right to set their own terms and conditions. Existing staff had the right to maintain their existing terms and conditions on transfer but trusts could employ new staff (including consultant medical staff) on whatever terms they wished. In practice, most trusts modelled their contracts on existing ones.

In addition, the policy of the NHS Executive was to devolve to Trusts responsibility for annual pay negotiations for staff who transferred to them with their existing terms and conditions. The latter progressed slowly and contentiously. In 1995 it was agreed that pay for all staff, except doctors, would be negotiated locally although within national guidelines. Hospital doctors and nurses continued to have their pay determined by a national pay review body.

Staff in purchasing authorities remained on national terms and conditions. Proposals for local pay bargaining were considered but never implemented. General practitioners continued as self employed contractors working in partnership with other colleagues. They employed their own nursing and administrative staff but frequently using national terms and conditions as a guide.

The introduction of "The new NHS" reforms has put a halt to the gradual devolution of responsibility for employment. A review of salary structures has been initiated to investigate whether or not a common pay spine could be introduced covering all professional, managerial and other staff. NHS trusts remains as employers, but it is unlikely that they will be allowed to developed their own terms and conditions of employment.

Two other pieces of legislation have had at least as great, if not greater impact on working conditions as these changes in salary arrangements: the **Calmans reforms** of medical post-graduate training and the **European Union directive on working hours**.

The Calman reforms³⁷ were introduced to standardise and improve medical training. They required each specialty to established fixed-length training programmes with annual assessments of doctors in training. The numbers entering this training grade were strictly controlled, and supposedly matched to estimated future requirements for specialists. New regulations limited the hours that junior doctors in training could be expected to work each week and minimum rest periods between stretches of duty were specified.

Newly-created post-graduate deans were allocated a proportion of the costs of training doctors which, in the spirit of the internal market, they "spent" in individual trusts. This arrangements forced trusts to meet certain minimum standards for training and accommodation, at risk of losing a significant part of their funds (and therefore medical staff) if they did not deliver.

Simultaneously, European legislation required the Government to introduce new arrangements for accrediting specialists. New regulations were introduced governing the recruitment and appointment of consultants so that a doctor recognised as a specialist in any European Union country was able to apply for UK posts on an equal footing with UK graduates.

Despite the new training arrangements, workforce planning remains an imperfect science and professional estimates of staffing levels have rarely been matched by the resources necessary to achieve them. Shortage of doctors persist in some specialisms, for

example, paediatrics, psychiatry and anaesthetics, whilst there is now a surplus of obstetricians.

Problems are not limited to doctors; there are also concerns about the future of the nursing workforce, requiring action locally and nationally. Not only is it essential to maintain the recruitment of new trainees into nursing, but also to encourage returners in order to make best use of skills.

16. Conclusions

This document describes how the NHS, in particular its management, has evolved since its inception. It illustrates the complexity of achieving a uniform level of health care delivery nationally. The NHS developed from an existing, complex and historically determined mixture of health and social services. It has remained at the top of the political agenda throughout its existence and has been subject to repeated re-organisation and financial crises. Expectations of the service have risen exponentially, driven by technological advances and general societal changes that have emphasised individual rights and more consumer-focused services.

Until the 1990s the general management of the NHS was strictly controlled from the centre although clinical autonomy remained sacrosanct and little attention was paid to the processes of care that determine the major costs of providing healthcare. The stated intention of the internal market reforms was to produce a more responsive and efficient service where the provision of care matched available resources by devolving budgets to NHS Trusts, individual directorates within them, and to GP Fundholders.

The actual impact of the internal market was probably less pronounced than suggested from the degree of controversy that it generated. The balance between efficiency gains and increased transaction costs has been a fine one and the conclusion not yet proven either way. More detailed analyses of efficiency suggest that much of the increase in activity can be explained by better data capture, changes in medical technology and the patterns of care of individual patients. The fundamental principle underlying the reforms, that increased competition would be the driver for greater efficiency, has also been challenged on that basis that true competition never existed. Since health care is a notoriously imperfect market, it is in practice very difficult to enter or exit the market in the short term. In addition, in the USA, it has been observed that competition can, perversely, increase costs as providers attempt to win contracts by increasing the services offered.

It has been suggested that, far from increasing competition, the internal market resulted in a series of bilateral monopolies between purchasers and providers. Equally, although competition may have been a useful mechanism to achieve a rationalisation of the NHS through hospital closures, it can be argued that it is not the right tool to improve equity.

Two main issues related to equity in the context of the 1991 reforms. First, a "two tier" health service developed in which GP fundholders' patients received preferential access to treatment, partly because they sometimes received disproportionately generous budgets and because they benefited from substantial inherent advantages over Health Authority purchasers. Nonetheless, there is no evidence that patients of non-Fundholding GPs fared any worse than before the reforms. Indeed, it can be argued that two-tierism in an inevitable feature of services as they improve. Individual innovators and leaders will always "lead the field" and the challenge is to ensure that others are able to learn from their experience and not be systematically disadvantaged.

Secondly, there were initial concerns that Trusts and GP Fundholders would "cream-skim" patients with relatively easy and cheap conditions to treat. There is, however, no evidence that this occurred, although the potential existed and has been observed in, for example, the US health system. The reasons why cream skimming did not occur are unclear, although they probably reflect a strong ethical principle and the fact that

individual clinicians do not have any financial interest in the NHS. More importantly, perhaps, the most expensive and unpredictable elements of care were funded separately from mainstream services.

Less tangible benefits of the reforms, such as improvements in quality, choice or responsiveness, were also limited. Although the **Patient's Charter** was often derided, it raised individuals' expectations about the quality of care and encouraged them to demand better services. Regrettably, it led Trusts to focus on relatively meaningless measures. Patient satisfaction surveys fluctuated with the levels of funding made available for the NHS, whilst changes in the lengths of waiting lists were affected more by specific Government initiatives than any inherent improvements in quality associated with Trust status. For a detailed review of the impact of the internal market, see the short and very readable book published by the King's Fund ³⁸.

Despite the criticisms, the broad framework established by the internal market has been accepted and the newest reforms retain many of its features. The **purchaser-provider split** is recognised as providing a sensible division of responsibilities between those allocating resources and establishing health strategies, and those providing more narrowly defined health or social services. Similarly, **capitation funding** offers the potential for services to be developed to meet population needs, rather than organisational self-interests.

Despite the rhetoric of the 1997 White Paper, the establishment of **Primary Care Groups** builds on the principle of GP Fundholding that primary care staff are best placed to determine the quantity and quality of services required locally. The current proposals are much more prescriptive than the pre-existing voluntary schemes. All general practices are obliged to join a PCG and they are expected to commission all except the most specialist services. It remains to be seen how effectively such groups of independent practices co-operate and whether they will have adequate expertise, support and resources to manage the task. PCGs are also providers of care. They will have a significant role as the focal point of local networks of health care providers, integrating primary and secondary services for the populations they cover using the new National Service Frameworks. The long-term aim, that the groups will merge with community trusts, has already started to raise issues about the self-employed status of GPs and their eventual position within such organisations.

A highly significant, although so far unrealistic, development has been the attempt to integrate the NHS (largely focused on ill-health) into a broader strategy for health per se. The original **Health of the Nation** strategy was rather dissociated from mainstream NHS activities and avoided references to wider determinants of health. The new strategy, **Our Healthier Nation**, is more encompassing. The introduction of **Health Improvement programmes**, and the obligation to incorporate OHN priorities, offers the opportunity for NHS activity to be linked more explicitly into the strategy.

However, perhaps an equally fundamental change signalled by the new NHS strategy is emphasis on clinical quality. The introduction of **clinical governance** into all NHS organisations and the implied cultural change that will be required offers the prospect of a major change in the way healthcare is delivered. Additionally, the establishment of the **National Institute for Clinical Effectiveness** and the **Commission for Health Improvement** implies that clinical autonomy is likely to be eroded and accountability will be increased.

The position of doctors is being challenged on many fronts due to raised public expectations, demands for better regulation and the increasingly outdated contractual arrangements under which they are employed. Already, regulatory bodies such as the GMC and UKCC are reviewing their systems for accreditation and new revalidation processes will be introduced. The Government is reviewing the consultant contract and

the unique opportunities it confers on consultants to practise privately whilst simultaneously meeting their NHS commitments.

The new vision promised by the reforms is likely to require extra resources. Staff wages in the NHS are very low compared to the private sector and recruitment problems are pronounced. Much better information systems will be needed to underpin Clinical Governance if it is to be a meaningful process. Enhanced training and supervision of doctors and nurses will cut into clinical time, suggesting more staff will have to be employed.

Other, secular changes in health and social care present further challenges. **Community care** puts the medical responsibility for 24-hour cover with the GP, as do the changing trends in acute care (day surgery, shorter lengths of stay). Changes in medical staffing structures and training are needed to enable more care to be delivered outside hospital and to make better use of medical staff time within hospitals. The **Calman reforms** have led to restructured and shorter hospital medical staff training and career structures to allow hospital doctors to reach accredited standards in a speciality earlier in their careers. However, a major concern now is whether the pendulum has swung too far and that surgeons, in particular, have too limited an apprenticeship before becoming specialists.

Undergraduates need to spend more time in general practice to support the shift of medicine away from hospitals. General practice must become an attractive career option for more doctors. 25% of GPs are aged over 50 years and recruitment has slumped. It is unknown what impact the introduction of PCGs will have, although few people consider the extra responsibilities and the potential threat to self-employed status as an incentive to enter general practice.

In common with many other western countries, the UK population is ageing. Whilst people are staying healthier for longer, the future prospective burden of pensions, social support and health care on a diminishing workforce is causing concern nationally. Means-testing for some social services now takes place, with people who have more than a set level of savings paying for their nursing home or residential place, even if this means selling their home.

Whilst this may not seem unreasonable to those living outside the UK, it strikes at the heart of the cradle-to-grave concept of the post-war welfare state with which this paper opened. Many people who paid tax throughout their lives in the expectation that their needs in old age would be taken care of by the state have been disappointed.

It is inevitable that, in the face of limited resources, rather than expecting the NHS to provide everyone with all forms of care, healthcare will need to be rationed and a consensus achieved as to what the service's aims should be in the 21st Century.

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