EDITORIALS AND COMMENTARIES

Monitoring Value for Extra Money

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In my column from the United Kingdom for September 2002, I promised to return to the charged topic of funding for the National Health Service (NHS).¹ I need to begin with a little medicopolitical history. In the buildup to the introduction of the NHS in July 1948, the government of the day (Labour) was in favour, while the Conservative Party and the medical profession, as represented by the British Medical Association (BMA), were against. Today, the BMA is a stout defender of the NHS. The Conservatives, even in the Thatcher years, dared do no more than tinker with a market-driven service, and New Labour has health policies that a neutral observer would be hard-pressed to distinguish from Conservative ones. New Labour promised real increases in NHS funding, which was where I left off a year ago.

In April 2003, the Department of Health told us how well it was doing and would continue to do²; the department said that, in the 5 years to 2008, NHS expenditure in real terms will have increased by 43%. The myriad claims include 15,000 more consultants and family doctors plus 35,000 more nurses, midwives, and health visitors. In the financial year 2002–2003, NHS efficiency improved by 1%, the document tentatively stated.

The Chancellor of the Exchequer, while not begrudging the huge budgetary increases, wants Health Ministers to prove that the taxpayers are getting good value. This has involved setting targets. In the NHS today, there are performance norms for everything. Many of the norms involve time: How long do patients sit in emergency departments or in general practitioners' surgeries (offices) before they are seen, how long must they wait before a specialist referral takes place, and if an operation is advised, what will the delay be?

Clinicians get no sense that all this extra money is making it through to the front line, which was the complaint of Dr. Ian Bogle,³ the BMA's chair, in a speech on April 13, 2003. The complaint is familiar. Earlier concerns that the United Kingdom might not be doing well in the war against cancer had prompted extra money and the appointment of what was popularly known as a "tsar" to supervise improvements. The government reckoned that cancer services have improved²; critics say that the extra money is swallowed up in other ways. The acid test here, perhaps, is international cancer rankings. Dr. Bogle said that 80% of doctors have not seen any improvements from increased global NHS spending.

Hardly had Dr. Bogle stepped down from the podium when it was the turn of the Royal College of Nursing (RCN). Its annual congress on April 28, 2003, heard that government's claims on rising nursing numbers did not match the experiences of those on the front line.⁴ RCN general secretary Beverly Malone declared that "The nursing shortage is not sorted. It is nowhere near sorted."

That UK health policy is firmly back in a Thatcherite era, with any public service assumed to be all the better for being exposed to market forces, is nicely illustrated by the “foundation hospitals” idea.⁵ These hospitals would have much greater financial independence, and once more fears of a two-tier service are being raised. In its evidence to the parliamentary committee looking into foundation hospitals, the BMA articulated this concern.⁶ A government spokesperson denied this, claiming that in the future all hospitals could be foundation hospitals. Where would competition and the market be then? As W. S. Gilbert, in another context, wrote of well-intentioned enforced equality: “When everyone is somebodee, Then no one’s anybody.”^{7(p247)}

In July 2003, and despite fierce opposition from many of its own backbenchers, the Labour government did win a crucial parliamentary debate on its ideas on foundation hospitals.

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