

The British National Health Service: a history of reforms, 1990-2002

Sistema Nacional de Saúde britânico: trajetória de reformas, 1990-2002

Sistema Nacional de Salud británico: trayectoria de reformas, 1990-2002

Javier Amadeo ¹

Rosemarie Andreatza ²

Ademar Arthur Chioro dos Reis ²

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Abstract

Recent decades have witnessed important transformations in public services that involve changes in the State's role as central agent in the regulation of public-private relations and the definition of levels of public financing. Health system reform proposals are part of the process of social transformations that have affected various nations. However, changes in the linkage between different dimensions are the result of both broad processes of social transformation and specific experiences and timelines, essential for understanding the results of this process. In recent decades, the British National Health Service (NHS) underwent the most important reform process since its creation in 1948. This process began with a set of measures implemented by the Conservative government in 1991, which were continued through alterations introduced in 1997 and 2002. An analysis of the NHS reform not only provides elements for understanding the current debate sparked by the initiatives led by Boris Johnson and aimed at a new NHS reform starting in 2021; such analysis also allows identifying convergences with other reform proposals in public health systems that were shaped under inspiration from the British model, as in the case of Brazil. The current article aims to discuss and analyse a case of health system reform that can be considered paradigmatic for the development of major trends in this field. The article seeks to specifically analyse the reform processes carried out since the 1990s in the NHS and their consequences for the health system's restructuring.

Health System; Health Care Reform; Health Services; Public Health

Correspondence

J. Amadeo

Rua dos Pinheiros 447, São Paulo, SP 05422-010, Brasil.

javier.amadeo@unifesp.br

¹ Departamento de Ciências Sociais, Universidade Federal de São Paulo, São Paulo, Brasil.

² Departamento de Medicina Preventiva, Escola Paulista de Medicina, São Paulo, Brasil.



Introduction

Health systems, according to Immergut ¹, can be considered the most complex and controversial systems of all social policies. The discussion of these systems' characteristics raises major debates and political positioning among the various social actors involved. Physicians, trade unions, policymakers, health systems users, and other interest groups are permanently involved in the discussions and conflicts over health policy orientations. For political groups, national health policies appear as a prime space for clearly and openly presenting their ideological positions and as a way of garnering social support for their forces. The definition of public policies on the financing and provision of health services plays a central role in the definition of the predominantly public or private nature of a given system. According to the author, public policies "*have important consequences for the medical profession's autonomy, the control and direction of health systems, and their distribution and financing*" ¹ (p. 2).

The health systems that developed in Europe following World War II can be viewed as part of the Welfare State's expansion. Various studies, including the classical analysis by Marshall, have highlighted the relationship between the welfare system's construction and the expansion of economic and social rights during the Post-War period ¹. One central element for analysing the health system's structure and transformations relates to a set of dimensions: "*extent and type of public financing; type of regulation (public and private) provided by the financing; the State's role as owner of the means of production (services and inputs) and as employer (direct or indirect)*" ² (p. 762).

The specific shape of each health system in different countries results from the particular way these three dimensions interconnected over time, based on broader social arrangements and political struggles ^{1,2}.

According to Immergut, it is possible to theoretically construct three major health systems models that were linked in Post-War Europe based on the dimensions described above. First, the model based on mutual funds subsidies, in which government subsidises private organisations, which are responsible for the health services provision. Second, the national health insurance model, with public financing of the insurance cost. Finally, the National Health Service (NHS), with public resources via taxes for financing all expenditures. The models have different characteristics in addition to the financing, type of regulation, and State's role as owner of the health services ^{1,3}.

The British NHS is considered the principal example of this latter type of health service. The model is considered more equitable than the previously described models. The system's principal characteristic is that government guarantees health services for the population directly through public hospitals and physicians also paid with public funds. The founding idea is that health should be viewed as the population's right, and thus health services should be supplied by the State through public financing, with physicians and health care workers hired as public servants and with public health care establishments such as hospitals, clinics, emergency services, etc. The British model is based on the concept that social protection from the health system should be a universal right, regardless of the individual's ability to pay. In this model, the system is financed through general taxes, and government provides total coverage of medical treatment, including medicines, payment of physicians and other health care workers, and physical infrastructure. In the case of the British model, there is also a process of administrative centralisation, intended as a mechanism to control expenditures ¹.

In recent decades, the NHS underwent the most important reform since its creation in 1948. This process began with a series of measures implemented by the Conservative government in 1991, which were continued by the alterations introduced in 1997 and 2002 by the Labour government. This reform had fundamental consequences for the health system's restructuring and the entire public-private relationship.

For Klein, the situation of the NHS should be analysed according to the paradox it represents. The reform process involved the emergence of paradoxical elements within the health system that are essential for understanding the results achieved in the first two decades of the 21st Century. Due to these reforms, the NHS is the only system in Europe that has constantly increased the funding for health in recent decades. In fiscal year 2002-2003, the NHS budget reached nearly 10% of GDP as the result of a long-term strategy established by Tony Blair's Labour government. Simultaneously with this constant increase in funding, there was a profound process of transformation in the system's structure and logic. According to the same author, this process of transformation involved the shift

from a technocratic and paternalist system without adequate criteria to a system of distribution of funds to a consumer-oriented service. The author also states that the reforms were important for two reasons. First, because of a long-term policy of increasing health spending; second, due to the institutional redesign process, aimed at combining universal and comprehensive coverage with flexibility and capacity to respond to the population's demands and needs ⁴.

Dopson ⁵, in turn, states that the transformations in the NHS should be analysed according to the changes produced in a range of spheres: hierarchies, markets, and networks. An essential element according to the author is to understand the changes in NHS management based on the introduction of a set of practices from New Public Management (NPM). These practices assume the need to increase the health system's efficiency through growing competition in services provision; more efficient use of resources; creation of performance control measures; and introduction of private sector management styles. However, this management vision has been criticised for introducing a market-based ideology, with its practices invading sectors of the public service oriented by another management logic ⁵.

New Labour's role in restructuring the NHS is highlighted by Mohan, for whom the reforms conducted by Tony Blair's government deepened the logic established by the Conservative government, increasing the role of private interests in health services provision. Privatisation and commodification have expanded the private sector's importance in the health area and modified the relationship between State, NHS, and private sector, with important consequences for health's future in the country ⁶.

Talbot-Smith & Pollock ⁷ also highlight the transition experienced by the NHS. According to the authors, the NHS, "*a publicly-owned system of publicly-owned and provided health care is being replaced by a health care market, in which public providers of services compete with private ones for NHS funds, with legal contracts, and external regulation replacing direct political accountability*" ⁷ (p. 1). This transition is much faster and has a much greater reach than the experts have emphasised. In this process of change, the old forms of public health management, organisation, and provision were replaced by new structures, agencies, and logics ⁷.

The article aims to describe the history of reforms in the British health system, which can be considered paradigmatic in the development of major trends in the area, particularly since the NHS is a fundamental international reference on the subject. The text specifically aims to present the reform processes conducted since the 1990s in the NHS and the consequences for restructuring the health system. We will draw on secondary references that discuss the reforms and some of the most important official documents underlying the process.

The conservative government's reform: efficiency and response capacity

With the economic crisis of the 1970s and the emergence of neoliberalism, specifically in the United Kingdom, serious questions were raised concerning the financial sustainability of the Welfare State built in the Post-War period. The 1970s also witnessed arguments concerning the purportedly high costs of the NHS, and the Conservative Party began to defend the health system's reform to improve its economic efficiency, according to the argument.

From the ideological point of view, the conservative government believed that the NHS and other public services should adopt the private sector's management practices. The Griffiths Report was published in October 1983, presented as a letter to the Secretary of State for Health and Social Services with a series of recommendations on the NHS. As stated by Dopson ⁵, the Griffiths Report can be viewed as an example of the way the New Public Management (NPM) model was introduced into the proposals for public administration reform in the United Kingdom. The Report features five fundamental criticisms of the NHS: lack of strategic central direction; lack of individual management accountability; failure to use objectives to guide management action; negligence towards performance; and negligence towards consumers ⁵.

The report underlined the need to introduce a new management format that assigned to a person, at different levels of organisation, the responsibility for planning, implementing, and controlling

performance, abandoning the previous model of formal consensus-building in the decision-making process – which had been characteristic of NHS management ⁵.

However, it was not until the 1990s that the British government announced a more ambitious reform proposal for the NHS, based on the diagnosis presented in the white paper *Working for Patients*, which advanced further on questions raised by the Griffiths Report. In the new document, the conservative government presented what it considered the principal problems in the NHS: financing problems; low quality of care; prolonged waiting time for emergency treatments; and differences in standards of care in the country's different regions. The Thatcher government was seeking to introduce new management strategies to overcome the problems identified by the diagnosis and to make the system more cost-efficient ^{5,8}.

The NHS reform proposal, called the NHS and Community Care Act, was passed in 1990 and began to be implemented the following year. The measures sought to create an internal market within the health system, separating purchasers and providers of services, and incorporating mechanisms of competition which (in the government's reading) would improve the system's efficiency. As stated by Melo et al. ⁸, this meant important changes in the internal structure of the NHS vis-à-vis the role of the system's different actors, financing and management mechanisms, and integration among levels of care.

Before the reform, hospitals, health centres, and other medical services were administered directly by the local health authorities, which acted as agents of the Department of Health. According to Melo et al. ⁸, the NHS consisted of 14 Regional Health Authorities (RHA), and in Wales, Scotland, and Northern Ireland there were also regional offices of the NHS that supervised the District Health Authorities (DHA), responsible for planning and operating hospitals and health units. The hospital network was basically public, with 80% of the beds belonging to public hospitals. From the perspective of financing health services, the DHA received public financing based on the history of care performed and transferred these funds to hospitals and health units.

According to the proposal, as described by Tanaka & Oliveira ⁹, providers competed by offering health services with given quality and costs as a way of attracting interested buyers. The buyers, in turn, would have the freedom to choose between various providers and could acquire services outside of their district. The DHA would continue to be responsible for planning the health actions based on the population's needs. But with the reform, these authorities would receive public funds according to the district population's profile to hire the health services. Other purchasers of health services would become primary care groups called GP fundholders, consisting of groups of general practitioners with a certain number of patients who would receive public funds to hire secondary health services. The services hired by the GP fundholders could have a varied complexity, from the simplest to the most complex in the system ^{8,9}.

The reform implemented by the British government allowed general practitioners, who had functioned since the beginning of the NHS as the system's portal of entry, to organise as GP fundholders to care for the population. To receive public funds for costing, drug purchases, and investments, they needed to cover the health needs of a population of 11,000 persons. General practitioners that were not part of any group could continue to be paid by the DHA, but they would not have access to funds for secondary services ⁹.

Another fundamental element in the NHS reform was the reorganisation of the great majority of the public hospitals as autonomous and independent foundations called trusts. These trusts were organised administratively as autonomous entities, although the executive director was named by the national health authorities. The new trusts did not receive their budget directly from the DHA, and financing was performed through a hiring process with the health authorities, the GP fundholders, and the private sector ^{8,9}.

As a result of the reform, an internal market was created in the health system in which the trusts competed for the contracts of the GP fundholders and the DHA. However, as stated by Tanaka & Oliveira ⁹, important State regulation continued to exist, since the contracts allowed authorities to control the quality of the services provided by hospitals, subject to suspension in case of failure to meet the required quality standards.

According to Klein ⁴, the trusts became semi-independent companies that were supposed to manage their budgets "responsibly" through administrative decisions, but also to create incentives for

businesses to be “attractive” to the hirers of these services. This reform also had an impact on the work of the general practitioners, who could be responsible for hiring additional care or leave this hiring in the health authorities’ hands.

For Klein ⁴, the reform’s objective was clear: the notion that led these changes was that competition between providers to guarantee contracts, whether the health authorities or the general practitioners that opted to join the GP fundholders, would improve the efficiency and response capacity (our emphasis).

According to Dopson ⁵, the conservative reform of the NHS was based on a managerialist vision inspired by NPM that sustained the idea of a consumer- and performance-oriented culture and that believed in the possibilities created by market competition mechanisms as a way of improving the system’s efficiency. Another important issue in the reform was the incorporation of the figure of manager and administrative director in the NHS decision-making structure, conceived as the core of the new management dynamic.

In addition to the managerialist perspective introduced by the reform, another target of criticism was the health system’s increased fragmentation. According to Pollitt ¹⁰ the reform greatly increased the number of health services purchasers, leading to fragmentation of the system and raising doubts about its overall coherence.

For a complex set of reasons, the reform by the conservative government never worked as originally planned. However, some of its pillars, such as the idea of increasing the system’s efficiency and response capacity, remained as principles incorporated by the attempt at reform in subsequent years, but by a government that was not conservative.

A new NHS: modern and reliable. The 1997 reform

The election of Tony Blair’s Labour government in 1997 after 18 years of conservative governments appeared to offer the NHS less agitated times. Yet the new government also proposed a modernisation of the British health system ¹¹. According to Mohan ⁶, once the Labour government was in power, it embraced various pro-market ideas and principles from NPM that oriented its reform proposals for the NHS.

In December that year (1997), the Labour government submitted a reform proposal to Parliament – *The New NHS: Modern. Dependable*. The proposal stated that the government’s goal was to give people the best health system in the world. In the government’s diagnosis, the system took too long to offer treatment to patients, and the treatment’s quality varied. A series of reforms were thus necessary to improve the services’ quality and decrease patients’ waiting time for care.

The new proposal stated that “...the internal market would be replaced by “integrated care”, based on partnerships and driven by performance. It would form the basis for a ten-year program to renew and improve the NHS through evolving changes rather than organisational dysfunction” ¹² (p. 7).

According to Ham ¹¹, the document indicated that the Blair government aimed to build an alternative path to the conservative reform policies for the NHS and the traditional Labour approach. The development of this new approach to health, but also to public services in general, was related to the building of New Labour starting with the Blair government.

Taken as a whole, the proposal involved a series of profound changes in the functioning of the NHS. Although the horizon for implementation of the transformations was ten years, the accelerated pace of change that had started in the previous government continued during the Labour government. As stated by Ham ¹¹, the establishment of primary care groups, now called Primary Care Trusts, was the most important innovation by the government and signalled a trend towards continuity, with some of the fundamental elements from the reform initiated by the conservative government. Thus, according to Ham ¹¹, the new reform aimed to align clinical and financial accountability, resuming the financing experience from the conservative government and extending it throughout primary care.

For Klein ^{4,13}, the Labour government’s reform proposal had three main characteristics.

First, the new proposal criticised its predecessor for the creation of an internal market. It placed emphasis on cooperation rather than competition. However, in the author’s assessment ⁴, the difference was more rhetorical than real, and the system’s structuring on medical care purchasers and pro-

viders such as hospitals and health companies was maintained. The main difference was the change to more long-term contracts, from one-year contracts to three years.

A second characteristic, as mentioned above, was the creation of primary care trusts. Unlike the conservative government's reform, participation by these groups was now mandatory. All the general practitioners, dentists, pharmacists, and other primary care workers needed to register in a specific geographic region. These groups had their own budgets and were responsible for the medical care of their populations. The primary care trusts now controlled 75% of the health system's expenditures ^{4,7,13}.

Another characteristic of the proposal was the emphasis on offering services with the same quality throughout the country, reclaiming the original idea of the NHS. The government's diagnosis pointed to important regional disparities in the functioning of the NHS, and the proposed measures aimed to equalise the health service's functioning throughout the country and to monitor its quality ⁴.

Klein ⁴ states that this program entailed an inherent tension. On the one hand the emphasis on the creation of powerful primary care trusts, or placing general practitioners in the lead, as the government said, suggested a double service – power for the periphery, with decisions on which services to supply and how to configure them left to the local level. Meanwhile, the national standards suggested a centralised service, with decisions on the level and configuration of services made at the centre. The program also left a political vacuum. Once the idea of trusting in market discipline was abandoned, what was left was the issue of the type incentives that could be designed to reward efficiency or compliance with the government's policy. The history of the NHS since 1997 is a record of attempts to solve this tension and to fill the political vacuum.

This tension was reflected in a structure that aimed to strengthen the definition of needs from below, emphasising local priorities in health matters. However, at the same time, the Labour government announced a set of measures to strengthen the central government's power. These measures aimed to establish a national standard in the model to equalise care at the national level, one of the founding objectives of the NHS. One problem that this reform aimed to solve was the disparity in the scope, efficiency, and quality of patient care services across the different regions ¹³.

From the point of view of primary care, another important innovation by the government was the implementation of NHS Walk-in Centres. Forty of these centres began to function in January 2000 in 30 English cities. The objective of the NHS Walk-in Centres was to improve access to quality health with efficiency and supporting other local providers in the NHS. The centres' implementation aimed to improve access through multiple office hours, diverse sites, and minimum waiting time for care. Another goal was the use of software for clinical evaluation, providing high quality care, reducing the demand on other health services, and thus maximising efficiency. According to Salisbury et al. ¹⁴ this initiative and other primary care proposals such as NHS Direct, a 24-hour health information telephone hotline, were an important part of the governments' measures to modernise the NHS.

The Labour government also aimed to develop instruments to monitor and improve health services quality in the country. As reported by Walshe ¹⁵, the *Commission for Health Improvement* was created, linked directly to the Secretary of State for Health, in charge of monitoring, ensuring, and improving health quality in the country. The commission's principal functions included leadership in clinical governance, analysis of local governance arrangements via review of NHS providers, revision and implementation of national guidelines for the NHS, supervision of external incidents, and analysis of severe and persistent problems in health care. As cited by the same author, although other forms of inspection had also been used in parts of the British NHS in the past, "*this was the first time an agency with such broad competency for quality improvement was created*" ¹⁵ (p. 191).

The period following the reform of 1997 witnessed moves to resolve the tension described above between the attempt at a national health policy with centralised guidelines and the decentralisation of decisions with the implementation of the primary care trusts. This was accompanied by a certain political vacuum, as reported by Klein ⁴, resulting from the reform's implementation. The reform had set aside the idea of an internal market, proposed by the conservative government, but without indicating other types of incentives to improve the efficiency of care or to align with the policy guidelines set out by the central government.

Klein ⁴ contends that in the first period of the Labour government, this tension was resolved via centralisation of the decisions. The NHS had been designed originally to be a "command and control

model” for the organisation of health care. Yet it had never functioned this way in its practical implementation. For Klein ⁴, the NHS could be described more adequately as an “exhortation and hope” model, in which the central government exhorted the adoption of measures at the local level and hope that this would be done. The measures taken by the Labour government redesigned the organisational structure of the NHS and established more clearly the competencies of the system different levels. The creation of the Commission for Health Improvement and the National Institute for Clinical Excellence played a fundamental role in the construction of a more centralised management model and the establishment of national health guidelines ⁴.

This management format allowed the NHS to function as a more centralised system, permitting the central government’s command and control. Although the NHS structure historically involved some degree of centralisation due to the financing mechanism via national taxes, until this period there had been an important degree of autonomy in its functioning. One of the consequences of the reform by the Labour government was an enormous increase in interference by the central government. This centralisation sparked criticism and led to an evaluation by the government which served as the basis for changes in subsequent years ⁴.

Although it is beyond the scope of this article to discuss the creation of regional NHS in Wales, Scotland, and Northern Ireland as part of partial devolution of rights, it is important to mention that the Blair government’s election played a key role in this process. As stated by Ham ¹¹, the organisation of the NHS in these countries also displayed some specificities in relation to England. However, starting in 1999, with the creation of a Scottish Parliament and a Welsh Assembly with powers over services like the NHS, there was a growing divergence in the structuring of health in the constituent parts of the United Kingdom. The creation of regional NHS raised the question again, cited above, of centralisation/decentralisation of health policies and reopened a debate that had been resolved when the NHS was first created. Aneurin Bevan’s position had prevailed at the time, that the NHS should be established as a national service, contrary to the opinion of Herbert Morrison, who preferred local control of the service ^{11,16,17}.

The NHS and the new emphasis on localism

After five years in power, the Blair government began to find that the centralising proposals for the NHS had not been totally successful, and the idea of returning responsibility over the functioning of NHS to the local level began to gain force. This idea about decentralisation as a way of solving public services’ management problems began to be discussed internally in New Labour in the early 2000s ¹⁸. In 2002 the government designed a new management strategy for the NHS to attempt to overcome some of the impasses created by the 1997 reform. This new strategy, which the authorities called “real localism”, aimed to guarantee public health provision collectively, with a modern, fair, and consumer-oriented format ¹⁸.

In the speech entitled *Localism: from Rhetoric to Reality*, delivered in 2003, the Secretary of State for Health, Alan Milburn, proclaimed, “I believe that we can win the argument for public service investment and reform but to do so we have to accept that the era of one-size-fits-all public services is over and that the Centre-Left’s approach today should be based on decentralisation, diversity and choice” ¹⁸.

The government claimed that the new reform proposal was the best strategy to guarantee the values of the NHS, but that it was necessary to change the structure of the system’s functioning. The NHS goals remained the same, a universal system that guaranteed health for all, regardless of the possibility of paying for it. But it was necessary to change the way to reach these goals, since a management format based on the idea of a public monopoly was no longer possible.

In the government’s assessment, the NHS had enormous strengths, but also weaknesses that had to be corrected. One of the points to be corrected was the distance established between the central management of the NHS and local health provision needs. The document contended that the United Kingdom was not a uniform country, that there were major regional differences that needed to be considered in public policymaking. The NHS needed to be organised with attention to each local community’s needs, relying on people’s capacity to innovate and take decisions. The document further stated that health management decisions should be taken in the hospitals and health centres and

not in centralised fashion by the national government. Decentralisation of decisions would be the strategy adopted by government to improve efficiency in health services provision ¹⁹.

The new government strategy indicated the acknowledgement that a centralised command and control model as proposed in the 1997 reform had perverse effects. But it was also a strategy to alleviate the central government's responsibility for problems with the NHS and share the responsibility with local governments ⁴.

As stated by Allen ¹⁷, from the perspective of health services provision, the decentralisation proposal involved the introduction of Foundation Trusts. The creation of these organisations sought to address important elements for the government, improved efficiency, and consumer orientation. An additional element of these innovations according to the author was the creation of a new financial system, to be implemented starting in April 2005, based on payment by results.

According to Allen et al. ¹⁹, implementation of the Foundation Trusts sought to afford greater autonomy from the central government and guarantee the involvement of employees, patients, and public servants in the hospitals' management. The goal of increasing autonomy from the central government was linked to the introduction of market mechanisms that had been incorporated previously in the NHS structure. With this process of decentralisation and change in governance, the government intended to increase the health system's capacity to respond to local communities' demands and make them more receptive to the consumers' wishes ¹⁹.

For Klein ⁴, the new reform proposal aimed to introduce semiautonomous organisational units (Foundation Trusts) with the capacity to decide on wage structures for physicians and other health workers and with autonomy to raise resources on the market to finance health services. There were important differences between the existing health organisations and the new ones to be created through the announced reform. The health organisations were supervised by the Health Secretariat, and in the new proposal, the responsibility for oversight of the NHS Foundation Trusts came under the purview of an independent regulatory body. Initially, the 30 groups with the best assessment by the government were selected and allowed to become the new NHS Foundation Trusts ²⁰.

The introduction of the NHS Foundation Trusts meant an important change in orientation, established a less centralised and more consumer-centric system. We also see an important change in the emphasis placed by the Labour government – from the discourse of the previous reform, which highlighted the importance of placing health agents in the system's management, the shift was to a discourse that emphasised patient's choice. The government's objective was oriented by the principle of giving patients the right to choose, allowing the selection of specialists and treatments, as well as elective surgeries ²⁰.

The creation of the NHS Foundation Trusts can be considered one of the most important transformations in NHS history and involved a new form of provision and management in the British health system. The change led to a reconfiguration of services provision, which continued to be public, but not supplied directly by the State. Although the NHS Foundation Trusts continued to be part of the NHS, they were now defined according to Health and Social Care (Community Health and Standards Act of 2003) as independent organisations called Public Benefit Corporations, with the objective of supplying health services to patients and users of the NHS according to the principles and standards established by the NHS itself ⁴.

These organisations now had greater liberty and autonomy to manage resources and make investments. The new structure was expected to have a close relationship with the local communities where they provided services, and community members had the possibility of participating in the organisations' management. The government's objective was for the local communities to play a more active role in the definition of health service needs in the communities. The NHS Foundation Trusts could thereby supply services that were closer to the local communities' needs, and now with the freedom to develop a health services supply strategy in keeping with the population's expectations ¹⁹.

These changes were accompanied by alterations in the system's internal financing structure. A system that had functioned until the reform with the idea of "payment by results" was gradually altered to another system with the objective, according to the government's own document, "*of supporting patient choice, guaranteeing that diverse providers could be financed according to the patient's choice*" ⁴ (p. 940). The document published by the British government in 2002, entitled *Reforming NHS: Financial Flows*. Introducing payment by results, described this government strategy for financing the NHS ²⁰.

This set of measures implemented by the Labour government, adding to previous measures analysed above, led to the most sweeping reorganisation in health management and provision in the United Kingdom in the last 50 years, as shown in Figure 1.

Final remarks

As explained in the introduction, the reform of the British NHS in recent years provides interesting elements for reflecting on the problems, challenges, and inherent tensions in transformations of public health systems in contemporary societies. This reform process, the most important one in the NHS since its creation, involved three different moments.

First, the reform by the conservative government in 1991 involved a fundamental change in the direction of the NHS, introducing a new management vision in the system with the aim of improving its efficiency. To achieve this objective, the reform proposed to introduce market mechanisms with the creation of an internal market, separating services purchasers and providers as a way of improving the system's efficiency.

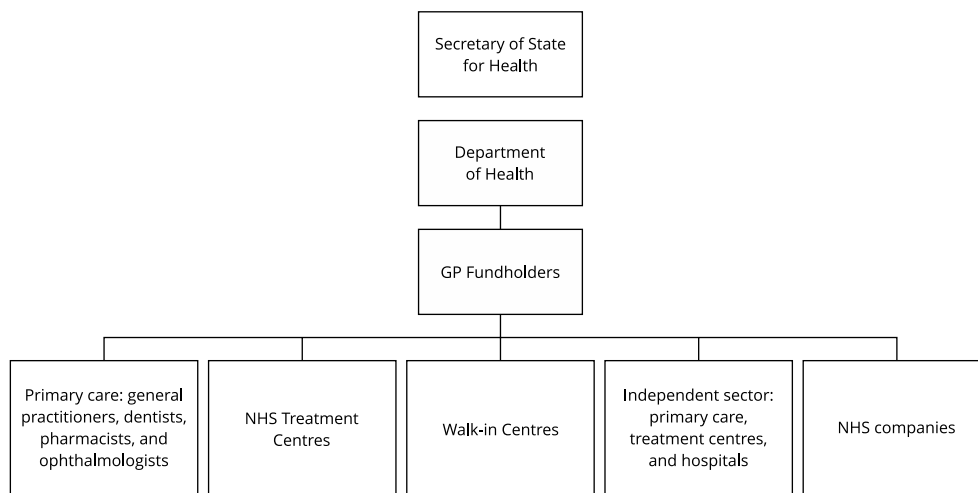
The second moment in the reform process featured changes implemented by Tony Blair's Labour government in 1997. The new measures sought to place greater emphasis on cooperation than on competition, but this new emphasis appeared to be more rhetorical than fundamental in relation to the previous measures. An additional element in the measures implemented in 1997 was the attempt to create a national standard to assess the health system's functioning.

The last moment in the reform was elaborated according to a strategy called "real localism", which determined that health services provision should be consumer-oriented, less centralised, and with greater leadership by local authorities. The proposed changes aimed to give consumers the possibility of choosing medical specialists and treatments.

This reform process involved a change that introduced market mechanisms in the health system, both with the modifications proposed by the conservative government and those proposed by the Labour government. The premise was that market mechanisms would improve the efficiency in distribution of the resources. The real localism strategy also brought the implicit idea of consumer orientation as the way to improve the services supply, an idea with clear neoliberal connotations.

Figure 1

The new National Health Service (NHS).



Source: Talbot-Smith & Pollock 7.

The reforms resulted in a profound transformation of the NHS and the State's role as health services provider and regulator in the United Kingdom. As stated by Talbot-Smith & Pollock ⁷, the model that gradually emerged from this process was an NHS that hired diverse health services from various providers, both public and private. The NHS became increasingly less a direct provider of health services to the population and increasingly a hirer of services financed by the State. Meanwhile, the old system of political accountability based on public service ethos changed to a model based on private law mechanisms ⁷.

The analysis of the NHS reform provides elements that allow understanding the current debate fostered by the initiatives led by Boris Johnson, aimed at a new reform of the NHS beginning in 2021 and revealing convergences with reform proposals in other public health systems inspired by the British model, as in the case of Brazil. A recent article on the reform of the Brazilian Unified National Health System (SUS) emphasised the need for integration between the public sector, responsible for providing the budget funds, and the private sector, responsible "for the 'efficient' and 'modern' management of the resources" ²¹. The similarities do not appear to be a mere coincidence. However, such potential similarities were beyond the scope of the current article, which aimed to raise elements for reflecting on how the reforms implemented in the British NHS can also be seen in other countries with universal health systems.

Contributors

All the authors participated equally in the article's production.

Additional informations

ORCID: Javier Amadeo (0000-0002-3941-2163); Rosemarie Andreatza (0000-0002-3332-2183); Ademar Arthur Chioro dos Reis (0000-0001-7184-2342).

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Resumo

Nas últimas décadas, assistimos importantes transformações nos serviços públicos que implicam mudanças no papel do Estado como agente central no processo de regulação das relações público-privado e na definição dos níveis de financiamento público. As propostas de reforma dos sistemas de saúde formam parte do processo de transformações sociais que afetaram os diferentes países. No entanto, as mudanças na articulação das diferentes dimensões são resultado tanto de processos amplos de transformação social como também de experiências e temporalidades específicas, fundamentais para entender os resultados desse processo. O Sistema Nacional de Saúde britânico (NHS) passou nas últimas décadas pelo processo de reforma mais importante desde a sua criação em 1948. Esse processo começou com um conjunto de medidas implantadas pelo governo conservador em 1991, mas que foram continuadas pelas alterações realizadas em 1997 e em 2002. Ao analisar a reforma realizada no NHS, para além de aportar elementos que permitam compreender o debate atual proporcionado pelas iniciativas lideradas por Boris Johnson que visam a empreender nova reforma no NHS, a partir de 2021, é possível encontrar convergências com outras propostas de reforma de sistemas públicos de saúde, que se inspiraram em sua conformação no modelo britânico, como por exemplo no caso do Brasil. O objetivo do presente texto é discutir e analisar um caso de reforma no sistema de saúde que pode ser considerado como paradigmático no desenvolvimento de grandes tendências na área. O artigo busca analisar especificamente o processo de reformas realizadas, a partir da década de 1990, no NHS, e suas consequências do ponto de vista da reestruturação do sistema de saúde.

Sistemas de Saúde; Reforma dos Serviços de Saúde; Serviços de Saúde; Saúde Pública

Resumen

En las últimas décadas asistimos a importantes transformaciones en los servicios públicos que implican cambios en el papel del Estado, como agente central en el proceso de regulación de las relaciones público-privadas, así como en la definición de los niveles de financiación pública. Las propuestas de reforma de los sistemas de salud forman parte del proceso de transformaciones sociales que afectaron a diferentes países. No obstante, los cambios en la coordinación de las diferentes dimensiones son resultado, tanto de procesos amplios de transformación social, como también de experiencias y factores temporales específicos fundamentales para entender los resultados de ese proceso. El Servicio Nacional de Salud británico (NHS) pasó en las últimas décadas por el proceso de reforma más importante desde su creación en 1948. Este proceso comenzó con un conjunto de medidas implementadas por el gobierno conservador en 1991, pero que continuaron con las modificaciones realizadas en 1997 y en 2002. Al analizar la reforma realizada en el NHS, además de aportar elementos que permitan comprender el debate actual, debido a las iniciativas lideradas por Boris Johnson que tienen como objetivo emprender una nueva reforma en el NHS, a partir de 2021, es posible encontrar convergencias con otras propuestas de reforma de sistemas públicos de salud, que se inspiraron en su conformación en el modelo británico, como, por ejemplo, en el caso de Brasil. El objetivo de este trabajo es discutir y analizar un caso de reforma en un sistema de salud que puede ser considerado como paradigmático en el desarrollo de grandes tendencias en el área. El texto busca analizar específicamente el proceso de reformas realizadas, a partir de la década de 1990, en el NHS, y sus consecuencias desde el punto de vista de la reestructuración del sistema de salud.

Sistemas de Salud; Reforma de la Atención de Salud; Servicios de Salud; Salud Pública

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