Part I
Theoretical overview

CHAPTER 1

History and structure of the National Health Service

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It is perhaps important for everyone working in the National Health Service (NHS) to have some idea of the origins, development and current structure of what is one of the biggest and most complicated organisations in the world. A detailed analysis of the NHS and its history is outside the scope of this chapter; suggestions for further reading are given at the end. Its purpose is instead to outline briefly how the NHS has evolved and to put into perspective the current changes.

Healthcare before the NHS

Until the middle of the 19th century, the state had virtually no control over the medical profession. Doctors had developed their own organisational structure which satisfied the need for self-protection. Members of the Royal College of Physicians mainly worked in the London teaching hospitals and treated those who could afford their fees. Members of the Royal College of Surgeons (which was the Company of Barbers a century before) were more experienced in the practice of medicine and treated patients both in London (in competition with the physicians) and outside. The vast majority of people were treated at the hands of members of the Society of Apothecaries, who basically prescribed medication. For a considerable time churches provided forms of treatment to people with mental illnesses.

The state became more involved in the health of the population and regulation of the medical profession throughout the 19th century and in the early 20th century. The 1834 Poor Law was the first acknowledgement that government had some responsibility for the care of the population. Among its effects was the statutory provision of a parish medical officer to care for the poor. These established that the parish workhouses should have sick wards where the able-bodied inmates could be treated when they became ill (Levitt, 1976). Free services were offered by boards of guardians to those who could pass a means test.

The Public Health Act 1848 established statutory powers that enabled a local medical officer of health (an official of the local authority) to cater

for the health of the local population. Following the Poor Law reforms, the medical officers' responsibilities were extended to some Poor Law hospitals which were considered to be providing healthcare rather than welfare. By the 1930s, these included control over environmental hazards, infectious diseases, the school medical service and district nursing/midwifery services.

Local acts (e.g. in London and Liverpool) had proved the benefit of providing care for people suffering from infectious diseases and for those with mental illness and handicap. The establishment of the General Medical Council under the Medical Registration Act 1858 granted the profession self-regulation by establishing a basic qualification for doctors and instituting a register of qualified medical practitioners.

In the first half of the 20th century there were some important changes in the mode of delivery of healthcare and in the organisation of the medical profession (Stacey, 1988). The medical profession had gained prestige and status but lacked tools; these came about with the development of microbiology, which led to the establishment of a scientific basis for medicine.

The National Health Insurance Act 1911 was passed to ensure that workers were afforded some protection in the event of sickness. It involved compulsory contributions from the employee, the employer and the state. (The National Sickness Insurance Bill was to have been an early provision, but this was changed to the National Health Insurance Bill, from which the NHS took its name – had this not happened we might be referring today to a National Sickness Service.) The 1911 Act concerned mainly general practitioners (GPs) and the working classes; the middle and upper classes could afford their own care and the Act, which covered the cost of GP care and medication, did not include the cost of hospital care, nor did it cover workers' families.

Around this period GPs were perhaps the least contented of medical men, and were also the most vociferous (Stacey, 1988). The 'sick clubs' offered treatment to their members and sometimes their dependants. GPs were unable to choose their patients, and to be controlled by a committee of working men was 'not a pleasant matter for an educated gentleman to serve under' (*British Medical Journal*, 1875: p. 484). Before 1911, only a small proportion (5 million) of working-class people could afford GP care through membership of friendly societies or other agencies. The 1911 Act immediately covered 15 million people, and by the mid-1940s covered about 24 million (half the population).

However, the scheme was inefficient. Local insurance committees (the forerunners of family practitioner committees) and approved societies (private insurance companies, friendly societies and trade unions, all of which tended to be confined to a particular occupation or location) formed the administrative agencies. The approved societies brought the system into disrepute. As they were not allowed to be profit making, money was

purposefully wasted by increasing the numbers of staff. They paid sickness benefit and were able to pay for specialist care only if there was a surplus at the end of a defined period, which was rare, especially in those occupations where morbidity was high and which caused the greatest drain on the resources of an individual society. Those earning over the income limit were excluded. Needless to say, this limit had to be changed regularly, always against the wishes of the doctors, because of inflation.

Whereas before the 19th century treatment was offered at home, by the next century treatment was gradually being shifted to hospitals, in the public domain. A major consequence of the increasing influence of hospitals was an increasing differentiation between GPs and the hospital consultants under the 1911 Act (Honigsbaum, 1979). Increasing specialisation among consultants and the development of a hierarchy were two major factors that were to affect the running of the NHS subsequently. Non-clinical advances contributed to the development of specific skills and interests in specialties such as psychiatry (Stevens, 1966).

By the time the NHS was formed, in 1948, there were about 2800 hospitals in England and Wales (just over 1000 were voluntary hospitals and the rest were municipal hospitals). The voluntary hospitals ranged from the London teaching hospitals, staffed by consultant specialists, to non-teaching hospitals with little money, staffed by local doctors who combined general practice with hospital practice. About one-third of the voluntary hospitals were larger hospitals where the beds were controlled by consultant specialists, who were unpaid and relied on private practice to generate income. An appointment to such a hospital was regarded as a stimulus to the recruitment of patients. This part of the hospital system was affected by the rise of specialism in the 19th century, as only very large centres were able to support all specialties.

Voluntary hospitals were run using money gleaned from endowments, donations, public appeals and schemes whereby care from the hospital was guaranteed by means of a regular weekly payment. The municipal hospitals provided about 80% of the total number of beds. They consisted of a number of Poor Law hospitals (the former workhouse infirmaries, handed over to the local authorities when the Poor Law was reformed, and run by the local medical officers of health) and local infectious disease hospitals. Mental asylums (also under local control) accounted for half the total number of beds. Although some of the Poor Law infirmaries were of a standard equivalent to that of the voluntary hospitals, they were mainly concerned with the care of the elderly and chronically sick.

The hospital component of the health service was therefore unsatisfactory. Many of the hospitals were old and ill equipped; scant provision was made for the ordinary worker and there was relatively little healthcare available between private medicine and the Poor Law; there was inequality in the distribution of services and a financial crisis developed in the London teaching hospitals towards the end of the 1930s.

The Emergency Medical Service (EMS) was an important development in the hospital system. It was established in 1939 by the Ministry of Health to coordinate the response to the expected number of war casualties and to arrange supporting services. The EMS took over financial control of the hospitals (but not ownership), divided England and Wales into 12 regions, and categorised each hospital by its particular function. Many of the voluntary hospitals became second-line hospitals (outside the main centres of population) and specialists worked in them on a salaried basis. It is interesting to note that by the time the NHS was formed in 1948, many hospital specialists had been paid on a sessional basis for a decade. Thus, the payment system was never a political issue in the same way that it was for GPs, who had maintained their freedom of practice despite the introduction of the National Health Insurance Scheme in 1911. It was the threat to this independence which was at the root of the GPs' suspicion of the introduction of the NHS. The EMS proved that the central administration of the hospital system could work, and it was the forerunner of the NHS.

The formation of the NHS

The NHS provides an administrative structure by which healthcare can be properly organised and financed. The essence of the NHS is that it provides, free at the point of service, healthcare to anyone who wants it, regardless of ability to pay. The idea of the NHS originated as far back as the Health Insurance Act 1911. The originator of the Insurance Bill (the then Chancellor of the Exchequer, Lloyd George) had the idea that the Act would be extended to cover dependants, specialist care and, eventually, hospital care.

With the creation of the Ministry of Health in 1919, an attempt at extending the bill was made, embodied within the Dawson report (after Lord Dawson, the leading physician of the day). The report had recommended that preventive and curative medicine be combined, that hospital inefficiency be corrected by elected regional authorities (each of which would have a principal medical officer in administrative charge) and, in an effort to increase standards, that all general hospitals be brought into line with teaching hospitals. No mention was made of the funding of these health services, but the report specifically warned of the dangers of a salaried service, suggesting that this would 'discourage initiative, diminish the sense of responsibility and encourage mediocrity'. However, the necessary political commitment to respond positively to the Dawson proposals was absent, and it took the threat of war and the consequent creation of the EMS in 1939 to resurrect these principles.

Sir William Beveridge produced his report *Social Insurance and Allied Services* in 1942. As part of an attack on the 'five giants' impeding social progress (want, disease, ignorance, squalor and idleness), he suggested that

the burden of the cost of a health service should be borne by everyone, in the belief that such a service would make the nation healthier, thereby saving on social security payments and increasing national efficiency. However, he missed the point that better health, if it leads to longer life, inevitably leads during that longer life to a greater use of services (Godber, 1975).

The wartime coalition government accepted the principle of a national health service and set about finding a formula which would be acceptable to the medical profession, politicians, the voluntary hospitals and local authorities. The Minister of Health, Ernest Brown, proposed that the service would be administered by local authorities (with voluntary hospitals retaining their independence) and that GPs would be paid a salary. The doctors effectively rejected these proposals and they were dropped when Sir Henry Willink succeeded Brown in late 1943.

In February 1944, the government published a white paper on the NHS. The plan was to make local authorities responsible for health, directly in control of municipal hospitals, and to make contractual arrangements with the voluntary hospitals. Hospital doctors would be salaried and GPs would have the choice of a salaried service or capitation fees. The British Medical Association (BMA) held a postal ballot and doctors (especially GPs) came out strongly against the proposals. They were opposed to the idea of local authority control and to a scheme which would be available to all, free at the time of use, restricting scope for private practice. There was widespread general public acceptance of the proposals, in particular the fact that services would be free at the time of use.

Before a bill could be drafted on these proposals, a Labour government came into power with Aneurin Bevan as the Minister of Health. Bevan took a much harder line, claiming that Willink had merely cobbled together conciliatory proposals to keep everyone happy. He objected to the political erosion of the supremacy of Parliament and made the point that he should consult, but not negotiate with, outside bodies such as the medical profession. He felt that the Minister of Health should have total control of the service. The bill was put forward in spring 1946 and was opposed by both the Conservative opposition and the BMA. The former argued that the nationalisation of the hospitals and loss of independence of GPs discouraged initiative, and deprived the profession and voluntary hospitals of their freedom.

However, experience with the EMS had shown that central control of hospitals could be a success. The reasons why the medical profession objected were more complex – restriction of individual freedom was one – but it is possible that they were fuelled by resentment over the Labour government's attack on the middle classes, from which the medical profession generally drew its members. The objections spanned the spectrum from doctors being guardians of vested interests to doctors waging a war on the government on behalf of their class.

Both Bevan and the BMA (an incredibly complex negotiating machine where its leaders had very little room to manoeuvre) stood firm. The deadlock was broken when Bevan introduced an amendment saying that he could not introduce a fully salaried service for GPs without further legislation. Leaders of the BMA (helped by the Royal Colleges) saw the chance to save face and accepted the new service. Thus, on 5 July 1948, the NHS was born.

The principle of universalism which characterised welfare and health legislation in the post-war period was perhaps manifested most dramatically in the Health Service (Stacey, 1988). To provide good healthcare to the whole population without a financial barrier was the original aim of the NHS.

The Health Service in Scotland

The Scottish Health Service was created in May 1947, on the same tripartite principles as the Service in England and Wales. The hospital and specialist services were administered by five regional hospital boards with 65 boards of management. The community and environmental health services were provided by 55 local health authorities, and family practitioner services were administered by 25 executive councils. The Secretary of State for Scotland was responsible for the whole of the NHS in Scotland (Levitt, 1976).

Under the National Health Service (Scotland) Act 1972 health boards were created for each area of Scotland to act as the single authority for administering the three branches of the former tripartite structure. Two new bodies – the Scottish Health Service Planning Council and the Common Services Agency – were created.

1948–1974

The NHS developed a tripartite structure, as much because of vested interests as from an overall view that this structure was the most efficient. What the founders of the NHS thought they were doing and what in fact emerged are two distinct questions, for there were undoubtedly a number of unintended consequences (Stacey, 1988). Out of the negotiations leading up to the brave new world of 1948, the consultants overall, but especially those in teaching hospitals, did better than the GPs. The nurses did less well and the ancillary workers were not considered at all. The role and function of multidisciplinary teams needs to be addressed in the light of this historical development.

The hospital system was nationalised and taken away from local authorities (mainly as a result of the profession's unwillingness to work under local authority control). The Minister of Health was responsible for hospitals through hospital management committees (336 in number) and

non-elected regional hospital boards (numbering 16). Teaching hospitals retained their independent status (not wishing to 'come down' to the level of all voluntary hospitals) and were responsible through 36 boards of governors to the Minister, independent of the regional hospital boards.

General practice was unaffected by the changes, retaining independent status. The Health Insurance Act 1911 was extended to cover the whole population and general practice was controlled by 134 executive councils (the successors of the local insurance committees). The rest of the service was left to the 174 local authorities' medical officers of health, essentially because no other influential medical interest wanted them. These consisted of the maternity and child welfare services, health visitors, health education and prevention, the ambulance service and vaccination/immunisation.

The problem of what doctors should be paid emerged soon after the creation of the NHS. Sir Will Spens chaired three committees dealing with the pay of GPs, consultants and specialists, and dentists. The committee on consultants' pay recommended that the salary for a consultant aged about 40 should be £2500, compared with £1300 for a GP of equivalent age (both 1939 prices). Consultants' pay before the NHS had such a wide range (from a consultant in a non-teaching voluntary hospital to one in a London teaching hospital with income from private practice) that a salary scale incorporating both ends of the spectrum was impractical. The distinction award scheme was introduced as a solution to this problem, with the top grade doubling the basic consultant salary. Much discontent still existed following the Spens committees and it took a Royal Commission into doctors' and dentists' pay (the Pilkington Commission) to recommend the establishment of an independent review body to advise the Prime Minister directly.

Another problem concerned the number of junior doctors. By 1950 there were 3800 registrars and senior registrars, but only double that number of consultant posts. There also existed the grade of senior hospital medical officer (devised at the inception of the NHS to employ those practitioners in hospital practice who were not of consultant calibre), many of whom were in competition for consultant posts. The Ministry of Health attempted to force hospitals to terminate contracts of time-expired senior registrars (after three years in higher professional training), but following an outcry from the profession it was decided that their contracts could be renewed annually. The suggestion was made that consultant numbers be expanded, but this was rejected by the Ministry on the grounds of cost, and by existing consultants for fear of added competition for private patients. The result was a review of the numbers of doctors required in the UK, conducted by Henry Willink (formerly the Minister of Health in the coalition government). The recommendation was a 10% reduction in intake to the medical schools. However, the review did not take into account the numbers of doctors emigrating and the increased numbers required because of advances in medical technology, and this led to a shortage of

junior doctors in the 1960s, with an attendant influx of foreign graduates to fill posts in unpopular specialties, of which psychiatry was one.

The need for change

Almost as soon as the NHS was established, there was recognition that reorganisation was necessary. It was noted as early as 1952 – by Dr Ffrangcon Roberts in *The Cost of Health* (see Watkin, 1978) – that Sir William Beveridge was wrong in assuming that the demand for healthcare was limited. The aphorism of the NHS, 'infinite demand, finite resources', was born. A committee was set up under the chairmanship of the Cambridge economist C. W. Guillebaud, with the remit of reviewing the cost of the NHS and to make recommendations for changes in administration which would make the service more efficient. The committee's conclusion was that the service was not wasteful and that a major change in organisation was unnecessary.

Inequalities in the distribution of resources both geographically and within medical specialties highlighted deficiencies in the system, the latter causing embarrassment to successive Ministers of Health because of scandals concerning ill treatment in mental and geriatric institutions. Klein (2010) argues that the NHS in 1948 was as much a product of messy compromises as of inspired visions, and the same remains true today.

In 1968, the government published a green paper on reorganisation, the basic proposals being integration of all services under 50 area boards (each to have 16 members) with responsibility for all hospital, general medical and health community services. Objections raised included the remoteness of the regional boards to local services, the problem of the continued independence of GPs, and the mismatch of the 50 area boards with proposed local government reorganisation that would result in 90 local government units. A second green paper in 1968 set out that there would be 14 regional health councils advising the Secretary of State on planning and 90 area health authorities (the word 'authority' having replaced 'board' without explanation) would coincide with 90 local government districts set up earlier in the year. The functions of the service were to be divided between health and local government, based on the skill of the provider rather than the needs of the user (e.g. all social workers were to be employed by local government, all nurses by the Health Service).

1974–1989

In 1971, the Conservative government published a further document, the thrust of which was embodied in the NHS (Reorganisation) Act 1973. The reorganisation came into being on 1 April 1974, which coincided with the reorganisation of local government. The reformed service was to have two characteristics: it was to be an integrated service and there was to be responsibility upwards, to managerial authority. The reorganisation led to

the formation of regional health authorities, which had the responsibility to plan all services. The reforms led to a 30% increase in administrators and the influence of managers increased, leading to the creation of a managerial hierarchy.

The doctors insisted on retaining clinical autonomy, and this was noted: 'The distinguishing characteristic of the NHS is that, to do their work properly, consultants and general practitioners must have clinical autonomy, so that they can be fully responsible for the treatment they prescribe for the patients' (Department of Health and Social Security, 1972). This notion of a one-to-one doctor–patient relationship has been challenged by Stacey (1988). The clinical autonomy and security of tenure for the consultant were seen as advantageous (Beeson, 1980).

However, the final document differed from the second green paper in that regional health authorities were in line management with the area health authorities and the 90 family practitioner committees (replacing the executive councils) were coterminous with the local government areas. Community health councils became essentially watchdogs of the Health Service. There were also 'district' management teams under the 1974 organisation. Some regions had 'single district areas', but more commonly each area had several such teams. The aim of the reforms in 1982 was to abolish this duplication.

Readers are recommended to read the account by Draper *et al* (1976) on the influence of the 1974 reorganisation of the NHS. A detailed analysis of the political and practical ramifications of the relationship between central and local government and their representation on the authorities is given by Forsyth (1982).

The Conservative government also introduced general management of hospitals following the Griffiths report in 1983. Sir Roy Griffiths, a supermarket executive, had been commissioned to review the management of hospitals. He concluded that the traditional NHS management by senior consultants and administrators had led to 'institutionalised stagnation'. The report's recommendations, including that hospitals be managed by general managers, were accepted and in the middle of the 1980s they took over the role of managing hospitals. This change in emphasis brought about a large increase in general or senior managers in the NHS, from 1000 in 1986 to 26 000 in 1995, with spending on administration rising dramatically over the same period (Webster, 2002). This also resulted in a number of managers being 'classified' into their primary professions, for example nursing, also indicating that a number of people from professions were brought into management.

There was also a new business/commercial culture in the NHS, which led to the policy in the 1980s of 'contracting out' or 'outsourcing'. The clinical work of the NHS was retained in the public sector but, to reduce costs, support services such as laundry, cleaning and catering were contracted out to private service providers. The number of non-clinical NHS employees

had nearly halved by the end of 1980s. To ensure they could make a profit, the private companies paid the support staff less, while quality of service reduced – and in fact, the cleanliness of hospitals is still a major issue for the NHS.

From the changes to the NHS in the early 1980s four themes emerged which had a lasting influence (Klein, 2010). First, there was a sharp turn towards centralisation. This led to the second theme – that of managerialism and bureaucratic rationalisation. Third, the expansion of private medicine continued apace, along with privatisation of ancillary services within the NHS. Fourth, there was increasing consumerism within the health sector. The demand for increased NHS funding was accompanied by the development of healthcare as a public policy issue. A consumer-led service was being emphasised rather than a professional-led care system (Davies, 1987). Klein (2010) argues that the 'politicisation' of the NHS between 1974 and 1989 was also to do with shifting accountability from local to central authorities.

A crisis in the NHS developed in the second half of 1987. Since 1979, resources for the NHS had been increased by the Conservative government and the cost of the service had increased from £7.7 billion in 1979/1980 to £18.35 billion in 1988/1989. Despite this, the service was not doing well. Although resources were increasing, demand was outstripping this. The increasing elderly population, advances in medical technology and priority objectives (e.g. kidney transplants) meant that services had to be increased by 2% per annum just to keep up.

To reduce costs and stave off a crisis, some services provided by the NHS were effectively privatised in the late 1980s. Resources for dentistry in the NHS were reduced and as dentists were, like GPs, mostly 'independent contractors' they stopped taking on NHS patients and worked increasingly in the private sector, where they could earn more money. In 1989 routine eye examinations became free only for children and the elderly. It was argued by the government that people could now afford to pay for tests but the new policy led to a major reduction in examinations. Long-term care from the NHS was also eliminated, which stimulated the growth of private nursing and residential homes throughout the 1990s. These measures were implemented to reduce costs, in an attempt to avert the financial meltdown of the NHS. They also, however, compromised one of the founding principles of the NHS – to provide a comprehensive service.

Following the June 1987 election, when Margaret Thatcher was returned for a third term, a financial crisis began facing the health authorities. Beds began to close, charities began to shore up NHS operations, cancer patients were being denied operations and both the Institute of Health Service Management and the King's Fund announced their own independent reviews of NHS funding.

In early December 1987, the lack of heart operations on children in Birmingham was publicised and nurses from St Thomas' Hospital in

London picketed the Houses of Parliament in their uniforms. Probably the most significant event, and certainly a historical one, was when the Presidents of the Royal Colleges of Surgeons, Physicians and Obstetricians and Gynaecologists issued a joint statement suggesting that the NHS was almost at breaking point (Hoffenberg *et al*, 1987). The BMA supported the Presidents and added to the media clamour for increased resources. The government responded on 16 December by announcing an extra £100 million for the NHS, but despite this the crisis continued and more nurses began to strike.

The Prime Minister reassured the public that the NHS was in safe hands and was not about to be abolished. She, however, was still advocating tax cuts to encourage private health insurance. It was generally accepted that a government review of the NHS was inevitable.

1989–1997

The results of the government's review were initially announced in the white paper *Working for Patients*, published on 31 January 1989. A year later the NHS and Community Care Act followed. These two policy initiatives instigated what was at the time the most radical reform the NHS had undergone since its inception in 1948. The policies were criticised for containing a lack of strategic planning and many were unhappy that there had been no consultation inside the NHS.

The main reforms were:

- *Self-governing hospitals*. Stand-alone hospital trusts were established which were separate from the health authority and were accountable directly to central government. These NHS hospital trusts were to be managed by a board of directors with a chair appointed by the Secretary of State for Health. The hospital trusts were able to contract out services and buy and sell assets, borrow capital, employ staff on local terms and advertise their services. The government's idea was to move decision-making to as near to patients as possible.
- *Fund-holding GPs*. Fund-holding GPs were created, who were given their own budget which they used to buy hospital services directly from source. The scheme was voluntary for GPs but provided financial incentives to encourage them to sign up. Initially only practices with lists of at least 11 000 could apply to be fund-holders and their budgets covered just elective surgery, out-patient and diagnostic services, prescribing and staff costs.
- *The internal market*. To create an internal market, the NHS was split into 'purchasers' (health authorities and fund-holding GPs) and 'providers' (hospital and community trusts and non-fund-holding GPs). It was envisaged that providers, which were still all part of the NHS, would compete with each other to secure contracts with the purchasers by offering higher-quality, more responsive and more efficient services.

The internal market did not lead to the benefits the government thought it would produce. Hospitals could not truly compete with each other as the government could not, for political reasons, allow less competitive hospital trusts to go out of business, as would happen in the commercial world. GP fund-holding was also an unpopular policy. Being a fund-holding practice offered many financial advantages but it was available only to larger practices, which were already better resourced. A two-tier system was therefore created. Fund-holders' contracts with healthcare providers gave fund-holders' patients quicker access to hospital services than patients from non-fund-holding practices. There were distinct advantages for patients whose GP belonged to a fund-holding practice (the 'haves') over patients whose GP was part of a non-fund-holding practice (the 'have-nots'). The reforms of 1989 severely compromised the premise of equity that the NHS had been founded on.

The Conservative government under John Major won the 1992 general election and continued to develop the internal market in the NHS. Many still feared privatisation, as part of the 1989 reforms had allowed hospital trusts to raise income from other sources, such as private beds. The collectivist model of the NHS was being threatened, although the 1992 white paper, *The Health of the Nation*, appeared to readdress the government's responsibilities for the health of the country. The document moved towards health promotion and set out 25 specific policy targets, including reducing the suicide rate by 15%. There were also targets to reduce the proportion of the population who were obese, smokers and heavy drinkers. The white paper was criticised for setting targets that were easily achievable and for failing to address the effect poverty, inequality and unemployment have on health. Kearney (1992) concluded that the policy had no strategy at all and was merely 'window dressing'.

The Patient's Charter (Department of Health, 1991), implemented in the early 1990s, reinforced the consumerist model the government had been encouraging. The document set out explicitly patients' rights, some of which reflected the original philosophy of the NHS, for example with the statement that people have the right to receive healthcare on the basis of clinical need, regardless of ability to pay. Standards were promised for patients, such as waiting no more than 2 years once placed on a waiting list and to be seen within 30 minutes of a specific out-patient appointment time. A performance guide in relation to *The Patient's Charter* was published by the Department of Health in 1994 and hospital trusts were rated on whether they had achieved its standards, using a five-star system. This system gave the public information on how their local NHS services were performing, but gave little true power to choose between different NHS providers: only to opt out of the NHS or to choose private services, which they would have to pay for.

The reforms of the 1990s moved the power base of the NHS, for the first time in its history, away from hospitals and towards primary care. The

advent of GP fund-holders altered the relationship between hospitals and GPs. The hospitals were now in effect answerable to the GPs and therefore, in essence, the patients. Community service providers were also encouraged to establish themselves as separate trusts from acute hospital services, which further promoted community services over hospitals. The multitude of reforms did not lead to an improvement in services, however. GP fund-holding was a moderate success as a relaxation of entry requirements had allowed approximately 50% of GPs to become fund-holding by 1996. Many, however, had joined under duress, as they felt they would be left behind if they did not become fund-holders. The cost of reorganisation (e.g. purchaser and provider) had been covered by two short-term increases of funding to the NHS in 1992/1993 and 1994/1995. The extra money was quickly absorbed and no benefits were seen to services. The government remained prudent but its belief that the NHS would become more efficient and save money if there were strict financial pressures was misguided.

Further reorganisation was implemented and by 1996 regional health authorities had been abolished and replaced by eight regional offices of the NHS Executive. There were 425 NHS trusts, which acted as 'providers' of services, and 8500 GP fund-holders, who were 'purchasers'. In addition to fund-holders, there were non-fund-holding GPs, who were still under the management of 100 health authorities. This division of the NHS into purchasers and providers made it difficult for the NHS to plan and distribute resources on the basis of the population's health needs. Many NHS trusts were failing financially and waiting lists remained static. The NHS had lurched from reform to reform, nearing a crisis so many times that on the eve of the 1997 general election the *Sun* newspaper implored its readers that they had '24 hours to save the NHS' (*Sun*, 1997).

1997–2010

The 1997 Labour Party general election victory brought new hope to the NHS, which in many people's eyes had been in a permanent state of crisis for over 20 years. Eighteen years in opposition had forced the Labour Party to instigate major policy reform. Traditional party beliefs of nationalisation, central planning and state paternalism, which the creation of the NHS was based on, were abandoned. The new government adopted what was to be known as 'the third way', mixing notions of equality and social justice with privatisation and free market competition (Blair, 1998). The 'third way' of running the NHS was based on partnership and driven by performance and led to the biggest period of reforms in its history.

The newly elected government had committed to sticking to the overall expenditure plans of the previous Conservative government for the first 2 years of its term. An extra £1.2 billion was, however, invested immediately into the NHS, which was just the beginning of increased resources. Following the Wanless report (Wanless, 2002), which recognised that the NHS was and

had for many years been under-funded, UK taxes were increased to finance extra NHS expenditure, averaging an increase of 7.4% a year in real terms for the next 5 years. This raised total health spending in the UK from 6.8% of gross domestic product (GDP) in 1997 to 9.4% in 2007/2008, which made the UK one of the higher spenders on health in Europe (Stevens, 2004).

Extra investment in the NHS coincided with a programme of major reforms, which focused on reorganising services and raising standards of health and care. In 1997 the UK's first Minister for Public Health was appointed. Subsequently, the policy document *Our Healthier Nation* (1998) was published to replace *Health of the Nation*. The new policy set a national target of saving 300 000 lives over the next decade, focusing on cancers, coronary heart disease and stroke and mental illness. *Our Healthier Nation* shifted focus away from the policies of the 1990s, based on the principle that individuals were responsible for improving their health, and recognised that there needed to be a framework to empower individuals as well as strategies to decrease inequality and poverty.

The first significant set of reforms by the new Labour government were set out in a white paper *The New NHS: Modern, Dependable* (Department of Health, 1997), which was published at the end of 1997. The paper proposed the dismantling of the internal market but many components of it were maintained. The purchase–provider split remained but the emphasis was on cooperative relationships rather than competition. GP fund-holding was abolished and instead all general practices were obliged to join primary care groups (PCGs). PCGs covered populations that varied in size from 30 000 to 250 000 and functioned as both providers of primary care and purchasers of secondary care. They were still led by GPs, although their boards also contained representation from community groups and the local health authority. PCGs were set up so they were able to retain any surplus from their budgets, which could be spent on services or facilities of benefit to patients. Although competition was disapproved of by the Labour government, purchasers (i.e. PCGs) were still able to switch to other providers if they were dissatisfied with the services they received.

The 1997 white paper also began to address quality and standards in the NHS and was expanded upon by *A First Class Service: Quality in the New NHS* a year later (Department of Health, 1998*b*). Clinical governance, which was seen as a radical idea, was introduced to the NHS and placed a statutory responsibility for the quality of care upon trust and health authority chief executives. Hospital trusts and PCGs developed systems and committees to meet the clinical governance requirements of quality assurance, audit and risk management. There has been criticism that the implementation of clinical governance in the NHS was impeded by lack of time and resources – too much change, too quickly – and a lack of clear guidance (Roland *et al*, 2001).

The government also set up two new national bodies: the National Institute for Clinical Excellence (NICE; which in 2013 became the National

Institute for Health and Care Excellence, after some interim changes of name and specific responsibilities, while retaining the acronym unaltered) and the Council for Health Improvement, which evolved into the Commission for Health Improvement (CHI) in 2000. In 2002, the CHI was replaced by the Commission for Health Audit and Inspection (CHAI), which combined its work with that previously done by the Audit Commission. The CHAI also had responsibility for regulation in private healthcare (e.g. private nursing homes and hospitals). The work of the CHAI was in turn taken over by the Healthcare Commission in 2004 and later conducted by the Care Quality Commission (CQC). In simple terms NICE was expected to set standards while CHAI enforced them. NICE's aim to address the lack of national standards and resultant wide variations in quality of healthcare was at first very popular. There had been growing public concern over 'postcode prescribing', where the availability of effective treatment depended on where in the country the patient lived. NICE's assessment of the effectiveness of drugs and other medical technologies led to it recommending their use in virtually all cases. A large part of NICE's remit was to attempt to limit the growth of the NHS drug bill, but even when its experts asserted that the anti-viral drug zanamivir had little therapeutic benefit, they back-tracked on their original judgement and recommended its use. Moreover, CHI/CHAI inspections proved truly effective only when discovering gross incompetence and negligence, as they had few solutions to offer still under-resourced trusts which were not meeting the performance standards (Day & Klein, 2002).

Other innovations to modernise the NHS and change the ways it had previously worked included NHS Direct and the National Programme for Information Technology (NPFIT). NHS Direct was a nurse-led 24-hour health advice phone service. Five years after its inception in 1998 it was handling over half a million calls a day and expanded into an equally busy online service in 2001. The NPFIT was an ambitious project which originally aimed for NHS trusts to have electronic records in place by 2005 (NHS Executive, 1998). However, it was riddled with logistical and technical difficulties, and failed to meet its aim (Hendy *et al*, 2005). Critics of the Labour government of this period often cite the project as an example of NHS mismanagement and wasting precious public investment.

The NHS Plan

The New NHS: Modern, Dependable (1997) was only the beginning of the reforms the Labour government intended for the NHS. Its full programme to modernise the NHS was announced in July 2000, in *The NHS Plan* (Department of Health, 2000*a*). This described the government's vision for the NHS for the next 10 years and led to unprecedented change. The plan was enterprising, impressive in scope and in places daring. It concentrated on the areas of capacity, standards, delivery and partnership, but at its core

was the aim of creating a patient-led Health Service. It proposed an NHS that responded to the needs and preferences of patients, rather than their choice being prohibited by 'the system' or health professionals. Significant improvements were expected to proceed from the new investment:

- *More health professionals*. Over a 5-year period it was expected to provide 7500 more hospital consultants (a rise of 30%), 1000 more specialist registrars and 2000 extra GPs and 450 more trainees. There would also be 1000 more medical school places each year, on top of 1000 places that had been announced before the NHS Plan.
- *More hospitals and beds*. Provision was made in the Plan for 100 new hospitals over a 10-year period and 7000 more hospital and intermediate-care beds.
- *National standards for waiting times*. By 2005 the maximum waiting time was expected to be 3 months for out-patients and 6 months for in-patients. No one should be waiting more than 4 hours in accident and emergency departments by 2004. It was also promised that all patients would be able to see a GP within 48 hours by 2004. Waiting lists for hospital appointments and admissions would be abolished by the end of 2005 and replaced with a booking system designed to give patients a choice of a convenient time.
- *Performance monitoring*. The performance of hospital trusts and primary care groups would be rated by CHI, using a traffic light system: 'green light' organisations, the 'best performers', would receive funds from the National Performance Fund and be given more autonomy; a 'red light' rating would lead to intervention from government agencies and if necessary the installation of new management. (The traffic light system was later replaced by the equally loathed star rating system, whereby trusts were evaluated against performance standards such as finances and waiting lists and awarded up to three stars.)
- *Expansion of nursing roles*. To make up the shortfall of doctors, the NHS Plan also proposed training for around 20000 nurses so that they would be able to prescribe a limited range of medicines.

To implement the NHS Plan, the government set up the National Modernisation Agency and local modernisation boards for each regional office of the NHS. The *Implementation Programme for the NHS Plan* was published at the end of 2000 and included provisional milestones and key targets for the early years of the Plan (Department of Health, 2000*b*). More targets followed and many working in the NHS felt overwhelmed by the pace of change.

Another reorganisation of the NHS

The NHS Plan promised greater power and authority for patients and the public. *Shifting the Balance of Power* (Department of Health, 2001) attempted

to give that greater authority to patients as well as to decentralise decision-making. The NHS Executive was dismantled and all English and Welsh health authorities were abolished. They were replaced with 28 new strategic health authorities (SHAs), which had a strategic role in improving local health services and also monitoring the performance of local health trusts.

Primary care groups evolved into new primary care trusts (PCTs), which inherited the health authorities' powers, responsibilities and resources. PCTs became the new powerhouses of the NHS. They were responsible for health improvement, and developing and delivering primary care, but also for commissioning hospital services. PCTs held approximately 75% of the NHS resources. While there were nearly 100 health authorities, there were over 400 PCTs, each covering an average population of 175 000.

One of the most controversial reforms during this period was the formation of foundation trusts. Initially, only top-performing trusts could apply for foundation status, but it was envisaged that all hospital trusts and PCTs would eventually be eligible. Becoming a foundation trust offered more financial freedom, as they were allowed to retain operating surpluses and to access a wider range of options for capital funding to invest in new services. They could also recruit and employ their own staff. Although they still had to deliver on national targets and standards, they were not under the direction of the Department of Health and the regional strategic health authorities. There had been much resistance to the introduction of foundation trusts, however, as many felt they indicated the break-up of the NHS, with individual hospitals having almost complete independence and determining their own priorities.

The NHS and the private sector

For the NHS to reach the targets of the NHS Plan it needed to increase its capacity, but extra resources to build new hospitals were unavailable. Previous governments had used the Private Finance Initiative (PFI), whereby private capital was used to build hospitals and hospital trusts would then lease the buildings from the private companies, under contracts lasting 25 years or more. The NHS gained new buildings without raising taxes, as the public's payment was deferred, although over the long term the arrangement was more expensive than if the buildings had been built using public money. The 2002 white paper *Delivering the NHS Plan* announced that 55 major hospital building schemes would be carried out, mostly through the PFI system (Department of Health, 2002). The PFI schemes were later renamed 'public–private partnerships' (PPPs).

Some NHS services, such as psychotherapy, were contracted out to private companies. This was done in the hope of increasing capacity and meeting targets. Most contracts involved elective surgical procedures or diagnostic tests. The primary concern of private healthcare providers is profit and so they were too prone to choosing activities that would yield a profit and leaving less financially attractive services to the NHS. There were

also concerns about the quality of work provided by the private companies and so contracts included expected performance levels. During this period there were sustained concerns that the NHS was slowly being privatised through PPPs, although at the time the government was committed to a maximum of 15% of the NHS's output being provided by the private sector. For an in-depth discussion of the relationship between the NHS and the private sector, readers are recommended *NHS plc* (Pollock, 2005).

The results of increased investment

There was massive investment in the NHS in the period 1997–2006: NHS spending increased from £46 billion a year to £94 billion a year. This investment led to some modest improvements, including nearly 200 000 extra front-line staff. However, over half the extra money was spent on pay and pensions for staff, most significantly in increased National Insurance contributions. GPs and hospital consultants received new contracts, which, while increasing the scrutiny and accountability of their work, considerably increased their pay. UK doctors became some of the highest paid in the world outside the USA. However, as perhaps was to be expected, with increased salary came increased public expectations. There was also a contradiction that with the new GP contract patients had access to new clinics and general practices had extended their opening hours but the contract also allowed GPs to opt out from out-of-hours work. The government was perhaps surprised by the high proportion of GPs who took that option and there was concern about the quality and cost of the night visiting services that were commissioned to replace the patients' regular GPs.

There were some successes from the increased investment. The number of patients on waiting lists, a favourite marker of success for politicians, fell to an all-time low, although the average out-patient waiting time was reduced only to 6.6 weeks, compared with 7.7 weeks in 1997. The government set a new target in 2008 that patients would wait no more than 18 weeks from referral to treatment. This was an ambitious aim, as only 10 years before there had been over 280 000 patients waiting for more than 6 months for admission to hospital and it was not uncommon to wait more than 2 years (Nicholson, 2009). From 2009, patients were also given the right to choose where they would be treated, from a menu of providers which included private healthcare companies.

There had been improvements on many measures of NHS activity following the implementation of the NHS Plan and subsequent policies. However, there was a general feeling that too much had been spent on delivering too little. NHS productivity had not increased enough and the Service ended up costing more and delivering less value for money. Even before the worldwide economic downturn following the collapse of the banking industry in 2008 there were concerns about the future financing of the NHS. In 2006 the NHS in England had a net deficit of £512 million, which at the time was equivalent to 0.8% of its turnover.

This led to services being cut in some areas. The introduction of the 'payment by results' funding scheme, where hospitals were paid only for the work they did, rather than given a budget at the start of the year, also increased competition between providers. Each procedure, whether it be a surgical operation or an out-patient follow-up appointment, had an attached national tariff/price and the hospital received this payment only if it completed the activity. This change in funding, along with patients being able to choose their provider, led to increased financial pressures for some hospitals as they struggled to attract enough work and compete with other hospitals. The hospitals that faced the worst financial adversity already had financial deficits and were tied into long, expensive PPP contracts for the construction of new buildings.

In 2009, the then NHS chief executive, David Nicholson, established the QIPP (quality, innovation, productivity and prevention) programme to deliver efficiency savings to the NHS of £15–20 billion between 2011 and 2014 (Nicholson, 2009). This put further emphasis on NHS organisations redesigning their services and making savings while maintaining patient safety and standards of care.

Patient safety and clinical standards

The Labour government was aware that it would not be able to continue increasing funding for the NHS to the same degree. To set out a strategy for the NHS for the next 10 years, a review was conducted by the then health minister in the House of Lords, Lord Darzi, who was also Professor of Surgery at Imperial College London. The Darzi report had the advantage of presenting a clinician's vision as well as being informed by an extensive consultation with 60 000 staff, patients and stakeholder groups. Lord Darzi's final report, *High Quality Care For All* (Darzi, 2008), reflected, but also developed, many existing policies, including patient choice, the role of NICE and competition. However, importantly, it changed the emphasis of policy and highlighted the need to increase quality of care and ensure patient safety. It also promoted the involvement of clinicians to lead and manage improvements in the services in which they worked.

The Darzi report also set out the values contained in the first NHS Constitution (Department of Health, 2009) in the form of patients' rights and pledges that the NHS would strive to deliver. It also set out the responsibilities which the public, patients and staff owe to one another to ensure that the NHS operated fairly and effectively. It enshrined the principle that access to NHS care was based on clinical need and not the individual's ability to pay and the principle that patients have the right to be treated with dignity, respect and compassion.

The positive impact of the NHS Constitution was reduced by one of the biggest scandals to ever hit the NHS, which occurred in the same year. The Healthcare Commission investigated the high mortality rate in Stafford Hospital and uncovered 'appalling' standards of care (Francis, 2010). It was

a reminder that despite increased resources, new policies and values, there was still unacceptable variability in the standard of care provided by the NHS. This added to the next government's argument that major reform in the NHS was required.

Developments since 2010

No party had an outright majority after the 2010 general election which led to the Conservative–Liberal Democrat coalition government being formed. Neither party set out any significant reform for the NHS in its election manifesto. The Conservatives promised that, despite the need for a programme of austerity measures to address the country's financial crisis, they would 'ring-fence' the funding for the NHS. Before the election they also guaranteed that, if they were in power, there would be 'no top-down reorganisation of the NHS'. Politicians and the public alike were almost universally shocked that in its first year in government the coalition presented the first draft of the Health and Social Care Bill, which set out the most wide-ranging reforms of the NHS since it was formed in 1948. The bill received a strong reaction, including claims that it would lead to the privatisation of the NHS.

The comprehensive organisational changes contained in the bill included:

- A new NHS Commissioning Board (NHSCB) was to be directly responsible for the day-to-day running of the NHS, rather than the Department of Health.
- The PCTs were to be abolished and replaced by several hundred clinical commissioning groups (CCGs), made of consortia of GPs. They would receive 60% of the NHS budget and, with other clinicians and support from managers, commission services on behalf of the local population to meet its specific needs.
- The strategic health authorities were also to be abolished, with the CCGs being accountable to the NHSCB.
- All NHS providers of hospital and community services were to become foundation trusts. Foundation trusts were to be allowed to generate up to 49% of their income from private patients.
- Monitor, the organisation that oversees the running of foundation trusts, was to become the economic regulator for the healthcare sector. It was specifically set the task of promoting competition as well as licensing providers and setting prices through a national tariff, with price competition allowed.
- A new body, Public Health England, was to lead on public health at a national level, while local authorities were to take the lead at a local level.
- A new national patient body, Health Watch, was to be set up, with local Health Watch groups.

There was a strong negative reaction to the bill and many saw it as the dismantling of the NHS, and ultimately its privatisation. It was feared that the entitlement to free health services would be curtailed (Pollock *et al*, 2012). There was also a fundamental change in the role of the Secretary of State proposed in the bill, whereby they would no longer have a duty to provide a comprehensive health service but instead have a duty to 'promote' a comprehensive service. The bill also transferred from the Secretary of State to CCGs the power to determine what is 'appropriate as part of the health service' for certain individuals. Those against the bill felt that it would ultimately lead to some patients being excluded from parts of the NHS and that it would lead to an increase in the services that could be charged for.

The provisions of the original bill were extensively debated in Parliament and some 2000 amendments were made before it was passed. The duty and accountability of the Secretary of State to provide, and not 'promote', comprehensive healthcare was maintained. The original duty on Monitor to 'promote competition' was dropped and amendments were made to rule out competition on price, while other safeguards were added to reduce the emphasis on competition. However, despite these amendments there was still strong opposition to the Health and Social Care Act, as it was still felt that the emphasis on competition would lead to greater privatisation and fragmentation of the NHS.

The government's appraisal of the need for such a radical reorganisation was not supported by the public's view of the NHS. When the coalition came into power in 2010, the NHS had its highest public approval rating, at 70% of respondents, since the start of records in 1983, and had the support of 97% of the population (Taylor, 2013). However, satisfaction fell by 12 percentage points in 2011 when the bill was published, which was the biggest fall in 1 year ever recorded, although the satisfaction rate was still the third highest recorded.

Other concerns about the Health and Social Care Act included that the radical restructuring of the NHS would be a major distraction for clinicians and managers at a time when it faced the biggest financial challenge in its history. The government claimed that the proposed reforms would save at least £1.5 billion. However, others suggested that abandoning the Act would actually have saved £1 billion (Walshe, 2012). The NHS had been struggling to address the 'Nicholson challenge' of saving £20 billion over 4 years. NHS organisations' efforts to make efficiency savings had largely been disappointing and what was still required was a real and painful reconfiguration of services.

The Health and Social Care Act was unpopular in many quarters but the coalition government had consistently highlighted that it shared many values with the policies of the previous Labour government. Clinicians, mainly GPs, were still central to the commissioning of services, while the Darzi report had encouraged the empowerment of clinicians to be involved

in the design, change and structuring of services. The Act also increased competition between healthcare providers, which, it was presumed, would increase quality and efficiency. Critics of the Act believed that such a major reorganisation of the NHS was not needed. However, the coalition's case for change to improve quality of care was supported by the Francis report on the Mid Staffordshire NHS Foundation Trust (Francis, 2010) (see above). He reported examples of appalling nursing care and an extra 500 deaths that occurred between 2005/2006 and 2007/2008. Francis made 290 recommendations to improve the NHS, with the focus being on putting patients' needs first and avoiding a fixation on financial issues and targets.

The scrutiny of the Health and Social Care Act highlighted the inequalities across the NHS as a consequence of devolution. The universal, national service that the NHS was set up as had already been diminished prior to the Health and Social Care Act and there were now essentially four different NHS organisations across the four jurisdictions of the United Kingdom. This has led to a variability in the provision of services. An example of this is the NHS in Scotland, where the Scottish National Party government introduced a policy of free prescriptions, which is not the case elsewhere.

Conclusion

It is hoped that this brief précis of the history of the NHS will act as an introduction to the subject for doctors interested in the management and the complex organisational structure in which we work. Two things can be learned from taking this historical overview: first, that history repeats itself and it is remarkable how recent plans for the NHS are similar to earlier ideas; second, as an administrative machine the NHS is continually evolving, and that should be borne in mind by all of us who intend to plight their troth to it for the vast majority of our professional careers.

It will be several years before we know whether the most recent policies for the NHS will 'save' it, as the government hopes, or be the beginning of the end of the NHS, as others fear. History perhaps tells us that they are most likely to do neither.

Changes in NHS management structure since 1974 are summarised in Table 1.1.

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Table 1.1 Some important changes in NHS management structures since 1974

Year	Initiative
1975	*Better Services for the Mentally Ill*, a white paper based on a report of the Audit Commission
1982	The Korner report, from the Department of Health and Social Security's Steering Group on Health Services Information, concerning the collection and use of information on hospital clinical activity
1982	Abolition of NHS area health boards
1983	Management budgeting experiment started
1984	Griffiths report on Health Service management
1986	Introduction of the Resource Management Initiative
1987	*Achieving a Balance* published by the Department of Health and Social Security, making recommendations for staffing levels for doctors
1988	NHS review announced
1989	*Working for Patients* and *Caring for People*, white papers leading to the 1990 Act
1990	The NHS and Community Care Act (reforms effective 1 April 1991) and introduction of the purchaser–provider split
1991	Postgraduate and continuing medical education introduced
1991	First wave of trust hospitals
1992	Second wave of trust hospitals
1993	Managing the new NHS – new proposals
1994	Fourth wave of trust hospitals
1997	*The New NHS: Modern, Dependable* published: GP fund-holders abolished; moves away from competition; PCGs established
1998	*A First Class Service* introduced clinical governance
2000	The NHS Plan increased resources and introduced performance monitoring (traffic light system)
2001	*Shifting the Balance of Power* launched: primary care trusts set up; NHS Executive replaced by strategic health authorities
2002	Wanless report – highlighted under-funding of the NHS
2003	Health and Social Care Act presented the concept of foundation hospitals
2008	Lord Darzi's *Next Stage Review* published, based on a consultation involving 60 000 staff, patients and members of the public
2009	*The NHS Constitution* published, outlining patients' rights
2010	The *Liberating the NHS* white paper set out putting patients at the heart of everything the NHS does
2012	The Health and Social Care Act set up care commissioning groups and disbanded the strategic health authorities and primary care trusts

GP, general practitioner; PGC, primary care group.

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