The systems of health care delivery in the United Kingdom and the United States were compared at the recent American College of Surgeons meeting in Chicago, Ill.

The opening speaker, Anthony Giddings, MD, FRCS, introduced the session by outlining the development of the current National Health Service and provision of health care in the United Kingdom. Prior to its inception in 1948, there was marked inequality in the provision of health care to the wealthy and the poor. Wealth was held by a few and poverty was the lot of many. During both world wars, many of the conscripts to the armed forces were medically unfit because of poor social conditions, including medical care. The National Health Service was introduced in 1948 as a response to the social need; at the same time, it took over what were virtually bankrupt hospitals that were provided by the local councils. Consultants, who had previously relied on private practice for their income and treated patients in the hospitals, merely became salaried employees but retained the right to run a private practice. The concept of the National Health Service at its inception included the provision of universal care, competent treatment, and, above all, free service at the point of delivery. The architect of the National Health Service, Lord Beveridge, thought that it would reduce the need for treatment by practicing what should be described as preventive medicine. Unfortunately, this has not occurred as there is an increased demand in response to patients’ high expectations as well as advancing technology.

Funding of the National Health Service comes, as it always has, from general taxation and not from the national insurance contributions paid by all. It continues to be free at the point of delivery. The general practitioner remains the gatekeeper of the profession, with hospital physicians and local community medical care as the other part of the total patient care program. The general practitioner works in the community, which means that there is comprehensive coverage from the hospital to the community in theory. The financing of the National Health Service has changed considerably.

Originally, the general practitioners were paid a capitation fee depending on the number of patients on their list, and the hospital treatment was funded by the government. This funding has changed, with the general practitioners becoming budget holders and being able to negotiate a contract for the work to be done with the hospitals. The hospitals were allowed to become trusts, which is similar to a private hospital, and managed their own budgets, with the income coming from the fund-holding general practitioner. At the same time, an internal market was set up within the hospitals in which the individual departments charged each other for their services. This current situation, in other words, a purchaser and provider concept, was set up by the government in an attempt to control costs. Unfortunately, there is no extra money, which has led, in a way, to a form of rationing. There are still long waiting lists for treatment despite availability of additional funding.

Within the sphere of surgery, there has been no strategic planning. The gen-
eral surgeons who have a specialty may or may not practice that specialty to maximum efficiency, depending on the area and hospital. Some surgeons could be practicing the whole spectrum of surgery, while others sporadically could be undertaking a specialist procedure with which they may or may not be fully experienced. Much of the surgery was originally performed by physicians in training, who were frequently inadequately supervised. This was shown in a confidential inquiry into perioperative deaths that has now become an annual exercise. As a result of legislation, the number of hours worked by physicians in training in the United Kingdom has been reduced to 54 hours per week. This reduction, combined with the reduction in the length of training, was thought to be beneficial to the development of a better, more efficient delivery of health care with increased numbers and more specialized physicians. This system has just started and has its problems, not only financial.

There is underfunding of the service, which successive governments have tried to reduce. At the same time, governments have tried to cap the spiraling costs as much as possible. Other changes have led to the current low morale in the service. In addition to the general practitioner becoming the pivot of patient care, the patient has been given considerable power in the Patients’ Charter. It has given the patients this power by dictating how soon they should be seen, how long they may be on the waiting list for treatment, and a right to complain about any aspect of their care. This charter has put considerable pressure on the consultants, who are already under stress from the increasing numbers of patients receiving both elective and emergent care without a proportional increase in the number of consultants. The United Kingdom has one of the lower ratios of surgeons to patients, 6 per 100,000, compared with the United States, which has 51 per 100,000. The ratio of physicians in training to consultants is high, 1.7:1.0; in the United States, the ratio is 0.6:1.0. It was hoped that the United Kingdom’s concept of managed care, combining hospital care with care within the community, would be the right approach for the provision of care for the individual patient. This concept has produced problems because of underfunding and a relatively inadequate number of support personnel.

Sir David Carter, MD, FRCS, professor of surgery in Edinburgh, Scotland, gave a succinct overview of the changing pattern of health care in Scotland. It differs from the rest of the United Kingdom in terms of the major centers as well as the patient population when related to surgical needs. He was undertaking a review of the whole service, principally in relationship to major subspecialties and the needs of the patient, the latter particularly in remoter areas. Advances in surgery, particularly minimally invasive procedures, indicated that the divisions between medicine and surgery were no longer as clearly defined as they had been in the past. It was suggested that in the future, units might be formed with a common medical and surgical interest to deliver care for the patient based on major centers. Whether this was the answer to providing optimal care for the patient was uncertain.

The Oregon Health Plan, as outlined by Richard Crass, MD, FACS, who was involved in the development of the program, created much interest. It appeared that the involvement of health care delivery organizations as well as the patient in the determination of the relative priority of health care funding might provide one answer to the provision of managed care and the containment of costs.

There is no doubt that both countries are facing problems in the delivery of health care in the future. It is difficult to define what is best for the patient as an individual and as a member of the community. Is it the United Kingdom’s current approach to managed care, which might need further modification, or is it the various approaches being tried in the United States? In both countries, cost appears to be a common factor. Bruce Spivey, MD, FACS, indicated that future health care should be comprehensive, compassionate, and competitive in cost, and this might require a degree of consolidation.