Better Healthcare for All

Replacing the NHS monopoly with patient choice

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FOREWORD

THE RIGHT TO BUY legislation of 1980 was in Shirley Letwin's words 'something near to a revolution'. Over a million and a half council house tenants took the choice of using their own money to invest in what became their most valuable physical asset – their own home. It was a policy that gave former tenants a new-found sense of independence and self-sufficiency. It showed that the British people, when given the opportunity, would choose to free themselves from reliance on the state. And it was, of course, immensely popular.

Providing everyone with access to high quality, independently managed healthcare is today's political prize equivalent to council house sales. For, as with council house sales, it is the poorest and weakest who are least well-served by state bureaucracy. Those who have the capabilities can work the system to their advantage – or even opt out of it altogether. Just as council house sales gave the opportunity to the less well-off to buy their own homes, so today a choice of healthcare schemes should be opened up to everyone, not just reserved for the rich.

The result of breaking up the current state monopoly over healthcare would be to drive up efficiency, innovation and quality of care – objectives that cannot be met by simply pumping more money into the existing NHS structure. And it too could prove to be immensely popular.

Lord Blackwell
Chairman of the Centre for Policy Studies May 2002

SUMMARY

The diagnosis

- Despite steadily rising investment, the NHS has failed to deliver the noble aspirations outlined by its founders: the best modern healthcare is simply not available to everyone who needs it.

- The fundamental problem of healthcare in the UK is not a lack of 'investment'. It is nationalisation at three levels: the provision of healthcare is nationalised; the purchasing of healthcare is nationalised; and the allocation of healthcare resources is nationalised. All are state monopolies.

- The recent Department of Health document, *Delivering the NHS Plan*, announced some potentially far-reaching changes to the provision of healthcare. Its aim to allow hospitals to become self-standing and autonomous institutions is welcome. The proposals in this paper build on this liberalisation of supply by extending the principle to the liberalisation of demand.

- However, the Government's proposals fall far short of real reform. Most importantly, while the purchasing of healthcare remains a state monopoly, the NHS will have only one customer: the government.

- The proposed increases in expenditure do not address the inefficiency inherent in the NHS. There will still be no method of judging the 'right' amount of money to be spent on health. All but the most well-off patients will still have no method of expressing their demand for health care.

- The ability of the NHS to absorb extra money is not in doubt. What is in doubt is whether funding increases can deliver equal increases in medical activity. While NHS spending rose by 9% in 1999-2000, levels of activity rose by only 1%. This low rate of return should concern those who have argued against liberalising the purchasing of healthcare in the UK.

- Despite the best efforts of staff and management, the NHS is bedevilled by waste and inefficiency. This is a common feature of all nationalised industries.

- It is the most vulnerable who suffer at the hands of the NHS. The system inevitably distributes its resources not according to who needs its services most, but by headline-driven political priorities and by the individuals and special interest groups who can best manipulate the system.

- The monopoly of health provision in the UK reduces both the pressure to innovate and the pressure to reduce costs. It draws all power to centre, away from patients. The manipulation of waiting lists is the most glaring example of how the system puts the interests of managers and politicians above those of the patient. Again, these are features common to all nationalised monopolies.

- Doctors and nurses are also victims of the NHS monopoly. Poor pay, limited flexibility, poor working conditions and limited professional development are all the result of a system in which there is just one single employer.

The vision

- Only by replacing this monolithic, bureaucratic, nationalised monopoly with a liberalised, plural and mixed health system will the UK have the standards of care that it deserves.

- To this end, a patient-centred service should be encouraged through the development of self-governing specialist and community hospitals, as well as private tertiary care providers.

- Purchasing of healthcare must be liberalised. Providers should be paid on the basis of the services they provide. Money should follow the patient.
- The funding of healthcare must also be liberalised. However, both private medical insurance and social insurance have significant drawbacks in terms of equity, cost and administrative burden.
- A more attractive option is the development of 'Community Mutual Insurers' (CMIs), which would be non-profit, member-owned providers of healthcare products and insurance. They would either purchase cover on their patients' behalf or insure a patient directly.
- A patient would have the option of transferring part of his NHS entitlement out of the NHS into the CMI of his choice. This 'NHS Credit' would guarantee access a comprehensive set of services matching those available in the NHS. The patient would also be free to top up the NHS Credit with additional payments to gain benefits above the core CMI entitlement.
- The list of those services covered by the NHS Credit could be defined by criteria which assess the patient's needs (as opposed to a list of specific treatments). This system works successfully in countries such as Holland and New Zealand.
- The state would continue to fund core services (such as Accident and Emergency, maternity services, treatments for serious illnesses etc.). The provision of such services would be open to competitive pressures.
- All patients could, if they chose, have access to affordable private healthcare. Rather than healthcare spending being artificially constrained by the Treasury, consumer demand for care would, for the first time be freely expressed. And the healthcare treatment of all would be greatly improved.

The short term

- The move to a system of diverse healthcare must be incremental. The following measures, however, could all be implemented in the short term:
    - a commitment to increasing capacity: more doctors, nurses and facilities are needed;
    - the investment in Information Technology necessary to deliver patient-centred care;
    - a focus not on process but on outcomes;
    - a single system of healthcare regulation;
    - vouchers for elective healthcare where treatment is delayed;
    - a stronger commissioning role for Primary Care Trusts;
    - an enhanced range of GP services;
    - more integrated support services for elderly people;
    - tax breaks for private medical insurance.

- These short term reforms would extend choice, create the conditions for investment and innovation by alternative providers and would enable today's healthcare system to evolve from the current nationalised monopoly into a properly plural healthcare market – to the benefit of all.

CHAPTER ONE

INTRODUCTION

IN 1945, a few weeks after his appointment as Minister of Health, and charged with the creation of the National Health Service, Aneurin Bevan addressed a group of doctors in London. 'I conceive it the function of the Ministry of Health', he told them:

> …to provide the medical profession with the best and most modern apparatus of medicine and to enable them freely to use it, in accordance with their training, for the benefit of the people of the country. Every doctor must be free to use that apparatus without interference from secular organisations. The individual citizen must be free to choose his doctor and the doctor must be able to treat his patient in conditions of inviolable privacy.[1]

This is a succinct summary of how healthcare should operate. Yet, a little over 50 years later, each of these aspirations remains unfulfilled. The medical profession does not have the best and most modern apparatus of medicine. Doctors are not allowed freely to use the apparatus available; they suffer 'interference from secular organisations', in the form of intrusive officialdom, many times a day. The individual citizen is not free, in any meaningful sense, to choose his doctor; nor, indeed, is he or the doctor truly free to choose the specialist to which he is referred. Most patients would raise a weary laugh at the idea of 'inviolable privacy' in an NHS hospital. And worst of all, the NHS is riddled with inequities: the people it was designed to help – the worst-off – remain serially excluded from access to high-quality care.

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[1] M. Foot, *Aneurin Bevan*, 1975.

Why, after fifty years of steadily rising investment in the NHS, and widespread public and professional commitment to the institution and its principles, does Bevan's vision remain so elusive? The answer, we argue, is the 'triple nationalisation' of the NHS. The *provision*, *funding* and *resource allocation* of healthcare are all monopolies under the exclusive control of the state. It is from this basic fact that all the familiar problems of the NHS – the delays, the poor conditions, the disempowerment of patients and the demoralisation of staff – flow.

In the last year, there has been startling progress in the debate on healthcare. The *status quo* is on the defensive. Indeed the Government itself has issued proposals which directly address one of the aspects of triple nationalisation identified in this paper: the nationalisation of provision. The day after the 2002 April Budget, the Department of Health published *Delivering the NHS Plan*, which expanded on a speech the Secretary of State made in January introducing the concept of 'foundation hospitals'. The document holds out the prospect of successful hospitals being given 'full control over all assets and retention of land sales', 'freedom and flexibility' in the remuneration of staff, greater freedoms 'to access finance for capital investment', to 'establish joint venture companies', and 'to take over poorly performing trusts'. But for all this privatising rhetoric, the freedom hospitals are being offered remains strictly conditional. They might be given self-ownership in the form of control of their own assets, but the important questions – about management freedom (including over staff terms and conditions) and the regulatory framework in which they will have to operate – remain unanswered. *Delivering the NHS Plan* is an important step in the right direction; but its value will only be seen once its proposals are implemented.

The real reason why no amount of ostensible reform to the supply-side of healthcare will deliver a real rise in standards is that it is not, under the current Government's plans, to be matched with reform to the demand-side, or funding arrangements.

Indeed the major Government initiative of the last six months on this issue has been a sustained public relations exercise, conducted by the Treasury, with the intention of arriving at a 'national consensus' in support of tax-only finance for the NHS. This reached its zenith with the publication of the Wanless report accompanying the April Budget, which pledged significant increases to NHS funding.

All the evidence suggests that the state cannot ensure adequate care for all people through its own providers and its own finances, in a system administered by its own officials. This paper sets out to demonstrate the inherent unworkablity of the current arrangement. Its purpose is to establish the problem and to point towards, without defining closely, the outlines of a solution. Later papers will provide in more detail the precise elements of a reformed system which will deliver the founding aspiration of the NHS: to ensure that all necessary healthcare is available at a high quality to everyone, irrespective of the individual's ability to pay.

CHAPTER TWO

SYMPTOMS AND DIAGNOSIS

THE PROBLEMS THAT the National Health Service face are both simple and complex. Recognising this, most partisans of the current NHS depend on one of two explanations and two remedies. The simple explanation is money: it is argued that the NHS has suffered 'chronic under-investment' for decades; the remedy is to pump it full of funds. The complex explanation is that the problems of the NHS are diffuse and variable: the remedy involves a multitude of problem-specific instruments, initiatives, targets, plans and process reforms, most of them directed by, or at the behest of, the Department of Health in Whitehall. In fact, these analyses are not vastly different, and are often employed in tandem. Both assume that the present model is intrinsically workable, if it just receives enough money and enough micro-level 'process reform'. Both rely for improvement on the use of existing resources: the wealth of the Treasury and the expertise of NHS managers.

Yet arguments about funding and structure – the need for 'investment' and 'modernisation', in the language of the Prime Minister – miss the real point. Both are stale debates, going back to the early days of the NHS. The concerns about the under-funding of the NHS started in the early 1950s with the Guillebaud Report on NHS finance.[2] The questions about structure began in earnest ten years later. Since then, changes in structure and management have multiplied. Yet during this debate, there has been a reluctance to face the fundamental reason why the NHS cannot deliver on its aspiration: its character as a super-nationalised industry.

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[2] *Report of the Committee of Enquiry into the cost of the NHS*, HMSO, 1956.

Triple nationalisation

Lack of money and inadequate management processes are symptoms, not causes, of the problem. The underlying cause is the fact that the NHS is a near-monopoly. And it is a nationalised monopoly. And this nationalisation operates at three levels:

- Supply, or provision, is nationalised: patients receive their care in state-owned institutions and at the hands of state employees.
- Demand, or funding, is nationalised: all the money in the NHS comes via the state.
- Decision-making, or resource-allocation, is nationalised: the all-important decisions about which services get which resources, and which patients get which treatments, and when and how, are made by state officials.

The problems in the NHS flow from the combination of this triple nationalisation. The nationalisation of supply causes capacity restraints at almost all levels and eliminates professional autonomy. The nationalisation of demand means that patients are denied choice and, as a result, are systematically disempowered by the system. The nationalisation of decision-making means that the NHS fails to adapt its supply to fluctuations in demand; it takes power over healthcare away from patients and professionals, and gives it to managers and ministers.

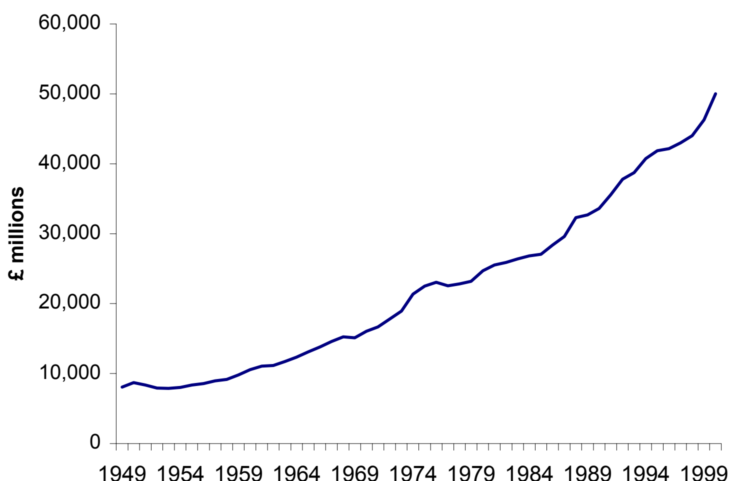
The founding misconception

The triple nationalisation of healthcare is due to a fatal misconception in the minds of the politicians and planners who designed the NHS in the 1940s. The misconception was this: that there is in the country *a finite quantity of need* for healthcare, and one which could be met by the resources of the Government. Indeed, Bevan believed that not only could the NHS meet this quantity of need, but that the NHS would also cause it to fall. Bevan correctly foresaw that demand for healthcare would surge in the early days of

the NHS. There was, he recognised, considerable unmet need which would have to be satisfied at the outset. But he also believed that the costs of the NHS would fall off as it improved the state of the nation's health, so reducing the need for care.

The NHS as designed by Bevan would only work if this assumption were true. Only if there were a finite 'lump of need' – like there was once supposed to be a 'lump of labour', or available work in the economy which could be shared out equally – could a structure be designed, and resources be planned, to meet it in its entirety. But there is no such lump, as became apparent very quickly. The original cost projection for the first nine months of the Service was £132 million, worked out by estimating the total health expenditure in 1939. The real cost turned out to be two-thirds higher, at £208 million. The first full year, 1949-50, required another 70 per cent rise to £358 million. Over the first 40 years, the health budget quadrupled in real terms. In the last 15 years, it increased by a further 50 per cent.

Real Spending on the NHS (constant 1995 prices)



The April 2002 Budget commits the Government to a further 43 per cent increase in real NHS expenditure over the next five years. At the same time, the final report of the Wanless Review forecast an annual real terms increase of between 4.2 per cent and 5.1 per cent over the next 20 years.[3] This implies a further trebling of health spending. If that is the case, expenditure on health in 2022-23 would be twenty times greater – in real terms – than it was when the NHS was founded.

From the outset, the idea that the NHS would cause health expenditure to fall proved hopelessly optimistic. As Charles Webster, the official historian of the NHS, observes:

> Bevan was unleashing a social experiment which would entail an ever-increasing commitment of public expenditure to healthcare.[4]

This is the basic fact about the NHS: it can never satisfy the demand placed upon it. As the BMA put it in its 1970 report:

> The NHS has never since the early years been able to fully cope with the rising demands that it, and the parallel development of new methods of treatment, were responsible for stimulating.[5]

The nationalisation of healthcare provision means that progress in science imposes intolerable strains on the sole provider. Two factors have exacerbated this. Firstly, as Geoffrey Rivett points out, 'in medicine more has happened since 1948 than in all the centuries back to Hippocrates.'[6] The expansion in the range of specialist treatments has occurred notably in the fields of elective surgery and non-essential, including cosmetic, treatments which nevertheless come under the 'comprehensive' umbrella. But there have also been major advances in life-saving medicine which themselves impose considerable pressure on the NHS by prolonging life-

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3 D. Wanless, *Securing our Future Health*, HM Treasury, 2002.

4 C. Webster, *The Health Service since the War*, HMSO, 1988.

5 BMA, *Health Service Financing*, 1970.

6 G. Rivett, *From Cradle to Grave: fifty years of the NHS,* King's Fund, 1988.

expectancy and hence the need for (often long-term) care for the elderly. Social and scientific progress has not, as Bevan hoped, caused demand for healthcare to fall, but to rise inexorably.

The second factor is a fundamental shift in the very concept of medical care which has occurred over the last half-century. Before 1948, medicine was primarily about emergency treatment, with long-term and remedial care taking place outside the medical sector (in the home, in short). The initial conception of the NHS was based on this understanding: it existed to deal with major events, such as might be expected to occur only a very few times, if at all, in the course of an individual life. Yet over time, partly as a result of the very promise the NHS held out – to provide all care – and partly because of the non-emergency treatments which science has developed, medicine has come to be seen as a way of life. A visit to the GP, and thence to a specialist, was once rare but has now become a common thing: one goes not for 'treatment' as of old, but for 'service'; not for damage repair, but for ongoing maintenance. Healthcare is now a permanent aspect of experience, and one in which, incidentally, the whole of one's well-being is the responsibility of the state.

'Cost containment'

These two considerations – the expansion in the range of treatments and the shift in the concept of healthcare – did not make themselves felt until the 1960s. But costs began to rise as soon as the Service began. The immediate effect was a breach in the 'comprehensive' principle: the aspiration to provide all services for free. Within three years, charges had been introduced for optical and dental services and for prescription drugs. And at the same time an even more fundamental, if less dramatic, breach occurred in the founding theory of the NHS. In 1949, in order to delay the introduction of prescription charges, Bevan agreed with the Chancellor of the Exchequer to the imposition of a 'ceiling' on NHS expenditure.

It is a measure of the naïveté with which the NHS was launched that such a provision was not considered necessary from the outset. Bevan might have expected NHS costs to fall over time: in reality, however, the 'comprehensive, universal' aspiration means that there is no *intrinsic* restraint on demand. This necessitates an *extrinsic* restraint – the brutal expedient of a capped budget. The 'lump of need' has been made finite by force. The expenditure ceiling has remained the governing feature of the system, and one which puts paid to the myth that the NHS can provide a comprehensive service for all people. In fact, the amount of healthcare that British people are entitled to is limited by the Treasury.

The effect of this is perverse. For all that the Treasury imposes a limit on NHS expenditure, the result is a constant escalation in costs. It should be pointed out that though the NHS is the nominal provider of healthcare, it has to acquire the essentials of this service from elsewhere. Labour accounts for 70% of NHS costs; drugs and equipment a further XX%. The NHS, like Adidas or Nike, is little more than a logo and a system of administration, providing the 'value added' to the materials it sources from the private sector. Yet, unlike Adidas or Nike, it adds little value. A recent study by the Institute for Global Health compared the NHS with an integrated private healthcare system, Kaiser Permanente in California. It concluded that 'Kaiser achieved better performance at roughly the same cost as the NHS'. This better performance included longer GP appointments, faster access to specialist care, and better access to expensive treatments, all tending to better health outcomes. The report attributed this superior value for money to 'efficient management' and 'the benefits of competition'. The commonly-held belief that the NHS uses its resources efficiently, the authors concluded, is 'not supported by this analysis.'[7]

[7] 'Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente', *British Medical Journal*, vol. 324, 19 January 2002.

This should not be surprising, for as a nationalised monopoly the NHS shares the characteristics that have bedevilled all other nationalised industries. No effective mechanism has ever been found to enable nationalised industries to provide essential freedoms and incentives for local management; the culture and systems always end up promoting 'upwards management' to deliver centrally defined targets that fail to recognise and respond to local needs and opportunities.

The questionable value for money the NHS achieves is the result of its aspiration to deliver all care for all people through its own providers and its own finances. The Department of Health itself admits that up to a fifth of the NHS budget is lost through fraud, waste and inefficiency.[8] Waste is a natural effect of monopoly provision. But there is a more fundamental problem. The absence of a satisfactory mechanism for establishing marginal utility – the relative usefulness, and hence the cost, of a single unit of service – means that other methods must be employed to relate paying-power to the amount of services bought. The expenditure ceiling is the only means available; and it is not a very good one. While triple nationalisation means that the NHS achieves apparently good value for money in terms of its average costs, its marginal costs – the key determinant of economic efficiency – are exorbitant. Hence the 9% increase in funding which the Service has received in the last two years has delivered only a 1% increase in productivity.[9] As the King's Fund has pointed out:

> The figures show that there has been a fall in the rate of increase in NHS activity despite a large increase in funding for the NHS. The most recent quarterly evidence suggests a decline in NHS elective activity.

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8 'Fraud and waster cost NHS £7 billion a year', *Sunday Times*, 2 December 2001.

9 Hospital and Community Health Services Cost-Weighted Activity Index.

> The result is a divergence between the rate of increase in spend on the NHS and the rate of increase in the usual measure of activity. The government's key problem is being able to show that its extra spending is working: that it results in extra activity that will begin to deliver the ambitious waiting-time targets. However, unless there is a significant redirection of cash into activity-generating areas of the NHS which impact on waiting times, the service will struggle to meet its targets.[10]

It might have been expected – indeed the founders of the NHS did expect – that, as the main buyer, the NHS would be able to dictate prices to its suppliers. But by the nature of business, the ceiling will constantly be pushed higher as suppliers increase their prices to the maximum they can hope to achieve. Between 1996 and 2000, as health expenditure increased by nearly a third, the cost to the NHS of generic warfarin prescriptions rose from 64p to £4, and that of generic penicillins from £2.33 to £3.27.[11] The monopsonistic arrangement has meant that the NHS is at the mercy of unofficial price fixing on the part of its suppliers – including the public sector unions. Bevan himself recognised the difficulty in his resignation speech in 1951. He had resigned from the Government in protest at the imposition of charges for dental and optical services, which he correctly saw as a betrayal of the principles on which he had founded the NHS. Yet he equally correctly observed that the imposition of the expenditure ceiling, although necessary to contain the demand on the system, carried its own inexorable logic: 'the Health Service', he said, 'is squeezed between the artificial figure and the rising prices.' This is a fact from which the NHS cannot escape, and it explains the unending increases in the 'ceiling', or NHS budget.

For all that the expenditure ceiling was a late addition to the NHS, and for all that it ultimately disproves the NHS's claim to

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10 S. Boyle and J. Appleby, 'Short Measures', *Health Service Journal*, 13 December 2001.

11 'Fraud swoop on NHS drug firms', *The Guardian*, 11 April 2002.

fund all healthcare for all people, it is now often used as the system's principal justification: it is argued that the nationalisation of funding which the Treasury enjoys is the only way to 'contain costs'. Indeed many other countries, which pay more both publicly and privately than the UK, look with envy at our low health expenditure. Yet this 'cost containment' is the explanation for the short-term horizon which characterises the NHS. It is the explanation for the under-investment which the system has suffered for decades. Under-investment is a feature of the success of the nationalised model: it is what happens when the Treasury is in charge of healthcare.

An obvious effect of 'cost containment' has been the starvation of resources going into non-immediate services. A frequent criticism of the commercial sector is that it rarely takes a long view: that, concerned with short-term profit, it fails to make the investments necessary for services to improve, and costs to fall, in the future. Yet this failure is a striking feature of the NHS. A particular victim has been hospital building. One of the principal objections to the old haphazard healthcare arrangement was the poor state of the hospital stock. But from the outset, NHS capital spending fell far short of pre-war levels. For the first five years it barely matched a third of pre-war expenditure. No new hospitals were built during the first ten years of the Service. The proportion of health spending devoted to capital rather than current expenditure declined from 20% in 1938-9 to 4% in 1952-3 (the proportion in America in 1951, meanwhile, was 23%).[12] It was not until Enoch Powell arrived at the Department in 1960 that a real building programme began, when £500 million was found in order to build, over a decade, 90 new hospitals and refurbish 134 more. Only then did capital spending match pre-war levels. The Government is now embarking on a similarly ambitious, and necessary, building programme, this one financed (in the short term) with money from the private sector.

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[12] B. Abel-Smith and R.M. Titmuss, 'The Cost of the National Health Service in England and Wales', published in the *Guillebaud Report*, 1956.

Yet hospitals themselves are not the main determinant of health. A second, even more important effect of the short-term horizons imposed by the constant cost pressures on the NHS is the neglect, over decades, of public health. If there is one health function everyone must agree should be the responsibility of government, it is preventative healthcare: epidemiology, the promotion of healthy living and the maintenance of a safe environment. Yet, as Dame Rosemary Hue, former President of the Faculty of Community Medicine, has remarked, public health has always been a 'sideline' in the NHS, marked by 'isolation, complacency, and relative inactivity'.[13] It is a telling irony that this function has been so neglected for so long, and that the system which its founders believed would lead to an overall improvement in the nation's well-being, so causing the demand on curative medicine to fall, has caused this aspect of healthcare to be under-funded and disregarded almost since its inception.

Rationing

The concentration of power in the hands of the Government has an even more pernicious effect on the curative services the NHS offers. Having imposed the expenditure ceiling, the Government simply passes the responsibility on to NHS managers, who are forced to live within their budgets by prioritising those treatments, patients and districts which will, and those which will not, receive the necessary funding: in short, rationing.

The nature of the NHS ensures a permanent shortage of capacity. Rationing is, *de facto*, the method by which the NHS maintains its 'comprehensive, universal' aspirations. All people can get all services only if they wait for it, and wait for months and often years. The waiting list is a phenomenon almost unique to the UK, at least in its institutionalised form; certainly the length of time people have to wait is unmatched in the rest of the developed world.

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[13] 'The Changing Status of Public Health', in *Our NHS*, BMJ Books, 1998.

It is important at this point to distinguish between the 'natural' rationing or cost containment that occurs when treatments are intrinsically expensive or rare, and that which occurs as a result of supply limitations arising from monopoly. Organ transplants are the best example of the former sort: given the limited supply of available organs and the great demand for them, an 'expenditure ceiling' and priority-setting are necessary. *Scarcity* is the major determinant of price on the open market, and short of farming organs in a laboratory, political decisions will inevitably have to be made about which patients are to receive transplants. Even in the United States, there is general agreement that rationing is preferable to market forces as a means of apportioning the supply of available organs.[14]

The rationing which occurs as a result of monopoly, on the other hand, is not necessary: the areas in which it occurs are those where treatments are, or should be, cheap and widely available, and are not, therefore, the proper subject for 'political' decision-making. These shortages derive from *unnatural* blockages in the chain of supply. And the effect is misery and increased costs for those who have to endure them. This misery and cost has been exacerbated by an important change which has taken place over time in the content of the waiting list. Lists were originally introduced for patients needing 'cold surgery': they experienced discomfort but their condition (or so it was believed) was unlikely to worsen very much while they waited for treatment. Today, however, patients are on waiting lists for a greater range of more serious conditions, such as major heart surgery, for which the adverse consequences of waiting are likely to be much greater. The waiting lists also increase the costs of the eventual treatment, as people suffer adverse medical events while waiting. Though the NHS collects no data on this topic, there is striking new evidence from a study in Canada which suggests that both in terms of

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[14] H. Redwood, *Why Ration Healthcare?*, Civitas, 2000.

medical outcome, and in terms of the patient's longer term future, long waits add to the ill-health of the nation. Rationing is not just inconvenient and costly: it seriously comprises the life chances of the patients who have to endure it.[15]

Unfair treatment

The people who suffer most from the supply constraints in the NHS are those the system was founded to assist: the vulnerable. Over 30 years ago, Julian Tudor Hart defined what he called the 'inverse care law': that those who need the most medical care receive the least while those who need the least receive the most, and use it more effectively. This is not a law the NHS has broken. In the 1980s the LSE economist Julian Le Grand has estimated that the NHS devotes forty per cent more resources per illness episode to patients in social classes I and II than it does to people in social classes IV and V. Old people, people from ethnic minorities, and poor people generally get worse treatment from the system than young, white and middle class people.

Fifty years after the launch of the NHS there remain startling divergences in health outcomes. If on average 100 people die in the UK under 65 years of age, 234 die in Glasgow Shettleston against only 65 in Wokingham. This is a failure both of public (preventative) healthcare and of treatment. Both factors are accounted for in the King's Fund league table of health authorities, which tells the old tale of two nations: the five best authorities are

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[15] According to the Canadian research, patients with a long wait (97 days or more) had significantly more medical events (24 per cent) after surgery than those with a shorter wait (11 per cent). For every seven patients who waited longer than 97 days one more had a major medical event post-operatively than if they had a wait of less than 97 days. It also found that six months after surgery, when the waiting time was less than 97 days, 85 per cent of employed patients in the study remained employed. But when the waiting time was more than 97 days, only 53 per cent of patients remained employed. 'Waiting Quality and Outcome', *Bandolier*, vol. 8 Issue 11.

Oxford, North and East Devon, Herefordshire, Somerset, and Dorset; the five worst are Manchester, Liverpool, East London and the City, St Helens and Knowsley, and Wolverhampton.[16]

Anecdotal and opinion poll evidence supports the contention that poor and marginalised people get worse treatment than the rich. The old are particular victims. A recent King's Fund study, based on a survey of managers in hospitals, primary care groups, community trusts and social services departments, found evidence of persistent ageism in the way the NHS allocates resources and prioritises treatments.[17] An American study found that 'British elders are frequently denied access to expensive technologies from which they are likely to benefit'.[18] The interim Wanless Report into NHS financing confirmed the low priority status of services for the old, including the lack of effective and integrated support for many patients.[19]

In terms of variations in service according to social class, the 1998 General Practice Survey found that 20% of patients dependent upon non-manual work had been given a choice of hospital, while only 13% of manual workers or their families were offered such a choice. The same inequality applies to waiting times for specialist care: people in social class I are the least likely to wait for more than three months for a referral appointment (16%), while those in social class V are the most likely (23%).[20] As we have seen, long waits for secondary care impose major costs, in terms both of health itself and of one's long-term future. These costs cannot be covered by the NHS: they must be borne by the patient.

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16 J. Appleby and J.A. Mulligan, *How well is the NHS performing? A composite performance indicator,* King's Fund, 2001.

17 E. Roberts & L. Seymour, *Old Habits Die Hard*, King's Fund, January 2002.

18 *Mortality, Income, and Income Inequality Over Time in Britain and the United States*, A. Deaton and C. Paxson, NBER October 2001.

19 D. Wanless, *Securing our Future Health: taking a long-term view*, HM Treasury, Interim Report, 2001.

20 *National Surveys of NHS Patients: General Practice 1998*, NHS Executive, 1999.

Another report studied three million adults and 18,000 children in England and Wales, who had been diagnosed with cancer.[21] It found that England and Wales had a worse survival rate for most cancers than the US and Europe. But the most affluent people in England and Wales had similar survival rates to the European average. For example, the rich were 16 per cent more likely than the poor to survive for five years after getting tongue cancer.

Another report by the King's Fund found that black and ethnic minority patients had considerably worse experience of the system than white patients. [22] Black people, for example, are frequently given more, and more powerful, drugs to combat perceived mental illness than white patients. The report observes that 'higher rates of compulsory treatment and drug therapies, instead of 'talking' treatments, may reflect the assumptions of health workers as much as real differences in need.' And discrimination also occurs in terms of the range of services catering for the differing medical needs of different ethnic groups. Such specialised services as are available, the Fund reported, 'often exist… outside mainstream healthcare and rely on precarious, short-term funding.'[23]

Inequality within the NHS is due to the three levels of nationalisation – decision-making, demand, and supply. Decisions on which services should receive funding are primarily political decisions. Hence we have resource-allocation by decibel count: the lobby groups representing patients with ailments closest to the top of the political agenda, and those most expert at manipulating the media, gain priority over sufferers from less 'fashionable' diseases. Services which treat lung cancer and bronchitis, for example – which are disproportionately working-class diseases – receive considerably less resources than the number of sufferers warrant.

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[21] M. Coleman, *Cancer survival trends in England and Wales, 1971-1995: deprivation and NHS Regions,* ONS. 1999.

[22] King's Fund briefing, July 2000.

[23] Ibid.

The nationalisation of funding, is even more pernicious in its effects, for it eliminates patient choice for all those who cannot afford to leave the system altogether. The irony is that an arrangement which attempts to remove the role of money in the system, far from abolishing inequality, reinforces it. As the French philosopher Bastiat observed over two hundred years ago:

> When under the pretext of fraternity the legal code imposes mutual sacrifices on citizens, human nature is not thereby abrogated. Everyone will then direct his efforts toward contributing little to, and taking much from, the common fund of sacrifices. Now, is it the most unfortunate who gains from this struggle? Certainly not, but rather the most influential and calculating.

How does this happen? As observed above, the system is monolithic and therefore incapable of the flexibility required, for example, to provide high-quality tailored services to minority ethnic groups. The NHS is also so vast and complex that a certain degree of canniness is required to exploit it successfully. In a properly functioning market, information – the key to proper access – is transmitted through the price mechanism, and standards across the board rise as a result. In a nationalised monopoly, such information is unavailable to the user, and standards vary widely. In the absence of the truly 'public' force of money – which is anonymous and equally attractive no matter who is offering it – far more 'private' forces prevail. These include educational attainment, manners, cultural habits, and above all knowledge of how the system works, gained through establishing a complicit relationship with the best sources of information of all: the staff.

Put simply, a bureaucratic health system inevitably distributes its resources not by market forces but by how well an individual can work the system of allocation. The middle classes are just better at insisting on their rights and standing up to administrative gatekeepers than their less confident, less articulate fellow sufferers. They demand and get priority treatment.

A disincentive to innovate

If the nationalisation of decision-making favours 'fashionable' treatments, and the nationalisation of demand skews the service the NHS offers in favour of the educated and articulate, it is the nationalisation of supply which causes the real inequality in health outcomes. It has done this directly, through its low levels of activity and the discrimination which marginalised groups suffer in gaining access to the limited capacity in the system. But more importantly, it causes inequity indirectly, by crowding out or discouraging medical and managerial innovation.

The fundamental cause of British health inequality is that the NHS has actually worked to promote scarcity rather than to reduce it. The traditional case against monopoly defined its effects in terms of higher price and lower levels of output, and these effects were assessed against the background of a static market. But monopoly also stifles the rate of change. Monopoly reduces the pressure to innovate in the first place as well as slowing down the diffusion of innovation. It is the subtle effect of this feature of the NHS which hurts marginalised groups the most.

In open markets, the threat of entry by newcomers not only puts pressure on prices – it also acts as a pressure towards innovation. In monopolies, however, the resistance to innovation is strong. The yearly budget, capped by the NHS expenditure ceiling, imposes a disincentive to take on extra work, a problem which has not been alleviated by the new three-year budgetary cycle. Hospitals that carry out extra activity put pressure on staffing hours and on their budgets. Change in service patterns often requires initial costs and involves risks for staff: as observed above, at the local level the NHS is unable to take a long-term view. However helpful the protocols and guidance from the centre, there is additional risk involved in change which the nature of the system makes unattractive to managers.

The relationship between innovation and improvement in outcomes is a strong one, especially when innovation is defined to

include the diffusion of innovation to high-risk groups. Slowness in introducing effective innovation is likely to have most adverse consequences for those with the poorest health. A recent study by the National Bureau of Economic Research (NBER) found little evidence of a link between levels of nominal income inequality and mortality: on the contrary, in both the UK and the US, mortality has declined during times when inequality has widened. This is due to the expansion in the range, and the speed of the diffusion, of new treatments which occur during times of economic growth, of which increasing income inequality is another consequence. Importantly, the study found that 'medical innovations are introduced first and diffuse more quickly in the US than in Britain. There is a lag of about four years in the development and diffusion of new treatments in the UK compared to the US.

Recent figures from the Office of National Statistics show that in the UK in the late 1990s, half a decade after a period of strong economic growth began, life expectancy at the bottom of the social scale improved by three years, while for those at the top it increased by only a year.[24] Economic growth improves health outcomes for the poor, but in the UK it takes longer for expensive and rare treatments to become cheap and widely available. The NBER report concluded that 'the centralized healthcare system in the UK may impede the adoption of expensive new technologies. In the competitive US healthcare industry, there may be greater pressure to adopt new technologies as soon as they are feasible, regardless of cost.'[25] Thus a system which starts with the demand side aim of improving access to services for the less advantaged has an in-built supply side incentive to make their access to services less likely.

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[24] 'Life expectancy gap closes between social classes', *Financial Times*, 29 January 2002.

[25] A. Deaton and C. Paxson, *Mortality, Income, and Income Inequality Over Time in Britain and the United States*, NBER, October 2001.

A disincentive to serve

The problems with the model of the NHS identified above can be summed up in one phrase: 'producer capture'. It is a system which delivers all power to the producers of the service and none to the users. There is no incentive for the providers of healthcare to have regard for the wishes of the patient: any form of 'customised' care simply imposes costs for which there is no balancing benefit.

The extent of the problem is expressed in the observation that, under the current arrangements, the 'comprehensive, universal' NHS would like as few patients as possible. Each new patient is not another opportunity to be welcomed, but another burden to be shouldered. This is not how supply should regard demand. Indeed the NHS contains no natural method by which supply and demand can adjust to each other. Yet these two must be approximated somehow, and the only available method is guesswork, backed up by the coercive power of the Treasury. The effect is that the individual patient is disregarded.

The near-total disempowerment of the patient, in favour of the priorities of the bureaucracy and the politicians who direct it, is most evident in the dangerous phenomenon known as 'clinical distortion', by which the *clinical* decisions which health professionals take are distorted by the *operational* requirements of management. This problem is endemic in the system.

Attempts to meliorate it tend to have adverse effects. For instance, until recently the prime example of the way in which the needs of the system took precedence over those of patients was the concentration on waiting *lists* rather than waiting *times* – the NHS seemed not to consider real people's real experiences (i.e. how long they were waiting), but their numbers (i.e. how many of them there were). Now, the Government has decided that the NHS should concentrate on waiting times, which is on the face of things a more sensitive way of dealing with the problem of queuing. But unfortunately, an inadequate attention to clinical priorities has

meant that patients who have been waiting for long periods of time for a relatively minor, elective operation take precedence over those waiting for shorter periods for more vital treatment: operations to reverse vasectomies, for instance, have displaced patients waiting for bladder cancer surgery.[26] It also appears, from research by the National Audit Office, that hospital managers have been systematically ‘adjusting’ their lists – by altering patients’ records, by not adding names to the list or by removing them in advance of their operations – in order to appear to have met the targets imposed by Whitehall, and many hundreds of people have had to wait longer for operations as a result.[27] A National Audit Office survey found that 52% of consultants admit to distorting their clinical judgements as a result of pressure to meet the Government’s target to cut the outpatient waiting list.

The basic political principle that the NHS provides care according to need is invalidated by the practices which the politicisation of the Service necessitates. As the BMA commented:

> Artificial targets imposed on an over-stretched service cannot be met without resorting to ingenious massaging of the figures. It does not fool, nor does it help, patients.[28]

The manipulation of waiting lists is the most glaring example of the way the NHS fails to respond to patients’ needs: all the incentives in the system are against honesty and responsibility towards the users of it. This is a direct result of not only of the ‘triple-nationalised’ model but of all the procedures designed to overcome the problems the model produces. As the Institute of Directors has pointed out, the attempt to replicate the functions of the market has prompted an enormous array of measurement indicators and delivery mechanisms:

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26 ‘Bad medicine’, *The Times*, 27 July 2001.

27 ‘Hospitals “betray trust” by fiddling waiting lists’, *The Times*, 19 December 2001.

28 British Medical Association, March 2001.

> Instead of the market there are edicts, initiatives, paperwork, Patients' Charters, league tables, health tables, finished consultant episodes, 'clinical indicators', patient episodes, clinical audit, clinical guidelines, clinical governance, National Service Frameworks, top-down monitoring, bureaucratic regulation, employment of explicit standards, targets, box-ticking, waiting times targets, waiting lists targets, etc…[29]

A feature of the NHS in recent years not mentioned in this list is the pervasive culture of the 'pilot scheme'. This is the attempt to do by artificial means what a market does naturally, i.e. to establish, on a small and local scale, what works – in short, to innovate. But 'innovation' can no more be 'piloted' than Government can pick winners in medical science. Another hopeless effort to mimic the processes of the market is at the next stage, that of diffusing innovation quickly through the system: the device is 'Best Practice', for which a multitude of processes and plans exist, each of them a strain on the harassed professionals expected to deliver them.

The pilot scheme, best practice, and all the other initiatives listed above are attempts to achieve the effects of freedom and choice, but which in fact limit those salutary mechanisms further. The result is always more, not less, bureaucratic sclerosis. 'Patient empowerment', in particular, is a self-defeating exercise in a structure which *systematically* disempowers the patient. One such initiative was to end the practice by which health services received a lump sum with which to carry out their functions, and replace it with a system whereby each patient commands a separate account. This attempt to have the money 'follow the patient' has simply increased the complexity and the volume of NHS paperwork without realising any gains for the patients who, unbeknown to them, now 'command' their own accounts. Without a proper price mechanism in place, attempts to replicate the conventions of the commercial sector can only produce *ersatz* consumerism – worse, in some respects, than the total collectivism which preceded it.

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[29] IoD, *Healthcare in the UK: the need for reform,* 2000.

An increasingly common instrument of artificial consumerism, is the introduction of 'user councils' or patient representative groups. This tendency is endorsed in the Wanless Report, which recommends 'reinforcing patient involvement in NHS accountability arrangements through measures such as Patients Forums… and better patient representation on Trust Boards'.[30] But as Pirie and Worcester argue:

> In many cases the User Councils themselves quickly become detached from the real public, and operate in a kind of producer triumvirate alongside government and the actual producers of the service.[31]

The apparent need for user councils should explain why they can not work – users are *systematically* disregarded in the provision of healthcare, not through the wishes of the professionals responsible, but through the nature of the system. Managers allocate vast resources, in matters of great intricacy and specialist knowledge, to even vaster demand: it is inevitable that individual patients are routinely ignored. The 'User Council' approach misses the real point of consumerism: it is not a handful of 'representative' consumers, but every single consumer in the land, who should be empowered. The object should not be to nod in the direction of consumerism with a new quango, but to bring into the equation the wants and inclinations of every patient in the system.

Unfair for doctors and nurses

The final irony of producer capture is that it also systematically disempowers the most important producers of all: the healthcare professionals. It is the managers who are in charge, not the doctors and nurses, who are treated in a manner which would not be tolerated – would hardly be legal – in the private sector.

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[30] D. Wanless, op. cit.

[31] M. Pirie and R. Worcester, *The Wrong Package*, ASI, 2001.

The belief persists that public provision ensures decent terms and conditions for its staff. An objection of some to increased private sector involvement is that NHS staff will be subjected to the uncertainties and pressures of private employment, with a corresponding loss of the 'public service ethos' and its replacement by the 'profit motive'. In fact, NHS staff are already profoundly demoralised. They are under-paid and over-worked. Worse than this, they are denied operational and clinical autonomy. As things stand, indeed, the 'public service ethos' amounts to little more than the obligation on public servants to work as hard as they are told to, for little money and with limited professional discretion. The imperative of meeting Whitehall targets – not to mention the time spent in demonstrating, through endless form-filling, whether or not the targets are being met – means that the 'public service ethos' is thwarted: the 'service' is not to the 'public' but to the system, and the 'ethos', insofar as it remains in the breasts of these harassed professionals, becomes one of joint conspiracy with the patient against the iniquities of the service one party is supposed to be providing to the other.

In return for a high degree of job security, NHS staff relinquish all the other perks which employment should bring: the respect of others: flexibility, decent pay and conditions, responsibility, and professional development. As a result the NHS has unusual and growing problems in staff motivation, impacting seriously on retention and morale. Applications to medical schools fell from 12,000 in 1997 to 10,000 in 2000, the most significant drop for 40 years. By some indicators, NHS staff are now the most dissatisfied employees in the UK.[32]

The NHS inherited a massive resource in the world's leading medical and nursing professions. This is, indeed, the major resource the NHS has at its command. Like all its other resources, it is being wasted. In the early years of the NHS the nursing badge

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32 (IoD Survey) [FULL SOURCE DETAILS PLEASE]

was worn with great pride and a great sense of responsibility; now much of that pride has gone, to be replaced with great frustration. According to a recent survey 96% of nurses feel stress in the NHS is increasing; a third claim to have suffered minor mental health problems such as anxiety and depression.[33] Research suggests that:

> It is not the nature of caring work that is stressful but rather the barriers that impede nurses in this role.[34]

The structures of the NHS are preventing professionals from doing their jobs; and the public service ethos is not enough to keep them at it for long. A recent study into the reasons nurses left the NHS, entitled *The Last Straw*, commented that:

> Those who remained in nursing did so for a variety of reasons, in particular because of loyalty and commitment. However, there was a strong suggestion that this may not safeguard the future of nursing and such loyalty cannot be relied upon.[35]

There are, indeed, now more trained nurses *not* working as nurses than there are nurses working. A similar process of decline is now affecting the medical profession. 100% of consultant paediatricians questioned by Neurolink, and two-thirds of consultant surgeons, said they wanted to leave the NHS early. Half of the GPs questioned have suffered 'psychiatric distress'; two thirds are less likely to recommend the profession than they were five years ago.[36]

The problem, as ever, is monopoly (or more precisely, monopsony). The NHS is the only major buyer of healthcare

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[33] *Solutions to Occupational Stress,* Neurolink Survey, April 2001.

[34] S. Muncer et al, 'Nurses' representations of the perceived causes of work-related stress: a network drawing approach', *Work and Stress*, vol. 5, University of Nottingham, 2001.

[35] S. Meadows, R. Levenson and J. Baeza, *The Last Straw: explaining the NHS nursing shortage*, King's Fund, 2000.

[36] Neurolink survey, op. cit.

labour. The small size of the private sector means that the labour market is dominated by this single huge employer (the largest employer in Europe, indeed). Staff have little power of 'exit' if they wish to remain in public service, which in turn severely limits their power of 'voice', or bargaining power.[37] Indeed it is natural that when pressures are exerted on the system, it is the interests of the staff which suffer first. Further pressures simply add to their obligations. So it is that GPs are subjected to the infamous 'John Wayne clause' in their contracts (a GPs gotta do what a GPs gotta do); that junior hospital doctors suffer such extreme working hours; and that consultants are to be banned from working outside the NHS for seven years after they qualify.

It is easy to understand why doctors and nurses complain of a loss of professional respect and status: not only are they severely underpaid, but they are unable to work in the interests of patients. It is less easy to comprehend why the only major instrument of 'voice' which staff enjoy, the public sector unions, direct all their efforts at reinforcing the present system. This is not the route trades unions follow in other countries, where union leaders perceive that their members' pay and conditions, not to mention their professional discretion and status, all stand to gain from a more plural and diverse labour market.

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[37] The recent rapid growth in the number of nurses leaving the NHS to join Nursing Agencies is evidence both of job dissatisfaction and how, if there is an 'exit', many will choose to take it. The Audit Commission reports that NHS expenditure on agency staff grew by a third in 1999/2000.

CHAPTER THREE

PRESCRIPTION AND PROGNOSIS: THE LONG-TERM VISION

THE NHS SUFFERS from perennial funding crises and poor value for money. It fails both to innovate and to diffuse innovation effectively. Patients are systematically disempowered. The morale of health professionals is at rock bottom. The underlying malaise is deep and can be traced to the state's control over provision, funding and resource allocation. Any proposal for reform must seek to end this 'triple nationalisation' of healthcare.

The Government now seems to recognise the need for structural reform. It has given the NHS greater power to buy from private providers and to use private sector management. Although purchasing by the NHS of medical care from the private sector is still marginal, this promises to introduce more capacity, as well as expertise, into the system. The Government has also announced that successful hospitals might 'earn autonomy' and become self-governing mutuals called 'foundation hospitals'. All this is welcome, as far as it goes.

But it is not nearly far enough. Exploiting private sector capacity does not break down the nationalisation of supply, only reduces it. Private sector managers, meanwhile, are likely to be limited in their freedom to deliver improvements while the structure, culture and staffing practices of the public sector remain in place; it is not the inherent incompetence of public sector managers which is to blame for the state of the Health Service, but the structures in which they have to work. There is a risk that managers from the private sector will have no more freedom of action and, therefore, no more realistic chance of success.

'Earned autonomy' is a more positive concept. The proposals for 'foundation hospitals', outlined in the Department of Health document, *Delivering the NHS Plan,* would return hospitals to the status of voluntary self-ownership from which they were taken in 1948. But 'earned autonomy' promises only a very conditional freedom, for the 'autonomy' can only be 'earned' by meeting Whitehall targets. The document does not allow autonomous staffing practices, nor for freedom from the NHS regulatory system. True autonomy has to be supported by freedoms over current and capital funding, management control and an absence of prescriptive regulation. It is not something that the government should be able to take away. Unless these hospitals are given real operational freedom, even if they become notionally self-governing and self-owned, they will remain *de facto* part of the state monopoly.

More fundamentally, however, progress will be impeded because the Government remains committed to retaining the nationalisation of demand and the allocation of resources: its monopoly of funding and the control of how that funding is spent. If the UK does need to spend more on healthcare, under the current arrangements this can only come from a centralised decision to increase taxes and/or charges. The new funds would still be pumped through the NHS allocation system.

A recent suggestion that the NHS will be only 'overwhelmingly', rather than totally, 'free at the point of delivery' suggests that the Government is considering the possibility of extra charging for services.[38] But this will not deliver the competitive pressures and patient responsiveness so essential to improving standards; moreover, when existing charges (for optical and dental services and prescription drugs) raise just 2% of the NHS budget, only exorbitant increases in charges will deliver significant increases in funding levels; the only likely effect is a small contraction in demand among the poorest people in society.

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[38] 'Labour rethinks free NHS', *The Times*, 7 February 2002.

Nor will the extended purchasing role of PCTs substantially improve this. They will still be allocating block funds on behalf of a captive group of local residents who have no alternative to choose from. Real reform is required, not only on the supply side, but on the demand side of healthcare: private choice – and the control that goes with it – must be admitted into the system.

An agenda for change must be realistic. The old adage 'I wouldn't start from here' applies nowhere more than in healthcare. Yet systems which, on the face of things, are inefficient and wasteful often work well on the basis of the experience of the people who operate them: staff adapt themselves to the situation and do their best. One of the most common complaints from NHS professionals concerns the frequency of organisational change: if only, it is said, one system were allowed to 'bed in' for more than a few years before being replaced with another, things would operate more smoothly. At a personal level, this complaint is understandable. However well-meaning, attempts at performance improvement within a system that is fundamentally flawed only delay the delivery of major improvements, while creating further frustration for those attempting to do the impossible.

The imperative is to implement changes to the delivery of healthcare which are both *thorough* – ending the triple nationalisation – and yet *organic* and *incremental*. We must radically alter the way healthcare is provided, but do so in a way which causes the minimum of disruption to the professionals and organisations whose responsibility the actual job of provision is.

A vision of future healthcare

The ultimate objective for Government must be to replace the State Health Service with a National Health System; to move from a monolithic, bureaucratic, nationalised monopoly to a plural, liberalised, mixed health service economy. The aspiration of the NHS – to ensure that all people have the high quality care that they need – remains. But in order to deliver it, the focus must

change: rather than attempting to improve the exclusive provision of healthcare by the state, the aim should be to ensure that all people have access to the best available services, whether public, private or voluntary. This requires changes to all three areas currently under nationalised control: supply, demand and resource allocation.

1. Supply

There are, roughly speaking, five elements to the provision, or supply-side of healthcare:

- primary care (delivered by GP surgeries and non-critical treatment clinics);
- emergency and some specialist secondary care (delivered by local or 'community' hospitals);
- further specialist and elective secondary care (delivered either by local hospitals or by those, like Great Ormond Street Hospital for paediatrics, dealing in specific branches of medicine and, increasingly, by high-volume units dedicated to specific treatments);
- tertiary care, including long-term, nursing, palliative and rehabilitative treatment (delivered in special clinics and residential homes or in the patient's own home); and,
- public health services, including epidemiology and immunisation (delivered by or under the supervision of the Health Authority).

All bar the last of these elements of provision need changes to the manner in which they are owned and operated in order to replace state monopoly with a system of diversity of supply and decentralised management.

Primary care needs more freedom to operate through the surrounding structures. When the NHS was created, GPs were allowed to remain self-employed professionals and to retain ownership and control of their own practices, though both these freedoms were limited. However, because of the heavy-handed regulation of their activities, the current tendency is for new GPs to become more like state employees than self-employed professionals. This tendency should be reversed. General Practice surgeries should continue to be run as private concerns. GPs should also be given greater freedom to buy and sell their practices, and to establish specialist units (such as sports injury or Sexually Transmitted Disease (STD) clinics) in primary care.

Secondary care requires more radical change in order to stimulate capacity and competition in those areas where it can be introduced. These can be considered in two categories: **emergency and local** care, and **specialist and elective** care. Although a hospital whose primary function is emergency and local care may still wish to provide some elective treatments, it is necessary to move beyond the conception of a local hospital providing all the health services an area can need: its main responsibility should be to provide all the care which an area needs locally. This includes, most obviously, Accident and Emergency (A+E) and intensive care, as well as treatments which a community has a right to expect to be available locally, such as maternity services. But for the great bulk of elective and specialist treatments, especially much surgery, care may be provided far more efficiently and effectively in high-volume treatment centres, with many patients being willing to travel further than their local town in order to take advantage of the best available option.

It is, in fact, in the field of routine, one-off operations such as hip replacements that the most lengthy waiting times occur: everything must be done to enable capacity to increase. It was recently suggested (by Frank Field MP) that by employing a European firm called German Medicine Net to operate in pre-fabricated surgery

units across England, the 500,000 out-patient waiting list could be eliminated altogether. It is instructive that this company's estimate for the 500,000 operations was £725 million, a little more than a third of the sum which would be required to perform them, even if the capacity was available, in conventional private sector hospitals.[39] More high-volume, cost-effective, treatment centres are surely desirable. They would expect adequate remuneration and could, as now, operate as commercial enterprises.

Local community hospitals should also be given the freedom to operate as independent self-governing institutions. But, as they remain 'local monopolies' for Accident and Emergency and critical care services, it may be preferable for them to remain as non-profit organisations.

All NHS hospitals (not just successful ones, though these might go first) could be turned over, assets and all, to non-profit community trusts, operated under independent Boards answerable to the community they serve for the quality of care they deliver. They would be free-standing, independent, locally-owned and self-managing institutions on the model of mutuals or voluntary associations, with the right to set their own terms and conditions for staff without government interference. They would be free to earn revenue from other sources, and be free to buy and sell their assets. The fixed costs of maintaining emergency facilities could be met either by block funding according to the catchment area as currently, or by payment based on the volume of patients treated. But they would have the freedom to manage their budgets and set their own local priorities as long as they delivered the local services demanded. The required level of emergency services for each area could be set, and their performance monitored, by the Department of Health or the Strategic Health Authorities. If they chose – and if they were competitive – they could also offer specialist treatments on the

[39] 'German doctors "can end NHS waiting lists"', *Financial Times*, 4 March 2002.

same site under the same terms as the specialist institutions – thereby further widening patient choice. If they were not competitive, however, patients and the associated funding for specialist treatments would move away.

The combination of local community hospital trusts and specialist hospitals and treatment centres would free up the supply of secondary care, breaking the centralising constriction of nationalised industry structures and controls. Local management would then have the real opportunity and incentive to pursue innovation and efficiency.

Tertiary care is also primarily a private activity, in that it has no third-party effect and is best delivered in a manner which is responsive and tailored to individual needs. It has various aspects, ranging from midwifery, ante- and post-natal care to palliative care for the chronically sick and dying, rehabilitation for drug abusers, and long-term care for the elderly and disabled. It is delivered in hospices and clinics, residential homes and in patients' own homes. It is best done not by agencies of the state but by small private and charitable concerns. These need to be greatly stimulated and admitted properly into the family of healthcare providers, with their importance to a wide range of patients, and their role as the principal relief of 'bed-blocking' in NHS hospitals, recognised. If provision is to expand, it is important that the state does not rely on the charitable sector to top up the costs of supposedly state-funded places.[40] And the regulatory regime which applies to care homes is unduly rigid: over the last five years, 1,543 private and voluntary care homes have closed, with a loss of 50,000 beds. The recent Care Standards Act imposes further burdens on private care homes, and should be significantly amended or repealed.

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[40] Research compiled by the Liberal Democrat Party shows that charitable care homes for the elderly are subsidising the costs of over half their residents. *Cap in Hand: how charities are bailing out the state in care homes for elderly people,* Liberal Democrats, January 2002.

Stimulating the provision of private tertiary care facilities would have a major impact on costs and waiting lists. It would ensure that hospital resources were available for patients who genuinely need hospital care.

Public health services and similar activities should remain the responsibility of the state, though not necessarily delivered by the state structures. Immunisation, health visiting, ambulance services, and other aspects of care which have third party, environmental or social effects should continue to be the responsibility of the Health Authority. However, these functions could well be contracted to one or more independent providers, under its aegis. The historic neglect, by the NHS, of this basic function should be reversed.

2. Demand

It is the demand side of the equation which will determine how the new supply systems work. For the reforms which are necessary to liberate the provision of healthcare from state control will not achieve much in the way of consumer responsiveness unless purchasing is also liberated. Providers will only use their new freedom in the interests of patients when the patients control the finance they receive. This principle has been rejected by the Government, which has re-affirmed its commitment to a state-run NHS funded exclusively from taxation. But whether funding comes from taxes or some other source, the critical reform that is needed is to displace the state's current monopoly in spending that money.

One radical option would be to replace the NHS funding arrangement with compulsory minimum private medical insurance (PMI), with tax levels reduced accordingly. Hospitals would charge patients' insurers for treatment.

This option has the advantage of simplicity. It would break down the dominance of the state both in purchasing and providing, giving to patients the power of choice, and the providers the power of flexibility and customisation, which are so urgently needed.

Even if government paid the insurance premiums of those on low incomes, and undertook to provide default cover for those whose treatment costs become uninsurable, there could however be drawbacks. PMI would abolish the implicit cross-subsidy between rich and poor that is central to all public health systems. If it fails to pool the risk of different patients, PMI can generate the well-known problems of moral hazard and adverse selection – with different risk-rated premiums charged to different groups. Experience elsewhere suggests that it could also involve high administrative costs if the insurance funds had to negotiate every treatment on behalf of each patient. And most of all, it might not deliver effective 'cost containment', leaving the state with an ever-increasing obligation to pay the bills of those unable to afford premiums. While private insurance will continue to have a place, a universal system of compulsory conventional PMI seems unlikely to be the best answer.

There are alternatives to the two extremes of NHS monopoly and compulsory PMI. These aim to combine the social solidarity and risk-pooling which the taxation model provides with the flexibility and responsiveness of PMI. One route to this is the system of social insurance common in many continental countries. Under this model, employers and/or employees pay community-rated contributions (that is, irrespective of individual risk) and income-related premiums into government-approved 'sickness funds'. Often these sickness funds operate in competition with each other, either competing on price or the terms of the benefits they offer. As with private insurance, social insurance removes the state's control over health finance and spending. But unlike private insurance, this model preserves the implicit cross-subsidies between rich and poor, and healthy and sick.

Yet social insurance also has its drawbacks. One concern is that it could impose considerable burdens on business: by making people dependent on their employer for their healthcare, it could introduce unwelcome rigidity into the labour market. High unemployment in Germany, for example, is partly due to the

disincentive to hire staff which social insurance engenders. Other countries seem to be moving away from an earnings-based model to a broader tax-based system.

A further option, which may avoid some of these pitfalls is to leave funding primarily tax-based – at least initially – but to allow individuals much more choice by contracting for their healthcare to be delivered through competing healthcare schemes. They could also be free to 'top up' their basic NHS entitlement with additional insurance to cover incremental services. An attractive model to which members can belong is the 'managed care' system prevalent in the US, the outlines of which are given in the box overleaf.

In the UK, this model could be adopted as a template for a similar range of providers which might be called 'Community Mutual Insurers' (CMIs): non-profit, member-owned providers of healthcare insurance which patients could join as an alternative to the NHS. CMIs could contract with providers for specified care facilities, or pay one-off bills as they arise, or even provide care themselves through their own hospitals and doctors. The mutual mechanism would reflect the concern that insurers should not be profiting from people's health needs, generate loyalty among its members and return the profit they earn (called, euphemistically, a 'surplus') to their members in the form of lower premiums or higher investment in services. Competition between the purchasers (the CMIs) of healthcare resources would ensure that the cartel effects of the current purchasing system are avoided.

Organisations similar to the CMIs outlined here already exist in the UK. BUPA, Simplyhealth and other non-profit insurers provide a range of services independently of the NHS, either by paying for members to have private treatment or by treating them themselves at their own hospitals. Many of these schemes are mutuals and co-operatives organised by friendly societies and trade unions, catering specifically to the low-paid. These serve either specific localities or particular professions, generating both loyalty and commitment

PRESCRIPTION AND PROGNOSIS: THE LONG-TERM VISION

between members and management and delivering services specially tailored to the needs of the community. It is in the field of 'affinity group' insurance – offered on a non-selective basis to those people living within a geographical area or those working for a particular firm or in a particular sector – that private insurance has grown most strongly in recent years.

By giving the CMI the central rather than the peripheral role in healthcare provision, these organisations, together with alternative types of providers, could be expected to flourish.

3. Resource allocation

How would the financing of the system work? Assuming that a significant measure of state funding is necessary, what must be decided is:

a) how will this money be distributed through the system?

b) what exactly is the state prepared to pay for?

c) how far are other sources of funding allowed in as well?

While it is too early to be definitive, the system described above suggests that the first and third questions could be resolved in principle by a system of 'NHS Credits'. These would:

- give the patient control over a portion of his NHS budget in the form of a credit to transfer to the provider of his choice;
- enable people to top up the state allowance with their own money to pay for additional services.

The second question requires a method of defining a 'core' range of services that would be covered by the NHS Credit.

An NHS Credit

A patient could be entitled to transfer a risk-related 'portion' of the NHS budget out of the NHS and into the Community Mutual Insurer of his choice. CMIs would be obliged to provide the

essentials of healthcare for the cost of this credit, so that the state would provide a more explicit and funded guarantee of service standards for basic primary care, treatment for severe illness and social care. In addition, CMIs would compete to offer the best range of services for the NHS Credit.

The value of the NHS Credit would not be the same for every individual. Given the wide range of health costs across demographics, it seems likely that some version of the current health funding formulas, reflecting the age and sex of the patient, as well as other considerations, would need to be applied in fixing the individual credit. But so long as the organisations are large enough to undertake their own risk-pooling, it should be possible to avoid overly complex formulas, while ensuring that CMIs do not operate selection criteria to achieve a more favourable risk profile.

Individuals would be able to choose the package that best suits their needs. They would also be free to top up the credit with their own contributions, though it is essential that the full credit continues to cover the cost of all necessary care. The value of the NHS Credit could be reduced for those with higher incomes who in particular might be expected to top it up with their own contributions. The benefit of this approach, however, is that the market would determine whether or not the amount set was adequate to procure the core health package without 'topping up' – and as such would provide the market signal for health spending that the current top-down model so visibly lacks.

The fact that the core package was defined outside the Government would reduce one element of Treasury control over health spending. But as long as the NHS remained the default option for those not moving to CMIs, the Government would have a benchmark by which to define the overall value of NHS Credits.

For this model to work, it will be necessary to guard against the problems that will arise when, as happens in decentralised systems, contracts are inadequately defined, and one or other party runs into financial difficulty. There will not necessarily be a single model

which all CMIs and provider organisations conform to, but governance arrangements would need to be in place to safeguard patients' interests in the event of financial collapse. There are different models for dealing with this, such as reinsurance within the sector, by which other suppliers agree to take over the patients and meet contractual commitments, or the state acting as funder of last resort while 'failed' organisations are taken over or restructured.

Defining the core

An implicit part of this system would be a mechanism for defining the core service package which the state agreed to underwrite. This is not a new issue. Rationing is already latent in the NHS. As Derek Wanless observes, patients need 'a clearer understanding of what the health service will, and will not, provide for them.'[41]

How would the core package of healthcare be defined? Different approaches can be adopted. One well-known method is that employed in Oregon. This was the first state in America to make rationing decisions explicitly. In 1990, it appointed a Health Services Commission charged with developing 'a list of health services ranked in priority from the most important to the least important, according to the comparative benefits of each service to the entire population', judged by social values as well as clinical effectiveness. The first list, completed in 1991, consisted of 709 treatments for specific conditions. The state legislature then examined the list in the light of fiscal considerations, and decided to fund 587 of the 709. The list now includes 696 treatments of which 565 are funded. This fairly closely mirrors the package of care available on the Medicaid programme, making explicit a procedure which had previously been opaque.

While the Oregon plan has the advantage of simplicity, transparency and accountability, many consider it too restrictive of the clinical autonomy of doctors. Patients differ in their conditions, while doctors differ in their assessment of clinical effectiveness. It

41 D. Wanless, op. cit.

requires a cumbersome, highly prescriptive decision-making structure and has the danger of fossilising available treatments based on the historic *status quo* – slowing up the introduction of new treatments and approaches which have not yet 'made the list'.

Other governments have attempted to get around this problem by devising 'qualified lists' based on the considerations which should be taken into account in deciding whether a treatment is appropriate for state funding. The idea is that the core should be decided upon in each individual case, and done so by means of flexible guidelines rather than prescribed inclusions or exclusions.

The value of a qualified list over a prescribed list is that it releases the final aspect of nationalised care, resource allocation, from the control of the state. Doctors, not bureaucrats, would decide what care was available from public funds. But in order to avoid a potentially unlimited financial exposure for the Treasury, they would do so in reference to a framework agreed nationally, and against which their decisions could be checked and, if necessary, challenged in the courts. Equity would be preserved in this manner, while professional discretion would be brought to bear on what should, ultimately, be patient-oriented decisions.

In the Netherlands, the Government set up a Committee on Choices in Healthcare, which advised that four basic criteria should be met for a treatment to be funded by the state.[42] It must be:

- *necessary* (i.e. to enable an individual to 'function normally' and 'participate in social life');
- *effective* (i.e. proven to be so: many physicians in the Netherlands considered that fewer than 50% of treatments previously paid for by the state, such as lasting physiotherapy or routine laboratory tests, had been proven to be effective);

[42] See W.P.M.M. van de Ven, 'Choices in healthcare: a contribution from the Netherlands', in R.J. Maxwell (ed.), *Rationing Healthcare*, British Medical Bulletin no. 51, 1995.

- *efficient* (i.e. when marginal costs are not out of all proportion to marginal benefits), and;
- *cannot reasonably be left to individual responsibility* (i.e. where future risks cannot be expected to be fully appreciated by the patient, for instance geriatric and psychiatric care, and treatment for drug and alcohol dependency; also where failure to treat will result in the suffering of others, as in the case of contagious conditions and, again, substance addiction).

New Zealand, which set up a National Advisory Committee on Core Health Services in 1992, took a similar approach. Concluding, as in Oregon, that 'the current core reflects fairly accurately the values and priorities of several past generations of New Zealanders', the Committee recommended that the core be defined as what was already being provided, and set about establishing what precisely that was. It did not do this on the basis of an Oregon-style prescribed list, however, but as in the Netherlands by a 'qualified list' of the clinical circumstances in which a treatment is to be deemed appropriate. As the chairman of the committee recalled:

> One of the first things the committee did decide was that the core could not simply be a list of services, treatments or conditions that would or would not receive public funding. Very early on we decided that that approach just wouldn't work – it would be impossible to implement because it would either have to be so broad as to be meaningless, or so rigid as to be inflexible and unfair… The approach we decided to take was one that has the flexibility to take account of an individual's circumstances when deciding if a service or treatment should be publicly funded. For example… instead of a decision that says hormone replacement therapy (HRT) is either core or non-core… the committee has decided that in certain circumstances HRT will be a core service and in others it won't be…' [43]

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[43] M.H. Cooper, 'Core services and the New Zealand health reforms', in R.J. Maxwell (ed.), *Rationing Healthcare*, British Medical Bulletin no. 51, 1995.

To receive state funding in New Zealand a treatment must: 'provide a benefit' to the individual concerned, be 'cost-effective'; 'a fair and wise use of available resources'; and 'in accord with the values of communities'. In pursuit of this last objective, the Committee engaged in extensive public consultations, from which it derived such 'values' as the priority of quality of life over quantity of treatment, of basic services over high technology, and of community services over institutional care.

The value of the Netherlands/New Zealand approach is that it allows for considerable clinical discretion. The system does not include or exclude whole treatments by name, allowing that effectiveness varies from patient to patient. The key criterion in the Dutch list is *effectiveness*: this is necessarily a subjective assessment and one which places significant responsibility on the health professional. The downsides are that the focus on professional discretion reduces the patient's autonomy over his treatment and deepens the mystery in which doctors shroud their art, to the detriment of that transparency which should be a priority; it also tends to result in patients being subjected to a lottery of care and unsure of what treatments their tax contribution entitles them to. The other (almost reverse) problem is that the approach does not, in a major way, constrain the demand for care: it is far easier for a professional to judge a treatment necessary, effective and so on than to deny a patient access to it. Patient choice could therefore lead to a situation where patients made their way to doctors known to apply the guidelines generously: the market would encourage a lax interpretation of the core services.

Both the 'prescribed list' and the 'qualified list' approaches have their pros and cons – but their experience shows that viable schemes can be implemented. The great advantage of such an approach is that decisions on rationing are then open to public debate as opposed being concealed – as they are today – by waiting lists, postcode lotteries and so on.

The question for the UK is whether a better hybrid can be defined. This will be the subject of a later paper. But it is worth noting that the concept of agreed criteria for state funding is already acknowledged in the Government's National Service Frameworks, which attempt to give guidance on the priorities of resource allocation between different services within the NHS. The Government has also created the National Institute for Clinical Excellence (NICE), which exists to make decisions on the best practice to be adopted by the NHS, with reference both to clinical and financial considerations. This is, in effect, a rationing process. It is also instructive that the final Wanless Report recommended that NICE should not just confine itself to judging the worth of new treatments but should also examine 'older technologies and practices which may no longer be appropriate or cost effective'.[44]

Top-up funding: expanding the market

The advantage of such a structure, however, is that demand for healthcare would no longer be artificially constrained to the Treasury limit for all but a minority. By transferring a credit for core care to a CMI health purchasing organisation, it would be open to everyone to top up with additional payments that gained them additional benefits over and above the core healthcare entitlement. Most US HMOs have a range of such options, ranging from access to private rooms in hospitals, to more choice of locations, to more ability to schedule appointments for convenience and so on. At the moment, in the UK, only a small minority who can afford to pay for private medical insurance can exercise their choice in this way. By opening up the market, the opportunity to attract additional private funding into healthcare would be greatly expanded; and, at long last, freely expressed market demand for supply would exist – to which the market could respond as it saw fit – instead of the NHS's artificial Treasury-imposed expenditure cap.

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[44] D. Wanless, op. cit.

The benefits of such a system would only come, of course, once a large number of people had opted out of the NHS structure into CMI-type providers. Initially there would be a 'deadweight' cost as those who currently have private medical insurance used the NHS Credit to offset that part of their premium related to core services. But this effect could be lessened if the value of credits was reduced both for higher-income groups and lower-risk groups. In time, the benefits of a more competitive purchasing structure would begin to apply and many more people would find it affordable to add private contributions on top of their NHS Credit in order to benefit from a higher level of healthcare package. More corporate employers would also find it attractive to include top-up schemes as part of their employee-package. The market would also have the incentive to offer new, innovative services and insurance benefits (such as health cash plans). As a result, over time, the UK would move towards a mix of private and public mix of healthcare spending that was comparable to that of most of our European neighbours.[45] And private healthcare would no longer be the preserve of just the rich – it would be opened up to all.

This would represent a radical change in the system of healthcare provision in the UK. Only by breaking the triple nationalisation of supply, demand and resource allocation can we hope to break out of the inefficient, rationing-dominated NHS that exists now. And only then would the true objectives of universal healthcare that have so far eluded us be achieved.

Outstanding issues

While the direction that this restructuring of our National Health System should take is clear, there are of course many issues which require more detailed analysis and debate before a clear blueprint can be finalised. These include:

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[45] See the Appendix for data on international spending levels and sources.

- What governance structures and regulations would be appropriate for the proposed independent hospital trusts? On what conditions should assets be transferred into these trusts from the public sector? What form of accountability would be appropriate?
- Which is the best way for the UK to define the core service obligations of CMIs or other health-purchasing organisations? Should these core packages include minimum service standards on measures such as waiting times? How should the danger of 'inflation' of core services be guarded against?
- To what extent is the purchaser-provider split necessary in a plural healthcare market? Should CMIs be allowed or even encouraged to own their own hospitals and employ their own medical staff, or should they only be insurers and purchasers of healthcare?
- What rules or obligations might be required to prevent adverse selection being applied to exclude high-risk patients from CMIs? Should they be obliged to offer open enrolment? Or should the state take the higher-risk categories?
- If CMIs are not allowed to exclude patients, how can the danger of a disproportionate number of high-risk patients joining CMIs be managed? Can this be accomplished by the transfer values from the NHS?
- What is the best funding option for CMIs to secure universal access: credits funded from taxation, employer contributions, social insurance or private insurance contributions with the government funding low-income families?
- How should the value of an NHS Credit be assessed to take account of all the different risks? The variables to consider would include the individual's age, sex, and locality. How can accuracy in risk-assessment be balanced against clarity in the formula?

- Should the value of an individual's NHS Credit be linked to income in order to offset the deadweight costs involved in a decline of PMI? What would be the simplest way to achieve this?
- What is the residual role of the NHS executive in supervising the National Health System?
- How can the risk of inadequately defined contracts be minimised? How can patients interests be safeguarded should a CMI run into financial difficulty?
- What is the most practical transition plan to move from the current NHS to the new structure, and over what timescale could it be implemented?

These and related questions will be the subject of future publications from the CPS.

CHAPTER FOUR

PRESCRIPTION AND PROGNOSIS: THE FIRST STEPS

THE SYSTEM OF HEALTHCARE which the UK should be moving towards would comprise a diversity of self-owned, non-profit providers and insurers as well as the present commercial operators. But there is likely to be great professional and political resistance to alterations to the *status quo*. Hence steps in this direction must be incremental.

The following changes could all be implemented in the short term. They would extend choice. They would create the conditions for investment and innovation by alternative providers. And they would help the NHS, over time, to evolve from the present nationalised monopoly into a properly plural healthcare market – to the benefit of all.

An explicit change in government focus

The Government should aim to maximise quality and access from all healthcare sources in the UK rather than just concentrating on the role of the NHS as a monopoly provider. Attention should be paid not to levels of NHS activity but to the standards of care people receive – not to processes, but to outcomes. This essential conceptual shift is a prerequisite for reform.

A single system of regulation

The Government rightly intends to develop a single system of regulation covering the private, voluntary and public sectors. However, there are valid fears that reforms will simply extend the culture (not to mention the staffing practices) of the public sector to the independent sector, with predicable consequences. It is

important that a new scheme seeks to encourage, rather than to minimise, the competition between providers, thus empowering patients and stimulating innovation. Rather than imposing public sector regulation on independent operators, the Government should bring the NHS within the scope of competition legislation. NHS providers would have to prove that they are ensuring a level playing field for local competitors and new entrants.

Vouchers for elective care

The best means of ensuring a level playing field would be for patients to be granted credits or vouchers funded by the State for elective care, perhaps if treatment is delayed for longer than, say, two months. The development of such schemes would of course need to be phased to allow time for the private sector to respond with additional capacity. And in the medium term, this would relieve the pressure on NHS waiting lists, and liberate the potential of alternative providers in the innovation and diffusion of new treatments.

Investment in Information Technology

The final Wanless Report recommended a doubling of IT spend. Whatever the right number, the Government and the NHS should clearly commit considerably more of their budget to investment in Information Technology. The system already suffers excessive paperwork, and there are justified fears that the pluralism which is so necessary for reform will stimulate the creation of more. To avoid a bureaucratic contract culture, it is essential to modernise the systems in the NHS, to create better patient records, eliminate multiple data entry, and provide better management information for cost control. To this end, Wanless's idea of Patient Smart Cards detailing patients' medical history might also be considered: it would certainly ease the transition to a more diverse system.

Strengthening the role of Primary Care Trusts
More power needs to be devolved down through the system. While PCTs have only limited potential compared to the CMI approach, they could be given enhanced powers to commission services from outside the NHS, thus encouraging a variety of providers. Over a period of time the aim would be a move towards much greater competition in contracting out services, with an increased proportion of NHS funding going to private and voluntary suppliers.

An enhanced range of GP services
There should also be greater freedom for GPs and primary care teams to provide an enhanced range of services working with local community pharmacies and remedial professions. GPs should provide a core service but also be able to offer additional services in areas such as complementary medicine, rehabilitation and health screening. Funding constraints within the NHS mean that the availability of such free services will always be highly problematic. This proposal would allow much more rapid development by bringing into play the consumers' own interests and spending power. It would also encourage the development of new forms of insurance to cover the cost of additional services.

More integrated support services for elderly people
There should be a range of new and specific measures to promote the development of more integrated support services for elderly people and their carers at home. Payments for home support and health services should be tax deductible, covering self-pay services in medical treatment and home support. This would promote greater security and develop alternatives to long term institutional care. People receiving NHS or social services would be able to opt much more easily for cash payments so as to access the services of their choice. Furthermore the Care Standards Act, which imposes heavy regulatory burdens on small care homes, should be significantly amended or repealed.

PRESCRIPTION AND PROGNOSIS: THE FIRST STEPS

Tax breaks for all forms of medical insurance

Tax breaks should be introduced for all forms of medical insurance. Although non-profit forms of PMI may be preferable in the long term, the commercial sector has a vital role to play in stimulating both the injection of private money into the healthcare system and the development of new medical treatments. The 7% annual rise in the cost of premiums must be halted by deductions both in the tax on contributions paid by policy holders and in the corporation tax paid by the companies. At the very least, the tax breaks on PMI for the over 65s, abolished by the Government in 1997, should be reinstated.

CHAPTER FIVE

CONCLUSION

IN 1948, the Government issued a leaflet to every home in the UK. It promised that the NHS 'will provide you with all medical, dental and nursing care. Everyone – rich or poor – can use it.' But this 'comprehensive, universal' aspiration has never been fully met; a fact subconsciously accepted by the imposition of the expenditure ceiling in 1949. This ceiling – the cost of providing the limited package of care which the NHS offers – has risen inexorably, as technical progress and cultural change have served to stimulate demand.

The alternative system outlined in this paper is likely to deliver the founding aspirations of the NHS more faithfully. Later papers in this series will set the proposals out in more detail and the steps by which we can move from here to there. It comprises three aspects.

Provision liberated from the state

Most aspects of provision would be liberated from state ownership. GPs would remain as self-employed professionals, with more freedom over their surgeries and more opportunity to access private funding for alternative and ancillary treatments. Hospitals would become self-owning and self-governing institutions treating NHS and private (CMI or PMI) patients on the basis of a fee for service or under contract with the NHS or the insurer. Private and voluntary nursing and residential homes and other providers of tertiary care such as home support would be freed from excessive government regulation, while the fees they charge for public patients would be more honestly and fully met

by the state. Only public health functions, as well as emergency ambulance services and the like, would remain the exclusive responsibility of state providers.

Liberating funding

Funding too would be freed up: patients would be entitled to transfer their portion of the NHS budget into private (though non-profit) hands, and to top it up with their own money if they wish.

Liberating the allocation of resources

The allocation of resources would also be freed from exclusive state control. Insurers would be required to provide, as a condition of receiving the NHS credit, the basic package of core services. This could be determined by a set of criteria similar to that in place in New Zealand and the Netherlands. These criteria would be assessed by professionals. Patients could have the right of appeal through a body similar to the National Institute of Clinical Excellence and, ultimately, the courts.

These changes would bring substantial benefits across the whole field of healthcare. The artificial 'expenditure ceiling', imposed in 1949 as the first and fundamental recognition that the NHS as designed by Bevan could not work, would be lifted. For the first time, we would have a true expression of consumer demand for healthcare. Consumer choice, and a diversity of providers, would help stimulate service improvements and innovation in healthcare across the board. Satisfying the needs of individual patients would become the objective and measure of healthcare organisations – an essential turnaround from the nationalised industry ethos of seeing patients as 'problems' for the system to deal with. Rather than constantly managing upwards, delivering reports on the vast range of central initiatives, plans and performance indicators, health professionals would at last be freed to address the individual and local needs of patients and communities.

INTERNATIONAL DATA ON HEALTH SPENDING AND METHODS

	% of GDP spent on healthcare	% of health care spending that is:		% of public health care expenditure from tax (as opposed to social insurance)
		Public	Private	
US	12.9	44.8	55.2	67
Switzerland	10.4	59.1	40.9	42
Germany	10.3	75.8	24.2	8
Canada	9.3	70.1	29.9	98
France	9.2	77.7	22.3	3
Netherlands	8.7	68.6	314	6
Australia	8.6	70.0	30.0	100
Belgium	8.6	71.2	28.8	51
Norway	8.6	75.8	24.2	85
Greece	8.6	56.3	43.7	43
Denmark	8.3	81.9	18.1	100
New Zealand	8.1	77.0	23..0	100
Austria	8.0	71.8	28.2	40
Sweden	7.9	83.8	16.2	100
Italy	7.7	67.3	32.7	98
Portugal	7.7	66.9	33.1	93
Spain	7.0	76.4	23.6	82
Finland	6.9	76.3	23.7	81
Ireland	6.8	76.8	23.2	91
UK	6.8	83.3	16.7	100

Sources: OECD, *Health Data 2001,* 2002. Data for 1998.

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