United Kingdom (England): Health Care System Overview and SWOT Analysis

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Abstract

This is the sixth article of the International Health Care Systems series. The first part of the article provides an overview of the United Kingdom health care system, mainly the National Health Service England, including its historical evolution, service delivery, and aspects like equity, cost-control, and health technology. The second part analyses the strengths, weaknesses, opportunities, and threats for the United Kingdom health care system.

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An Overview of the United Kingdom (England) Health Care System

The history of the United Kingdom (UK) health care system can be divided into the pre-National Health Service (NHS) and the post-NHS eras. Before the origin of the NHS, the UK had a social health insurance system for employees (not covering dependents) that covered about half of the population.[1,2] Benefits included primary care, drugs, and sickness and disability benefits.[1] The voluntary insurance landscape was fragmented, including friendly societies, doctor's clubs, and commercial insurers.[1,2] The hospital landscape was mainly comprised of non-profit voluntary hospitals and public hospitals. During the second world war, in 1942, the Beveridge Report (social insurance and allied services) spearheaded by William Beveridge, a British civil servant, laid the groundwork for a universal, tax-financed, free at point of service health system.[1] The NHS began in 1948, lead by the initiative of the new labour government; its health minister, Aneurin Bevan; and the overarching post-war consensus on welfarism.

The NHS is universal in its scope, financed mainly out of tax revenues. Unlike in countries like US and Germany, insurance and access to care is not related to employment. The seven key principles of NHS:[3]

1. Provides a comprehensive service, available to all
2. Access to services based on clinical need, not on the ability to pay
3. Aspires to the highest standards of excellence and professionalism
4. The patient at the heart of everything
5. Works across organizational boundaries
6. Committed to providing best value for taxpayers' money
7. Accountable to the public, communities and patients served

A comprehensive set of preventive, promotive, outpatient and inpatient curative care services are cov-

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ered. Certain services like ophthalmic care, dental care, pharmaceuticals etc. attract co-payments in England (not in Scotland, Wales, and Northern Ireland).[4] Exemptions to co-payments exist based on certain deprivation criteria (e.g. children under 16 years of age, pregnant women etc). Even though the NHS covers everyone universally, there is a private insurance market that covers around 11.5 percent of the population. [2] These allow skipping queues and waiting lines and certain high-end services like private rooms in hospitals.

The NHS was characterized by one major change from the pre-NHS era in terms of health service delivery organisation: it nationalised its hospitals across the country.[2] This was achieved on the scaffolding of the Emergency Medical Services (EMS) set up during the world war 2, to cater to military and civilians. The pre-NHS tradition of general practitioners (GP) being first points of contact continued.[2] The NHS was thus set up as a tripartite system, with GPs as independent contractors, community health services under local governments, and hospitals under NHS regional boards.

The GP acts as the gatekeeper to the health system.[2] Every individual is enrolled to a particular GP, which they may change provided the recipient GP has free slots. GP referral is needed for elective hospital services, the patients of which are usually referred to district hospitals. GPs are principally paid through capitation, even though performance-based payments and capitation carve-outs exist for certain services (home visits, immunization).[2] Specialists employed in hospitals are largely salaried staff. In recent years, a good degree of private investment has flown into the NHS, particularly in the form of outsourcing certain functions. While NHS permits private practice by specialists, almost the whole physician and nursing workforce is employed primarily in NHS.

The National Institute of Clinical and Care Excellence (NICE) was established in 1999 to undertake three basic functions: appraisal of health technology, prescribe clinical guidelines, and assess invasive interventional procedures.[5] This was to address the inconsistencies and variations in clinical practice, particularly with respect to proven emerging techniques and technologies. The NICE assesses health technologies, including pharmaceuticals, medical devices, treatment and diagnostic procedures etc for clinical and cost-effectiveness. Interventions within a certain Incremental Cost-Effectiveness Ratio (ICER) threshold are regarded cost effective, while those exceeding it require special reasons to be approved. NICE also prescribes clinical treatment guidelines based on scrupulous review of existing and emerging evidence. This upholds evidence-based practice, care quality, safety, and efficiency.[5]

Over the years, the NHS has seen a number of initiatives directed at improving efficiency, quality, and patient choice and satisfaction. The National Health Service and Community Care act, 1990 resulted in NHS hospitals being turned into autonomous trusts rather than being run directly by NHS authorities. GPs were made fundholders, and entrusted with commissioning specialist care for their patients. This was inspired by the 1989 white paper "working for patients" and the Thatcherian idea of increasing competition in health care. This idea of managed competition didn't work, and after the mid-1990s, the consensus shifted from 'competition' to 'collaboration' under the Tony Blair administration.[6] In 2003, primary care trusts (PCT) were introduced, comprising of about 50 GPs being entrusted with responsibility of commissioning specialist care, planning primary care and community services for a population of around 10000, and fostering quality improvement activities.[2] This was replaced in 2013 with clinical commissioning groups (CCG), which are GP led groups that commission acute care services and community care. In 2004, a points based pay-for-performance system was introduced based on a number of clinical and administrative indicators.[2]

While regional inequities in health services do exist, a number of progressive measures, including greater pay for GPs serving in underserved areas and severely ill patients, and diverting greater resources and building more facilities in underserved areas.[1] Further, all specialists are paid on the same salary scale, and GP lifetime incomes equal those of specialists. Further, a tax-financed system rather than insurance ensures greater equity.

Waiting lines and rationing of care are the major avenues of cost-control.[3] While emergency hospitalization doesn't require GP referral, elective hospitalization does, and waiting times are substantial. Further, medical budgets, hospital beds, and specialist slots are tightly controlled by the NHS. Low-powered modes of physician/hospital payments, like capitation and salary, hold down costs in comparison to countries like US with substantial prevalence of fee-for-service arrangements. In addition, influx of new health technologies is regulated. For example, the UK has much lesser number of MRI machines per capita than the US, and al-

so lesser number of unnecessary diagnostic and treatment interventions while not compromising on essential care and health outcomes. Further, the UK health system design entails fewer administrative costs than the US.[2]

SWOT Analysis

Strengths

The prime strength of the UK health system can be summarized as "Good heath at low cost", even though substantial spending is incurred on health, and rising demand for care and costly interventions present a challenge to this dictum. The NHS has been able to hold down costs while not impinging on care quality and health outcomes. For e.g., while performing better than the US on many health indicators, fewer high-end procedures and interventions are performed in the UK.

A strong primary healthcare along with a GP-based gatekeeper system is also one of the fundamental strengths. This deters unnecessary specialist consultations, encourages health prevention and promotion activities, and ensures continuity of care. Further, added incentives for preventive services and capitation-based payments encourage more use of preventive care.

Coverage is universal and largely equitable. Essential services are free at the point of care, and this has been preserved despite many free-market like changes over the years. While elective hospital care is rationed, emergency care is timely. And while unnecessary procedures are fewer, number of physician visits and hospital days per capita are better in comparison to the US. Further, the UK maintains a healthier GP: specialist ratio. The NICE was a pioneering initiative to ensure evidence-based practice and appraisal of technologies for clinical and cost-effectiveness. Pharmaceutical costs are kept in check through regulation of profits and discouraging "me too" research.[1]

Weaknesses

The biggest weakness of the NHS remains rationing of needed care. Waiting times for elective hospital care remain substantial, which results in delaying of care and even putting off accessing required services. The NHS constitution gives patients the right to access their specialist treatment within 18 weeks post referral. However, as reported by The Guardian in 2011, 10.2 percent patients had to wait more than 18 weeks for such treatment.[3]

NHS hospitals remain overstretched, and underfunding is held responsible. In 2017, the state of UK hospitals was held as a humanitarian crisis by the British Red Cross.[7] The bureaucratic nature of the NHS has often been criticized, and the restricted patient choice and autonomy has been held as a disadvantage.

Opportunities

Despite the acknowledged weaknesses, public satisfaction with the NHS remains high. This reflects public confidence in the health care delivery system and offers a basis to mobilize political and civil consensus on healthcare reform. It has been posited that while the flaws of the US health system are attributable to design (and not inadequate funding), the shortcomings of the NHS are attributable to inadequate funding and not to design issues.[1] Considering that funding issues are easier to overcome in comparison to entrenched design features of the health system, the traditional strengths of the NHS, like the GP-based gatekeeper system, offer an opportunity for effective and cost-effective scale-up.

Despite market-like reforms over the years, the UK has been able to preserve a largely tax-financed health system with limited co-payments for a limited range of services. There could be opportunities to further diversify funding sources and look for additional avenues of revenue as health care demands soar.

Threats

Health care demands from the NHS are steadily rising with increasing aging population and rise in the number of chronic ailments. This entails increasing health care costs and is increasingly stressing the ability of the NHS to live up to the dimensions of universality, equity, and quality.

This is compounded by a spiral of underfunding and privatization. It has been noted that the public satisfaction with the GP services has fallen in recent years. This is attributable to aggravated waiting lines and limited access.[8,9] The workload on GPs and primary care staff has increased in the face of limited resources and rising demands,[8,9] which has nudged many GPs and nurses to leave the system. This could pose a serious threat to the sustainability of primary care in the NHS.

A leaning towards privatization can have three consequences: first, it could increase out-of-pocket share in health care spending. Second, it could expand the scope of private insurance. Both of these are likely to increase inequity. Third, a greater share of private care can adversely affect public healthcare within the NHS. This was noted when allowing private practice

by NHS specialists aggravated waiting lists, prompting the government to separate waiting list management from specialists. Private facilities in UK have often tended to offer poorer quality of care compared to the NHS, and dump severe and critical cases on the public health system while skimming the more profitable ones. Better ways of collaborating with the private sector need to be configured to avoid such undesirable effects.

With rising health care demands and pressures to increase the scope of services available under the NHS, the current tax-financed system of financing public healthcare will be increasingly stressed, and may become unsustainable. In such a situation, looking for additional sources of funding shall become instrumental to ensure that the NHS continues to deliver on its foundational principles.

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