# National Health System of UK: Universal Coverage with People Taking Health in Their Hands

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## Preamble

A significant number of countries, including the UK, are embracing the goals of UHC as the right thing to do for their citizens. It is a powerful social equalizer and contributes to social cohesion and stability. Every country has the potential to improve the performance of its health system in the main dimensions of UHC: coverage of quality services and financial protection for all. Priorities, strategies and implementation plans for UHC will differ from one country to another. Moving towards UHC is a dynamic, continuous process that requires changes in response to shifting demographic, epidemiological and technological trends, as well as people's expectations. But in all cases, countries need to integrate regular monitoring of progress towards targets into their plans. In May 2014, the World Health Organization and the World Bank jointly launched a monitoring framework for UHC, based on broad consultation of experts from around the world. The framework focuses on indicators and targets for service coverage- including promotion, prevention, treatment, rehabilitation and palliation- and financial protection for all.

## Introduction

The National Health System in the UK has evolved to become one of the largest healthcare systems in the world, and for many a model to follow. It provides services to over 1 million patients every 36 hours. The UK healthcare system, National Health Service (NHS), came into existence in the aftermath of the Second World War and became operational on the 5th July 1948. It is the legacy of Aneurin Bevan, a former miner who became a politician and the then Minister of Health. He founded the NHS under the principles of universality, free at the point of delivery, equity, and paid for by central funding. Despite numerous political and organizational changes the NHS remains to date a service available universally that cares for people on the basis of need and not ability to pay, and which is funded by taxes and national insurance contributions.

Health care and health policy for England is the responsibility of the central government, whereas in Scotland, Wales and Northern Ireland it is the responsibility of the respective governments. In each of the UK countries the NHS has its own distinct structure and organization, but overall, healthcare comprises of two broad sections; one dealing with strategy, policy and management, and the other with actual medical/clinical care which is in turn divided into primary (community care, GPs, Dentists, Pharmacists etc.), secondary (hospital-based care accessed through GP referral) and tertiary care (specialist hospitals). Particularly over the last decade led to a greater shift towards local rather than central decision making, removal of barriers between primary and secondary care and stronger emphasis on patient choice.

This article will present an overview of the UK healthcare system as it currently stands.

The NHS in 2010

The Health Act 2009 established the "NHS Constitution" which formally brings together the purpose and principles of the NHS in England, its values, as they have been developed by patients, public and staff and the rights, pledges and responsibilities of patients, public and staff.

The NHS is the largest employer in the UK with over 1.3 million staff and a budget of over £90 billion. In 2008 the NHS in England alone employed 132,662 doctors, a 4% increase on the previous year, and 408,160 nursing staff (Table 1). In 2007/8, the UK health spending was 8.5% of Gross Domestic Product (GDP)—with 7.3% accounting for public and 1.2% for private spending. The net NHS expenditure per head across the UK was lowest in England (£1,676) and highest in Scotland (£1,919) with Wales and Northern Ireland at approximately the same level (£1,758 and £1,770, respectively).

Table 1

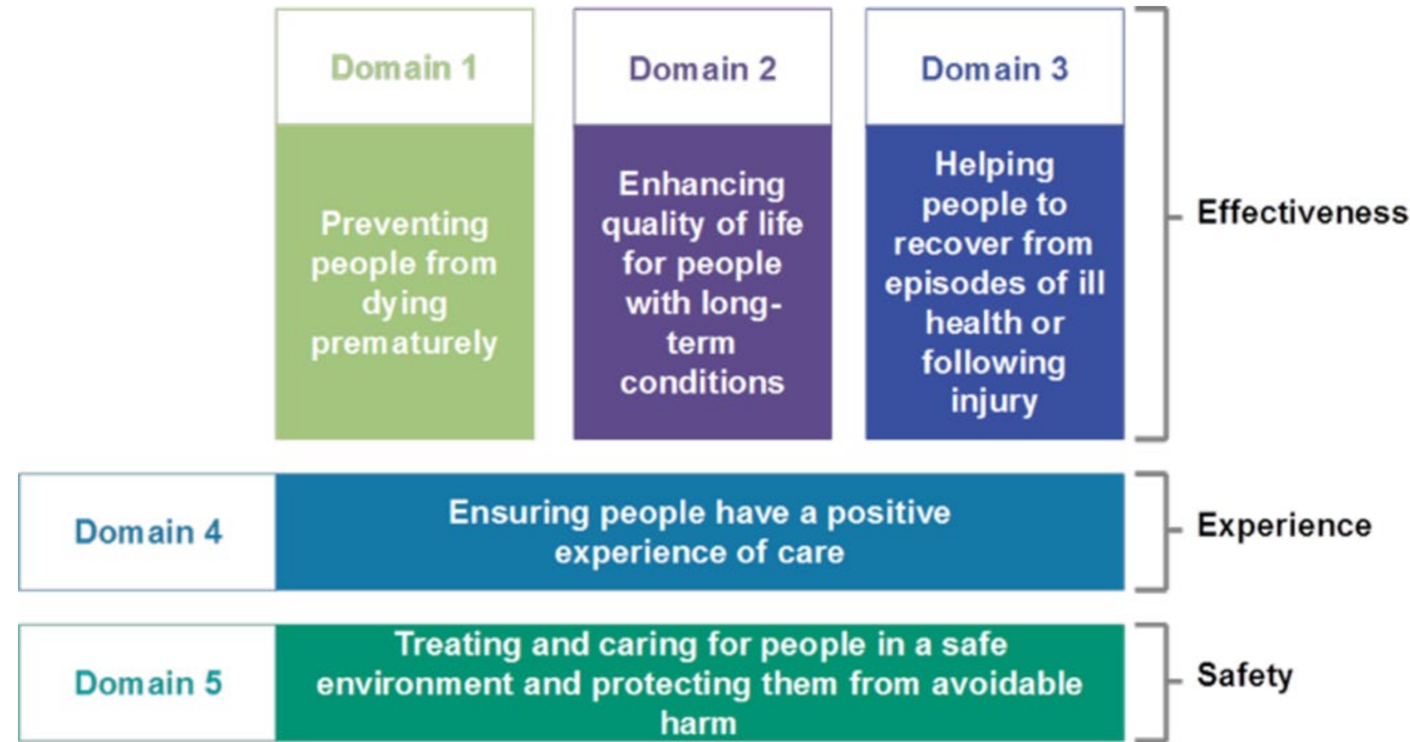
The distribution of NHS workforce according to main staff groups in the UK in 2008 (NHS Information Centre: www.ic.nhs.uk)

| NHS main staff groups | No. of staff | % of total NHS workforce |
|---|---|---|
| All doctors | 132,662 | 9.6 |
| Qualified ambulance staff | 17,451 | 1.2 |
| Scientific, therapeutic & technical staff | 142,558 | 10.4 |
| Qualified nursing staff | 408,160 | 29.8 |
| Support to clinical staff | 355,010 | 25.9 |
| Support to GPs | 58,572 | 4.3 |
| NHS infrastructure | 219,064 | 16 |
| Other GP practice staff | 92,436 | 6.8 |
| Other | 353 | 0.02 |
| Total | 1,368,693 | 100 |

The overall organizational structure of the NHS differs between England, Scotland, Wales and Northern Ireland. In England the Department of Health is responsible for the direction of the NHS, social care and public health and delivery of healthcare by developing policies and strategies, securing resources, monitoring performance and setting national standards. Currently, 10 Strategic Health Authorities manage the NHS at a local level, and Primary Care Trusts (PCTs), which currently control 80% of the NHS' budget, provide governance and commissions services, as well as ensure the availability of services for public health care, and provision of community services.

The National Institute for Health and Clinical Excellence (NICE) was established in 1999 as the body responsible for developing national guidelines and standards related to, health promotion and prevention, assessment of new and existing technology (including medicines and procedures) and treatment and care clinical guidance, available across the NHS. The health research strategy of the NHS is being implemented through National Institute of Health Research (NIHR), the total budget for which was in 2009/10 close to £1 billion (www.nihr.ac.uk).

## The NHS has five domains




## Predictive, Preventive and Personalised Medicine (PPPM) in the NHS

Like other national healthcare systems, predictive, preventive and/or personalized medicine services within the NHS have traditionally been offered and are part of disease diagnosis and treatment. Preventive medicine, unlike predictive or personalized medicine, is its own established entity and relevant services are directed by Public Health and offered either via GP, community services or hospitals. Patient-tailored treatment has always been common practice for good clinicians in the UK and any other healthcare system. The terms predictive and personalized medicine though are evolving to describe a much more technologically advanced way of diagnosing disease and predicting response to the standard of care, in order to maximize the benefit for the patient, the public and the health system.

The government considered the development of preventive, people-centered and more productive healthcare services as the means for the NHS to respond to the challenges that all modern healthcare systems are facing in the 21st century, namely, high patient expectation, ageing populations, harnessing of information and technological advancement, changing workforce and evolving nature of disease. Increased emphasis on quality (patient safety, patient experience and clinical effectiveness) has also supported innovation in early diagnosis and PPPM-enabling technologies such as telemedicine.

A number of preventive services are delivered through the NHS either via GP surgeries, community services or hospitals depending on their nature and include:

The Cancer Screening programmes in England are nationally

- The Cancer Screening program in England which is nationally coordinated and includes Breast, Cervical and Bowel Cancer Screening. There is also an informed choice Prostate Cancer Risk Management program (www.cancerscreening.nhs.uk). The Child Health Promotion Program is dealing with issues from pregnancy and the first 5 years of life and is delivered by community midwifery and health visiting teams. Various immunization programs from infancy to adulthood are offered to anyone in the UK for free and are generally delivered in GP surgeries.
- The Darzi review which set out six key clinical goals in relation to improving preventive care in the UK including, 1) tackling obesity, 2) reducing alcohol harm, 3) treating drug addiction, 4) reducing smoking rates, 5) improving sexual health and 6) improving mental health. Preventive programs to address these issues have been in place over the last decades in different forms and through different initiatives, and include:
- Assessment of cardiovascular risk and identification of people at higher risk of heart disease is generally preformed through GP surgeries.
- Specific preventive programs (e.g. suicide, accident) in local schools and community, family planning services and prevention of sexually transmitted disease programs, often with an emphasis on young people.
- A variety of prevention and health promotion programs related to lifestyle choices are delivered though GPs and community services including, alcohol and smoking cessation programs, promotion of healthy eating and physical activity. Some of these have a specific focus such as health promotion for older people (e.g. Falls Prevention).

## Equity and Excellence: Liberating the NHS

The government in 2010 has set out the vision of the future of an NHS as an organization that still remains true to its founding principle of, available to all, free at the point of use and based on need and not ability to pay. It also continues to uphold the principles and values defined in the NHS Constitution. The future NHS is part of the Government's Big Society which is build on social solidarity and entails rights and responsibilities in accessing collective healthcare and ensuring effective use of resources thus delivering better health. It will deliver healthcare outcomes that are among the best in the world. This vision will be implemented through care and organization reforms focusing on four areas: a) putting patients and public first, b) improving on quality and health outcomes, c) autonomy, accountability and democratic legitimacy, and d) cut bureaucracy and improve efficiency.This strategy makes references to issues that are relevant to PPPM which indicates the increasing influence of PPPM principles within the NHS.

Accordingly the principle of "shared decision-making" (no decision about me without me) will be at the centre of the "putting emphasis on patient and public first" plans. In reality this includes plans emphasizing the collection and ability to access by clinicians and patients all patient- and treatment-related information. It also includes greater attention to Patient-Reported Outcome Measures, greater choice of treatment and treatment-provider, and importantly personalized care planning (a "not one size fits all" approach). A newly created Public Health Service will bring together existing services and place increased emphasis on research analysis and evaluation. Health Watch England, a body within the Care Quality Commission, will provide a stronger patient and public voice, through a network of local Health Watches (based on the existing Local Involvement Networks - Links).

The NHS Outcomes Framework sets out the priorities for the NHS. Improving on quality and health outcomes, according to the White Paper, will be achieved through revising goals and healthcare priorities and developing targets that are based on clinically credible and evidence-based measures. NICE have a central role in developing recommendations and standards and will be expected to produce 150 new standards over the next 5 years. The government plans to develop a value-based pricing system for paying pharmaceutical companies for providing drugs to the NHS. A Cancer Drug Fund will be created in the interim to cover patient treatment.

## Challenges facing the UK Healthcare System

Overall the health, as well as ideological and organizational challenges that the UK Healthcare system is facing are not dissimilar to those faced by many national healthcare systems across the world. Life expectancy has been steadily increasing across the world with ensuing increases in chronic diseases such as cancer and neurological disorders. Negative environment and lifestyle influences have created a pandemic in obesity and associated conditions such as diabetes and cardiovascular disease. In the UK, coronary heart disease, cancer, renal disease, mental health services for adults and diabetes cover around 16% of total National Health Service (NHS) expenditure, 12% of morbidity and between 40% and 70% of mortality. Across Western societies, health inequalities are disturbingly increasing, with minority and ethnic groups experiencing most serious illnesses, premature death and disability. The House of Commons Health Committee warns that whilst the health of all groups in England is improving, over the last 10 years health inequalities between the social classes have widened—the gap has increased by 4% for men, and by 11% for women—due to the fact that the health of the rich is improving much quicker than that of the poor. The focus and practice of healthcare services is being transformed from traditionally offering treatment and supportive or palliative care to increasingly dealing with the management of chronic disease and rehabilitation regimes, and offering disease prevention and health promotion interventions.

Preventive medicine is solidly established within the UK Healthcare System, and predictive and personalized approaches are increasingly becoming so. Implementation of PPPM interventions may be the solution but also the cause of the health and healthcare challenges and dilemmas that health systems such as the NHS are facing. The efficient introduction of PPPM requires scientific understanding of disease and health, and technological advancement, together with comprehensive strategies, evidence-based health policies and appropriate regulation. Critically, education of healthcare professionals, patients and the public is also paramount. There is little doubt however that harnessing PPPM appropriately can help the NHS achieve its vision of delivering healthcare outcomes that will be among the best in the world.

## An Overview of the Health and Social Care Act 2012

The Health and Social Care Act 2012 introduced radical changes to the way that the NHS in England is organized. The legislative changes from the Act came into being on 1 April 2013 and include:

**A. A move to clinically led commissioning.**
Planning and purchasing healthcare services for local populations had previously been performed by England's 152 primary care trusts (PCTs). The Act replaced the PCTs with 211 clinical commissioning groups (CCGs), led by clinicians. CCGs now control the majority of the NHS budget, with highly specialist services and primary care being commissioned by NHS England.

**B. An increase in patient involvement in the NHS.**
The Act established independent consumer champion organizations locally (Healthwatch) and nationally (Healthwatch England) to drive patient and public involvement across health and social care in England. The Healthwatch network has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

**C. A renewed focus on the importance of public health.**
The Act provided the legislation to create Public Health England (PHE), an executive agency of the Department of Health. PHE's aim is to protect and improve the nation's health and to address health inequalities.

**D. A streamlining of 'arms-length' bodies.**
The Act conferred additional responsibility on the

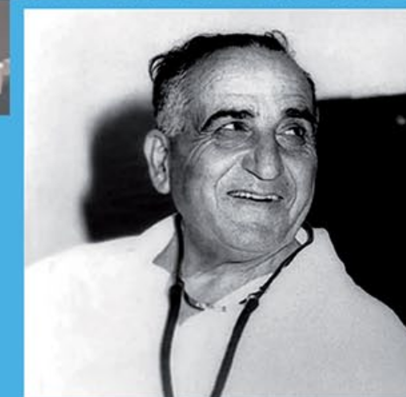
National Institute for Health and Care Excellence (NICE – formerly the National Institute for Clinical Excellence) to develop guidance and set quality standards for social care. The Health and Social Care Information Centre (HSCIC) was also tasked with responsibility for collecting, analyzing and presenting national health and social care data.

**E. Allowing healthcare market competition in the best interest of patients.**
The Act aimed to allow fair competition for NHS funding to independent, charity and third-sector healthcare providers, in order to give greater choice and control to patients in choosing their care. To protect the interests of patients under these new arrangements, Monitor was established as the sector regulator for health services in England. Monitor issues licenses to NHS-funded providers, has responsibility for national pricing and tariff (in conjunction with NHS England) and helps commissioners ensure that local services continue if a provider is unable to continue providing services.

## NHS Values and the Constitution

The NHS values describe what we aspire to in providing NHS services, to facilitate co-operative working at all levels of the NHS. The NHS values were derived from extensive discussions with staff, patients and the public, and provide a framework to guide everything that we do within the NHS.

The NHS Constitution was published by the Department of Health in 2011. It is the first document in the history of the NHS to explicitly set out what patients, the public and staff can expect from the NHS and what the NHS expects from them in return. The Constitution cannot be altered by government without the full involvement of staff, patients and the public, and so gives protection to the NHS against political change.



Notre-Dame Maritime est un hôpital privé, fondé en 1981 par le Dr Antoine Chami en collaboration avec les docteurs Khalil et Robert Germanos. Il est situé à Jbeil, à 30 km au nord de Beyrouth. Les propriétaires sont les docteurs Joseph et Jean-Pierre Chami.

L'hôpital compte actuellement 95 lits d'hospitalisation. En plus des lits de médecine et chirurgie, on dénombre 9 lits de gynécologie-obstétrique, 16 lits de pédiatrie (dont 2 couveuses), 12 lits de réanimation adulte et 5 lits d'hospitalisation de jour. Toutes les spécialités sont représentées sauf la chirurgie cardiaque. La psychiatrie est assurée en consultation et en hospitalisation pour les cas mineurs uniquement.

Un processus de modernisation de l'hôpital a été mis en place depuis 1998. Toutes les façades ont été refaites et trois nouveaux étages ont été construits.

- **2000:** ouverture du service de radiologie invasive et cathétérisme cardiaque
- **2004:** ouverture du service de dialyse qui comporte 10 lits.
- **2005:** acquisition d'un terrain de plus de 10.000 m2 adjacent à l'hôpital ayant permis l'aménagement d'un parking et d'une cafétéria. Il permettra dans l'avenir de réaliser des projets d'extension de l'hôpital.
- **2010:** réaménagement du 2ème étage en un service mère-enfant réparti sur les deux ailes. Ouverture du 3ème étage. Réaménagement de la polyclinique au rez-de-chaussée avec une salle de soins ambulatoires. Mise en place d'un nouveau système informatique de gestion.
- **2011:** réaménagement du service d'imagerie médicale avec numérisation du système. Achat de deux nouvelles machines de radiologie conventionnelle, d'un scanner 16 barrettes et un nouvel échographe.
- **2012:** ouverture du 4ème étage, du centre de physiothérapie et d'une unité de sommeil.
- **2013:** réaménagement et modernisation du laboratoire.
- **2014:** réaménagement et agrandissement du service des urgences. Création d'une salle d'endoscopies. Installation d'un système PACS facilitant la diffusion et l'archivage de l'imagerie médicale.

*Petite anecdote concernant l'appellation de l'hôpital. Le nom «Notre-Dame Maritime» a été donné à l'hôpital en référence à la chapelle Notre-Dame Maritime qui fait face à l'hôpital. En arabe, la traduction a transformé «Sainte Maritime» en «Saydat Martine» qui a été retraduit en français par «Sainte Martine». D'autres personnes de la région continue d'appeler l'hôpital «Chami» en commémoration à son fondateur, le docteur Antoine Chami.*

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