Topic: The National Health Service

Discussion led by Vivian Newall

Summary

Vivian gave us a brief history of and the reasons behind the founding of the NHS and then led us through the development through the years. She considered its strengths and weaknesses and illustrated with some of her personal experiences.

Discussion

Events leading up to the creation of the National Health Service

Until the early 1900s it was accepted that people, whether rich or poor, were entirely responsible for their own condition, including medIcal needs. Serious or chronic illness could be catastrophic for the poor. Help might be provided by charity but this obviously was patchy. One of the early proponents of a publicly organized health system was Dr Benjamin Moore, who published his ideas in 'The Dawn of the Health Age' and he was probably one of the first to use the phrase 'National Health Service'. He created the State Medical Service Association which held its first meeting in 1912. It would be another 30 years before his ideas were echoed in the Beveridge Plan for the NHS.

Some local authorities began to run hospitals for local ratepayers, some with reduced charges available for the poorer. By 1929 the Local Government Act amounted to local authorities running medical services for everyone. By the outbreak of the Second World War the London County Council was running the largest public service of its kind for healthcare.

A White Paper was issued in 1944 by the Minister of Health Henry Willink which set out the principle that healthcare was to be available to everyone including visitors to the country and to be funded by general taxation. It was Aneurin Bevan who embarked on the campaign to bring about the NHS in the form we are now familiar with. This project was said to be based on three ideas which Bevan expressed at the launch on 5th July 1948. These essential values were, firstly, that the services helped everyone; secondly, healthcare was free and finally, that care would be provided based on need rather than ability to pay. Not everything is free nowadays, for example, in 1952 prescription charges were introduced at one shilling per prescription. It is true, however, that children, pregnant women and pensioners receive their prescriptions free of charge.

Problems facing the NHS

The initial enthusiasm of doctors was later tempered by fears of reductions in their income; this problem was solved by 'stuffing their faces with gold'. Even now doctors receive relatively large salaries while the remainder of the medical professionals and nursing staff are less well rewarded.

Funding for NHS spending in the year 2020/21 is budgeted at £148.9 billion plus £51.9 billion in respect of covid-19. The budget for the following year is £160.9 billion and £20.9 billion extra covid-19 spending respectively. This represents around 7% of UK GDP. As a rough comparison the Netherlands spends about 13% of GDP but this includes much more spending on social care.

The NHS currently employs 1.3 million people full time and 1.2 million people on a full-time equivalent basis. Staffing costs represent 80% of annual running costs, so labour intensive.

Management of Hospitals

To combat rising costs and streamline services modern management practices were introduced during the Thatcher years. In some instances, hotel managers were put in charge. However, whereas in the hotel industry high occupancy rates are essential for profitability, in hospitals it is of utmost importance to ensure that sufficient beds remain free in anticipation of unforeseen calamities (like pandemics).

*Key strengths of the UK's NHS include: **

- It provides unusually good financial protection to the public from the consequences of ill health. For example, it has the lowest proportion of people who did not access medicine due to cost (2.3% in 2016 compared to an average of 7.2% across the comparator countries).
- It is relatively efficient: the UK has the largest share of generic prescribing of all comparator countries, at 84% in 2015 compared to an average of 50%.
- It performs well in managing patients with some long-term conditions like diabetes and kidney diseases: fewer than one in a thousand people are admitted to hospital for diabetes in a given year, compared to over two in a thousand admitted in Austria or Germany.

*Key weaknesses include: **

- The UK's NHS performs worse than the average in the treatment of eight out of the 12 most common causes of death, including deaths within 30 days of a heart attack and within five years of being diagnosed with breast cancer, rectal cancer, colon cancer, pancreatic cancer and lung cancer, the gap narrowing in recent years.
- It is the third-poorest performer compared to the 18 developed countries on the overall rate at which people die when successful medical care could have saved their lives (known as 'amenable mortality').
- It has consistently higher rates of death for babies at birth or just after (perinatal mortality), and in the month after birth (neonatal mortality): seven in 1,000 babies died at birth or in the week afterwards in the UK in 2016, compared to an average of 5.5 across the comparator countries.

*Source: The NHS at 70: How good is the NHS (A survey published in 2018)

The role of private medical care

Over 12 million people are covered by private medical insurance in the UK, giving them the opportunity to obtain treatment much earlier than via the NHS, in many instances provided by specialists contracted to the NHS also treating patients privately. The private sector already provides many services for the NHS, such as psychiatric care and long-term residential care for people with learning disabilities. The NHS provides many private beds.

Funding of Care Homes

Fees payable fall principally on the individual requiring care, with support by Local Councils being mean tested. Basically, in England, if capital is less than £14,250, the Council will pay in full, capital between £14,250 and £23,250 will require a private contribution. When granted any level of support a contribution out of income may be required. In theory all clinical needs

costs are fully funded, but arguments over what are ‘hotel’ or ‘clinical’ costs are plenty and long-lasting.

32% of older people are self-funded, 25% are topped up and 43% are wholly funded.

A personal experience

About five years ago a friend had a bad knee and saw her doctor, who sent her to have an x-ray. Two years later the knee was very much worse and physiotherapy did not improve matters, so they tried steroid injections. They didn’t help and after a further six months she had fallen out of bed at night she saw a consultant who organised an MRI scan. This showed that a knee transplant was necessary and the operation was duly listed to be done. A year later she had still not been called up and was offered a chance to see another specialist who might be able to operate, but nothing came of that. Covid-19 came along, delayed everything and now, as a category 5 patient she has been promised to have the operation this year. In the meantime, the other knee is bad due to the increased pressure put upon it.

Conclusion

We are all of the opinion that, whilst the care provided by the NHS at the ‘coal face’ is exemplary, sympathetic and well intentioned, the increasing demands placed on it by patients are not matched by increasing resources and are putting it under extreme stress.

Before Covid-19 came along the long waiting lists were indicative of underfunding. These waiting lists have increased and are continuing to increase - eg now 350,000 people are due to wait a year before surgery etc. Additionally the questions of funding mental- and after care, convalescence and social care for the elderly need to be addressed urgently.

It is perhaps an understatement to suggest that funding the NHS is likely to be a major political challenge in the immediate term.