The UK NHS

How can the UK National Health Service be broke?

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Is the NHS today flabby and inefficient, or an organisation to be proud of, delivering healthcare free at the point of delivery?

A colleague recently took me aside and said conspiratorially, "These NHS deficits—it's not real money." Is it true that the National Health Service (NHS) has a deficit of £800 million, and if so, what does this mean for children's healthcare in the UK?

NHS FINANCES

In 1997, the NHS budget for England was £34 billion (US\$63 billion and €50 billion). By 2008, this will have reached £92 billion following the Chancellor of the Exchequer's pledge of 7.4% growth year on year in real terms for five consecutive years.¹ This has been possible thanks to a booming economy in the UK and low unemployment. Despite this, NHS Trusts are now having to institute draconian measures to balance the books, resorting to job losses and financial turn-around teams. With all this investment, how can the NHS be broke?

Of course, some of this new money has been swallowed up by added costs. The new consultant contract may have added £140 million to NHS costs, and the new General Medical Services contract for general practitioners a further £250 million but against a backdrop of a £58 billion increase, this is not the whole story. More than 190 000 new staff were recruited, of whom managers accounted for only a small fraction, to start to rectify the historical short fall in the NHS workforce. These new staff have to be paid. The expansion of medical student training to almost double what it was a decade ago is already improving the ratio of doctors to patients in the UK to something closer to the western European average. New innovations and new drugs also cost more, and the experience with herceptin, for example, shows that once these drugs are available in the market, it can be difficult for the NHS not to accede to demands to prescribe them. Connecting for Health—the largest health based information technology scheme in the world—has also consumed £6.2 billion, and only time will tell whether this investment brings future savings through

reduced costs for clerical staff and fewer errors leading to litigation. About £1.4 billion was also spent on the NHS pension scheme.

In simple terms, the NHS is not broke. Even a deficit as large as £800 million is <1% of the total turnover of the organisation—well within the variance to which most enterprises of comparable size can run their budgets. Of total public spending in the UK of £519 billion in 2005–6, the NHS is the second largest government spending programme (after social security),¹ but the NHS still accounts for only about one sixth of the total spend. So if the government chose to spend less on, say, defence or transport, then the NHS deficit could easily be wiped out. Indeed, this is what has always happened in the past. The problem arises if deficits continue year after year, especially if they become larger. In reality, the government is choosing for the first time to tell the NHS that there is no bottomless pit in the Exchequer. The NHS must tighten its belt and balance the books rather than turn to the government and ask to be bailed out once again.

NHS DEFICITS, PAYMENT BY RESULTS AND THE DIFFERENCE BETWEEN COST AND PRICE

Deficits arise only when expenditure exceeds income. In the NHS, the price (the "tariff") paid by the government to an NHS Trust for many episodes of care completed is fixed irrespective of the costs. (There do remain, however, some items which are paid for at a price locally agreed between purchasers and providers). So those trusts which are less efficient than a nationally set standard complete fewer cases for the same cost of staffing, consumables and overheads, and therefore generate a deficit.

Private companies have the potential to increase income by producing more goods or raising prices. The NHS income is almost entirely from the tax payer and once the government states that there will be no more hand-outs, income to the NHS will be fixed. The only way to get out

of the deficit is to reduce expenditure. In all, 70% of the NHS spending is on salaries and so, inevitably, any sizeable financial saving will involve job losses. Owing to the relatively high turnover of staff in the NHS, this can often be achieved by ceasing recruitment rather than resorting to redundancy.

But payment by results (PBR) has added a new twist.² PBR would be more accurately named as payment by activity. As NHS Trusts are now paid for what they do (each case attracts a certain centrally set fee or tariff from the Department of Health), losing jobs is pointless if the value of the Trusts' activity (the number of cases treated multiplied by the tariff price) declines by the same amount as the decrease in staffing costs. In that scenario, the income of the trust will simply reduce too and the hospital is no nearer to ensuring that income matches expenditure.

Under PBR, there are only two options. Either the trust can continue to maintain the same activity but with fewer staff (ie, become more efficient and increase productivity per person) or the trust can try to perform more activity with the current complement of staff. Unfortunately, carrying out more activity may be a theoretical option. A trust can only carry out more activity if someone chooses to purchase that activity. In the UK, that means private patients choose to buy care from either the NHS or the primary care trusts that act as the commissioners of NHS care on behalf of the public.³ But the primary care trusts have a finite budget; so once they have bought all the services they can afford for that year, they cannot buy more. What about fee-paying private patients? Private health sector spending in the UK is only £10.5 billion annually, and therefore a much smaller fraction compared with state spending on health than in many other countries. The NHS investment of the past few years has achieved the government's electoral priority of cutting waiting lists—there are a million fewer patients on waiting lists than in 2000, and few patients now wait >6 months. The government cancer target that no patient should wait >14 days between referral and specialist opinion is also widely met. So will there be more people willing to sacrifice an overseas holiday or a new car to pay for a treatment they can have free on the NHS and just as quickly in their local NHS hospital?

Reform of the NHS

The determination that the NHS Trusts should break even financially is part of a wider series of reforms over the past decade.^{4–7} The NHS has not become a true free market as the Minister remains

accountable to parliament for the NHS. However, the move is from a top-down, centrist monolith run from Whitehall—The Department of Health says—to an NHS celebrating diversity, local variation, innovative competition and a plurality of providers. The irony is that this smacks of the postcode medicine lottery, which innovations such as the National Institute for Clinical Excellence were supposed to bring to an end. The government seems to be committed to encouraging the private sector to provide approximately 15% of NHS care (ie, care free to the recipient). Their hope is that competition from lean, mean private sector health organisations (such as independent treatment centres, whose contracts are paid by government taxes on behalf of the NHS patients) will force the NHS to compete in terms of customer friendliness, quality of food, cleanliness, methicillin resistant *Staphylococcus aureus* rates, etc.

WHAT DOES ALL THIS MEAN FOR CHILDREN'S HEALTH SERVICES IN THE UK?

For hospitals, children's services will have to fight to get their voice heard, as most cause few headaches for politicians, local or national. Cancer in adults, heart disease and mental health services were identified as the NHS plan's top clinical priorities. The war on waiting was central to delivering the plan. The NHS plan said "the public's top concern about the NHS is waiting for treatment. Waiting to see a General Practitioner, waiting to be seen in a casualty department, waiting to get into hospital and, sometimes, waiting to get out of hospital".⁶ Most of the children's admissions to hospital are unexpected, as is much surgery on children.⁸ Using the most recently available national statistics (for 2004–5), 46% of 1.15 million paediatric medical admissions (children aged <15 year) were emergency admissions.⁹ For every child admitted as a medical emergency, two children attend the accident and emergency department and are sent home.¹⁰ Between June and August 2006, of 168 000 patients waiting >8 weeks to be seen, only 4000 were paediatric patients.¹¹ Historically, therefore, there have been few long waiting lists for children with serious medical problems, and most children with serious urgent problems have ready access to medical services. Hence, the government's obsession with waiting list targets has brought less investment to children's services over the past decade. Child and Adolescent Mental Health Services do have long waiting times but this has not been a target of government activity, unlike, for example, hip replacements and cataracts, with the "grey voter" in

mind. The cynic might observe that users of Child and Adolescent Mental Health Services do not yet have a vote.

Currently, the tariff system includes "specialist top-ups", where specialist cases attract a higher tariff, and "specialist exclusions", where high cost items are funded separately. Most NHS Trusts and Foundation Trusts have a balanced mix of routine and complex cases, which results in losses and gains being offset. However, for specialist children's services, this does not in all cases work in practice.

The government's white paper "*Our health, our care, our say*"¹² commits the NHS to move 5% of spending from secondary care to primary care, year after year. Undoubtedly all of us favour prevention rather than cure but little evidence from the previous 60 years of the NHS suggests that demand for acute care will diminish.¹⁰ This will therefore squeeze the provision of emergency services for children and expensive tertiary services for children with rare but expensive conditions. There is also the very real danger that the shift of resources to the community will be consumed by the demographic changes in the age profile of the population—the reduction in acute services for children effectively subsidising chronic services outside hospital for elderly patients. Care of children in the community may see little benefit. Further, PBR militates against the movement of funds from the acute sector to the community. Because hospitals are paid per case, there is a perverse incentive to see more children in hospitals and no incentive for hospitals to deflect children away to care in the community.¹³

The government claims that PBR is fundamental to patient choice and that the public has expressed a wish for more convenient healthcare closer to home. However, local solutions, patient choice and competition between a plurality of providers may not be the best option for children, especially those with several coexisting long-term problems. They may receive fragmentary care with multiple appointments in different institutions instead of a seamless, one-stop service. What children need are quality health services as close as possible to home and delivered by a single integrated children's service.

The inscription on the Statue of Liberty in New York harbour states:

Give me your tired, your poor, Your huddled masses yearning to breathe free,
The wretched refuse of your teeming shore.
Send these, the homeless, tempest-tossed to me

This was the ethos of the NHS as envisaged by Aneurin Bevan in 1948, and the ideal endures. But with investment over the past half decade at levels not seen since 1948, is the NHS today flabby, inefficient and wedded to outdated working practices or still an organisation to be proud of, delivering healthcare free at the point of delivery irrespective of capacity to pay? Or both? You choose.

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