Using the nhs as a primary example, describe the provision

Health & Medicine, Healthcare

In order to describe the provision, management and effectiveness ofhealthcare systems in England, one must first define healthcare. Health care in nature is a universal requirement and is essentially (in economic terms) a derived demand from health. Health care is provided by personnel in a multidisciplinary team who work to advance and sustain a state of physical, mental and social wellbeing for all. A health care system can therefore be defined as a medium through which health care is provided to the population. The varying types of health care systems have arisen from each health service having their own different health objectives. Fundamentally there are two models of systems that health care seems to be based around (Culyyer et. al, 1981). The first is a market system where health care is selective and based on disposition to pay; this authority is attained by the purchase of private medical insurance.

The main significance of this is that government has little control, and price and reward is determined by the market. The second system is a state run system funded by taxation to ensure that care is provided based on need and is free at the point-of-use. The two systems described are prototypes; the reality is that health care provision can be at either end of the extremes described or a mixture of the two. The health care systems that have been applied are commonly known as multi payer and single payer health care (single payer following closely to the latter system described by Culyer, Maynard and Williams (1981), multi payer tends to follow the former systems but can be a mixture of both). A multi payer health care system is typically financed more regressively, with private insurance companies (which can be profit or non-profit) providing the main funding with the government usually

being the other source. The government and non-profit insurance companies tend to regulate the market to ensure fair pricing. Benefits of this system are that patients can select from a variety of coverage getting only the services that they require. Also there are usually shorter waiting times for non-emergency health services. Some of the main disadvantages are based around equity of the provision of treatment. It is seen as unfair that some are excluded from provision of treatment based upon their ability (or inability) to purchase the necessary insurance (btoema, 2011). Also in most countries much of the health coverage is provided (or at least matched) by a person's place of work, meaning that health care is influenced greatly by employer sponsorship.

The United States is an example of a multi payer health care system. A single payer health care system is whereby a public body covers all health care costs (not private insurers). The public body can employ health care staff and resources or can incorporate the single payer health care into a wider mixed payer system. This type of system ensures that health care is wealth dependent and is typically free at the point-of-use (as mentioned above). A single payer system promotes universal coverage ensuring fairness in society (Rice, 2002). Government systems also push preventative medicine more and increase awareness, something a multi payer health care system may not do. The nature of a single payer market is that it is publically funded and run through taxation. Theoretically a government run market tends to be more inefficient (in economic terms) than that of a free one due to poor cost minimization. Furthermore budgets and other constraints can lead to gaps in the health care system and longer waiting

times. The National Health Service is an example of a socialized single payer health care system in England. N. B. As the British NHS is in fact devolved (England, Wales and Scotland each have their own separate funding), use of the term NHS should be associated with the NHS in England unless otherwise stated. Although a monopoly, the publically funded NHS has existed alongside a small private health sector since its inception in 1948. Table one reflects the relatively minor spending of the private sector compared to the public sector. Looking at spending on health care in table 1, the trends indicate from 1997 to 2009 health care expenditure increased as a percentage of GDP with a slight decrease in the last result (-0. 2% between 2009 and 2010).

The mean yearly percentage increase on health care expenditure is 7. 5%, however the year on year increase in expenditure of healthcare from 2009 to 2010 was a data low of only 3. 1%. This result may be indicative of the new reform proposal and budget applied to the NHS model and the government. An important feature to note from table one is the 256% increase in public spending over the 13 years compared to the 217% increase in private sector health care spending. In 2005, $2 trillion was spent on health care in the US amounting to 16% of total GDP (Catlin et al., 2007), looking at the data of UK health care only around half as much (8. 2 %) was spent. This piece of data could potentially give credibility to the theory that in a single payer system there a fewer managerial and administrative costs (Rice, 2002). Also in 2003 administrative costs accounted for 31% of US health care expenditure whereas in Canada such costs only accounted for 16. 7% of health care expenditure (Woolhandler et. al, 2003). Healthcare in Canada is not entirely

a single payer system but rather a mixed payer system because there is delivery of both public and private health care and doctors are not government employed. Canada is a country that has socialized health insurance as opposed to Great Britain which has socialized medicine. The difference between the two is that socialized medicine is whereby health care workers such as doctors take their salary from the government via taxation. Table 1: UK Health care expenditure from 1997 to 2010

Total healthcare expenditure (£bn)Of which public sector (£bn)Of which private sector (£bn)Year-on-year increase in total healthcare expenditure (%)Total healthcare expenditure (% of GDP) Source: ONS

19975544. 1710. 83 6. 6

199858. 747. 3111. 396. 76. 7

199964. 252. 112. 19. 46. 9

200068. 753. 9814. 7277

200174. 258. 9515. 2587. 3

200281. 465. 1216. 289. 87. 5

200388. 670. 4318. 178. 87. 8

200496. 278. 1618. 048. 58

2005103. 484. 4918. 917. 58. 2

2006112. 491. 2421. 168. 78. 5

2007119. 296. 7622. 4468. 5

2008125. 6103. 9421. 665. 48. 7

2009136. 6114. 322. 38. 89. 8

2010140. 8117. 3323. 473. 19. 6

(Jurd and Office for National Statistics, 2008, Tables 1 and 2 combined) Over the course of time, the NHS has changed drastically after being influenced by a variety of organisational attempts - some are discussed below. The marriage of medicine and management in the NHS arrived in the 1980s where the modern management process was introduced after pressures to increase efficiency in public spending arose. The introduction of the internal market

was the next big structural change in the organisation of the NHS. The internal market introduced the theory of competition between NHS trusts; this market has since been pursued as a response of increased public expenditure. A particularly controversial reform that was first introduced in the early millennium was the privatefinanceinitiative (PFI) and it involved outsourcing to the private sector (prior to this PFI initiative the government owned all resources of production of health care). The current NHS system is a structural hierarchy whereby the Department of Health is in control and is primarily led by the secretary of state. There are ten strategic health authorities which oversee primary care trusts who in turn provide funding of health care services. The Health and Social Care act of 2012 is the latest reform proposal and provides the source of current on-going debate and controversy. The act effectively abolishes the primary care trusts and strategic health authorities in place of many GP consortia. Each consortium will have a budget and will contract out provision of health care. This moves the health care (slightly) towards a mixed payer system and away from its current single payer health system as it could allow private companies to arrive and compete in the health service market. The notion of a more active

private sector alongside a pre-existing public sector was researched by Hoel and Saether (2000). Their research showed that theoretically results were optimal due to increased competition and efficiency savings. The implication of this in terms of management is that it will be less autocratic (Burns, 1978) and will engage in moreleadershipandresponsibilityin health care settings. It is important to look at and understand changes that have occurred in the NHS to fully grasp the influence that certain management and leadership styles have had. The introduction of general management in the NHS brought about a leadership style described by Burns (1978) as a transformational leader. This type of leader embraces change and encourages innovation which could explain the arrival of the internal market. The most systematic type of leadership is an autocratic one, where a pyramid hierarchy is incorporated. It is seen as a regressive form of leadership because it requires the leader to make all the decisions and be the most knowledgeable (Burns, 1978). This form of leadership clearly has no place in a public system, due to the nature of how the government is run but it could be used in a private health care system.

The leadership style of the NHS currently follows most closely to a connective style (Ewens, 2002), where the focus is that of building combined networks to promote and incorporate change. However the current proposal (involving removing PCTs and SHAs) adheres to the shared leadership, where leadership is dispersed throughout an organisation (Pedler & Burgoyne, 2006). Kotter (1996) defines management and leadership separately; management involves planning, budgeting and organising whereas leadership involves establishing direction, aligning people and inspiring.

Leadership is extremely fundamental to any application of management, and studies by Baker (2011) show that the best performing health care systems (whether single, multi or mixed payer) are the ones in which leadership development is prioritised at all levels.

The NHS in England is sometimes portrayed as being over-administrated and under-managed. Connolly et al. (2010) found that despite having relatively fewer doctors in the English NHS compared to Scotland and Wales, there were shorter waiting times for patients. One of the reasons could be because NHS (England) had more managers. A paper published on the effectiveness of the NHS by Walshe and Smith (2011) found that there was a 28% increase in management personnel between 1997 and 2010, despite health care spending more than doubling as represented in Table 1. The insinuation here is that shorter waiting times can be associated with an increase in effective management, or indeed leadership. Measuring the effectiveness of a health care system is very difficult to do as it is perceived as objective in the sense that some factors bear more weight than others. One way in which effectiveness could be measured is the satisfaction of the heath care users, this methodology is somewhat flawed though because comparing effectiveness typically involves expenditure with other factors. A usual comparison tends to be of life expectancy against health care spending. Table 2: Efficiency of Health Care Systems in 2010 (Life Expectancy vs. Total Expenditure an an indicator) CountryLife Expectancy of Total Population at Birth 2010 (Years)Total Expenditure on health care compared to GDP in 2010 (%)Effectiveness: Life Expectancy vs. Total Expenditure (Ratio) Germany80. 511. 66. 9

Japan	83.	09.	58.	7
United Kingdom	80.	69.	68.	4
United States	78.	717.	64.	5
OECD Average (of all OECD countries)	79.	89.	58.	4

(OECD, 2012)

Table 2 shows the life expectancy and expenditure on health of four countries with differing health care systems. Japan and Germany both have a mixed health care system, the UK a single payer and the US a multi payer health insurance. Two mixed payer systems have been included to show the variability of the mixed health care system; Germany being below the average effectiveness and Japan being above. The life expectancy does not fluctuate much; instead the variability of the effectiveness arises from health care spending. The UK is seen as being averagely effective but only for OECD countries, but as a single payer health care system and taking into account countries not in the OECD it can be viewed as an effectively run service. The US clearly spends the most on health care than any other single country (Table 2), and it also has the largest multi payer system and private health care in the world. Its poor effectiveness (life expectancy vs. expenditure) could be attributed to the type of system it enforces or simply its inefficiencies could be due to a theory known as diseconomies of scale. Krugman (2007) estimated that the US spent $98 billion in excess (relative) administrative costs and $66 billion in excess (relative) drug costs compared to nations with a single payer health system. The indicators (life expectancy and health care expenditure) used may allow for bias for wealthier countries; this makes it difficult to measure effectiveness fairly. The degree to which

core health care systems are implemented also make it increasingly difficult to judge effectiveness due to the increased variability. Each country has their own different targets for the type of health care that they would ideally like to provide, and these targets ultimately decide which system of health care is implemented. It is very difficult to switch completely from a system to another (there have been talks in the US about introducing a universal health care); but how effective would an implementation of a mixed health care system be? A mixed payer health care system can be desirable in terms of equity but the balance of public and private provision must be right in order to be effective and equal for all users. For example, limited government resources can result in low quality infrastructure, meaning private services flourish due to poor public provision. When private sector is the main provider of health care in a mixed payer system, there are usually problems with management and provision of public sector provision (similar problems that single payer systems face). The regulation of a private health care sector is important when considering a mixed payer system that promotes both quality andequalityof services. The notion of a mixed health care system is very desirable for all and universal health can only be pursued realistically if health care financing is increased and private providers have a symbiotic relationship with the public sector. Many single payer health care systems have a functioning private health care sector, a prime example being the British heath care system. The role for private health care is limited in Britain compared to a mixed payer system due to the highly regulated NHS. Both

single and multi payer health care systems have their own pros and cons, one system’s pros are typically the other one’s cons.

The best type of health care system is not a clear cut decision. The NHS as a single payer system means that medical decisions are left to health care workers and their patients as opposed to rationing care based on ability of users to pay for the care. The problems that the NHS faces synonymous with most single payer systems today with restricted resources and budget cuts. The implementation of the new reform may allow for a slight shift towards a mixed health care system which has the potential to be effective. It must be taken into consideration that the provision of health care will not shift completely into a mixed health care system but instead imbibe some qualities of the system into the well-developed current one. The application of management and leadership skills will be important for GPs due to the consortia (Dobson, 2012) but it is crucial to remember that in order to run an effective health care system that leadership is crucial at all levels as discussed by Baker (2011). The research by Baker (2011) is applicable to all provision of health care mainly because increased bureaucracy can lead reduce costs and increased health care planning. Hartley and Benington (2011) found that in order to increase efficiency and effectiveness the ‘ NHS needs to picture itself as an organic living system evolving with a changing internalenvironment’. The NHS is seen as an efficiently run health care system and despite it being seemingly impossible to be completely effective, management is integral to try and strive for a better run health care system.

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