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Culture Versus Competition:  
The Reforms of the British National Health Service  
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## Culture Versus Competition: The Reforms of the British National Health Service

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**T**HE reforms of the National Health Service (NHS) are important to the citizens of the United Kingdom (UK), but they also represent a significant change in health care policy that will influence a large number of other countries that are in the process of deciding on their own reforms or implementing them. For many years the NHS has been held up as the standard of an equitable and cost-effective system. It has been used by many countries as a "model" of what a health system should desire to achieve.

This glowing report of NHS is a bit overstated, given the well-known queues for hospital procedures and the lack of productivity in some areas of physician practice (1-3). However, it does have many features that are very attractive: universal coverage, a sense of equity, little interference in the practice of medicine, and a global budget system that keeps aggregate costs under control. Perhaps even more attractive is the trust and support that the NHS has earned for more than 40 years from a large majority of the population and the providers. Indeed, the NHS is a cherished institution in the UK.

### WHY THE NHS WAS REFORMED

The obvious question, then, is why change the NHS in fundamental ways even if it has some problems? Understanding this question is at the heart of the reform proposals. For more than ten years the conservative government in the UK has been moving the country and its economy away from its socialist values and more towards capitalism and the use of markets. A middle class of young business persons, lawyers, and managers have been encouraged to use their skills and the market to increase productivity and profits. This pace has been accelerated because in 1992 the integration of Europe, with relatively open borders and movement of labor and capital, will begin.

The reforms of the UK economy being pursued by the conservative government have had some general principles: more power to the consumer and more choices in the market place. Americans call this consumer sovereignty. The reforms emphasize profit-making and financial rewards for productivity. They also stress decentralized decision-making and flexibility.

Thus, it is no surprise that these same elements are the principles found in the NHS reforms. The White Paper reforms were subtitled "working for patients," suggesting a theme of consumer sovereignty. The key point is that the NHS reforms had less to do with seeking the best health policy and more to do with the overall reforms of the UK economy. This is an important point to be considered by countries that may want to follow the reforms in deciding on their own health care policy. The option of spending a little more on the existing NHS to improve it and shorten queues was not a viable option if the real goal of the government was a transformation of the economic and social fabric. A market model was being introduced into all aspects of the UK economy: education, law, theater, and the airlines, to name a few. It is interesting to note that, of the market-type reforms, the NHS was perhaps the last major institution that the government selected for reform. The public support for the NHS was clearly a major reason for the government's reluctance to act sooner.

#### THE ESSENTIAL INGREDIENTS OF THE REFORMS

The NHS reforms seek to alter the economic power relationships (5). Primary care physicians (GPs in the UK) are to be given more economic power, and specialists (known as consultants in the UK), less power. Hospitals, especially hospital managers (the entrepreneurs), are to be given more autonomy and power, with the rewards (higher wages) that go along with economic success. Patients are supposed to get more choices and a service responsive to their needs. The government's role is now that of an economic agent to purchase services in the market. Obviously, this is a very different set of assumptions than those underlying the NHS before the reforms.

For over 40 years, a culture had developed that permitted the government to pay GPs a relatively low wage by international standards (about twice the average wage in the UK). By comparison, the United States, French and German physicians earn about five times the average wage earned in their respective countries. The number of physicians is controlled by the government, and training is fully supported. Physicians

control their own practice style and negotiate contracts with the government. These sets of relationships and the role of the GPs are perhaps the key to the historic success of the NHS. It may have needed a few fixes but, in my view, little fundamental change.

The changes that I would have suggested were in fact accomplished by changes in the physicians' contract. More of the income of physicians was made a function of capitation payments and less of salary; this would encourage competition for patients. Targeted payment to meet specific goals, especially in the prevention area, also make sense. These include bonuses for cervical cancer-screening exams and immunizations for children. In addition, the government reforms encourage GPs to become business persons and entrepreneurs. GP groups, initially with 11,000 patients, now down to 9,000 patients, can opt to hold their own budgets. They then receive a fixed budget to cover data systems, practice staff, and a defined set of hospital services including initial outpatient referrals, diagnostic tests, and minor surgical procedures. Yearly patient costs over 5,000 pounds are paid for by the District Health Authority. Funds that are not spent for these purposes can be invested back into the practice and cannot be taken directly as income. It is of course likely that their investments in the practice will help to attract more patients to the practice lists and increase income in future years.

The GP practice needs to manage its own costs and to sign contracts with hospitals for diagnostic tests, outpatient referrals, and minor surgery. The budget-holding GPs must negotiate directly with the hospitals. This buyer/seller relationship can give many GP practices a considerable amount of economic power in areas where hospitals can be played against each other (e.g., London). The government is happy to provide funds for data systems to improve this contracting process. However, the difficulty in writing contracts for hospital services that are understandable and enforceable was not well understood by the reformers. Contracts for services that have a large variation in quality are extremely difficult to write, especially where economic rewards and perhaps economic survival are a strong motivating force.

I believe that physicians and hospitals will learn to write contracts over time. The physicians that learn the needed economic skills or purchase them will be successful, and their income will surely increase. Hospitals will be attracted to contracting with practices that have patients who are less costly to serve. They will find ways of identifying these less costly patients. Favorable selection by hospitals will be the name of the game

(3). However, more important, in my view, will be the long run impact on the culture of GPs. They will no longer be satisfied with modest incomes when many of them will be making attractive sums. This will cause another type of selection effect. Individuals going into careers in medicine may be more interested in their earnings than the current group of physicians. This will surely change the culture of the future GPs, and this is what I believe the government had in mind. I suspect that its direct impact on health care was a secondary consideration.

In the hospital sector the reforms make more sense. Hospitals in the UK had become over-bureaucratic and inflexible. My distinguished colleague Alain Enthoven labelled this "grid lock" (6). He pointed out that hospitals that were efficient were rewarded with more work, not additional resources. Also consultants (specialists) had too much autonomy and very little responsibility to the hospital. They used the hospital as they liked and when they liked. They also controlled their own levels of pay. To remedy these problems the reforms permit hospitals to "opt out," that is to become autonomous and run their own affairs. This includes hiring staff and setting their pay levels, borrowing for capital improvements, and controlling their own assets (7). Hence they are to be like nonprofit hospitals in the US while still being technically in the NHS.

Hospital managers were given the power and authority to negotiate written contracts for salaries with consultants, and consultants were required to be more sensitive to economic matters in the hospital. Hospitals would sign contracts with budget-holding GPs, and District Health Authorities could use their economic power to induce hospitals to be efficient and cost effective. They can contract with hospitals inside or outside their district. The separation of the buyer (the District Health Authority), and seller (the hospital), is the key to the internal market for hospital services. I believe that this is a useful step for the most part. Hopefully, allowing them more flexibility and autonomy will encourage the improvements in efficiency that are needed. The culture that had developed in the hospital system was not in the best interest of the patients; more resources could have been spent on hospitals without an increase in useful hospital services.

#### WHAT WILL BE THE IMPACT OF REFORMS?

There is little doubt that the NHS reforms will increase the percent of GNP spent on health care. Some of the increases will be for information systems, legal fees for contracting services, and overall administrative

costs. The distribution of physicians and their incomes will become more uneven. GPs in "opted-out" practices will earn large increases in income. Consultants (specialists) in areas of short supply will earn high incomes. Successful hospital managers will be rewarded handsomely. There will be much activity and sorting out of the new economic relationships. Some districts will use their new economic power well, while others will be captured economically by the hospitals in their areas and little will really change. These are the ways of the "market." The distribution of services will become more unequal. Distributional equity has never been the goal of market economies.

The move towards revising the NHS by using market principles, many of which have been borrowed from the US, is part of a plan to change the UK economy. I believe that the potential impact on the culture of GPs in the UK is most alarming. GPs in the UK were perhaps the most important part of the system and its strongest element. It is what the population cherishes and supports. It is a culture worth keeping.

The hospital reforms will have their implementation problems but they may be worth the trouble. Hospitals will become more efficient and the internal market will prove to be a worthy reform. This is the good news and the lesson other countries may want to look at carefully.

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#### REFERENCES

1. Light, D. W. "Embedded Inefficiencies in Health Care," *The Lancet* 338 (1991): 102-04.
2. Light, D. W. "Bending the Rules," *The Health Service Journal* 100 (1990): 1513-15.
3. Scheffler, R. M. "Adverse Selection: The Achilles Heel of the NHS Reforms," *The Lancet* (1989): 950-52.
4. Secretary of State for Health. *Working for Patients*. London: HMSO, 1989, CM555.
5. Day, Patricia, and Klein, Rudolf. "The Politics of Modernisation: Britain's National Health Service in the 1980s," *The Milbank Quarterly*. 67 (1989): 1-34.

6. Enthoven, A. C. *Reflections on the Management of the National Health Service: An American Looks at Incentives to Efficiency in Health Services Management in the UK*. London: Nuffield Provincial Hospitals Trust, 1985.
7. Enthoven, Alain C. "Internal Market Reform of the British Health Service," *Health Affairs*. 10 (1991): 60-70.

#### ABSTRACT

This paper first examines the usefulness of the internal markets being proposed in NHS reforms. The impact of those reforms on hospitals and general practitioners (GPs) is then assessed. Finally, the long-term implications of replacing medical culture with competition are discussed.