

**Re-Thinking Approaches to Government Reforms**  
**OPI-Magdalen College Seminar Series**  
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**The Case of the UK NHS**  
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*The UK National Health Service is an apolitical, professional organisation with a strong public service ethos, which enjoyed strong public support in the past. It was characterised by obedience to rules and a hierarchical, managed structure. It was accountable to Ministers and Parliament. Thus, the conditions for New Public Management-style reforms to effect an improvement were largely fulfilled. Reforms were driven, at first, by the need for financial austerity, and later by managerial initiatives. However, NHS reform is a potent political issue. There was, and still is, a hostility from the public and from clinical NHS staff to the use of the language of markets, to efficiency and to local variations in priority-setting. As a result, after 25 years of reform, the combination of rising costs, lengthening waiting lists and declining public satisfaction that generated the political space to initiate change still characterise the Service. Despite a number of important management innovations, most notably the introduction of GP fund-holding in 1991, it is still not possible to assess the benefits to the NHS as a whole from NPM. The main lesson from this example is that managerial and financial reforms of the NPM type may be less than fully successful if the public or the service providers are not co-opted to the reform process and see benefits from it.*

There have been three main phases of NHS reforms over the past 25 years: the reforms that followed the 1976 IMF deal, the 1989-97 Conservative reforms, and the post-1997 Labour reforms.

*The managerial reforms between 1976 and 1988*

The events leading up to agreement with the IMF in 1976 on a draw-down facility drew attention to the weak control over rising public service costs. The NHS, a case in point, was run through consensus management between doctors, nurses and administrators, with little knowledge of, or concern for, costs and no clear chain of responsibility in decision-making.

The emphasis between 1976 and 1988 was on the efficiency gains that could be generated from improved public sector management: the use of efficiency scrutinies, value for money targets, resource management initiatives, executive agencies and contracting out. Despite these measures, spending on the NHS more than tripled in 11 years, from £8bn in 1978-79 to £26bn in 1989-90. Moreover, public satisfaction was compromised through wide variations in performance and the perception that the Service had become bureaucratic and unresponsive.

*Conservative Government Reforms between 1988 and 1997*

The reformist Thatcher government left the NHS alone until 1987 realising that fundamental changes would have powerful political implications. However, continued increasing costs and declining public satisfaction finally led to the introduction of

radical reforms in 1991. They were made possible by the relative ease with which a government, under the UK Constitution, may obtain legislative approval for change without a broad electoral consensus, and by the existence of a strong political will on the part of leading Conservative politicians, notably Margaret Thatcher and, later, Kenneth Clarke.

The core themes were the introduction of weighted capitation funding in order to move resources towards areas with the greatest health needs, split between the purchasers of healthcare and those who provided it (partly through the 'internal market') and the devolution of management authority and accountability. These measures were implemented by contract-based management, agreements on explicit service targets, efficiency and effectiveness measures (including charging for capital - a novel concept in the public sector where capital was a free good - benchmarking and audit), the more effective use of staff, local pay-setting and performance-related pay and, later, the introduction of the Private Finance Initiative (PFI).

One of the most influential reforms was the introduction of GP fundholding. General Practitioners were given budgets to buy treatment for their patients in the NHS 'internal market.' Fundholding was voluntary but the uptake was far greater than had been anticipated. It started a process of dynamic change that was unplanned. A variety of GP purchasing models developed. This, in turn, resulted in the concept of a 'primary care led NHS' and the introduction by the Labour government of Primary Care Groups in 1999 and of Primary Care Trusts in 2000.

However, against its consultants' advice, the government left the core principles of a tax-financed, free-at-the point-of-delivery NHS untouched, dismissing the introduction of compulsory health insurance as politically unacceptable.

#### *The NHS under New Labour since 1997*

The new Labour government brought both continuities and changes in NHS management. It re-affirmed its commitment to the values and the tax-funded base of the NHS, and also re-affirmed that quality and efficiency would be the key goals of NHS management. However, GP fundholding was abolished and new universal Primary Care Groups were established. The emphasis was on collaboration between medical services, not on competition. Other reforms have included the introduction of 'Joint Action Zones', to bring together resources that bear upon health from all sectors. Although technical innovations have moved the pattern of treatment from in-patient towards outpatient care, PFIs to finance hospital construction and refurbishment have been extended, tying up the government's financial commitments for 20-25 years (and in one case for 60 years). There has also been a new emphasis on public health and citizens' self-responsibility for healthy behaviour

#### *Reflections on the reforms*

Somewhat surprisingly, NHS reforms have not been the subject of any systematic assessment. As a result, there is inadequate evidence about the impact of 25 years of reform on either health service efficiency or equity. However, NHS reforms have resulted in innovations in healthcare provision. The rate of efficiency improvement

has increased and there has been a quality improvement resulting from fundholding, although the extent to which this has been off-set by increased transaction costs has not been determined. Public dissatisfaction in the NHS declined, at least until 1995-6, although it is not clear whether this result was a consequence of the reforms or to an increase in NHS funding.

Despite these improvements, access to healthcare and the outcomes of care still differ widely. Pressure on staff remains. The hope that money would 'follow patients' has not been realised. Indeed, the reverse is true. The funding crisis in the NHS remains, confirmed by the HFMA in November 1999. The same concerns, about waiting lists, about critical shortages of staff in key groups, about clinical quality and about 'priority setting' (rationing), that led to the reforms remain apparently unchanged.

Although the UK's NHS exemplified many of the conditions thought to be necessary for effective New Public Management-style reforms, the reform managers failed to co-opt either the clinical staff or the public. Staff morale has fallen and exit rates are accelerating. Public hostility to competition amongst providers, local pay and managerial reform remains, leading to suspicion of "privatisation" and the destruction of NHS values. The reforms have shown that the control of money is a potent force in shaping public service outcomes but, in the case of the NHS, it is impossible to say that NPM-style reforms have been a success.

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