Report from the Field

Reforming the British National Health Service: Implementation Problems in London

John H. James
Kensington and Chelsea and
Westminster District Health Authority

Often Americans, even experienced observers, seem surprised that in the late 1980s the British government decided to make fundamental changes in the British National Health Service (NHS), introducing ideas visibly adapted from the United States. More than 6 years have elapsed since Margaret Thatcher, then prime minister, introduced the Review, which led to these fundamental changes. Now that the United States is debating intensely proposed reforms to its own health care system, it seems timely to reflect on the impact that the British reforms have had, and the extent to which these were foreseen by those involved in preparing the proposals for change. In Britain, the reform's effect has been greatest in London. These reflections center on events in London as an extreme illustration of the problems encountered when government introduces radical change.

The British government introduced a market system into the supply of free health care for all U.K. residents but retained overall control of the funds available to pay for its NHS. A fundamental problem it has struggled with since has been how to reconcile its own role with the essentially market-driven issues that have arisen. In the original vision, a market for supply would make clear cut the decisions about future rationalization of health services. The best hospitals would thrive, and the weaker would not. There may have been an element of wishful thinking that the difference between the most successful and the weaker hospitals would be self-evident and would reflect popularity with patients. This has clearly proved to be illusory. To that extent, the commercial analogy was flawed. Individuals, with no direct involvement in the manner or matter of pay-

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ment, appear still to regard health care as a noncommercial commodity. In other words, a market has been introduced but market behavior has had a limited impact on the public imagination. Health purchasing organizations are influenced by price, as well as by the quality of a product, but their "commercial" approach may not be reflected in public perceptions, particularly when these are created largely by media interests.

A related problem is that the market for supply may have exposed the problem, but it does not necessarily provide a clear solution. This was partly because a backlog of decisions going back many years all had to be faced at the same time and partly because the purchasing authorities themselves could not sustain the case for the capital investment needed to rationalize London's hospital services. Government, which in Britain controls the level of public sector investment in capital, was a key player in determining the recipient and amount of the investment. When it became clear that London's hospital care had to be reformed, the government's control over access to capital forced it to take a leading role. The problems of that leading role form the prevailing theme of this report.

This report is written from my close-quarter observation, before 1990, as a senior government adviser instrumental in developing parts of the reforms, and since then as the chief executive of an inner London health authority. In that capacity, I presented one of the cases for hospital rebuilding that triggered the review of services in London, coordinated one of the subsequent reviews of specialist tertiary services, was a member of the government's research task force, and am leading the further study of whether London has too many acute care hospital beds. In all respects, this is a report from the scene of the action.

Principles Underlying the National Health Service

To understand the reforms and why they were introduced, we must appreciate the main features of the NHS as it existed before then. Established in 1948 as one of the fundamental facets of the British welfare state, the NHS has always provided nearly free health care to all permanent residents.[1] Expenditure of revenue and capital was financed largely from taxation, which meant that the government was in a very strong position to control the overall level of spending. In a top-down budget system,

1. Initially all health care was free, but over the years charges for prescriptions dispensed by family doctors and for dental care and eye tests have been introduced, albeit with exemptions for categories such as the poor, the elderly, and mothers and young children. Private health insurance and private hospital provision coexisted with the NHS but did not affect entitlement to largely free NHS health care.

funds were funnelled down through several tiers eventually to individual hospitals and units. Special subsidy or protection arrangements covered hospitals designated for undergraduate or postgraduate teaching, and the latter group in fact received their money directly from the government. Recognition that resources were not evenly distributed across the country led, from the early 1970s, to use of formulas to identify fair shares and to allow a slow levelling up by concentrating additional real spending in so-called under-target regions and districts; although this had some effect, the general position was stable. Hospitals generally knew the source of their income, and established hospitals and services had little reason to feel threatened. The hospital did not need to consider whether their patients wanted the services they provided, and they did not need to pay any particular attention to where their patients came from. The hospitals were secure.

The only difficulty the hospitals faced was a general squeeze on money available for the NHS. Because the British government has always used the overall level of public spending as an economic regulator, there were times when health spending was restricted to meet wider economic goals. This happened, for example, in 1976 at the behest of the International Monetary Fund and after the 1983 general election when the in-coming chancellor of the exchequer, Nigel Lawson, provoked controversy by cutting the expenditure plans on which the government had been elected.

A more important event in the long run occurred a few months later, when the chairman of a major food retailing company, Sir Roy Griffiths, produced a report that recommended the introduction of general management into the British NHS system, to replace an administration system based largely around consensus. In the years that followed, many of these NHS managers began to challenge the institutional structure of the hospitals that they ran, while pressure from government to improve NHS efficiency added further spice. The traditional stability of institutions that had never really been threatened began to be challenged. Relations with the medical profession deteriorated. A bitter strike involving ambulance workers occurred. Mrs. Thatcher, who had defeated much more damaging strikes, held firm on this one. The seeds of discontent within the NHS were, however, clearly increasing.

Recognition of the Need for Change

The issue came to a head after the Conservatives returned for a third term in the 1987 elections. All British governments are unpopular half way through their period of office, and the Conservatives' re-election

in 1987 could not have been taken for granted. With an election imminent in the early summer of 1987, many hospital managements delayed making decisions about service cuts until after the election. The impact of the cuts, when they became clear in August and September, was even greater for being concentrated, and throughout the autumn pressure on the government grew, climaxing with the publication in November of the government's spending plans for the next year. These plans made clear that constraint on the overall level of NHS spending would continue. Those who delayed acknowledging the need for cuts now realized that there was no hope of deferring them into the following year. Background noise became a clamor.

The responsible secretary of state, John Moore, became sick with a throat infection and was unavailable for a few vital weeks; his career never really recovered. In his absence, his deputy asked for and obtained in-year financial help from the treasury, but because it was nonrecurrent, it did little to ease the underlying financial problem. The presidents of the main Medical Royal Colleges, the most respected figures in British medicine, condemned the secretary of state, and it was a beleaguered Prime Minister Thatcher who was interviewed on BBC television's current affairs program *Panorama* in late January 1988 about the crisis in the NHS. To the surprise of many, she countered by announcing that the Government would institute a fundamental review of the NHS, which she would lead personally. The surprise was that by convention such an announcement would be made first to Parliament, and nobody else appeared to know that it was coming.

In approaching its review, the government started from the perception that the overall resources that had been made available for the NHS had increased steadily each year, and that the real burden on the tax payer to fund this system had increased with it. Why, then, did this increase in expenditure seem to generate not only a lack of gratitude but an insatiable demand for more? Health care, they argued, was one of the areas of public expenditure they had protected while reducing substantially the overall percentage of gross domestic product consumed by the public sector, and yet demand just increased. No comfort could be derived from studying other nations, because all other developed countries spent a higher proportion of their gross domestic product on health care than did the United Kingdom. The first thought was that other countries might be achieving this because they funded the system differently, but within a matter of months the review concluded that alternative funding methods, such as social insurance or private insurance, were less efficient than taxation, and

as they might seem to be inconsistent with the perceived principle that the NHS was free at the point of use, these methods were probably not politically saleable. The review was therefore forced to address a very different issue—whether the system by which the money was used within the NHS encouraged efficiency. They concluded that the system did not achieve this efficiency. The relative stability of the previous system, whereby hospitals knew their income before the beginning of the year and had only to ensure that their expenditure stayed within that amount, was seen as a fundamental problem. Money, they observed, did not follow the patient.

The Government's Reform Package

The solution was unveiled in a package of reforms at the beginning of 1989 in a White Paper, "Working for Patients" (1), launched with a series of simultaneous conferences linked by closed-circuit television at seven venues around England. Overall central control of the amount of money going into the system would be retained, but a market for supply of services would be introduced. Hospitals would become self-governing and would have to earn their income by attracting patients. Purchasing authorities, not unlike health maintenance organizations in concept, but covering geographical districts and with no right to exclude persons residing within them, would have the right to place contracts with hospitals based on established quality standards, price, and workload. They could switch contracts so that the better providers—measured in cheapness, in quality, or both—could secure patients at the expense of the less effective hospitals. A complication was the introduction of a second category of purchasers, general practice fundholders. These were primary care physicians, who could receive a part of the budget that would otherwise have been spent by the purchasing authorities to buy a selection of procedures for those patients registered.

The changes were introduced formally in April 1991 and 57 hospitals then became self-governing. Since then, almost all hospitals have achieved self-governing trust status. The first year of the new system was deliberately "steady state" because the financial complexities underlying the changes were recognized to be so fundamental that to have allowed shifts in purchasing behavior in the first year would almost certainly have been unmanageable, but the brakes were removed beginning in April 1992.

The Impact of the Reforms

Once a market for supply came into operation, several things became apparent. Some had been anticipated, but in all honesty some had not. First, faced with the need to account for their activity, hospitals began, in many instances for the first time, to take a genuine interest in their productivity and their costs. They also began to try to maximize the flow of patients. Improved counting and improved efficiency are realistically impossible to distinguish, but both seem to have been involved. Second, comparative information on prices charged by different hospitals became available for the first time. Massive differences emerged. Some of them were probably due mainly to inexperience in setting prices, and a hospital that looked absurdly uncompetitive for some procedures might look ridiculously cheap for others. However, both purchasing authorities and general practice fundholders began to be influenced, as soon as they were free to change contracts, by apparent differences in price. In many cases, the expensive hospitals were responsible for undergraduate medical education in London and other major conurbations (despite direct subsidy for the presence of this activity). The financial incentives to move work to cheaper hospitals were reinforced where, as was often the case, the cheaper hospitals were closer to patients' homes. London's position was particularly important in this regard. Inner London contained more undergraduate teaching hospitals, which proved to have an excessive reliance on flows of patients from outer London and from the rural counties beyond. As the flows of patients from these more distant purchasers began to decrease, several of London's teaching hospitals went into deficit, and as 1992 progressed it became clear that many were facing substantial deficits, which could not, as in the past, be solved by reducing community or mental health care services.

In a true market economy, those who cannot supply their goods and services at an affordable price necessarily go out of business. When the supplier has existed for 800 years, is a household name, and commands a high degree of emotional support from patients and the public at large, not to mention a tradition of teaching and research, allowing the market to take its natural course becomes rather more difficult. This might have been accepted had the institution in question been in some other part of the country, but being in London, the capital city, just added to the problem. No government, of whatever political complexion, could simply opt out of the situation. It had to find a solution.

The Effect on London

That London would be a problem should have been apparent when the reforms were announced. The partially successful redistribution of resources instituted in the 1970s had been directed principally to reducing the excess proportion consumed in London. Report after report had said that London had genuine problems.

History and tradition have left inner London with a plethora of teaching hospitals, undergraduate and postgraduate, each with a substantial academic component, serving a diminishing local population. The supply market hit the undergraduate hospitals hard because distant purchasers redirected patient flows, but also because London purchasers' resources continued to diminish under redistribution policies. Although the number of hospital beds in London had been reduced substantially, it had more beds than could be used. It retained a much higher ratio of consultant medical staff to facilities than elsewhere in England. Consultants were reluctant to move, and most managers were not tough enough to force the issue. Other staff groups, in contrast, were generally less easily recruited and retained than elsewhere. Much of London's hospital stock was outmoded and expensive to maintain, whereas some sites would command high value for alternative uses. That this situation had continued reflected another problem, the unwillingness of famous institutions and their powerful physicians to change, and the concomitant unwillingness of successive generations of politicians to tackle them. Primary care in the capital, in contrast, had not developed to the standards elsewhere, increasing the local population's propensity to rely on secondary care, particularly through accident and emergency services.

The government realized in mid-1991 that London would be a difficult area even before the scale of the financial problem could be gauged. It had, however, faced the situation from a slightly oblique angle. On a sunny day in June 1991, a meeting took place in the aptly named Versailles room at the department of health headquarters in Whitehall. William Waldegrave, then secretary of state, accompanied by junior ministers, political advisers, and officials, heard two presentations about hospital rebuilding in London. The first was the case for rebuilding University College Hospital and the Middlesex Hospital, prestigious teaching facilities with a combined medical school, on one site. The second proposal would build phase II of the redevelopment of St. Mary's Hospital, another prestigious London teaching hospital. Both proposals were largely self-financing from land sales income and had been approved in principle by

officials. For those presenting the submissions, it seemed likely, therefore, that this was the last hurdle before approval of their redevelopment plans.

There was, however, a problem. The two proposed developments were only about one mile apart; and as the crow flew, St. Mary's, in turn, was little more than one mile away from another teaching hospital, the Chelsea and Westminster, which was being rebuilt, at much expense, away from its original site in Westminster, but still tantalizingly close to the center of London. The cost of the hospital, eventually some £220 million, was attracting major criticism, particularly as the expectation that it too would be self-financing from land sales had not been realized. Against this background, the secretary of state correctly concluded that approval to the two schemes would be seen as giving undue preference to London teaching hospitals relative to the equally legitimate and by now far more pressing demands of localities outside London. Why, he asked, should not the patients go to the new hospital than to the rebuilt old facility? The meeting concluded with no decisions made.

The Tomlinson Inquiry

A few weeks later and as a direct result of the meeting, William Waldegrave, jointly with the secretary of state for education, announced an inquiry, chaired by a distinguished retired pathologist from northern England, Professor Sir Bernard Tomlinson,

> to advise . . . on how the relevant statutory Authorities are addressing the provision of health care in Inner London working within the framework of the reformed NHS, including the balance of primary health services; and the organisation and provision of undergraduate medical teaching, postgraduate medical education and research and development; taking account of: the health needs of London's resident day time population; the emerging purchasing plans of Health Authorities and their likely impact on Inner London hospitals; future developments and the provision of acute and primary care; the need to maintain high quality patient care and, as a foundation for this, high standards of medical teaching research and development (2).

Tomlinson's recommendations were published in October 1992, by which time a substantial proportion of inner London's hospitals were receiving deficit funding. The main thrust of the recommendations was that London had too many acute hospital beds, at least 2,500; that the best way to deal with this was to close whole hospital sites; that a major investment

needed to be made to improve non-hospital-based primary care services; that the special separate central funding status of postgraduate hospitals should be ended; and that a special group should be established to oversee the changes. The report named the hospitals that it thought should close and recommended associated amalgamations of medical schools. It also recommended a further study of the distribution of specialist tertiary services.

The government gave the report a general welcome, but without immediate commitment to its recommendations. Howls of protest arose from the institutions that considered themselves to be disadvantaged or misrepresented, and campaigns to save them began. The minister for health visited all the hospitals affected by the report to hear both general and parochial reactions. Armies of management consultants, with sundry different employers, examined the hospital-specific recommendations, rarely with a brief to endorse them. Some health authorities were reported to be anticipating implementation of the Tomlinson recommendations in placing contracts for the next fiscal year (1993–1994).

The King's Fund Commission

While the government gave itself time to think, the omens for a degree of success in implementing the recommendations looked reasonably favorable. Before the publication of the Tomlinson report, the authoritative and influential King's Fund published a series of reports by its London commission (3), which had been at work since before the Tomlinson inquiry began. The commission looked both at the present deficiencies and at a strategic view of London's health care system in the year 2010. The commission reached conclusions that in many respects anticipated those Tomlinson would make four months later. Both the commission's conclusions and the detailed research underpinning them were undoubtedly helpful to Tomlinson in arriving at and justifying his own recommendations. But for various reasons the commission's reports have not been seen as directly providing the basis for later action. Their publication did, however, provide a foretaste of what was to come, notably hostility from sections of the media and individual interests within the London health care community to the changes that were presaged. Nonetheless the very independence of the King's Fund, and the fact that its role was to support health care in London, undoubtedly gave the Tomlinson proposals a measure of wider credibility when they were received, uncomfortable though they were.

The Government's Response to Tomlinson

The government published its response to the Tomlinson recommendations under the infelicitous title *Making London Better* (4) in February 1993. Noting that this was at least the twentieth report during the last one hundred years on the problems of London's health services, the response set out what has proved to be a massive action program. A London implementation group (LIG) was established to oversee the changes. A London initiative zone was created to enable substantial funds to be fed in to improve primary care facilities. A slightly more cautious estimate than Tomlinson's of the scope for acute care hospital bed losses was accepted. Some of his hospital-specific recommendations were endorsed, some were not, and others were subjected to further review. Reviews of specialist tertiary services were commissioned to report within three months, with an explicit recognition that their outcome would contribute to the eventual hospital site solutions. Changes in relation to the postgraduate hospitals and the medical schools were accepted.

The driving force behind the changes was to be the LIG. It was given responsibility to determine the level of deficit funding for inner London hospitals and for implementing whatever changes were needed to reduce their reliance on them. That the group was created at all must be seen as a recognition that the instant transition from top-down funding of hospitals to a competitive market for the supply of health care needed, at least for a period, of a form of market regulation. The LIG, therefore, operated as a market regulator and as the catalyst for change. Always the hope was that it would have a time-limited role, but in fact present indications are that some form of market regulation mechanism is likely to continue after LIG, in its catalyst role, has disappeared.

Detailed studies were commissioned of the scope for rationalizing the services provided on two or more hospital sites in different sectors of London onto single sites. The crunch issue was generally whether sites should be chosen based on the criteria of accessibility or whether they should reflect recent investment, particularly in research facilities, albeit on less accessible sites.

Reviews of Specialist Tertiary Services

The LIG played a major role in coordinating the reviews of specialist tertiary services. There were six in all, addressing cancer, cardiac services, neurosciences, plastics and burns, renal, and associated children's ser-

vices. Each was led by a distinguished clinician, invariably non-London based, and a chief executive of an inner London purchasing authority. These persons assembled review groups of six to ten persons, comprising a mix of clinicians, other relevant health care professionals, users or lay interests groups, and in some instances health economists. All used broadly the same approach—literature reviews, questionnaires to the existing tertiary hospitals, visits to all sites, evidence from national and local interests, focus groups around particular topics, data analysis, and report writing. All reports were completed within three months and they were published collectively not long afterward (5–10).

The experience the review groups gained in performing their tasks in many ways typified the wider problems that Tomlinson had identified in London. At a level of general principle, the review groups found a high degree of unanimity about the optimum way that these specialist services might be provided in the future. There were well-established, clinically accepted criteria for the organization of tertiary services and for their relationship to secondary and primary care. Most of the review groups supported the concept of a hub and spoke under which the tertiary center was seen as part of a wider network of services at the secondary level, with which it would be expected to work closely and collaboratively. Criteria for the work to be undertaken at the tertiary center varied, but typically they would be responsible for more specialized service delivery, alongside a program of research and development and teaching that might be focused on either undergraduate or postgraduate work. For most of the reviews, there were accepted minimum-size criteria for the service delivery element, which taken together with epidemiologic evidence on the levels of need that had to be met, and rather more judgmental views on the extent to which distant purchasers would try to purchase these specialist services away from London, led to views that were reasonably robust about the number of tertiary centers that London and the surrounding countryside would require. The review groups used criteria such as links with other specialties and the relative contribution that existing tertiary units made, or could make, to teaching and research to identify the sites that they considered most suitable for the future location of specialist centers. At precisely the point that general principles were turned into detailed recommendations, however, adherence to those general principles fell apart among those who perceived themselves to be the losers.

With the exception of the cardiac review, which saw the need for eight or nine tertiary centers, most came down to four or five in greater London, whereas the children's review came down to two or three. This contrasts

with the situation in which as many as fifteen hospitals claimed to be tertiary centers. A common finding of the review groups was that the small and dispersed pattern shared by most tertiary services meant that they did not meet criteria that were being achieved in other parts of the country. That such a dramatic recommendation to decrease the number of tertiary centers was unwelcome to hospitals that feared for their own future or feared that they would become nothing more than standard general hospitals was not surprising.

Shortly afterward, a review of the research ratings of the postgraduate hospitals was completed. Some emerged with very high overall ratings, and some did not. Taken together with the outcomes of the specialty reviews, the report lent academic weight to the need to reorganize service provision in London to support the better research centers and to provide them with an environment in which the necessary patient flows for research were sustained.

Government Decisions

Ministers wisely distanced themselves from the specialty review reports. They emphasized that the reports were advice rather than decisions, and that other factors would have to be taken into account, notably the reviews, then nearing completion, on the research of the postgraduate hospitals, the various site-option appraisals that had been set in hand after publication of *Making London Better*, and the reactions of purchasing authorities to the reports. Undoubtedly, too, the ministers believed that an interval of time would allow them to assess more accurately the strength of political opposition to the particular recommendations, both locally and perhaps nationally, and to assess the extent to which essentially clinically driven recommendations could be implemented in practice at an acceptable price and timetable.

At intervals since, there have been ministerial announcements in relation to specific hospitals or groups of hospitals. In several sectors of London, the managements of neighboring hospitals were unified where only one was envisaged to continue in a tertiary role. The hope was that with a single management structure, the process of change would be facilitated, although this did not prevent supporters of one hospital within such a combined organization from trying, albeit unsuccessfully, to challenge the government's position in the courts. In another instance, the government gave an undertaking that services would continue on two sites "for the foreseeable future" notwithstanding that both the specialty review rec-

ommendations and the detailed hospital site option appraisal suggested a need to reduce to one. In a third instance, the new combined management was instructed to consult about an option not of its own choosing for the future organization of services. Progressively, therefore, the government has found turning principles into hard decisions as difficult to handle as would be a policy of staying aloof and letting the purchasing authorities determine, through their decisions on the placement of contracts, which hospitals would cease to be viable.

In the last twelve months, the government has faced increased concern, nationally but at its greatest in London, that the market for supply of NHS services was beginning to damage medical education and research, despite the elements of protected funding. Hospitals with undergraduate medical schools were losing the patients they needed to facilitate teaching, whereas hospital managements were considered to be cutting back on continuing medical education and on research, to improve price competitiveness. Understandably, pressure built up for greater protection of these elements of the service. The government is now consulting on how best to ensure that continuing medical education is protected, and it has published the report of a research task force recommending protection of funds for research and for the additional service costs associated with it. In both instances, it is effectively excluding these activities so far as possible from market forces.

Improvements in Primary Care

The government has been able to derive more comfort from its program of investment in primary care under the London initiative zone scheme. It made £40 million available in the first year of the plan and £85 million in the second, and committed itself to £170 million capital investment over six years, plus additional funds for voluntary or innovative schemes. Authorities within the area of the London initiative zone scheme were invited to submit plans consistent with the identified objectives, and many schemes were approved. In 1994, an additional £11 million a year was made available to improve community-based mental health services within the same area. The investment of resources therefore has been substantial, and provided that the schemes can be put into place within the timetable envisaged, the prospects are reasonable that the standard of primary and non-hospital-based care available in London will be raised to levels closer to standards in most other parts of the country.

Doubts remain, however, even in this area. The first is whether the

program can be implemented within the timescale envisioned. Early indications show the capacity to increase spending, where it depends heavily on recruitment of qualified personnel, is constrained, whereas the scale of slippage on capital schemes, even minor ones, has also been a matter of concern. The second area for doubt is the extent to which investment in non-hospital-based care, particularly primary care by general practitioners, which will eventually cease and have to be picked up from existing revenue, will reduce the demand for secondary care services. On the one hand, inadequate primary care has prompted self-referral of some persons to the hospital, particularly to accident and emergency departments, and the improvements should reduce this tendency. On the other hand, there are real concerns that good quality primary care will identify more persons who would benefit from hospital treatment, and that the number of referrals may increase. In contrast, the extra investment in community-based mental health services is likely to reduce the number of emergency admissions to acute psychiatric units brought about by the inadequate services outside those units.

But Is London Overbedded?

In the last few months, the government has faced not only the hostility of those deeply committed to a particular hospital whose future is called into question by the changes but also the growth of a philosophy that challenges one of the fundamental principles of Tomlinson; that is, that London has too many acute care hospital beds. The view that London is not overbedded, relative to other metropolitan centers in the United Kingdom, to England as a whole, or to standards of bed provision in other countries, has been led by a well-known educator and general practicioner based in London, Professor Brian Jarman. A series of articles and letters culminated in a special university lecture delivered to a packed audience on 5 July 1994 (11). Jarman's thesis had a number of key elements. First, he argued that both Tomlinson and Making London Better had concentrated on the situation in inner London, which he agreed was overbedded, but London as a whole was not. Second, the rate of acute bed closures in London overall had been running at more than twice the national rate in the decade since 1982, leaving London underbedded compared with other major conurbations in Britain. Third, he suggested that importance should be attached to the fact that the United Kingdom had the lowest acute care hospital beds per capita among the OECD countries for which reasonably comparable figures were available. Finally, he drew on his ex-

perience as a London general practicioner to suggest that London's acute care hospital services were overstretched. He did, however, accept that London had too many specialist tertiary beds, and the main thread of his argument was that there should be no further reductions in bed availability, but rather a switch to continuing care and nursing home facilities for older persons.

His lecture was enthusiastically received by most speakers who came to the microphone after its delivery. Many, it should be noted, were physicians from the very specialist tertiary hospitals that Jarman had acknowledged had too many beds; but no matter, those associated with prestigious but threatened institutions had found a new and persuasive ally with no obvious ax to grind and a wealth of statistics at his disposal. The government found scant encouragement in the press coverage that followed. In practice, Jarman's analysis is questionable on some counts. He made no allowance in his calculations for the effect of changes in medical practice, particularly day surgery. He also assumed bed losses in London in the previous two years well in excess of those recorded, and his international data compared total bedstock elsewhere with NHS beds in London, which meant that he ignored several thousand private beds in London. Nonetheless, his central concern that there are too few continuing care beds is probably correct.

The government's problems were increased by the publication at the end of July 1994 of an article (12) by Robert Maxwell, chief executive of the King's Fund, which it will be recalled had produced the King's Fund Commission Report two years earlier that advocated substantial changes in London's health services. Maxwell's argument was that although ". . . the need for changes to the balance of health care services in London remains overwhelming . . . what has happened (and some of what has *not* happened) over the past two years underlines the difficulties of making changes on the scale proposed." He referred to ". . . widespread concern that the changes underway are putting patients at risk and that some of London's most famous hospitals have been pushed into a downward spiral of decline. At a minimum, there is a need to re-establish confidence, revise timescales and review the management of the transition." The thesis thus described is balanced, substantially sound, and very much what a wise elder statesman might advise a beleaguered government minister. (Maxwell had expected, as many had, that the reshuffle of government ministers in July would have led to the appointment of a new secretary of state for health, and his article was conceived as an open letter to the new appointee; in the event Virginia Bottomley continued

as secretary of state, and the article's purpose was changed to a general publication).

Maxwell developed what he called "a sensible strategy." He restated Jarman's view that there should be no more acute bed reductions overall, he advised caution about changes in relation to accident and emergency departments, he recommended the continuation of development of primary care, a restatement of the long-term objectives for London within which "the Government should be forthright about the fixed points in its policy, for example which major institutions are to merge . . . ," and that special transitional funding should continue in London for the next three years "in return for explicit agreement . . . about the changed balance of services. . . ." His argument was widely represented as one in which even the body that had made the most authoritative contribution to the need for change now had grave misgivings about the pace and direction of change that the Government was seeking to pursue. The Government's frustration was increased by Maxwell's repetition of an assertion made previously by the King's Fund's research arm that London was not financially over-resourced, as had long been claimed, but rather under-resourced. No data have been published to substantiate this view. Although some commentators achieved a balanced presentation of what Maxwell had said, most seized eagerly on the points that best suited their case. The government, so it seemed, had no allies.

And there the situation rests. This has been a necessarily brief and selective chronology of events of the last few years, and in particular of their impact and reception within London. A fuller account of the changes until mid-1993 is available in "Transforming the NHS: The View from Inside" published earlier this year (James 1994). What lessons might be drawn from the experience of the British government, which has already embarked on this course, by an American government trying to promote change?

Lessons To Be Drawn

The first and most obvious lesson is that any change will have to overcome resistance from the vested interests in the status quo. In Britain the vested interests are the physicians, or at least a significant proportion of them, the old established hospitals, particularly those with a teaching or research role, and, I must admit, those persons, whether as patients or care givers, who feel affection and loyalty to an individual hospital. Britain does not have the insurance industry or that part of the legal pro-

fession with a vested interest in health care to oppose, but the forces of resistance have been strong. Indeed, when the reforms were first being launched, there appeared to be overwhelming medical opposition, and the main physicians' trade union, the British Medical Association, bought advertisements before the 1992 general election to press its opposition.

There were always, however, allies among the medical profession as elsewhere. Family doctors, self-employed physicians practicing away from hospitals, albeit fully within the NHS, had tended to be the poor relations of the old system, but as it became clear that their referral patterns influenced the success or failure of hospitals, they became more influential players on the field. The number choosing to become health care purchasers in their own right (the general practice fundholder scheme) has increased steadily, and perhaps 40 percent of the population of England are now covered for a proportion of their health care needs by this category of purchaser. There were many hospital physicians who also welcomed the changes because they believed that there were benefits to be had. Physicians practicing outside London resented the way in which London's hospitals had apparently secured a greater share of the national cake, and the specialty reviews showed how far, in terms of the organization of tertiary services, London's pluralist hospital system had caused it to lag behind standards accepted elsewhere. The Royal Colleges also have begun to recognize the potential power of working with purchasing authorities to raise standards of clinical practice, while epidemiologically based public health medicine has moved to center stage as the emphasis has focused on the health of populations. The program of investment in primary care in London has also been going reasonably well, albeit not quickly enough, and local improvements in services are appreciated by those who use them. Nonetheless, the overwhelming impression at this stage is that there are far more dissatisfied participants within the health care professions, particularly physicians, than those who will stand up and support change.

The second major point, and closely connected with this, is that it is very difficult to achieve a consensus around change in an adversarial political system. Government, of whatever political complexion, must anticipate that the opposition will side with those who wish to resist the thrust of any government decision. In the run up to the 1992 general election, the British Labour party tried to present its opposition to the changes in the NHS in terms that suggested a real difference between the parties. It was not wholly successful in this and was widely perceived to be planning only to make cosmetic changes. Its current position is that it may

well retain many of the features of the reforms, with the exception of the general practice fundholding system, which it sees as encouraging a two-tier standard of service, but it most certainly wishes to see greater democratic accountability to local populations for both the purchasing organizations and the hospitals. Being in opposition, it can also decry the government's handling of the problems of London without having to incur the unpopularity of suggesting hospital-specific alternative solutions.

Another problem that any government pushing through change must accept is that all difficulties occurring at that time will be ascribed to the changes it has made, regardless of whether this is a justifiable reading of the situation, and regardless of the fact that they might have occurred in exactly the same way with the previous system.

Undoubtedly one of the problems for the British NHS has been the coincidence between the government-inspired revolution in the method of supply of health care and the contemporaneous but wholly independent revolution in the clinical techniques for health care delivery. Minimally invasive surgical techniques and improvements in anesthesia have led to rapid increases in day surgery for conditions that only a few years ago would have required a substantial inpatient stay and convalescence. New developments in imaging techniques are affecting not only diagnosis but also treatment. These changes and many others, even without the encouragement of purchasing organizations, would have had a profound effect on the traditional practice of hospital medicine. The reforms also meant that family physicians, with the financial incentive and means now available to them, could further undermine the position of the hospitals by electing to perform more minor surgery themselves and by arranging for hospital consultants to visit their practices to conduct outpatient clinics rather than to do so in the hospital. Thus reinforcing the weaknesses of the analysis by Professor Jarman, the need for hospital beds is unquestionably decreasing as alternative forms of treatment that are every bit as effective and much less bed-based become available. Undoubtedly, too, the changes have led to a greater concentration on the efficiency with which resources are used, so an underlying trend toward better utilization has accelerated—turnover intervals in hospitals have been reduced, and preparation for discharge improved and throughput therefore have been increased. For all these reasons, there is a substantial body of opinion, albeit not much blazoned across the tabloid press, that accepts that health care in London would be made more effective by concentration on fewer sites. In this context, the main purchasing organizations across inner London have banded together, involving Professor Jarman in their work, to

support a program of research between now and the end of November to identify the effect of all these trends on London's future hospital requirements.

The events of recent years have also brought to the fore the issue of rationing. A cash-limited system of financing necessarily means that there is a finite sum of money available, and access to services has always been implicitly rationed in Britain. (The availability of a private insurance system has created a safety valve, particularly for elective surgery, but this is mainly accessible to employed persons and their families [some 10 million are covered], who by and large need less health care relative to the population as a whole.) NHS physicians therefore rationed access to health care at the margin without ever making it explicit. Thus intervention levels for particular conditions, such as coronary artery bypass grafts or renal dialysis, were lower in Britain than in OECD comparator countries. Purchasing health care has made the process of rationing more visible. The decisions are not taken behind closed doors by physicians in effect deciding which patients would benefit most from treatment, but rather are explicit in the levels of contracts placed by purchasing authorities. Expensive forms of treatment, requiring specific authorization, have been a particular focus of attention, whereas the government has reinforced the trend by stressing the need to account for clinical effectiveness when deciding what forms of health care to purchase. That the rationing process is nothing new and that, if anything, access to health care is now more widely available than it was five years ago is largely disregarded.

The central problem for government is, however, the one with which I began this analysis. A government that institutes change cannot distance itself from the hostility of those who are or perceive themselves to be disadvantaged by it. Allowing market forces to come into play seems on the surface an ideal way for government to achieve distance, but this has simply not proved possible within a centrally funded system.

Conclusions

At the end of the 1970s and well into the following decade, one of the most popular programs on British television was a comedy series called "Yes Minister" centering on the relationship between a government minister (later prime minister) and his most senior civil servant adviser, Sir Humphrey. The central theme was of the minister trying to make decisions and the civil servant trying to retain control. One of Sir Humphrey's most successful ploys was to describe a proposal that the minister had in mind

as "bold" or "heroic" or "courageous." Had Sir Humphrey been advising the government at the time they were drawing up the changes to the NHS, he would unquestionably have wielded all of these words. Changing fundamental, much loved institutions is unquestionably bold, heroic, and courageous. When, as here, the changes were overdue, exposed serious inadequacies in the previous system but also caused genuine fears such as about teaching and research, but above all created major foci of resistance among the dispossessed, qualities such as determination and the ability to take the long view come to the fore. The British government, which may not face a further general election until 1997, must hope that by then the benefits of the changes that it has introduced will be sufficiently apparent to drown out the clamor of individuals and organizations that have been disadvantaged, and that its solutions to protect teaching and research will have been successful. The United States electoral timetable, seen against that background, however, is much less accommodating.

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