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The NHS: the story so far (1948–2010)

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ABSTRACT – The NHS has long held a paradoxical position in the national psyche: a constant, reassuring presence that seems to be in a state of continual flux. This is partly because while the service is based in the public sector (with its reputation for risk aversion and change at a glacial pace), it is also exposed to the ever present currents of political pressure. Equally important is the changing nature of both medical technology and public expectation, each of which exert constant and inexorable pressures on the service. This article will briefly describe the story of the NHS from its inception in 1948 to the present day, with an emphasis on developments over the last 20 years. During this time the notion of organising healthcare has developed and formed the focus of much of the change in systems across the developed world. The narrative will highlight some of the major challenges that the NHS will face over the next few years, and introduce the series about the future of the NHS that will appear in this journal signposting some of the topics that will be followed up in these articles.

KEY WORDS: healthcare, history, NHS

The early days

The NHS was conceived during the dark days of the second world war along with many other aspects of the welfare state, such as the modern schooling system, family allowances and the social security system. These all finally appeared just after the end of the war partly as a result of having a radical Labour government in power, which was itself a reflection of the egalitarian mood that prevailed in the UK (and indeed, across much of Europe) at that time. The British class divide was at its narrowest, millions of battle- and strife-weary soldiers were returning to civilian life, and the mood of corporate altruism that was the obverse of the 'blitz mentality' all meant that the population at large welcomed the principle of social insurance that underpinned the entire concept of the welfare state. Behind it all was an attitude epitomised by an elderly civil defence worker who told Richard Titmuss, the social scientist, that 'The war made us realise that we were all neighbours'.[1]

The political battles with the medical profession that were associated with the formation of the NHS are well described (Frank Honigsbaum's readable treatise makes a good introduction[2]), but the end result was a service based on a small number of simple principles that were enshrined in the original act of 1946[3]:

- that it meet the needs of everyone
- that it be free at the point of delivery
- that it be based on clinical need, not ability to pay.

Implicit in this definition of 'meeting the needs of everyone' was the fact that the service was intended to be comprehensive in scope and coverage, encompassing all clinical conditions for the entire population. The model for delivering this care was also relatively simple, being based on just two components: a system of district general hospitals (DGHs) owned by the state, providing secondary (institutionally based) care, and a looser network of general practice, a motley collection of independent (ie self-employed) providers of primary care. There was a third arm to this arrangement, which lay with the local authorities, but for the purposes of this article only the medical model will be discussed.

The theories of health and healthcare were also simpler then, with smaller proportions of gross domestic product being spent on healthcare (around 3.5% in the 1950s, for example[1]), hospital services being far less specialised and hence able to be delivered in most DGHs, and even some who believed that the costs of the NHS were likely to fall as the nation's health improved.[4] Public expectations were far more focused on the public good, with a sense of gratitude for the newfound protection given by the NHS (especially to those who had not been able to afford reasonable healthcare before its inception) and perhaps less 'me-centred' than they are today.

So over the first 10 years or so of the NHS, public satisfaction was high, costs were fairly stable, and the honeymoon period seems, in retrospect, rosy indeed.

The inexorable rise in expenditure

However, a number of trends began to emerge that have since come together, consolidated and accelerated. The first of these has been the rate of medical progress; in the early days of the NHS, the diseases that dominated the attention of both the public and the medical profession were largely those of poverty: infectious diseases, malnutrition and overcrowding. As prosperity increased, overcrowding reduced and diets improved, leading to a dramatic reduction in deaths from infectious diseases. According to Rivett, the actual number of deaths from tuberculosis dropped from over 25,000 in 1943 to around 4,500

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in 1958, and deaths from diphtheria from around 1,500 to eight in the same period.[1] Medical intervention in the shape of prevention by immunisation and treatment by antibiotics appeared relatively late in this downward slope, and has ensured that their incidence has remained at historically low levels to this day.

However, these illnesses have been replaced by those of affluence and of longevity (diseases such as obesity and diabetes associated with the former, and cancer, dementia, and the arthritides with the latter). According to the World Health Organization, this substitution of the major causes of preventable mortality globally has taken place in the past two or three years.[5]

Changes have not only been seen in the pattern of disease, illustrated by the advances in the possibilities offered by medical technology that would have seemed literally incredible even 30 years ago. Whether in the worlds of organ replacement, the medical treatment of metabolic diseases or the emerging science of genomics, the possibilities offered by these technologies are now beginning to exceed the feasibility of providing them within a publicly funded, utilitarian system such as the NHS, where 'the greatest good for the greatest number' has traditionally been the driving force.[6] Such improvements have been led by a number of drivers, some purely scientific, but many linked to the illogical beliefs that lead patients to be prepared to buy almost any treatment offered, be it effective or not. Even where scientific advances have led these developments, the benefits in a capitalist system for providers that supply what their 'customers' want (or can be persuaded to want) may be huge, especially where their fears about illness, pain and death make rational thought so much harder.

The third driver for change in health services has been the changing attitudes to ill health. The so-called lifestyle illnesses (such as impotence, baldness or anxiety) have effectively been turned from dis-ease into disease and in that change, the treatment costs to society have risen with relatively little measurement of benefit.

All in all, medical progress over the last century or so suggests that preventable morbidity and mortality have reduced (sometimes as a result of, but often in advance of, the appropriate medical intervention) and that the cost:benefit ratio of maintaining this progress has increased almost exponentially. Whatever other factors are at play, this relative rise in costs is unsustainable in the long term and in itself calls into question the whole nature of a publicly funded health service.

In addition, there has been the inexorable rise of individualism: the sense of a growing 'entitlement culture' is almost the antithesis of the original 'corporate altruism' that heralded the rise of the welfare state in the 1940s, and thus also at odds with the utilitarian roots of the welfare state. The growing focus on individual rights, with its square peg of entitlement to services delivered when patients want in the way they want, by the individual (organisation, if not clinician) they want, cannot easily be fitted into the round hole of egalitarianism, equity and universal provision at the state's expense.

The way that all these tendencies came together was in the rising costs of healthcare and especially in cost pressures brought to bear from the acute sector, the 'sexy' end of supply that increased demand in ways that traditional welfare state control mechanisms could not handle. In the first three decades of the NHS, the rise in costs could be (more or less) matched by increases in funding, but by the 1970s and certainly the 1980s, healthcare cost inflation was outstripping politically acceptable levels of funding, with the result that services were being squeezed in the way that was most easily available to clinicians: waiting times and waiting lists grew ever longer, until delays in treatment began to be noticed in the lay press.[7]

The internal market

The crisis came to a head over the case of David Barber, a child waiting for heart surgery at the Birmingham Children's Hospital, whose operation had been postponed five times. The publicity surrounding these delays and his subsequent death put such political pressure on the Thatcher government that a wholesale political review was set up resulting in the White Paper *Working for patients* (which led to the NHS and Community Care Act 1990).[8]

The act was a seminal piece of legislation in that it separated service procurement from service provision (the so called 'purchaser/provider split' that created an 'internal market' in healthcare[9]), in an attempt to align the incentives for each to reflect their own organisational needs: procurers (health authorities in their various incarnations) needed to maximise cost effectiveness (the most impact for the least cost) while providers' inclinations were to maximise income for minimum outgoings. The mechanisms for this change were mainly financial; on the provider side, hospitals became notionally autonomous NHS trusts, with their own management boards, intended to deal on a contractual basis with their purchasers. A clearly intended consequence of this separation was the creation of formal contestability, the ability of purchasers to challenge the complacency of their providers by threatening to move their business elsewhere (and sometimes carrying out this threat) if providers were not prepared to be flexible in price, quality, and so on.

While purchasers generally comprised the health authorities, general practitioner (GP) fundholders acting as purchasers formed the second innovative aspect of the reforms; fundholding was a concept that capitalised on the fact that GPs nominally 'controlled' hospital expenditure by their referrals: they decided which patients to refer, and where (and to whom) to refer them. By allocating a budget to some large 'approved' general practices, it was hoped that they would feel enough ownership of 'their' money to control its spending in the acute sector. As a subtext, there was also a hope that they would have enough clinical impact to counter the 'emotional blackmail' traditionally exerted by that sector through the lay media (eg 'Cancer scans delayed in NHS funding crisis as doctors fear "slash and burn" cuts'[10]).

In the event, while the notion of the purchaser/provider split entered the lexicon its potential incarnation never developed its intended teeth; its original radical nature was seen politically as being highly risky, and so the NHS was encouraged to implement it slowly and incrementally with the result that much of its original impact was diluted.

The threats of moving services between providers were also rarely implemented except at a very marginal level, and 'market failure' was arguably only allowed to occur once at a small community trust (Anglian Harbours Trust), when two health authorities planned to withdraw their contracts because the trust was perceived as spending too much on management rather than on patient services.[11]

Fundholders (even in their most developed 'total purchasing' incarnation[1]) rarely attempted to disrupt the complacency of their acute providers, who could play off their multiple small purchasers against each other. The media pressures associated with any talk of closing an acute hospital were so high that it proved impossible to counter.

In retrospect it could be argued that the notion of a market in healthcare could never have successfully been introduced by a government whose defining orientation towards market mechanisms automatically alienated all those who had not voted it into power, thus ensuring that they resisted any hint that their beloved public sector might be commercialised.

Externalising the market

Ironically, it was only when the Labour government came into power in 1997 that such apparent privatisation (itself a debatable point: if a service is publicly funded but supplied by a private organisation, is it public or private?) became more acceptable; such a government had only to persuade its own supporters to accept the idea since its opponents were already wedded to the concept. Thus, the first piece of health-based legislation built on the Conservatives' developments by preserving the purchaser/provider split, reducing its diseconomies of (small) scale, and increasing the clinical input to managerial decision making by scaling up fundholding into primary care groups that eventually became the primary care trusts that now form the new health authorities.[12] The internal market was (notionally at least) expanded to become more like an actual market with the introduction of initiatives such as the Independent Sector Treatment Centres under whose aegis private companies could bid for routine, high volume NHS business such as cataract surgery and elective hip replacement.[13]

Such 'grit' in the oyster of NHS acute services did produce the pearls of higher throughput, lower waiting times, and (perhaps) some quality improvement, but it has never managed to change the public perception of hospitals as the cathedrals of the NHS 'religion' and so (like most of these initiatives) failed to alter the inexorable rise in hospital spending. While some of these failures may be attributed to the lack of government commitment to any single radical solution, the reality is that the public perception of health and healthcare has not been affected, and that the basic paradox remains: ever rising healthcare spending is producing ever diminishing returns in terms of further health benefit.

The future

And so the challenge remains: can the developed world change its approach to healthcare and find ways of spending its 'health dollars' in ways that are cost effective? It is a moot point as to how much of any change can be down to 'doing things better' (ie increasing efficiency), and how much to 'doing better things' (actions which may well lie far beyond the biomedical model of healthcare, and into the broader aspects of society). What can be said with some certainty is that the developed world seems to be a genuine 'node point': there is a growing realisation that the current system is rapidly entering the area of diminishing returns, while affordability in the public sector is set to reduce dramatically within the current economic climate and, at the same time, patients still seem to aspire to reach the summit of individual consumerism, where the credo is still 'I want it, I want it all, and I want it now'.

The series introduced by this article will attempt to look at many of the factors that are likely to influence this debate. There will be papers on the future of commissioning, debates on the place of the private and public sectors, treatises on the notions of rationing and of public health, and monographs on the tribalism that still affects the medical profession, as can be seen in the persistent chasm between primary and secondary care. In each instance, the hope is to provoke thinking among our readers as to the place of the active medical clinician in aiding and abetting the changes that are likely to happen. For the series to be optimally effective and influential, it is hoped that it generates a profuse and open flow of comments and discussions. Our pundits may be learned, but it is the jobbing physician who can make or break changes in the NHS, whether at a political or an operational level. Please, do join in…

References

1 Rivett GC. National Health Service history. www.nhshistory.net
2 Honigsbaum F. *Health, happiness, and security: the creation of the National Health Service*. London: Routledge, 1989.
3 *The National Health Service Act 1946*. London: HMSO, 1946.
4 Department of Health. *The NHS Plan: a plan for investment a plan for reform*. London: DH, 2007.
5 World Health Organization. *World health statistics*. Geneva: WHO, 2008.
6 Bentham J. An *introduction to the principles of morals and legislation*. London: T Payne, 1789.
7 Timmins N. Causes of a financial crisis facing the health authorities. *The Independent*, 18 September 1988.
8 Department of Health. *Working for patients*. London: DH, 1989.
9 Enthoven A. *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.
10 Martin D. Cancer scans delayed in NHS funding crisis as doctors fear 'slash and burn' cuts. *Daily Mail*, 20 March 2010.
11 Bevan G, Wyke S, Mays N *et al. Developing primary care in the new NHS: lessons from total purchasing*. London: King's Fund, 1999.
12 Department of Health. *The new NHS: modern, dependable*. London: DH, 1987.
13 Department of Health. *Independent Sector Treatment Centre (ISTC) programme*. London: DH, 2006.

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