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S E V E N

THE NHS IN BRITAIN: ANY LESSON FROM HISTORY FOR UNIVERSAL HEALTH COVERAGE?

At its inception in 1948 the British National Health Service (NHS) was regarded as highly distinctive, with its features of universal health coverage (UHC), comprehensive provision and services free at the point of use.¹ In the following decades, Britain also pioneered new methods of ‘universalising the best’, so that UHC did not simply extend access to inferior services. As we approach the post-2015 Millennium Development Goals with universalism firmly on the agenda, what can we learn from the experience of a forerunner? This chapter sketches the history of Britain’s health system and discusses ideas about its development and performance.

Before the NHS, Britain had an apparently successful mixed economy of health care, blending private, public and voluntary provision. By 1900 there were some 800 voluntary hospitals in which acute care was given, funded largely by philanthropy. The local state provided institutional care through the Poor Law, though mostly in low-quality, stigmatising workhouses. Local government also delivered public health services, both environmental and increasingly clinical, for mothers, children and infectious disease sufferers. Primary care was partly

commercial and partly accessed through friendly societies, a form of sickness insurance rooted in working-class culture. Change came first in 1911, when the foundations of the welfare state were laid. Borrowing from Bismarck’s model, National Health Insurance (NHI) legislation scaled up friendly society sickness cover, making it compulsory for manual labourers.

Why though, by 1948, had Britain diverged from the trajectory of countries taking the NHI route to universalism, like Germany, France and Japan? Standard accounts emphasize growing financial difficulties in the voluntary hospitals, as charity proved inadequate to mass demand, leaving user fees or unsystematic contributory schemes to fill the gap. Meanwhile popular sentiment rejected the deterrent philosophy underpinning the Poor Law. As municipal medicine expanded, opinion shifted to accept public provision as a right of citizenship, not a dispensation for the marginal. Dissatisfaction also grew towards the limitations of NHI, which by 1938 covered some 54 per cent of the population, though excluded not only the middle class but also those outside the workplace, principally women, children and older people. Thus a growing reform consensus emerged in the 1930s among health bureaucrats and medical elites in favour of greater rationalisation and integration. The immediate

1. For further reading on the history of the NHS, see Martin Gorsky, ‘The British National Health Service 1948–2008: A Review of the Historiography,’ *Social History of Medicine* 21, no. 3 (2008): 437–60.

catalyst though was World War II, and the formation of a state-directed Emergency Medical Service to deal with military and civilian casualties. Then came the Beveridge Report, whose popular blueprint for a postwar welfare state promised to slay the 'five giants': 'want', 'ignorance', 'squalor', 'idleness' and 'disease'.

It was the political expectation raised by Beveridge which set the context for the NHS legislation of 1946/7. Planning had begun under the wartime coalition government and a 1944 White Paper proposed a pluralist, localist NHS. This was soon mired in disagreement between the interest groups, and only when the left-wing Labour Party won a large electoral majority in 1945 was the stalemate broken. A unified, hierarchical system was established instead, with all hospitals 'nationalised' under appointed boards; GPs remained independent but became NHS contractors overseen by executive committees. Local government retained only minimal public health responsibilities, though a network of new health centres was planned in which primary and preventive care would be merged. Most finance came from the Treasury, apportioned according to existing expenditure patterns. Local democracy was now replaced by accountability to Parliament, and central ministerial responsibility.

How do theorists of health system development account for this outcome? Like all the pioneer welfare states, Britain was a rich country, though comparative researchers find no consistent correlation between level of development and state health spending. One classic argument emphasizes early democratisation, the broadening of

political citizenship bringing social entitlement in its train. It is certainly true that health and welfare had entered party electoral platforms by 1911. However, the earlier start of authoritarian Germany confounds this general explanation. Some Marxist theorists claim that labour mobilisation is the key, though in Britain trade unions and friendly societies were ambivalent towards NHI in 1911. Instead the 'legitimation' thesis, by which ruling classes conceded welfare to dampen socialism's appeal, seems more plausible. Labour's importance was undoubted in 1948 however, with Bevan's socialist stance underpinning hospital nationalisation and the redistributive mode of funding. British governance structures were also conducive to reform. A professional, neutral civil service was established from the 1850s, a broadening tax base fostered popular consent, and bureaucratic expertise in health was nurtured in the Local Government Board (1871) and then a Ministry of Health (1919). The electoral system typically delivered strong majorities to a single party, whose cabinet leadership proposed legislation; a strong party 'whip' guaranteed internal loyalty, and the legislative process offered few veto points to oppositional pressure groups. Lastly, political culture mattered, both at the elite level, where collectivist thought displaced individualism, and the popular, where charity hospitals and friendly societies had long engrained acceptance of free health care and mutual contribution.

So, universal coverage was achieved in 1948, and the early years saw a backlog of need addressed. It was soon clear however, that Bevan's assumption of demand quickly

stabilising was misplaced. Instead, like all health systems in advanced industrial nations, rising health spending exerted relentless pressure, fuelled by costly technologies, aging populations and consumerist expectations. There was also the founding promise that the NHS would ‘universalise the best’, with its implication that policy should enhance equity of access to high quality services. What also became clear, as comparative national indicators were standardised, was that the NHS model system was relatively cheap. Typically the UK spent a lower proportion of GDP on health than comparable high income nations, such as the United States, Germany and France, and, when broader economic policy dictated, expenditure growth was periodically restrained. UK policy-makers generally took this as effective cost containment rather than underfunding, dismissing comparatively poor population health indicators as too crude, at least until the 2000s when compelling evidence emerged of a British lag in outcomes. Some commentators ascribed this to the long period of tight settlements during the Conservative hegemony of the 1980s and 1990s, which ended the broadly bipartisan consensus for growth in the early decades, and which Tony Blair’s New Labour sought to overturn.

With the levers of the state controlling both finance and provision much scope existed for technocratic ‘supply-side’ policies, which sought, in a resource limited system, to ensure gradual improvement in equity of access regardless of place, income or condition. In the 1950s and 1960s progress was fairly modest. In the hospital sector standardised accounting, regional purchasing and financial

controls improved institutional efficiency, though on the clinical side there was only modest redistribution of medical specialties. The 1962 Hospital Plan began the process of replacing unsuitable Victorian infrastructure with new general hospitals, designed to meet accepted bed/population ratios; the reality fell short of the ideal however. In primary care the promised network of health centres also failed due to postwar austerity and professional hostility, but a new GP contract which offered better pay, cheap borrowing and administrative support raised quality and encouraged joint practices.

The arrival of health economists heralded more ambitious and complex programmes. In the 1970s the Resource Allocation Working Party devised a weighted population formula which progressively redistributed financing across and within regions. ‘Programme budgeting’ began a similar reallocation of resources across different activities: acute care, mental health, older people, and so on. As the fiscal crisis of the welfare state intensified in the 1980s, Mrs Thatcher’s approach emphasized cost containment over equity, and the Black Report, a celebrated report on inequalities of outcome, was sidelined. Rejecting a radical ‘privatisation’ approach as politically impossible, the Conservatives concentrated first on introducing commercial management disciplines into the NHS, alongside multiple performance indicators. The more sweeping ‘internal market’ reforms in the 1990s aimed to inject consumer demand and supplier incentives into the service, with organisations representing primary care becoming ‘purchasers’ of services that quasi-independent

hospital trusts would provide. Statist instruments were revived by New Labour, including publication of league tables to incentivise performance—‘targets and terror’—and the establishment of the National Institute of Clinical Excellence (NICE), which soon won international plaudits for its impartial and transparent approach to health technology assessment.

In sum, Britain’s NHS probably deserves the criticism that it ‘institutionalised parsimony’,² and although it generally scores highly on equity indicators, it is not always well-placed in comparative rankings of health outcomes. But nor is it *that* badly-placed either, and it is noteworthy that public satisfaction tends to rise alongside spending levels rather than in response to periodic structural reforms. The NHS has repeatedly demonstrated capacity for innovation within a statist system, and allayed uninformed prejudice against ‘socialised medicine’. On balance the affection it retains vindicates its founder’s belief that a society becomes ‘. . . more wholesome, more serene, and spiritually healthier, if its citizens have the knowledge that they and their fellows, have access, when ill, to the best that medical skill can provide.’³

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2. R. Klein, *The New Politics of the NHS* (Oxford: Radcliffe Publishing, 2006), 253.
3. A. Bevan, *In Place of Fear* (London: Simon & Schuster, 1952), 75.