A study on the history of the nhs

Since its launch in 1948, the NHS has evolved to turn into the world’s largest publicly funded health service. It is also one of the most efficient, most egalitarian and most comprehensive. The NHS in England is the biggest part of the system by far, catering to a population of 51m and employing more than 1. 3m people. Although funding is provided centrally by national taxation the NHS services in England, Scotland and Wales are managed separately. (1)

When the NHS was launched in 1948 it had a budget of £437million (roughly £9billion at today’s value). In 2008/9 it received over 10 times that amount (more than £100billion). Some 60% of the NHS budget is used to pay staff. A further 20% pays for drugs and other supplies, with the remaining 20% split between buildings, equipment and training costs on the one hand and medical equipment, catering and cleaning on the other. Nearly 80% of the total budget is distributed by local trusts in line with the particular health priorities in their areas. The money to pay for the NHS comes directly from taxation. According to independent bodies such as the King’s Fund, this remains the “ cheapest and fairest” way of funding health care when compared with other systems. (1)

The Department of Health controls the NHS. The secretary of state for health is the head of the Department of Health and reports to the prime minister. The Department of Health controls England’s 10 Strategic Health Authorities (SHAs), which oversee all NHS activities in England. These SHAs supervise all the NHS trusts in its area. The devolved administrations of Scotland, Wales and Northern Ireland run their local NHS services separately. The foundation trusts have been introduced recently to make sure that the people in the

local area run these hospitals and the decisions are made to address the health issues that are of particular concern within the local population. (2)

The modernization of NHS was proposed by Lord Darzi. The vision is to improve the quality care rather than the quantity of care. The main consideration is to make sure that the NHS is patient centered and clinicians are placed in the front line for providing the NHS services. It also considers clinical governance with an emphasis on the accountability of the results. This model involves the formation of GP consortia and centralizing the services which are led by the GP. The proposal was supposed to free the NHS services from bureaucracy and political influence. The proposal plans to open 150 GP led services offering better health services to patients. There is a long standing debate between health care professionals, politicians regarding this new concept. It might provide flexibility for the GPs to provide health services prioritizing appropriately with a true representation within the local population. The introduction of the new GP led system has advantages and disadvantages which are discussed as follows.

Patient centered care and concordance:

Patients will be put at the centre throughout the decision making process. All the healthcare related issues regarding a particular patient are addressed with patient concordance. This new system allows the patient to choose the health service provider, choice of consultant led- team and choice of treatment. They can access information and make choices about their healthcare. The new system is an open policy where every outcome is discussed with the patient whether it’s good or bad. Concordance and compliance are main issues in improving the health care outcomes. For

instance, if an osteoporotic patient does not like plain calcium supplements because of taste will not take the medicine even if it is prescribed repeatedly. Fruit flavored tablets might be an option. Patient would comply with medication and which would improve the clinical outcome. The patient has the right to know what procedures are being carried out, disease condition and treatment plan.

The concept of discussion of health issues between patients and clinicians is interesting. This will provide an opportunity for the clinician to address the healthcare issues at any time, Patient reported outcome measures (PROMS) can be helpful in assessing the improvement in the health care outcomes. The availability of information in future will improve accountability (2). In contrast, the new system expects the health authorities to be open if something goes wrong and report to improve the quality of care. However, there is a chance for underreporting and also lack of standardization of the information collected. True national extrapolation of the collected data might be difficult due to varied standard operating procedures, policies and different target population. The idea of making sure that the patient can access their data and transfer it to the third parties is daunting and not cost effective due to the data protection and technological investment issues.

NHS and the concept of ‘ improving healthcare outcomes’

NHS at present includes clinical staff who are among the most talented in the world. All the healthcare decisions are based on the evidence-based medicine. NICE funds for the clinical research for the publication of evidence-based medicine(2). Findings showed that poor health outcomes are achieved in some areas such as respiratory disease, stroke and cancer. The underlying

risk factors were considered to be the cause. For example, smoking can contribute to the cardiovascular disease, COPD and cancer. Much emphasis was put on the public health to address these health care outcomes. The current NHS has predesigned services and expects the patient to fit into these services rather than adjusting services around patients.

NHS remodeling will focus on removing the layers of management (administration staff) and enhance the clinical staff. Under the new system NHS will be accountable for all the clinical evidence- based outcome measures and not the process targets. The new system removes the previously set targets without clinical justification. NICE (National Institute of Clinical Excellence) sets the performance standards on which the NHS care quality is based on. NHS commissioning Board will have the responsibility to eradicate any inequalities in the outcomes from the health services.

NHS outcome framework addresses effectiveness of treatment, safety and patient experience. The quality care outcomes for the target groups such as elderly, children and mental health are difficult to quantify. International comparison on avoidable morbidity and mortality is difficult as the population used for comparison might be different from the local population and also varied health care issues.

Emergence of GP consortia and consultant burden:

The new system proposes to establish GP consortia and transfer of responsibilities from the primary care trusts (PCT). This will provide more options for GPs to prioritize the health issues and allocate the funds to address the health issues within the local population. The system was

introduced to make sure that the taxpayer’s money is used appropriately by the GPs, health care professionals and commissioner for the best possible quality outcome. NHS commissioning expects the provider to manage the healthcare data with contractual obligations. The downside of this is that the GPs have to be more of data collectors in addition to their clinical commitment to treat patients. This might add additional burden to their already existing workload.

Patient can chose to register with any GP. This will have a significant impact on surgeries because if a GP surgery has higher number of patients this will add extra workload to GPs and possible increase in waiting times for the patients. The appropriateness of the healthcare data collected might even be difficult. This is true if the patient from a different locality decides to join a GP away from his geographical sector and the patient’s health condition will represent the local population which should not be the case. However, this can be helpful for providing healthcare to the acutely ill patients during GP out- of -hours.

GPs are healthcare providers primarily. They are handed the responsibility to co-ordinate patient care. This will require extra time to negotiate with other health care providers in case of patient referrals. This will shift the primary role of a healthcare provider from treating patients to become a financial negotiator.

The quality of care by the provider is based partly on the patient’s response and the incentives are based on the implementation of NICE standards. NHS commission can impose contractual penalties to the service providers. This

will add to the already existing pressures to meet the health care outcome targets. Moreover, the incentives are based on the number of registered patients. GP surgeries in small villages with less local population might not get enough money because of this system. Prices and payments are considered on the basis of most efficient, high quality services. This is dependent on the local population being treated. Highly affluent community with healthy life styles might show better outcomes with little GP intervention compared to deprived community with lot of health care issues needing addressed.

Government's white paper ' Equity and Excellence' also states that patient can choose a particular consultant and medical team for his or her medical condition to be treated. This can be difficult for the GP to decide if any particular procedure needs to be done on the patient. The consultant chosen by the patient might be expensive compared to another consultant GP might prefer. This might lead to overspending of the budget. Secondly, if all the patients are considering to be treated by a particular consultant, there is a possibility of increased waiting times which can have significant effect on health care outcomes. ' Monitor' system will look at the competition between providers but once the patient's decision has been considered it might be difficult for the GP and the Monitor system to come to an agreement. (2)

Impact on NHS and healthcare staff

Proposals for commissioning education and training for healthcare professionals locally and nationally will have a significant impact on the work procedures and the knowledge gain. The structure and content of training, quality standards are reviewed by the professionals which can have a major

impact on the healthcare outcomes. NHS pay and staffing is allocated to the healthcare employers. Government plans to set the pay for all the NHS employers by consultation with healthcare employer. Staffing and affordability decisions are made by the ministers with the help of healthcare employer. The aim was to decentralize the system but this seems impractical as the decisions such as staffing and affordability are still made by the ministers together with the healthcare employers.

Government plan to decentralize the system and cut the costs of health bureaucracy might have a significant impact on the budget. However, the implementation might not be fair as this might result in loss of jobs and also transitional costs until fully implemented. The implementation of new system will liberate NHS from meeting targets such as 98% requirements for A&E waits and associated performance management bureaucracy(2). Eradication of these targets will reduce the pressure.

The royal pharmaceutical society has opposed to any further regulations on pharmacies unless it improves the patient safety. Pharmacists are already under pressure dealing with the pharmacy related tasks along with the public health. RPSGB is concerned regarding the commissioning of services by NHS commissioning board, GP consortia and local authorities. The society is concerned about the communication between these partners so that patients can receive high quality care. It also asked to define the functions of ‘ Monitor’ system in detail. The society also aims to strengthen pharmacist role in addressing public health issues.

Conclusion:

The white paper published with the intention of improving the health care outcomes. The main focus was to make the health services autonomous without political interference and influence. The proposal is based on the quality of care rather than the volume. Information revolution is supposed to bring a radical change for the dissemination of patient’s healthcare information. The GP consortia will be responsible for the care provision in the absence of primary care trusts. Local health issues are addressed and treated according to the standards set by NICE and NHS commissioning boards are responsible to meet the national health targets. This new GP led system will have significant impact on the GPs themselves and other healthcare professionals. GPs will become financial negotiators rather than healthcare providers. It will be interesting to see the contingency plans if the new system fails as this is the first time NHS is undergoing such a massive change.