# A brief history of the UK Health sector and NHS

We take the National Health Service for granted, but only 50 years ago health care was a luxury not everyone could afford. It is difficult to imagine what life must have been like without free health care and the difference that the arrival of the NHS made to people's lives.

## Before 1948

Just before the creation of the NHS, the services available were, as you might expect, the same as after; no new hospitals were built nor hundreds of new doctors employed. What was different was that poor people often went without medical treatment, relying instead on dubious and sometimes dangerous home remedies, or on the charity of doctors who gave their services free to their poorest patients.

### Hospitals charged

Access to a doctor was free to workers, who were on lower pay, but this didn't necessarily cover their wives or children, nor did it cover other workers or those with a better standard of living. Hospitals charged for services, though sometimes, poorer people would be reimbursed. Even so, it meant paying for the service in the first place, which not everyone could afford. The need for free health care was widely recognised, but it was impossible to achieve without the support or resources of the state.

### Philanthropists and social reformers

Throughout the 19th century, philanthropists and social reformers working alone had tried to provide free medical care for the poor. One such man was William Marsden, a young surgeon, who in 1828 opened a dispensary for advice and medicines. His grandly named 'London General Institution for the Gratuitous Cure of Malignant Diseases'.

A simple four-storey house in one of the poorest parts of the city was conceived as a hospital, to which the only passport should be poverty and disease and where treatment was provided free of charge to any destitute or sick person who asked for it.

### Royal Free Hospital

The demand for Marsden's free services was overwhelming. By 1844 his dispensary, now called the Royal Free Hospital, was treating 30,000 patients a year. With consultant medical staff giving their services free of charge and money from legacies, donations, subscriptions and fund-raising events, the Royal Free, now re-housed in larger premises, struggled to fulfil Marsden's vision. In 1920, when, on the brink of bankruptcy, it was forced to ask patients to pay whatever they could towards their treatment, just like every other voluntary hospital in the country.

### Municipal hospitals

As well as the charitable and voluntary hospitals, which tended to deal mainly with serious illnesses, the local authorities of large towns provided municipal hospitals, maternity hospitals, hospitals for infectious diseases like smallpox and tuberculosis, as well as hospitals for the elderly, mentally ill and mentally handicapped.

### Mentally ill people

Mentally ill and mentally handicapped people were locked away in large forbidding institutions, not always for their own benefit but to save other people from embarrassment. Conditions were often so bad that many patients became worse, not better.

### Older people

Older people who were no longer able to look after themselves also fared badly. Many ended their lives in the workhouse - a Victorian institution feared by everyone, where paupers did unpaid work in return for food and shelter. Workhouses changed their names to Public Assistance Institutions in 1929, but their character, and the stigma attached to them, remained.

## 1948-1957

The National Health Service became reality on 5 July 1948. It was a momentous achievement and everybody wanted the new service to work. However, food was still rationed, building materials were short, there was a dollar economic crisis and a shortage of fuel. The war had created a housing crisis, alongside post-war re-building of cities, and the designation of over spill areas, the New Towns Act (1946) created major new centres of population and all needed health services.

### Administrative difficulties

The NHS brought hospital services, family practitioner services (doctors, pharmacists, opticians and dentists) and community-based services into one organisation for the first time. But it was not easy. Holding everything together and keeping everyone on board continued to create administrative difficulties for years.

### Costs

Financial problems, however, were worse. It was impossible to predict the day-to-day costs of the new service and public expectations rose. Medical science was rapidly gathering pace, hospital beds for tuberculosis were closed, allowing cash to be released for other services.

More mothers wanted their babies delivered in hospital, cardiac surgery was being applied to rheumatic heart disease, and the first hip replacements were beginning to be performed. But initial estimates of the cost of the NHS were soon exceeded as newer, more expensive and more frequently used drugs were developed.

### Fees

Within three years of its creation, the NHS, which had been conceived as free of direct charges for everyone, was forced to introduce some modest fees. Prescription charges of one-shilling (5p), which had been legislated for as early as 1949 but had not been implemented, were introduced in 1952. A flat rate of £1 for ordinary dental treatment was brought in at the same time.

### Balancing demands

Many of the tensions that emerged in the early days of the NHS have challenged its senior management and successive Governments ever since. Today the NHS has a workforce of over one million people and a budget of around £42 billion a year - it is a sophisticated and modern organisation with all the advantages of state-of-the-art technology.

Yet, the fundamental questions that tested Bevan and his colleagues. How best to organise and manage the service, how to fund it adequately, how to balance the often conflicting demands and expectations of patients, staff and taxpayers and how to ensure finite resources are targeted where they are most needed. These issues continue to challenge the system.

Bevan foresaw this. We shall never have all we need he said. Expectations will always exceed capacity. The service must always be changing, growing and improving, it must always appear inadequate.

### Family doctors

The foundation of the new service was the family doctor or general practitioner (GP). Then, as now, the family doctor acted as gatekeeper to the rest of the NHS, referring patients where appropriate to hospitals or specialist treatment and prescribing medicines and drugs.

Dental services consisted of check-ups and all necessary fillings and dentures. There was a school dental service and a special priority service for expectant and nursing mothers and young children that was organised by local authorities. Ophthalmic opticians on production of a GP referral note provided eye tests.

### Community health

A major innovation was the community health centres - a special premise with accommodation and equipment supplied from public funds to enable family doctors, dentists and others to work together to provide a range of services on the spot. There were also specialist ear clinics at which patients could get an expert opinion and, if needed, a new hearing aid.

## 1958-1967

By the second decade, the NHS was beginning to settle down. Treatment was improving as better drugs were introduced. During this decade, the polio vaccine came in, dialysis for chronic renal failure and chemotherapy for certain cancers was developed.

### Doctors' pay

There were, however, problems for both GPs and hospitals despite the development of a measure of trust between the professions and the Government. The Royal Commission on doctor's pay alleviated some of the arguments that had caused problems during the first decade.

Negotiations between the Government and GPs leaders led to a review body award that provided a basis for the development of the modern group practice.

### Management

Better management became a priority. Hospital Activity Analysis was introduced to give clinicians and managers better patient-based information and divisions were created with the aim of grouping medical staff by speciality. Increasingly, though, the structure of the service was being criticised.

### The Porritt Report

In the 1962 Porritt report, the medical profession criticised the separation of the NHS into three parts - hospitals, general practice and local health authorities, and called for unification.

### Hospital plan

While much had already been done to appoint consultants in the major specialities throughout the country, their skills were not matched by the outdated and war-damaged buildings in which they worked. Enoch Powell's Hospital Plan, published in 1962, approved the development of district general hospitals for population areas of c. 125,000 and in doing so, laid out a pattern for the future.

The ten-year programme put forward was new territory for the NHS and it became clear it had underestimated the cost and time it would take to build new hospitals. But, a start had been made and with the advent of postgraduate education centres, nurses and doctors were given a better future.

### The Salmon Report

The Salmon report in 1967, detailed recommendations for developing the senior nursing staff structure and the status of the profession in hospital management. Also in 1967, the first report on the organisation of doctors in hospitals (known as the Cogwheel Report) proposed speciality groupings that would arrange clinical and administrative medical work more logically.

The variety of efforts being made at this time to reduce the disadvantages of the three-part structure showed the growing acknowledgement of the complexity of the NHS and the importance of change in order to meet future needs.

## 1968-1977

In 1968, clinical and organisational optimism prevailed in the NHS, but the mood progressively receded until, by 1977, various factors had combined to bring the third decade to an unpromising close.

### Medical progress

This said, medical progress continued, with advances including the increasingly wide application of endoscopy and the advent of CAT (Computerised Axial Timography) scanning as the service's investigative armoury was extended.

### Transplants

Transplant surgery was becoming increasingly successful, and genetic engineering slowly began to influence medicine. Intensive care units were now widely available and new drugs appeared, including for example non-steroidal anti-inflammatory treatments.

Kidney dialysis was introduced and surgery established a place in the care of coronary heart disease. On the downside, new infections, such as Lassa Fever emerged, and changes in abortion law led to new pressures on gynaecological services.

### GP's charter

In general practice, the GP's charter was encouraging the formation of primary health care teams, new group practice premises and a rapid increase in the number of health centres.

### New hospitals

As the result of the Government's Hospital Plan, new hospitals were providing more people with a better and more local service. The organisation of hospital nursing services was changed by the Salmon Report and nurse education by Briggs, while the advent of information technology saw the first steps in health service computerisation and clinical budgeting.

From 1968 to 1974 debate continued on the crucial question of how the NHS should best be organised. Key issues included local government reorganisation and the desire to improve the co-ordination of health and social services by matching the boundaries of health and local authorities.

### Resources planning

What was also needed was a planning system to distribute resources more fairly and to improve management. Two plans fell by the wayside; the third was implemented in 1974, but not until the Government that devised it had been replaced in a General Election. The new system soon earned criticism as too complex and managerially driven.

Within two years, a Royal Commission on the NHS had been appointed to look into the problem areas. Just as strategic planning, long-range forecasts and reallocation were introduced, inflation reached 26 per cent and wage restraint came in. Industrial action hit the NHS while consultants too were alienated by proposals to reduce private practice within the service.

## 1978-1987

The decade was characterised by the growing acknowledgement that clear financial bounds existed within which the NHS operated. It simply could no longer do everything that had become medically possible. The NHS had become a victim of its own success. New technology was being introduced and more people were being treated in more complex ways. This led to both rising expectations of the health service and an increasingly elderly population with all its attendant health needs.

### Advances

Advances spanned all fields of NHS activity: primary health care was improving, although less so in the inner cities. Genetic engineering was yielding its first drug successes and magnetic resonance imaging was introduced.

On the surgical side, the decade saw the advent of minimal access techniques, while the number of operations for fractured neck of femur and osteoarthritis of the hip was reaching almost epidemic proportions.

Increasing numbers of heart and liver transplants were being performed and surgical treatment for heart disease was becoming more common by the day.

### General management

Beginning in 1978 with what was dubbed by the newspapers as 'the winter of discontent', the service's financial problems were worsened by the oil crisis. NHS management tried to improve efficiency and there were attempts to set priorities in 1979, to restructure the NHS again in 1982 and to introduce a tier of general management between 1983 and 1985.

The 1979 change of government brought little immediate change in health service policy, as attempts to equalise the allocation of resources between different parts of the country continued.

### Performance indicators

As time passed, the tension between increasing demand and finite resources prompted experiments in clinical budgeting and a desire for better health service information. Performance indicators were introduced, and the London Health Planning Consortium examined the level of acute hospital services likely to be available in London in the future.

### Audit

Closer examination of what the professionals were doing followed international concern about rising costs. People began to discuss audit of, for example, the results of anaesthesia and surgery.

### Community health

Clinical advances placed increasing demands on nursing and medical staff, and each profession looked at its education and organisation. One option for the NHS was to move care from a hospital to a community setting. Community nursing was examined and the Government established a review of general practice and primary health care.

Yet by 1987 health authorities throughout the country were in debt, waiting lists were growing and hospital wards were being closed - despite evidence of higher spending, steady increases in staff numbers and the treatment of more patients.

Neither the public nor the health care professions were satisfied and the service was increasingly subjected to scrutiny in the media.

## 1988-1997

The NHS experienced the most significant cultural shift since its inception with the introduction of the so-called internal market, outlined in the 1989 White Paper, Working for Patients, and which passed into law as the NHS and Community Care Act 1990.

### The Internal market

The internal market was the Conservative Government's attempt to address problems, such as growing waiting lists, which had arisen in the 1980s as a result of NHS resources being constrained while demand rose inexorably.

Before the 1990 Act a monolithic bureaucracy ran all aspects of the NHS. After the establishment of the internal market, 'purchasers' (health authorities and some family doctors) were given budgets to buy health care from 'providers' (acute hospitals, organisations providing care for the mentally ill, people with learning disabilities and the elderly, and ambulance services).

To become a 'provider' in the internal market, health organisations became NHS trusts, independent organisations with their own management, competing with each other.

### NHS trusts

The first wave of 57 NHS Trusts came into being in 1991. By 1995, all health care was provided by NHS trusts. Over the same period, many family doctors were also given their own budgets with which to buy health care from NHS trusts in a scheme called GP fund holding. Not all GPs joined this scheme and their budgets were still controlled by health authorities, which bought health care 'in bulk' from NHS trusts.

### GP fund holders

Patients of GP fund holders were often able to obtain treatment more quickly than patients of non-fund holders. This led to accusations of the NHS operating a two-tier system, contrary to the founding principles of the NHS of fair and equal access for all to health care.

### The New NHS

Observers credit the internal market with improving cost consciousness in the NHS, but at a price: that the competition it encouraged between 'providers' saw unnecessary duplication of services. The election of a new Government in May 1997 brought a new approach to the NHS. Pledging itself to abolition of the internal market, the new Government set out an approach that aimed to build on what had worked previously, but discarding what had failed.

A new white paper issued by the Department of Health, "The New NHS. Modern and Dependable." put forward a "third way" of running the service - based on partnership and driven by performance. The paper set out an approach which promised to "go with the grain" of efforts by NHS staff to overcome obstacles within the internal market, building on the moves which had already taken place to move away from outright competition to a more collaborative approach.

### Six principles

The white paper described this approach as "a new model for a new century", based on six key principles:

1. To renew the NHS as a genuinely national service, offering fair access to consistently high quality, prompt and accessible services right across the country;

2. To make the delivery of healthcare against these new national standards a matter of local responsibility, with local doctors and nurses in the driving seat in shaping services;

3. To work in partnership, breaking down organisational barriers and forging stronger links with local authorities;

4. To drive efficiency through a more rigorous approach to performance, cutting bureaucracy to maximise every pound spent in the NHS for the care of patients;

5. To shift the focus onto quality of care so that excellence would be guaranteed to all patients, with quality the driving force for decision-making at every level of the service;

6. To rebuild public confidence in the NHS, accountable to patients open to the public and shaped by their views.

As the NHS entered its 50th year, a new era had begun.

## 1998-2005

Published in July 2000, The NHS Plan is a radical action plan for the next 10 years setting out measures to put patients and people at the heart of the health service, promising a 6.3% increase in funding over five years to 2005.

### The NHS Plan

The NHS Plan is a plan for reform with far reaching changes across the NHS. The purpose and vision of this Plan is to deliver a health service fit for the 21st century, designed around the patient. The NHS has delivered major improvements in health but it fell short of the standards patients expect and staff want to provide.

- Public consultation for the Plan showed that the public wanted to see:
- more and better paid staff using new ways of working
- reduced waiting times and high quality care centred on patients

improvements in local hospitals and surgeries.

In part the NHS is failing to deliver because over the years it has been under funded. In particular there have been too few doctors and nurses and other key staff to carry out all the treatments required. But there have been other underlying problems as well.

The NHS is a 1940s system operating in a 21st century world. It has:

- a lack of national standards
- old-fashioned demarcations between staff and barriers between services
- a lack of clear incentives and levers to improve performance
- over-centralisation and disempowered patients.

These systematic problems, which date from 1948 when the NHS was formed, are tackled by this Plan. It has examined other forms of funding healthcare - and found them wanting. The systems used by other countries do not provide a route to better healthcare. The principles of the NHS are sound but its practices need to change.

The March 2000 Budget settlement means that the NHS will grow by one half in cash terms and by one third in real terms in just five years. More money will fund extra investment in NHS facilities...

- 7,000 extra beds in hospitals and intermediate care
- over 100 new hospitals by 2010 and 500 new one-stop primary care centres
- over 3,000 GP premises modernised and 250 new scanners
- clean wards - overseen by 'modern matrons' - and better hospital food
- modern IT systems in every hospital and GP surgery
- 7,500 more consultants and 2,000 more GPs

### NHS Plan promises

- more power and information for patients
- more hospitals and beds
- more doctors and nurses
- much shorter waiting times for hospital and doctor appointments
- cleaner wards, better food and facilities in hospitals
- improved care for older people
- tougher standards for NHS organisations and better rewards for the best

### NHS Plan priorities

These are the biggest changes to face the NHS since it was set up 50 years ago. Making them happen means the Government needs to prioritise. It has decided to:

- target the diseases which are the biggest killers, such as cancer and heart disease
- identify the changes that are most urgently needed to improve people's health and well-being and deliver the modern, fair and convenient services people want.

**The Modernisation Board**

The Modernisation Board is leading the changes. Headed by health secretary John Reid, the board has an advisory role and comprises leading figures from healthcare institutions such as the royal colleges, together with clinical staff and managers from within the NHS and patient representatives.

**Taskforces**

The DoH has put in place 10 taskforces to drive forward the ideas and improvements outlined in The NHS Plan.

Six of these will focus on 'what' services it is improving:

- coronary heart disease
- cancer
- mental health
- older people
- children
- waiting times and access to services.

The remaining four will concentrate 'how' these improvements will be made, focusing on:

- the NHS workforce
- quality
- reducing inequalities and promoting public health
- Investment in facilities and information technology.

**Modernisation Agency**

The Modernisation Agency plays a crucial role in ensuring the commitments in the Plan are translated into reality. The agency helps local NHS staff and organisations such as Trusts and Primary Care Trusts to improve services for patients.

**Patient Choice**

Giving patients more choice about how, when and where they receive treatment is one cornerstone of the Government's health strategy. Another is giving members of the public a bigger hand in shaping local care systems.

Guidance, plans and local pilot projects to give patients more choice about where and when they receive elective surgery and other NHS services. The Patient Advice and Liaison Service (PALS) provide information, advice and support to help patients, families and their carers.

Reforms to cut waiting times and replace waiting lists by booked appointments systems. The reforms support the drive to give patients choice about when and where they are treated.