

Changing the Culture in Britain’s National Health Service

by Peter Holle

Almost 20 years older than Canada’s Medicare, Britain’s National Health Service (Medicare’s intellectual inspiration) could also be considered a template for the difficulties here. As in Canada, increased waiting times, the pouring of resources into bureaucratic structures without a corresponding expansion of services, and a built-in conflict of interest because providers and funders wear the same hat, have soured the system’s noble intentions.

One important difference lies in the fact that both Conservative and Labour governments in the UK have attempted to remedy this failure with a policy of creating internal markets. Over time, these efforts have been tentative, even occasionally reversed. But, however slowly and fitfully implemented, splitting the purchaser from the provider and expanding options for patients are steadily reducing waiting lists.

Whether or not this reform deserves credit for the improvement is a matter of considerable debate, because the British government has simultaneously poured more tax dollars into health care. Over the last five years, the NHS budget has increased an average 7.5 percent a year in constant pounds, to £65 billion, up 40 percent from 1999-2000. Perhaps we can draw a clue from the Canadian experience, where no structural reform has been attempted. The Fraser Institute’s valuable research on waiting lists demonstrates little or no improvement, despite an equivalent dedication of more resources.

Indeed, Reform and the Adam Smith Institute, two British think tanks that have led the charge for internal markets, maintain that the spending spikes have simply poured more money into a bureaucratic black hole. As Reform points out, “Between 1999 and 2003, the number of doctors increased by 16 percent and the number of nurses by 17.2 percent. But the numbers of NHS managers have increased three times as quickly. Between 1999 and 2003, the number of NHS managers and senior managers increased by 45.4 percent” (Reform, 2004, p.9).

Both organizations want the NHS to drop its self-imposed limit of 15 percent on the private provision of services, to encourage more innovation and enterprise. Although they regard the NHS’s reforms as tepid, they admit that they’ve had an effect. “It is true that the longest waiting times are being eliminated,” Reform states on its website (www.reform.co.uk). “Waiting times measured from outpatient consultation to hospital treatment of longer than 12 months were eliminated in March 2003. Nine-month waits were all but eliminated in March 2004” (Reform, 2004, p.4).

Whether or not the reforms deserve credit, the NHS started to experiment with contracting out in the early 1990s under John Major’s Conservatives. A 1989 government white paper entitled Working for Patients recommended three fundamental changes:

• Trusts: Hospitals could become self-governing businesses with significant financial freedom to contract services from outside the system.

• Fund-Holding Practitioners: Within limits, doctors could negotiate for patient services with non-government facilities.

• Purchaser-Provider Split: “The money would follow the patient.” Summing up the first two measures, that slogan explicitly stated that providers would no longer receive block funding, but be paid for services rendered in a competitive market.

These measures took effect in June 1991, eventually leading to dozens of trusts and hundreds of fund-holding practices. By 1995, no patients were waiting longer than 12 months.

But political divisions quickly arose over the issue of equality. Access to treatment and the willingness of local authorities to fund procedures varied widely from area to area. More importantly, the purchaser-provider split was diluted in the law itself and in implementation. As Reform’s Commission on the Reform of

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Public Services puts it, "Public sector financing rules made purchasers responsible for the financial health of providers and prices had to be set equal to cost" (CRPS, 2003, p. 33).

Tony Blair’s Labourites took power in 1997 partly on a promise to reverse the changes, but the existing, albeit feeble purchaser-provider split remained. It was weakened further when fund-holding doctors were re-organized into Primary Care Trusts. The intention to ensure equality of treatment while retaining the advantage of competitive purchasing in reality created Primary Care Trusts that acted much like our Regional Health Authorities.

Needless to say, the retrenchment provided no relief, and to its credit the Labour government has since engaged in reforms with a better chance for success. In December, 2001, in the face of dismal performance reports, the health minister declared, “Where we need to get to is a position where the NHS is no longer a monopoly provider of care but it does become a monopoly funder of care” (CRPS, 2003, p. 36). Although it continued to cloak its actions in socialist rhetoric, the ministry expanded internal markets considerably.

In July 2002, cardiac patients waiting longer than six months were allowed to choose between an NHS hospital or a private sector provider. “The result,” reported Reform, “was a significant reorganisation of NHS provision to free up capacity and very great reductions in waiting times. Choice was also introduced in London for patients waiting more than six months in certain specialties between 2002 and 2004. Waiting times fell significantly and some hospitals actually advertised for patients” (Reform, 2005).

On July 25 this year, the health minister announced that, as of November, NHS patients waiting longer than 20 weeks for MRI and CT scans can choose to have the tests done at a private hospital or another NHS hospital. The goal is to have such patients wait no more than six months.

Compared to continental Europe or the United States, where such waiting is rare, this may seem like weak tea. Indeed, both Reform and the Adam Smith Institute have fully developed proposals for policy reforms that could eliminate waiting lists entirely by marketizing health care on a much broader scale. In the meantime, the British reforms should at least give Canadian politicians a measure of direction. If we want to reduce waiting lists here, we at least need to split the purchaser from the provider.

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