



Resuscitating the NHS

A consultant's view

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SUMMARY

- The NHS is imploding. Since 1993, NHS funding in England has risen by 45% in real terms, with little or no improvement in patient care. The huge amounts of additional spending that the Government is pumping in over the next five years is unlikely to produce the desired results.

Two questions

- How can the elusive goal of high quality healthcare for all, free at the point of delivery, be achieved while keeping costs under control?
- And how can the balance of power and control in the NHS be taken from the bureaucracy, where it currently resides, and given to patients, where it belongs?

Two reforms

- Two fundamental, but achievable and financially neutral, reforms to the NHS could do much to achieve these two goals.
- The first is a simple voucher system. Every UK citizen would continue to have NHS care free at the point of delivery. The voucher could also be used privately (to cover part of the cost). To minimise the deadweight cost, the value of the voucher would be reduced to say 70% if used privately. Money will follow the patient; good hospitals will prosper; and all patients will have the power and respect of consumers.

- The second proposal is to reduce dramatically the numbers of managers and administrators in NHS, using the funds generated to substantially increase the number and pay of nurses and allied professions. Patient care is far better in the private hospital than in a typical NHS hospital.
- It is extraordinary that there are currently almost as many managers or administrators as there are qualified nurses employed in the NHS. In a large private sector hospital, which carries out similar range of operations and procedures as an NHS hospital, there is one manager or administrator for every four and a half nurses.
- If this private hospital were to have the same manager-nurse ratio as the NHS, it would either have to increase the number of its management, administrative and support staff from 43 to 186; or sack 186 of its 240 nurses.
- If the level of management in the NHS could approach that in the private sector, the quality of service in the NHS would be significantly improved. The money saved could be used both to increase substantially the number of nurses and radiographers and to increase their salaries by between 30% and 40%. Patients would benefit directly from both reforms.
- These two changes would transform the NHS into a dynamic, responsive and properly staffed institution without any need for extra taxation.

CHAPTER ONE

INTRODUCTION

I CAME TO ENGLAND from South Africa 24 years ago as a doctor and started to work in the National Health Service. Like so many other young doctors and nurses, I was full of enthusiasm and hope. My colleagues and I found working in the NHS exciting. We genuinely believed that we were contributing to something that was of high quality and of which we could be proud. Then, the NHS was still “the envy of the world”.

I still work in the NHS as a cancer physician. I have seen at first hand the steady decay of a great public institution.

Today the NHS is on the brink of implosion. As Sir Peter Morris, the President of the Royal College of Surgeons, said recently:¹

Things are in such a mess, much worse than I would have imagined possible. I’m hearing over and over again that there aren’t enough beds. In some places, elective surgery has just about stopped. Often a surgeon has an anaesthetist and surgical and nursing teams ready – only to find that they are all stood down because there isn’t a single patient and nothing to do. It is dreadful... Surgeons are miserable, depressed, frustrated.

We all now know that the quality of care delivered to the citizens of this country is far below that of other European countries and of the US. Survival rates for most common cancers are shamefully inferior to our European neighbours and the US.²

¹ Interview in the *New Statesman*, 10 December 2001.

² *Survival of Cancer Patients in Europe: the EURO-CARE-2 Study*, edited by F. Berrino et al., IARC Press, 1999.

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And the £40 billion that will be spent on the NHS over the next five years is unlikely to produce the results that we all want to see. For the failure is not a lack of money, but is systemic.

The problems are clear to anyone who works in both the NHS and the private sector. In the NHS the vast numbers of managers are there to stop things happening. In the private sector, the small numbers of managers are there to make things happen. Private sector managers are there to work with doctors to improve patient care. NHS managers, on the other hand, must concentrate on meeting government targets and staying within budget.

Despite the hard work of many doctors and nurses, the NHS is characterised by heavy-handed bureaucracy, low morale and, from the patient's point of view, unnecessary pain, suffering and even death. While consultants were once respected as a highly skilled élite, today they are treated like any other employee. They feel unable to influence events, are demoralised and no longer feel a sense of ownership in the NHS.

To get something new in the NHS is a struggle, involving many processes and committees, often with very little chance of success. As Professor Irving Taylor has noted, his work as a consultant surgeon and professor of surgery is either “assessed”, “appraised” or “validated” by 22 separate committees.³ Each one consumes an ever-increasing proportion of senior professionals' time and energy. As a colleague has noted:

³ See *Daily Telegraph*, 22 August 2002. The bodies include: the General Medical Council revalidation procedures; the National Clinical Assessment Authority; the UK Council for Regulation of Healthcare Professionals; the National Care Standards Commission; the Commission for Health Improvement; the National Patient Safety Agency; the Cancer Accreditation Teams; the Clinical Governance Committee; the Professional Advisory Panel; the Clinical Audit Committee; the Continuing Professional Development Committee; the Annual Consultant Appraisal; the Junior Doctors' Hours Action Teams; the Pre-Registration House Officer and Senior House Reviews for Postgraduate Dean; the Specialist Registrar Review for Postgraduate Dean and Royal College of Surgeons; the Internal Quality Assurance Committee; the Staff Review and Development Committee; the Annual University Appraisal; the Quality Assurance Agency; the Research Assessment Exercise; the Peer Review of Teaching; and the Research Governance Committee.

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You don't have to sit in on many contract meetings to see the waste of salaries sitting round the table and the drain on consultant time, never mind network meetings, specialist provider projects, HA/PCT drug advisory committees and so on.⁴

How different it is in the private sector. There a request for something new will be acted on immediately if it will generate more patients or more procedures. But more importantly, if an expensive change is necessary to improve patient care that will *not* generate funds, it almost always happens in a reasonable period of time. If it is to survive, a hospital in the private sector knows that it must invest for the future. It will take a long-term view – because it has to. The NHS is under no such constraint.

More money for the NHS

There is little evidence that extra money is making, or will make, much difference. Since 1993, funding for the NHS in England has risen by 45% in real terms, while waiting lists have remained above a million. From 1997/98 to 2000/01, NHS spending increased by 41% – yet the NHS treated just 2% more patients. For years in Scotland spending per head has exceeded that in England. But waiting lists are about as long as they are in England, and mortality for common killers such as heart disease or cancer are far higher, and falling more slowly than elsewhere in the UK. The NHS in Scotland has more money but it is not clear it is delivering any better care.⁵

The funding of cancer treatment is a case study in how money does not get to front-line care. The NHS Cancer Plan, announced in 2000, promised that an additional £570 million would be allocated to cancer by 2003/04. This money is not reaching many of the cancer networks. As the House of Commons Select Committee concluded, the money intended for cancer treatment was often diverted locally to pay for other services.⁶

⁴ Comment made by a Professor of Medical Oncology, London.

⁵ *The Times*, 27 November 2002.

⁶ Reported in *Funding for Cancer Services: an independent audit of cancer networks in England*, CancerBACUP, November, 2002.

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The increase in cancer care funding, often quoted over recent months, may not be reaching those who are relying on it to deliver the Cancer Plan. We are seriously concerned at the apparent ease with which Trusts can redeploy such funds if they choose. We consider it dissembling to allocate funding to cancer care, with great publicity, without taking even the smallest precaution to ensure that it reaches the intended areas.

An independent audit by the leading cancer charity, CancerBACUP, found that half of all the cancer networks received less money in 2002/03 than they expected from the extra resources allocated in the NHS Cancer Plan. The shortfall in funding was typically over 20%. Even those who had received their full funding reported that some of the allocated resources were being used to repay debt.

And despite the extra funds pouring into the NHS, the situation is getting worse, not better. Next year, 82% of respondents to the Cancer BACUP survey reported that they will not receive the necessary resources to enable them to meet local needs in 2003/04. The survey concluded, not surprisingly, that current funding arrangements are impacting negatively on the ability to improve cancer treatments.⁷

Bureaucracy and waste

The growth in management in the NHS is remarkable. There are now nearly 270,000 managers, administrators and support services working in the NHS. And since 1995, the number of senior managers has increased by 48%, and the number of managers by 24%. But the number of qualified nurses has only increased by 7.8%. Without significant reform, the new money promised for the NHS will simply disappear into deeper and deeper layers of bureaucracy, with more and more monitoring of more and more targets and other such administration (let alone conventional hospital or general practice management).

⁷ Ibid.

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A colleague's experience is shocking, but no longer surprising:

In our department in 2000 there were 15 doctors and 17 managers (administrative, clerical and managerial). In 2002, there were still 15 doctors, but the managerial staff had grown to the obscenely bloated number of 30 – in just 2 years! This is of course an underestimate, as there are innumerable nurse managers who don't nurse any more, but who are not counted as managers. Conservatively, I have calculated that this increase in managerial staff puts an extra funding burden of £500,000 per year on our department – year after year of course because none of these people are ever let go – without one iota of increased productivity.⁸

Waste is endemic: the Department of Health itself admits that up to a fifth of the NHS budget is lost through waste, fraud and inefficiency.⁹ Half of the time of an average appointment at an outpatient clinic is wasted as the result of bureaucratic inefficiency. The quality of the patient notes is abysmal and the IT structure primitive and often non existent. Patients often fail to come to their appointments because they never received the letter or it arrived only after the appointment was due. Every doctor and nurse in the NHS could provide many more examples.

Government initiatives to address the problems of bureaucracy are unlikely to succeed. The announcement of two new bodies, the GP Implementation and Monitoring Task Force and the Hospitals Implementation and Monitoring Task Force, does not inspire confidence. And the Department of Health, aware of the complaints of over-regulation, now plans to exacerbate the problem with the creation of a further body, the Commission for Healthcare Audit and Inspection. This new Commission will presumably assess, appraise and validate the work of the other commissions.

⁸ Comment made by a Consultant Medical Oncologist.

⁹ *The Sunday Times*, 2 December 2001.

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Even the Government is beginning to show alarm that the new investment in the NHS will not work. The recent leaked report from the head of the Prime Minister's Delivery Unit revealed these concerns:¹⁰

The report says the most urgent task is to establish local plans that can take advantage of the unprecedented three-year spending settlement given to primary care trusts, which purchase care on behalf of patients.

This, the document says, is “being managed to a very tight timetable. But we (the delivery unit) are concerned that there has not been enough forethought and planning (by the health department) for this one-off opportunity... the risk is immense.”

Among the “very significant challenges”, says the report, are the “weakness” of the primary care trusts and the strategic health authorities Mr Milburn created last year.

The report also raises concerns about the health department itself, which it says needs “to get the right people into the right jobs faster” to ensure delivery.

For the doctors and nurses who work in the NHS, it is worrying that the focus of these concerns seems to be that there is too little bureaucracy. For the Delivery Unit is primarily worried that there has not been enough “planning” in the preparation of the three year plans; is anxious about the “weakness” of the primary care trusts and the strategic health authorities; and has concerns that the health department itself must “get the right people into the right jobs faster”. If these are the problems, surely the solution is simple: more managers!

The Government's only fundamental reform, the creation of foundation hospitals, could be a valuable innovation if it applied to the whole NHS. It proposes setting hospitals free of at least one layer of bureaucracy. But as it is planned, this experiment will only affect a dozen or so trusts in the next few years. And still the discipline of patient choice is absent.

¹⁰ “Extra NHS cash may be squandered, PM told”, *Financial Times*, 8 January 2003.

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Scope of the paper

It is assumed that we all want to achieve the elusive goal of high quality healthcare for all, free at the point of delivery, while keeping costs and the burden on the taxpayer under control. To do this, we must learn what makes private hospitals successful: that is, consumer choice with power and control in the hands of the patient not the bureaucracy, where it currently resides.

This paper also accepts that the decision to fund the NHS from general taxation has, at least for the moment, been made. However, it should be noted that several other European countries have a model based on one or other form of social insurance. Those countries are widely accepted to have a higher standard of health care than the United Kingdom with widespread popular satisfaction. This satisfaction is likely to be based in large part on the perception that the power is in the hands of the consumer who has a great degree of choice about where and from whom they receive their healthcare, rather than on the source of the funding itself.¹¹ If the NHS is to once again become the envy of the world – or at the very least, offer a reasonable standard of care – patients must be given the power to exercise choice. Only then, under the current system, will the quality of care provided to individual patients be substantially improved.

¹¹ See for example, B. Irvine et al., “For and against – Social insurance: the right way forward for health care in the United Kingdom?”, *British Medical Journal*, 2002.

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CHAPTER TWO

POWER TO PATIENTS

THE NHS IS UNIQUE when compared to the healthcare systems of Europe and the US. In other countries, money follows the patient. Power resides with the patient. In the UK, it rests with bureaucrats.

Within the UK, this striking difference can again be seen in a comparison of private healthcare and the NHS. In the private sector, the patient is the purchaser of the medical services, while in the NHS the patient is the recipient of what the service can provide. In other countries' health services, and in the UK private sector, the patient expects to get the best treatment, provided quickly and in a respectful manner. If they are not satisfied they can change their doctor and hospital immediately and seamlessly. In practice this is uncommon, as the providers of the service, the doctors and the hospitals, are aware that the patient is the customer and that the power rests with them. As a result, they work hard to provide a patient-oriented service.

In contrast, the patient in the NHS has no option but to accept long, painful and often dangerous waits to see doctors, waits for investigations, waits for results and finally waits for treatment.¹² By the time they get to having treatment they are often so worn down by the system that they are not in a position to question or complain about the service they have received. Despite the admirable introduction of the two week waiting list initiative for suspected cancers, many patients still take months to get through

¹² This is particularly dangerous for operations such as cardiac bypass surgery and cancer investigation and treatment where time may be crucial.

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the diagnostic obstacle course and then have further waits, often months in length, for treatment such as radiotherapy. The patient is disempowered and made impotent by the system. Of course patients can request a change of doctor and hospital and very occasionally do. However that usually involves a long process of further waits. There is the fear they will lose their hard-earned place in the queue.

The internal market and foundation hospitals

The last Conservative Government tried to introduce a policy whereby money followed the patient. It was intended to give the power back to the patient. It was the right idea but unfortunately failed in the delivery.¹³ Firstly, each hospital was required to calculate for itself the cost of each procedure. This required large numbers of administrative staff simply to do the calculations. Secondly, individual hospitals negotiated contracts with other hospitals who agreed to provide a certain number of procedures at a fixed price. This meant that patients could only go to a contracted hospital (except in exceptional circumstances). The net result was a vast increase in non-productive administrative expenditure to calculate prices, devise contracts and collect money. At the same time, paradoxically, it also resulted in a substantially reduced choice for the patients. Individual consultants who saw more patients than they were contracted to see were criticised for being overproductive, rather than complimented on their hard work. Despite its failure in practice, the idea was excellent. A real opportunity to transform the health service was lost by a failure to create a workable system.

The current Government has created a new category of “Foundation trusts” for the best performing hospitals. These are intended to be not-for-profit organisations representing a middle ground between the public and private sector. They will be paid by results, and get extra funding for taking on more patients. In

¹³ See A. W. Macara, “Reforming the NHS reforms”, *British Medical Journal*, 1994.

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addition, foundation hospitals will have the freedom to prescribe drugs and treatment not available in other NHS hospitals. This is a praiseworthy initiative for two reasons: hospitals that perform well will be rewarded; and money will follow the patient.¹⁴

Only a dozen or so trusts have qualified for foundation status. It is to be hoped that the proposals will be trialled properly and then extended to the rest of the NHS. But foundation hospitals will not address the central problem in the NHS: that the patient must have some control over the system, and not as is currently the case, the other way round.

The case for vouchers

One powerful, simple and effective way to give power to the patient is to provide a voucher for the value of any procedure or operation. This voucher could be used anywhere in the NHS or privately.

However, for this to succeed it must be kept simple. It is unnecessary, bureaucratic and expensive for each hospital in the United Kingdom to calculate the costs of each procedure. It would be a simple matter for a committee of specialists to quickly and effectively calculate how much, for example, is the cost of the average hip replacement. Often these figures already exist, both in the NHS and the private sector. For example, let us assume that on average it costs about £5,000 for a hip replacement on the NHS. A simple formula could be derived to deal with special circumstances. For example, 10% extra for the cost of treating a patient in London and other major cities. There may also be centres that because of their expertise deal with a higher proportion of difficult hip replacements and it may be agreed that they need an extra weighting to take into account the complexity of some of their cases.

¹⁴ For details on Foundation Trusts, see www.doh.gov.uk/nhsfoundationtrusts

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The idea of vouchers for health care is not new, but vouchers are usually advocated as a means of asking the patient to contribute to the cost of health care.¹⁵ The proposal made here is that the voucher will always meet the full cost of investigation or treatment in any NHS institution, as so will not interfere with patients receiving free NHS treatment at the point of delivery.

In order to minimise the “deadweight” cost of this proposal,¹⁶ the value of the voucher could be reduced (to, say, 70% of its full value) if used privately. Patients could then shop around for the NHS hospital that could provide the best, quickest or most convenient treatment, at no cost to themselves. Alternatively, if the patient decided to go to a private hospital, they will take 70% of the NHS cost of the procedure (which may equate to say 50% of the private cost) with them and could choose to make up the difference through insurance or by a personal top-up. For example, patients who are told they have to wait four or five weeks for a CT scan (a very frequent occurrence across the NHS) to investigate a possible cancer (it is difficult to think of a worse form of mental torture) will have the option of trying different NHS institutions to see if it can be done sooner.¹⁷ Alternatively, they could choose to use their voucher to contribute to the cost of having it done privately.

The effect of such a system will be to provide a real degree of competition between different NHS institutions, and with the private sector. Properly implemented, it would not undermine the infrastructure of the NHS. It will also provide immediate evidence as to which institution is being the most productive. Those institutions that attracted patients and were productive would be

¹⁵ See for example, T. Congdon, *Towards a Low-tax welfare State*, Politeia, 2002.

¹⁶ The deadweight cost is the extra cost to the state generated by people who are currently privately insured (or pay themselves for private care) who would use the vouchers to contribute to their treatment.

¹⁷ This system already operates in Denmark, where patients have the right to choose their hospital. There, waiting times for operations are posted on the internet and patients can choose the hospital that best suits their needs.

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rewarded and would grow, while those that were not productive would receive less funding and would have to question their lack of productivity.

The result of this voucher system would be that every UK citizen would continue to have NHS care free at the point of delivery. Most importantly, they would also have the power and respect of a consumer. They would no longer be passive recipients of treatment. If the NHS provided a good standard of care, no patient would need to opt out for private treatment (although they may still choose to do so), but the option would be there and would increase the sense of consumer power for individual patients, even if it is only exercised by a minority.

It would also hold individual doctors and hospitals to account as it will be immediately apparent if a particular doctor or institution has an unusual number of requests to change to another provider. The practice of post-code prescribing would be rapidly reduced and eventually eliminated; waiting lists would melt away without artificial targets that distort patient priorities.

There is always a concern that such a system will result in chaos as patients move from hospital to hospital. In practice, experience shows that the great majority of people on the NHS or privately will go to the specialist recommended by their GP, and will stay with him or her unless there is a long waiting time or the service is unsatisfactory. The fact that patient choice exists does not mean that it will always – or indeed often – be used. It does mean that the balance of power between the patient and the NHS is reversed.

It may be argued that the last thing the NHS needs at this stage is yet another change. However this voucher system could be introduced stage by stage. Different variations could be piloted in different parts of the country. For example, initially it could apply to only two common surgical procedures, such as hip replacements and cataract surgery. If successful, it could then be rolled out to other common surgical procedures, radiological investigations such as CT, MRI and Ultrasound scans and investigative procedures such as endoscopy.

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These changes alone would transform the patient's pathway through the NHS by removing many of the blocks to effective and efficient care. Applying the voucher system to chronic and complex illnesses such as diabetes and cancer would be much more difficult and could only happen after careful pilot studies had been carried out to explore the different options. But each stage of introducing the voucher system would improve the efficiency of the NHS without requiring yet another pendulum swing in the way the NHS is run.

CHAPTER THREE

RATIONING

NO HEALTHCARE SYSTEM can provide unlimited care. As a result, every country has to define, whether openly or discretely, what it can and cannot provide. In the UK, despite the denials of politicians, *de facto* healthcare rationing has always taken place, either by a combination of not offering treatments that are not available or by long waiting lists or by both. This has happened to different degrees in different hospitals and in different parts of the country. It has resulted in wide variation in the quality of treatment available (so-called post-code prescribing).

The National Institute for Clinical Excellence (NICE) is currently in the process of defining what the NHS will and will not pay for. This will reduce post-code prescribing and enable rationing to take place in a politically acceptable manner, as it is done by making an assessment of the scientific evidence for clinical and cost-effectiveness of any particular therapy.

Transparency and honesty on this issue are essential and critical if the NHS is to succeed. NICE has not indicated what figure it is using to decide whether a treatment is cost-effective, but based on the decisions made so far it appears to be around £30,000 per quality life year gained (“Quality”).

Despite protests to the contrary, the NHS is defining what the state will pay for, and what is regarded as too expensive. This limit will of course vary over time, and there will be arguments about the terms “effective” and “cost-effective”; in addition, the question of how to measure “Quality” will continue to be hard to answer. Yet the principle that the capabilities of the NHS are finite has been

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accepted – and this is all to the good. Patients will know what they can and cannot get from the NHS. And the public will have the chance to debate and disagree with whatever figure is used to define a cost-effective treatment; and indeed to influence that figure.

Defining the core services that the NHS can offer

A transparent and politically acceptable declaration of what the NHS will provide could, for example, be based on the list in the first box on the opposite page. It should be noted that many of the items on this list are not currently offered by the NHS and only available to people who choose to buy them privately. By implication, those treatments, services or features that are not in the core list of NHS services will only be available to those patients who have private care. These items are listed in the second box.

Difficult political decisions would still have to be made. For example, should the NHS should pay for fertility treatment for infertile couples? If so, should the NHS pay for fertility treatment for couples who already have one or two children? Should there be a limit to the number of attempts at fertility treatment? Most people would agree that cosmetic surgery should be available on the NHS to people with facial deformities. But should it be available for those who simply wish to try and reverse the ageing process? Should it be available for people with no obvious abnormalities who feel their “non-optimal” facial features are a big psychological burden?

New technology will always create more and more such dilemmas. Treatments for fatal conditions that prolong life for a few months at great expense are being continuously developed. The view of the person with the cancer and their family about the value of a few months extra life may be very different to the objective decision made by applying the scientific approach.¹⁸

¹⁸ See for example, M Slevin et al., “Attitudes to chemotherapy: comparing views of patients with cancer with those of doctors, nurses and general public,” *British Medical Journal*, 1990.

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PROPOSED HEALTHCARE AVAILABLE ON THE NHS

- Treatment for all significant conditions where the treatment is judged by NICE (or other appropriate body) to be of proven value and cost effective.
- Immediate treatment for life-threatening diseases.
- Treatment of painful and debilitating conditions (e.g. hip replacements) provided with very little delay (perhaps weeks).
- Treatment for non urgent and non debilitating conditions eg. Hernia repair or varicose veins provided within a reasonable time (perhaps three months).
- Treatment in a respectful and caring manner.

NOT AVAILABLE ON THE NHS

- Treatments judged by NICE (or another appropriate body) not to be of proven value or not cost effective.
- Treatments judged not to be significant medical complaints (e.g. cosmetic surgery).
- Better accommodation i.e. guaranteed single rooms.
- Treatment where they are guaranteed to be looked after by a specific consultant.
- Treatment by doctors who do not work for the NHS.

CHAPTER FOUR

NURSES OR MANAGERS?

THE NUMBER OF UK TRAINED DOCTORS is not critically dependent on pay: there are still far more applicants to medical school than there are places available. Doctors are paid significantly less than comparable professions but are paid a liveable salary and for many it is possible to supplement their income from private practice.

Conditions of employment are probably more important than pay itself. This can be seen very clearly by what has happened to general practice. Ten years ago it was commonplace for there to be 50 applicants for a single general practice post. The obsession with bureaucracy in general practice has resulted in general practice becoming intensely unpopular, and many posts now have no applicants at all, resulting in a real recruitment crisis.

However, for nurses, radiographers and other essential staff involved in direct patient care, inadequate salaries are unquestionably the major deterrent to recruitment and retention. The large numbers of staff involved make any significant improvements very expensive, but unless this issue is addressed the problem of recruitment will not be solved. The shortage of qualified nurses and radiographers will be a brake to any significant improvement in the NHS. The importance of this problem cannot be overemphasised. Unless it is solved, the NHS will continue to offer a second-rate service.

In the NHS, large wards are today run by a skeleton staff of under-qualified and agency nurses. Operations are cancelled because of a lack of nurses. The quality of our nurses is widely

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regarded as comparing very favourably to that in other countries but it is not possible to provide safe, let alone high quality care, if there are not enough qualified nurses.

Attempts by government to increase surgical productivity will come to nothing if there are no nurses to staff the extra surgery and aftercare. Nurses are increasingly playing an extended role and taking on tasks previously carried out by doctors and are a crucial part of the new multidisciplinary approach to clinical care. They also are the backbone of information services such as those provided by NHS Direct and CancerBACUP. This further depletes the already limited body of skilled clinical nurses from direct patient care. A similar situation exists with X-ray and radiotherapy services. The problem will not be solved by having shiny new CT and MRI scanners or Linear accelerators if there are no radiographers to run them.

Healthcare bureaucracy: private and public compared

NHS managers have an impossible task. Overwhelmingly, they join the NHS out of the same sense of vocation as other healthcare workers. But instead of addressing real issues of concern to patients, they soon find that their careers and salaries depend on meeting government targets.

Simple problems like the appalling quality of the patients' notes have still not been addressed. As a recent study found, nearly half of the time of an average appointment at an outpatient clinic is wasted, with the most time being spent in hunting for missing notes or results.¹⁹ It is not uncommon for a doctor to see a patient they have not met before with no clinical notes at all, or notes that are such a mess that he or she cannot make head or tail of what the diagnosis is and what treatment the patient has received. The doctor has no option but to try and ask the patient themselves what the diagnosis is and what treatment they have received. That

¹⁹ H. Patel et al., "Outpatient clinic: where is the delay?" *Journal of the Royal Society of Medicine*, December 2002.

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does not breed a feeling of confidence for the unfortunate patient and inevitably leads to clinical errors.

What is immediately apparent to anyone who works in both the private sector and the NHS is the sense that the small numbers of managers in the private sector are there to make things happen, while the vast numbers in the NHS have the task of stopping things happening.²⁰ Private sector managers are there to work with doctors to improve patient care. NHS managers, on the other hand, must concentrate on meeting government targets and staying within budget.

The managers in the private sector are acutely aware that the patients and the referring doctors are their customers. Any concern or complaint from a patient is addressed immediately. It is believed that the consultants are in the best position to know what is needed to improve services. The consultant has considerable influence over the services that are provided, not because the “consultant is king” but because the “patient is king”. Doctors feel that they have the power to influence the system and patient care. Individual consultants and small consultant committees make suggestions which are addressed seriously and speedily. A request for something new in the private sector will be acted on immediately if it is clear it will generate new patients. If an expensive change is necessary to improve patient care that will not generate funds, it takes longer and goes through the budgetary process but almost always happens in a reasonable period of time.

Recruiting more nurses

The lessons of the market should be clear: the shortage of nurses, radiographers, physiotherapists and other support staff is a direct

²⁰ There are 62,500 doctors employed by the NHS in England including 31,700 trainees. In comparison, there are 252,760 management and support staff employed by the NHS – giving a ratio of about four managers for every doctor. Data for September 2001. In addition to this number, there are 30,685 GPs (who are not employed by the NHS). See www.doh.gov.uk/stats/doctors.htm

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result of low pay. It follows that the only way to increase the numbers is to increase their pay substantially. The problem cannot be solved by recruiting nurses from other countries. Apart from the dubious morality of taking nurses from countries that have a far greater need for them than we do, issues of language and cultural differences often make it difficult for foreign nurses to fulfil their role in catering to the emotional as well as the physical needs of patients. No one enters nursing or radiography to become rich, but it is difficult for hard-working professionals not to feel undervalued by society when they are doing such difficult jobs for so little money. The salaries that nurses and radiographers are paid are so inadequate that the increases in pay needed to make them viable professions are enormous.

If one compares nursing salaries to that of teachers, themselves acknowledged to be underpaid, the size of the problem becomes apparent. Newly qualified teachers earn about 10% more than newly qualified nurses, but within five years the teachers are earning nearly 30% more than nurses.²¹ The question is not whether to increase pay by 3% or 4%, but whether to increase it by at least 30% or 40%.

The only way to achieve this scale of increase, without politically unacceptable increases in taxation, is to find the money elsewhere in the health service. And where better to look than the ranks of the bureaucracy? The Department of Health website shows that there are now as many health service managers, administrators and support staff as there are qualified nurses in the NHS.²² In September 2001 the number of management and support staff in 2001 was 269,080 compared to 266,170 qualified nurses. Moreover the rate of increase of managers far exceeds that of qualified nurses. Since 1995, the number of senior managers

²¹ Evidence to the review body for Nursing staff, Midwives and Health visitors, Nursing and midwifery staffs negotiating council. www.rcn.org.uk/pdf/bro1.pdf

²² Statistical Bulletin NHS hospital and community health services non-medical staff in England: 1990-2001. www.doh.gov.uk/public/nhsworkforce/sb0202.xls

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has increased by 48%, and the number of managers by 24%. But the number of qualified nurses has only increased by 7.8%.

These management figures are underestimates. Nursing managers are included in the figures given for nurses and doctors are largely managed by other doctors, who do not figure in the calculation of numbers of managers.

It is difficult to obtain comparable figures for the whole private sector. Also many private hospitals do not deal with the full range of conditions and procedures and may not be a fair comparison to a large comprehensive NHS hospital. However, comparing these NHS figures to those from a large private hospital in central London provides some indication of the scale of the problem in the NHS. This private hospital has 138 inpatient beds, undertakes the largest surgical procedures in nearly all specialties, has a very active day surgery and endoscopy programme and performs high-tech procedures such as bone marrow transplants. It also has a well-equipped and well-staffed intensive care unit as well as the full range of radiological and pathological investigations. It thus deals with complex medical and surgical procedures comparable to those performed in the largest NHS hospitals. It also runs multi-disciplinary meetings and has high quality clinical governance.

This hospital employs 240 nurses and has 43 management, administrative and support staff, giving a ratio of one manager or administrator to nearly six nurses. This compares to a ratio of one manager or administrator to one nurse in the NHS. However, there are some areas where the figures are not directly comparable.²³ Taking these three differences into account the comparable figure for NHS managerial administrative and support staff is 212,020, giving a comparable ratio of NHS managers, administrators and support staff to qualified nurses of 0.80 (80%) compared to the private hospital ratio of 0.18 (18%). In other words there are about four and a half times as many

²³ See Appendix One for details of the calculation.

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managers, administrators and support staff to nurses in the NHS than in the private sector. Using the adjusted ratio, if the private hospital was to have the same manager-nurse ratio as the NHS it would either have to recruit a further 143 management, administrative and support staff; or sack 186 of their 240 nurses.

What would happen if the number of NHS managerial and administration staff was reduced by one half? This would still be double the equivalent number in the private sector. Even so, it would comfortably finance an increase in nurses' and radiographers' salaries by, say, 30% or 40%. It would finance an increase in the training of nurses. It would finance an increase in the number of nurses and radiographers. It would finance running radiotherapy, CT scanners and MRI scanners late into the night, as is done in other countries (thereby reducing the current intolerable waiting list for these investigations and treatments). Above all, it would make nursing a more rewarding profession. And a greater number of professional better-paid nurses would mean better-treated patients.

This may appear insulting to the many hard-working and skilled managers and administrators in the NHS. But those consultants who are old enough to remember the days when a large teaching hospital was run by a Governor, a Matron, an accountant and several secretaries will know that it is practical. Management of the crucial clinical services will be largely undertaken by senior members of the relevant professions (as happens already today). The vast increase in administrators and managers has not provided an improved service to patients that anyone can notice. Indeed it has happened at a time when the NHS has deteriorated substantially. It is time to put that process into reverse.

CHAPTER FIVE

CONCLUSIONS

IF PATIENTS ARE NOT GIVEN the power of the consumer, and if we do not have enough well-trained and motivated staff, the NHS plan and the £40 billion being poured into the NHS, will do little to change an inefficient organisation delivering sub-standard healthcare. The Government's reforms will make little difference to an institution that is on its knees.

Giving patients consumer choice through the use of vouchers will revolutionise the way people feel about the NHS at no extra cost. It could provide true accountability and give individual patients real power. It could allow people choice about where and by whom they wish to be treated without removing the principle of treatment given free at the point of delivery. It could also allow those who wish to purchase extra services to do so, without reducing the principle of equal care for all.

And the discipline of patient power must also be bought to bear on the way that hospitals are run. The bloated and inefficient NHS bureaucracy must be drastically cut and the money used to make nursing, radiography and other health professions attractive and viable. This will require a courageous political decision. It will mean being prepared to stand up against powerful vested interests. But if it were achieved, it would result in a real and meaningful improvement in the supply of the invaluable and critical staff without which the NHS cannot survive – to the great benefit of the patients.

APPENDIX ONE

NURSE AND MANAGER RATIOS

IT WOULD REQUIRE a statistical survey of great complexity to establish an accurate comparison of staff numbers in the NHS and the private sector – and such a survey is beyond the scope of this paper. However, the scale of the difference between the two sectors is possible to estimate, albeit in a broad manner. Any adjustments are likely to involve a relatively small proportion of staff and will not be likely to affect the overall ratios significantly.

The following assumptions give some of the background to the calculations made in Chapter 4. It should be noted that, in order to be as “fair” as possible, the assumptions have been made in such a way as to favour of the NHS.

1. The managerial numbers for both the NHS and the private hospital include managers and administrators, ward co-ordinators, and administrative support for clinical departments and secretaries.
2. The figures for the private hospital do not include managerial and administrative staff for the ambulance service (as the private hospital does not run an ambulance service). The adjusted calculation excludes comparable staff in the NHS.
3. Maintenance staff, cleaners, porters and catering staff etc., are also not comparable as accurate figures for these staff do not exist in the NHS (many are contracted out to agencies). Again, the adjusted calculation excludes comparable staff in the NHS.

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4. The figures for the private hospital do not include consultants' private practice secretaries as these are not provided by the hospital. The adjusted calculation for NHS administrative and support staff has been reduced again to exclude doctors' secretaries. For this purpose, it has been assumed that every NHS consultant has their own secretary; and that there is one secretary for every five junior doctors.
5. The data exclude any consideration of the staff working for private health insurance companies; similarly they exclude the staff employed centrally by the Department of Health.

These adjustments do not change the figures substantially. For every ten nurses in the NHS, there are eight managers, administrators and support staff; while in the private hospital, for every ten nurses, there are fewer than two managers, administrators and support staff.

APPENDIX TWO

SOME SECOND OPINIONS

Consultant Medical Oncologist – Midlands

I greatly enjoyed reading your pamphlet and was challenged by the ideas, especially the voucher system.

Like you, I see the extra billions having some effect but much of it will not be directly to patient benefit. Too much will go on the monitoring of targets and other such administration (let alone conventional hospital or general practice management).

The bureaucracy around cancer networks has been a depressing affair to watch.

Professor of Oncology, London

Congratulations!

I have been toying with such a paper myself for some time making most of the points you have covered. You have done an excellent job.

Consultant Clinical Oncologist – London

I enjoyed your pamphlet very much. I have heard the things that you propose before but never as eloquently expressed. I think that you are absolutely right that in the private sector managers are there to work with doctors and to make things happen. In the private hospitals where I work, the CEO works with the doctors to improve the service and to make sure everything is as streamlined as possible. I feel that if you had a similar system in the NHS, where the chain of the command was from the bottom up rather

SOME SECOND OPINIONS

than from the Ministry down, things would work whereas currently they do not.

I also would endorse the notion of money travelling with the patient. If money followed the patient, then certainly this would give good hospitals the flexibility to open more beds. In these circumstances, waiting lists would certainly be reduced.

I would agree entirely that Nurses and Radiographers are going to have to receive a pay increase of somewhere between 30-40%. Otherwise the whole system is going to seize up.

Finally, there is no doubt that there are far too many managers and the enormous burden of bureaucracy must be cut.

I heartily endorse your comments.

Professor of Oncology – London

You are absolutely right!

You don't have to sit in on many contract meetings to see the waste of salaries sitting round the table and the drain on consultant time, never mind network meetings, specialist provider projects, HA/PCT drug advisory committees and so on.

I have felt very strongly for some time that the waste in the NHS is not clinically-based but due to the purchaser-provider split.

Endorse your document? I embrace it!

Professor of Gynaecology – London

I feel your proposals deserve a full and open debate and I endorse your view that a voucher system should be very carefully considered as an alternative way of distributing resources in the NHS.

Professor of Gynaecology – Midlands

Your paper is well thought through and resonant with the feelings of many of us working within the NHS.

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As a profession we must accept some responsibility for not putting our message across to politicians, let alone patients. I believe that your pamphlet could provide a way back into the debate as its messages are positive and most importantly consumer based.

I am more than happy to endorse this pamphlet and would hope, perhaps naively, that it just might be the catalyst that the debate needs to start addressing the real and very critical problems now faced by public healthcare.

Medical oncologist – South West

I entirely agree with the thrust of your argument that the most serious problem facing the NHS is the proliferation of managers.

In our department in 2000 there were 15 doctors and 17 managers (administrative, clerical and managerial). In 2002, there were still 15 doctors, but the managerial staff had grown to the obscenely bloated number of 30 – in just 2 years! This is of course an underestimate, as there are innumerable nurse managers who don't nurse any more, but who are not counted as managers. Conservatively, I have calculated that this increase in managerial staff puts an extra funding burden of £500,000 per year on our department – year after year of course because none of these people are ever let go – without one iota of increased productivity.

So obviously I am very happy to endorse your pamphlet.

Just an aside – someone just knocked on my door to introduce themselves as the new, permanent secretary to the Cancer Centre Lead Nurse (not to be mistaken for the secretary to the Network Lead Nurse of course).

It is only if we can turn the tide of this insanity that we will see some improvement in medical morale, and patient outcomes.

Head of Clinical Oncology London

Your paper is excellent. I endorse its exposure of the problem whole-heartedly. I think a major thrust by doctors (as distinct

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from middle managers who have to make the next monthly balance sheet balance) is required and I congratulate you on this first step.

Consultant Cardiologist, London

I am delighted to see how much you – as an ideal example of one who divides his time between the NHS and the private sector – can present views that one has often heard but rarely explained.

There is a philosophical problem in the term ‘NHS’. Most of us believe that a civilised society should provide health care for its individuals and in that sense the NHS is a laudable concept. But very few of us believe that the process of actually delivering healthcare should be left to a state run monopoly. Such a Stalinist concept has had its day in virtually all other areas of human enterprise. If one was judging the NHS’ performance over the last 50 years in the same way as we run medical trials then the safety committee would have closed it down about 15 years ago. It has had its day.

You are right that health care delivery needs to be liberated. It is the only solution to the current mess both in terms of speed of investment and quality of care.

The big challenge, as you point out, is how to empower the patient.

I’m looking forward to seeing the pamphlet published.

Consultant Gastro-enterologist – London

This pamphlet is outstanding and embodies my opinions exactly.

I suspect you will have the backing of more than 90% of all doctors. You certainly have my endorsement.

Professor of Gynaecological Oncology

As you know I believe in and support the NHS passionately and I agree entirely with your sentiments.

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APPENDIX THREE

NHS CONSULTANTS WHO ENDORSE THE VIEWS IN THIS PAMPHLET

DR PETER CLARK

CONSULTANT MEDICAL ONCOLOGIST, CLATTERBRIDGE
CENTRE FOR ONCOLOGY NHS TRUST, WIRRAL. CHAIRMAN,
ASSOCIATION OF CANCER PHYSICIANS

PROFESSOR GUS DALGLEISH

PROFESSOR OF ONCOLOGY, ST. GEORGE'S MEDICAL
SCHOOL, UNIVERSITY OF LONDON

DR ROB GLYNNE-JONES

CONSULTANT CLINICAL ONCOLOGIST, MOUNT VERNON
HOSPITAL, NORTHWOOD. MEDICAL DIRECTOR, COLON
CANCER CONCERN

PROFESSOR MARTIN GORE

PROFESSOR OF MEDICAL ONCOLOGY, ROYAL MARSDEN
HOSPITAL, LONDON

DR PETER HARPER, CONSULTANT MEDICAL ONCOLOGIST,
GUYS AND ST THOMAS'S HOSPITALS

PROFESSOR IAN JACOBS

PROFESSOR OF GYNAECOLOGICAL ONCOLOGY, BARTS AND
THE LONDON NHS TRUST, LONDON.

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PROFESSOR DAVID LUESLEY
PROFESSOR OF GYNAECOLOGICAL ONCOLOGY, BIRMINGHAM
WOMEN'S HOSPITAL, BIRMINGHAM

DR RICHARD OSBORNE
CONSULTANT MEDICAL ONCOLOGIST, POOLE HOSPITAL,
POOLE.

DR NICHOLAS PLOWMAN
HEAD OF CLINICAL ONCOLOGY, ST. BARTS AND THE
LONDON NHS TRUST, LONDON.

DR ANTHONY RICKARDS
CONSULTANT CARDIOLOGIST, ROYAL BROMPTON
HOSPITAL, LONDON.

DR MATTHEW SEYMOUR
CONSULTANT MEDICAL ONCOLOGIST, COOKRIDGE
HOSPITAL, LEEDS

PROFESSOR JOHN SHEPHER
PROFESSOR OF GYNAECOLOGICAL ONCOLOGY, BARTS AND
THE LONDON NHS TRUST, AND THE ROYAL MARSDEN
HOSPITAL, LONDON.

MR ROGER SPRINGALL
CONSULTANT SURGEON, CHARING CROSS HOSPITAL

DR ANDREW THILLAINAYAGAM
CONSULTANT GASTRO-ENTEROLOGIST CHARING CROSS AND
HAMMERSMITH HOSPITALS, LONDON

SOME SECOND OPINIONS

PROFESSOR JONATHAN WAXMAN
PROFESSOR OF MEDICAL ONCOLOGY CHARING CROSS AND
HAMMERSMITH HOSPITALS, LONDON