



“Whither goest?”:

A look at Britain’s National Health Service

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The U.S. is a wonderful country, especially to those of us whose immigrant experience is not that far in the past. The opportunities, the freedom, the ability to participate, the meritocracy, and the ability to get where one needs to go through hard work, perseverance, and a little bit of luck are beyond compare with any other nation in the world. I point out to my children, and generally anyone else who will listen, what a wonderful opportunity we have to succeed in this country if we will only try.

However, other countries have my admiration as well. Food is better in Paris and, indeed, throughout all of France. It seems very difficult to get a bad meal there. Although the culinary status of the U.S. has improved dramatically with the training of young, enthusiastic American chefs, still one must admit that France and Belgium outdo us in this area. I happen to like England and find, despite the passing of its homogeneity,

that country much more civilized than here. For example, the British still queue up without line-crashing, although that is less common than it used to be.

There are some aspects of American culture that are difficult to comprehend, not the least of which is self-hate, which is evidenced periodically by the younger generation or some members of the intellectual elite and liberal left. To these individuals, it seems everything is better everywhere else, although this attitude is less stylish than it was before September 11, 2001.

In the 1980s, we were told that we were headed for economic disaster and that Japan was going to overtake us and become the dominant economic power in the world. I suppose the same group of people will shortly be telling us that China is about to overtake us as well. Periodically, a malaise sweeps through the country, fanned by the aggressive and liberal media.

One of the most flagrant signs of American self-hate is our love for other medical systems that do not perform as well as ours. The continued infatuation with the Canadian system, despite the wholesale flight of anyone who can afford to come south of the border to receive care, is utterly beyond me. Long waiting lists, inadequate opportunities to treat, continued restrictions on lifesaving technology, the gutting of premier medical programs and institutions, and a florid “brain drain” continue to be a part of the Canadian medical landscape.

Although the infatuation with the Canadian system is less prominent than it used to be, the media, and to some extent those economic gurus who think they know everything about the medical system, continue to trash what once was a pretty good construct in the U.S. My question to them is, What border would they cross to obtain their health care? At the present time, we can't go south, although perhaps with improvement in Mexico, that may one day be possible.

In my view, the most egregious admiration for a medical system is for England's National Health Service (NHS). It is true that the NHS has some wonderful qualities. It is totally free, not only for residents and citizens, but for visitors as well, and it is regionalized. People have their own family physician, and so they are not deprived of their support systems when they are most in need of medical care. It is civil and civilized.

Nonetheless, I have always said that if one wants to see where this county is going, then take a look at the NHS. The NHS has been suffering from chronic malnutrition. Only 6.8 to 6.9 percent of the gross domestic product of the U.K. has been allocated to the NHS. This starvation diet has finally wreaked sufficient havoc in the system that its problems—continuous undercapitalization, inability to improve physical facilities, lack of expansion of facilities, and loss of medical personnel at the same time the population is aging and presenting increased needs—have finally come home to roost. The result is not pretty.

History

First, a look back. The NHS, organized in 1948, was a bold step well ahead of its time. At the time, physicians in the U.K. occupied a position in society not quite the same as that held by physicians in the U.S., but not terribly different. They were

wooed into joining the NHS with financial and other benefits. And, to an extent, despite the fact that the NHS was chronically underfunded, some investment and the enthusiasm of many of the practitioners held the NHS together reasonably well for about 30 years.

The reason it lasted that long, I believe, is because early recruits to the NHS had been trained as professionals and continued to practice as professionals. It is unlikely that they would change their modus operandi to that of employees. Also, up until the late 1970s, the aging system had not seen the debility of outmoded facilities, lack of investment in technology, and aging infrastructure to the extent that one sees now.

Toward the middle of the 1960s, the almost universal approval of the NHS among Britain's patient population began to change, and signs of discontent were emerging. Accident floors began to close throughout London. In fact, a patient with a head injury at this time may have traveled for an hour before getting reasonable care at an accident floor. Physicians' and surgeons' salaries did not keep pace with inflation. Waiting lists began to lengthen. My guess is that the emergence of these indicators of discontent paralleled the appearance within the workforce of physicians who had never been trained as professionals, but who had been employees throughout their entire experience in the medical profession.

There is a difference between a professional and an employee. A professional gets the job done regardless of hours and circumstances. An employee does his or her job in the time allotted. Some “physician employees,” to be sure, realize they are dealing with human lives and go far beyond the expected effort, but others just do their job. Indeed, given the tax structure in the U.K., a number of the physician employees, when offered time-and-a-half or double-time to work, for example, overtime at accident floors or to keep accident floors open, simply said that as employees they had no obligation to do so, and besides, most of it would be taken by taxes. They would rather be home with their families or at the local pub with their friends.

This particular distinction between professionals and employees has been completely lost on the economists and the self-appointed gurus who control what happens to American medicine. They fail to understand that if you treat people as employ-

ees, even if they may have been trained as professionals, they will no longer act like professionals but like employees, and, indeed, if one looks around the U.S., there are signs of this shift in attitude throughout the health care system.

In the mid-1970s, when the last of those individuals who had entered the NHS as professionals retired, England had a physician workforce consisting largely of individuals who had always been trained as employees and had always worked as employees. The cracks began to widen and the infrastructure began to come apart.

Current status

Fast-forward 25 years. By this time, the chronic underfunding has become so pervasive that the Blair government has promised £1.5 billion investment in infrastructure, technical equipment, and new facilities. There are those who think that after the five decades of chronic underfunding, this is a drop in the bucket and will never restore what was lost. Of greater concern are three themes that seem to be surfacing simultaneously and that appear to signal a real crisis. The third is a symptom of the first two.

1. *Lack of physicians.* Britain's economy, after decades of stagnation, is now undergoing a rebirth with the advent of opportunities in technology, finance, and light industry. The traditional smoke-stack industries, such as coal, iron, and steel, have been driven into the ground by militant unionism, very much as in this country. Automobile manufacturing seems to be undergoing the same steady decline in the U.K. as in the U.S., in which the share of the U.S. market which American-made cars now comprise is less than 60 percent for the first time in history.¹ But now the U.K. has a shortage of medical students and physicians. Where choices abound, people vote with their feet. The Blair government has now requested 10,000 foreign physicians to join the NHS. Mind you, these are not physicians at the ordinary level. These are consultants—the individuals who occupy the highest level in the NHS and who apparently cannot be drawn from endogenous British medical schools.² The chronic “brain drain,” the lack of attractiveness of the NHS, and the persistent inability to pay physicians adequately has finally hit home. The parallel with what is happening in the U.S., as I will detail below, is frightening.

2. *The waiting lists are now out of control.* Waits of a year are common for just about everything in the U.K. Indeed, the government has finally taken steps to make certain that patients get needed operations. Where? Not within the U.K. The capacity, the skill, and the facilities simply do not exist. Forty thousand patients will probably go to the continent for surgery.³ What a disgrace. A country that holds itself as a second-tier world power cannot take care of its own sick, and has to export them to the European Union. Does anyone really realize what this says about a system that has totally failed?

3. *Long waits on accident floors.* Long waits in waiting rooms on accident floors now lead to deaths that seem to be avoidable. *The Times of London* indicates a death that was an accident waiting to happen in a hospital that everyone viewed as a “hell-hole” and that was chronically accused of having—in addition to horrid physical facilities, urine-stained walls, unbelievable stench in the corridors, and filth throughout—the inability to care for its patients.⁴ A patient with a relatively minor arm burn lay on a gurney for nine hours and bled out from a Cushing's ulcer. Apparently the question is whether he had been seen and monitored during the period of time on an accident floor.

The nature of having to send patients to a foreign country, and even worse, having to rely on foreign countries to furnish physicians, leads to an interesting quandary with respect to the NHS. Will interpreters be furnished?

The U.K. government now promises a massive infusion of funds in order to be able to rectify the situation. However, many, including a former health minister for a former Labor Party administration (and therefore not a member of the opposition), believe that no amount of money can rescue the system in its current form.


Parallels to U.S.

Does this all sound familiar? Perhaps. I assume that no one who is really monitoring the situation for the federal government, including those self-appointed gurus and economists who seem to control American medicine, is really concerned about a 21 percent drop in medical school applicants from a high of 46,968 in 1996-1997 to 37,092 in 2001,⁵ a year (2001) in which 68 places in general surgery programs remained

unfilled, and not only in mediocre training programs, but now in good training programs as well.⁶

The level of indebtedness of medical students is such that many of them, in my humble opinion, will never be able to repay their debt. The criminalization of medicine and the assumption that a physician is a criminal until proven otherwise has taken its toll in the standing of the medical profession. One cannot hope for physicians who are paid less and unable to educate their children in the schools they themselves attended (which is probably the line in the sand) to urge other people, including their children, to go into medicine. No one wants to get paid less than the neighborhood plumber and at the same time be subject to the barbs and arrows of society.

There is a crisis coming in the U.S., a crisis in access. My guess is that it will be here in less than five years, particularly at a time when the number of elderly is increasing and the needs are increasing as well. The gurus do not believe me, but there are lots of other individuals who are not MDs in medical care who do. Indeed, on the coasts, there are increasing numbers of physicians who refuse to see Medicare patients. It's a shame that this action will be necessary in order to have some redressing of the situation. My guess is that given the way the government responds to things, there will be more draconian laws, penalties, fines, imprisonment, and so on. These efforts will only make the matter worse.

Unless and until those societal leaders and politicians who have savaged a pretty good system come to their senses and look "across the pond," as the English say, and see what has happened to a once fine medical system, the same will happen here. No amount of criminalization, harassment, litigation, and downright threat will rectify this situation unless physicians feel better about themselves and their profession. It will be interesting to see which way this country will turn, but I certainly would not want to bet that sensible reforms, increased payment, decreased hassle, tort reform, elimination of unfunded mandates such as the Emergency Medical Treatment and Active Labor Act, and decreased criminalization of medical practice will occur. We will then reap the whirlwind. 

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