

[Volume 68 No. 9 October 2009]

SPECIAL COMMENTARY

The Review of the Changes of Britain's National Health Service for the Impending Change of the United States

Ming Chen MD, FACS

p. 212

President Obama is currently proposing a major change in our health and social care system. Since Britain has already had three major health care changes since 1991, its experience can be a good reference point for the changes of the United States.

The NHS (National Health Service of Britain) was established in 1948 to be a command-and-control model for organizing health care¹. The first change was the introduction of the so-called "internal market" by the Conservative Government in 1991. The Labor Government introduced the second change in 1997 and called "the modernization project." Years later, the strategy of centralized control has been criticized as being counterproductive. Finally, the emphasis on "localism" was introduced in 2002 with "foundation trusts". This paper will review the history of Britain's healthcare change, and relate them to the United States.

The change in the NHS started in 1991. Before then, hospital and other health services were directly managed and funded by the local health authorities. After the change, the local health authorities became responsible to contract with health service providers to take care of their own population, the so-called "internal market". General practitioners were also offered the option of becoming fund-holders while the local health authorities remained the key purchasers. The reason for this was to create competition among providers in order to improve efficiency and responsiveness. Unfortunately, this did not happen.

In 1997, the labor government introduced the "modernization project." This included three features:¹

- 1) Competition was replaced by cooperation, and a one-year contract was replaced by a three-year contract.
- 2) All primary care providers were enrolled in the primary care trust.
- 3) Emphasis was on uniform high quality care throughout the country.

A more centralized control of the clinical audit and clinical governance was developed for the implementation of the "modernization project." The Labor Government committed to a modern and dependable health care service. It has made every effort to implement the changes by creating more than 300 targets,¹ and over 100 organizations to perform the audits.² The anxious ministers transferred their ambitions to visible improvements by creating rhetorical exuberance of policy documents and a series of initiatives which eventually caused turmoil. Medical workers were swamped with duplicate demands. Clinicians spent excessive time and effort on the audits instead of on their patients. There were too many targets, service standards, penalties, data and budget disciplines in the clinical governance. Consequently, clinicians and service provider organizations were dealing with distortion, excessive time consumption and game playing. The National Institute for Clinical Excellence of Britain reported a "mixed record" and listed its flaws and shortcomings including poor project design, inadequate data, bad project management, lack of commitment, poor support and inconsistent follow ups.⁴ Although the data showed an overall improvement according to an independent audit by the Commission for Health Improvement of Britain, there was skepticism as well.¹ The budget of the NHS of Britain has increased by more than 10 percent in the fiscal

Untitled

year 2002-2003. With the money pumped into the service, the NHS was still plagued by discontent and controversy.¹ The poll showed that as many as 69 percent of those interviewed believed that the government was not improving the NHS's service. All of these factors caused the NHS to suffer from an acute case of "change fatigue." Finally, in 2002, the third change came with new ideas and new leadership in an attempt to react to the "change fatigue". The Secretary of State, Alan Milburn, acknowledged that the Labor's strategy of "a plethora of service targets, inspection regimes, and national standards," had become counterproductive.¹ He argued, "The NHS cannot survive as a monolithic top-down centralized system. Without greater diversity the NHS cannot be more responsive. Without responsiveness there cannot be public confidence. Without the public confidence the NHS will not be sustainable".¹ So, the "foundation trusts" were then introduced in 2002. The key changes in the "foundation trusts" are:¹

- 1) Have the freedom to decide on salary structures and levels for doctors and other staff. (Instead of being bound by national agreements)
- 2) Raise the capital on the market (instead of being dependent on the Treasury)
- 3) The governing bodies of the existing trusts are accountable to the Secretary of State; those of the new bodies will be elected locally and will be accountable to an independent regulator.
- 4) It is a more pluralistic, consumer-oriented health care system.
- 5) Patient choice by ensuring that diverse providers can be funded according to where the patients choose to be treated.
- 6) Uniform national prices for specific interventions and conditions like United States.
- 7) Consumer choice includes the private sectors.

Interestingly enough, the third change looks more like the current health care system of the United States. After almost a decade of multiple changes and researches, the NHS of Britain ended up copying the current health care system of the United States. In the mean time, because of the dissatisfaction of increasing health care cost and poor coverage of a large part of population in the United States; the Obama administration is seriously looking at a change away from the current system. Could this change follow the same path of the NHS "Modernization project" of 1997?

Walsh indicated that health care reform is clearly not "rocket science."⁴ Furthermore, the Oxman's pioneering review concluded that there were "no magic bullets" to change professional practice.³ Every time there is a change there will be an uncertainty and chaos. The time-consuming learning processes for both the government and health care professionals are required. All this can create frustration and anger among health care providers and subsequently can affect their patient care.

In conclusion, the health care changes in Britain during the past decade are a mirror to the proposed change of the United States. Shouldn't the Obama administration look carefully into the experiences of Britain before committing any changes to the healthcare system of the United States?

References

1. Klein, R (2004) Britain's National Health Service Revisited. *N Engl J Med*; 350; 937-942.
2. Lister, S (2004) How many inspectors does it take to check on how well a hospital is working? Try 102 (and counting). *The Times*.
3. Oxman AD, Thomson MA, Davis DA, et al. No magic bullets: a systematic review of 102 trials of interventions to improve professional practice. *Can Med Assoc J*; 1995; 153:1423-31.

4. Wal she K M J (2002) Principles for Best Practice in Clinical Audit. Quality and Safety in Health Care; 11, 4; 392.