

Quite Like Heaven?

*Thanks to the nurses and Nye Bevan
The NHS is quite like heaven*

J.B.S. Haldane

Quite Like Heaven?
Options for the NHS
in a Consumer Age

Nick Seddon

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Author

Nick Seddon is a freelance writer and journalist. After studying English at Cambridge University, where he also co-edited a literary anthology, *Figures of Speech*, Nick spent three years working as a freelance arts journalist for the *Spectator*, *Time Out* and *Times Literary Supplement*, among others, before taking up a post as Research Fellow at Civitas. Following the publication of his controversial book *Who Cares?* about how state funding and political activism change charity, he writes a weekly column for *Third Sector* magazine, as well as comments and features for the *Guardian*. He has appeared frequently on television and radio.

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Many of these individuals will disagree with the conclusions to some degree or other. Quite a few will feel outraged that I have lifted their thoughts and theories, in some cases in great detail. None should be associated with the views I propound. My contribution is to assemble diverse facts and opinions, binding them together in an attempt to make new insights and developments more accessible.

When it came to digging out sources and references, I was helped by both Alison Benney and Gaetan Lafortune at the OECD, along with the librarians at the King's Fund Library and British Library. It will be clear to anyone who knows anything about this subject that I have incurred major literary debts. This is particularly true in the analysis of the history and organisation of the NHS now, where I have relied heavily on the invaluable *The New NHS: A Guide*, by Alison Talbot-Smith and Allyson M. Pollock, *The Five Giants: A Biography of the Welfare State* by Nicholas Timmins, *A Better*

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The constant changes taking place in the NHS at the time of writing mean that the book will probably be out of date by the time it goes to press, and many issues are merely touched upon. As well as the debts listed I have incurred many more; at the same time, there were many to whom I should have liked to have talked, but I simply ran out of time. As a result this can claim to be no more than a scoping project, an attempt to provoke a more open discussion, low on ideology but high on pragmatism, as the NHS, the institution which delivers us into the world and very often ministers to us at our exit, creaks towards the venerable old age of 60.

Foreword

The NHS was conceived at a time when queues were acceptable and people were grateful for what they received. Even the architect of the NHS, Aneurin Bevan, noted 'we shall never have all we need. Expectation will always exceed capacity.' Yet, despite his observation, generations of politicians have held up the NHS as the envy of the world, able to provide healthcare for all, free at the point of need.

Generation Y, born between 1978 and 1995, is a new consumer generation, brought up desiring instant gratification in the form of iPods, laptops and Blackberries. They are a mobile generation who believe that everything is possible. They will not tolerate an NHS that does not deliver and they lack the social cohesion and responsibility of a wartime generation brought up on rationing, which inspired and built the modern NHS. The concept of universal healthcare provision is just and can be delivered; the question is how should it be funded?

The UK government believes that this can only be achieved through taxation, but there are excellent examples in Switzerland and the Netherlands that suggest a social health insurance scheme may provide a better service as judged by the OECD.

I have long expressed a view that Britain must continue to look to its European partners for evidence of alternative systems for funding health care. While recognising that the Swiss are an inherently healthier nation than the British, they do provide excellent health care despite rising costs. Their health service is provided without any contribution from employers, the key to overcoming the problem currently experienced in France and Germany, which allows the UK government to quote their problems tackling rising costs as a reason not to abandon taxation as a sole source of health service funding. The changes recently introduced by

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the Dutch warrant further examination, if only to understand why they felt change was needed. As healthcare costs in the UK rise to £100 billion, questions will be asked again as to whether funding the NHS is sustainable through tax alone.

In his excellent analysis, Nick Seddon is arguing not for the end of a tax-funded system, but rather asking us to review the evidence challenging the notion that it is only through taxation that the NHS can continue to be funded. He takes a much wider view of the NHS than we currently see portrayed in the media, which inevitably focuses on the acute sector at the expense of the 'Cinderella' services that provide for our elderly, chronically ill and our psychiatric patients. It is remarkable that in an NHS that is free at the point of need, there are often many in this category who have to look to the private sector to provide their care. True universal health care can only be provided if there is no restriction on funding. Unless this can be guaranteed, some hard decisions will be required in order to set priorities for care. The long-awaited debate on the future of the NHS has only just begun.

*Bernard Ribeiro CBE
President of The Royal College of Surgeons of England*

Abbreviations

BMA	British Medical Association
CCE	Centres of Clinical Excellence
CHD	Coronary Heart Disease
CMO	Chief Medical Officer
DGH	District General Hospital
DH	Department of Health
DHA	District Health Authority
DHSS	Department of Health and Social Security
FT	Foundation Trust
GDP	Gross Domestic Product
GMC	General Medical Council
GP	General Practitioner
HES	Hospital Episode Statistics
HPA	Health Protection Agency
HSMR	Hospital Standardised Mortality Ratio
ISTC	Independent Sector Treatment Centre
IT	Information Technology
LIFT	Local Improvement Finance Trust
MTAS	Medical Training Application Service
NAO	National Audit Office
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NPfIT	National Programme for Information Technology
OECD	Organisation for Economic Co-operation and Development
ONS	Office for National Statistics
PBC	Practice Based Commissioning
PbR	Payment by Results
PCT	Primary Care Trust
PFI	Private Finance Initiative
SHA	Strategic Health Authority
WHO	World Health Organisation

Introduction

If you always do what you always did, you'll always get what you always got.

Albert Einstein

I

Our spectrum of normal has narrowed and it is narrowing all the time. Where once people were content to be ill or put up with an ache, such discomforts have now become unacceptable, and this has profound implications for health systems around the world. Before 1948 medicine in Britain was primarily about emergency treatment, with long-term and remedial care taking place in the home, and the initial conception of the NHS relied on this being the case. The NHS was set up to deal with major events, such as might be expected to occur only a few times, if at all, in the course of an individual's life. Yet over time, partly as a result of the promise of the NHS to provide health for all, partly because of scientific advances, partly because of developments in the rest of society, medicine has come to be seen as a way of life. A visit to the GP, and from there to a specialist, was once rare. Now it has become a common thing. You don't go for treatment any more, but for a service. We have become consumers of health care.

Along with these raised expectations, medical and technological developments are increasing the scope of what can be treated, and the changes are mutually reinforcing. More has happened in the last 60 years than in all the centuries back to Hippocrates, but this progress has not, as the architects of the NHS hoped, caused demand for health care to fall, rather to rise inexorably. We assume that our health system should adopt new technologies and provide treatment where no treatment previously existed. The expansion in the range of specialist treatments has occurred

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mainly in the fields of elective surgery and non-essential—including cosmetic—treatments, but there have also been major advances in life saving medicine. As a result, it has been predicted that there will be a 53 per cent rise in the number of people in the UK aged 65 and over between 2001 and 2031, with a rise in incidence rates for coronary heart disease of 44 per cent.¹ This comes, very literally, at a price. As we find new ways of keeping people alive for longer, then they will, not to put too fine a point on it, cost the system more.

Take cancer care, where advances offer enormous potential. Chemotherapy is a carpet bombing approach: in laying waste to a tumour, the drugs also wipe out the body's entire immune system, causing numerous side effects and leaving patients susceptible to opportunistic infections. In the last decade, however, advances have led to the creation of new types of cancer weaponry such as monoclonal antibodies which, like mini guided missiles, target the tumour itself rather than the surrounding tissue. But estimates for the yearly costs of some of these cancer drugs put them as high as £70,000.² And there's more to come, too. Powerful tyrosine kinase inhibitors will become available as straightforward tablets without the need for complex administration systems. Soon we will be able to choose the right personal therapy using over-the-counter genomic and proteomic diagnostic services.³ Many of these advances will turn out to be cost-saving innovations in the long run, but the initial developments are expensive. We possess powerful weapons in the fight against cancer, but can we afford to use them?

And then there are the technological advances outside health care. We're used to lifestyles and possessions that a previous generation couldn't have conceived of—cars, consumer durables, holidays, personal services—and ordinary

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people have become accustomed to choice, variety and responsiveness to their demands. This has amplified our expectations of the healthcare system. And if the internet is rapidly changing the way that we live, in few walks of life does it have the potential to change things more than in health. Fifty years ago the *Index Medicus*, the main index of medical research, ran to a couple of slim volumes. Today, millions of medical articles are published in hard copy and online every month. Type 'health' into a search engine and you get a billion results. This torrent of information—and sometimes misinformation—is changing the cultural context. A rapidly growing community of researchers is bringing together a dizzying array of technical information, and with information the satisfaction of demand excites more demand. Online consultations, self-administered tests with the results sent to your GP by email, remote video diagnosis and much more can all be expected in the future.

Among other impacts, this has radically changed the doctor/patient relationship. The era of the patient is upon us. Just as the Protestant Reformation and the printing press shattered the monopoly of the priests, and so changed forever the average person's relationship with God, so too is information about the outcome of care altering the relationship between patients and doctors. Society has stopped thinking of doctors as high priests and started to consider them more, as Rudolf Klein has said, as mechanics, more like the technicians of your local garage than the miracle workers of your local church.⁴ People expect to be able to walk into a surgery and tell the doctor what they want. Revealingly, a 2005 survey found 43 per cent of respondents saying that, before visiting a new doctor, they would try to find out about his or her qualifications,⁵ and some estimates put the number of patients hitting the internet to find health and treatment information before

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seeing a doctor at as much as 60 per cent.⁶ Funnily enough, many doctors also report hitting the internet before treating patients. If information is power, then shared information inevitably leads to shared power.

If traditional models of healthcare delivery tend to posit the patient as being essentially passive, the recipient of medical expertise and treatment, recent years have seen a growing consensus that patients can and should be more involved in their own care. Increasingly we share responsibility for better health, particularly in the case of chronic disease. Of course, shared decision-making has its limits, but increasingly the patient wants to be the one who decides what is and isn't appropriate. In everyday life there are those who actively pursue radical choices and those who want decisions to be made for them. For every person who pores over a mobile phone catalogue to work out which model is best for their personal needs and desires, there is the customer who walks into the shop and asks the assistant to tell them which would be most suitable. Not everyone who's sick wants to be either the empowered patient or the informed consumer, but even if people do not always make choices, they still want the freedom to choose.

The bottom line is that we value our lives and we don't want to be told that we can't have a treatment that can save our life, or make it indescribably better. The globalised character of our society generates further pressures. The media, generally an excellent barometer of public opinion as well as a shaper of opinion, keeps us updated with news of the latest technological and medical advances and scares, not only in our country but across the world. If we can't get precision radiotherapy in the UK because centres that provide Intensity Modulated Radiotherapy (IMRT) are scarce and waiting times commonly around three months, it is frustrating to discover that IMRT is easily accessible in

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Switzerland and that a centre in Zurich currently has a working group engaged in re-engineering the time from first contact to radiotherapy delivery from five to three days.⁷

In this way, information and expectation are changing our patterns of behaviour. At the same time as the whole concept of the hospital is changing, downsizing and localising, clinical care standards are globalising and people are now willing to travel great distances for the best treatment. It is true that an increasing range of healthcare functions is moving out into the community, coming closer to the patient, with polyclinics and ambulatory care centres taking over the treatment of patients who don't need to be in an expensive hospital setting, but it is equally true that technology has shrunk space. People used to driving two hours on a Saturday to do their shopping in Selfridges are doing the same to get elective surgery. They are doing so because, as Aristotle would have it, to be happy is to live in the absence of pain—and fear.

The historic paradigm has been overturned: proximity is now less important than quality. So hospitals are now having to compete not just locally but also globally. New strategies will be required to do so effectively. What they provide will have to be truly world class, or else people will just jump on a plane and get their cancer care in New York. In time, global franchises will provide specialty therapies through structures similar to the internationally branded shops in today's supermarkets. And if outsourcing is changing the way we live it's also changing things like diagnostic services. In the States, for example, radiologists are already outsourcing the reading of scans to doctors in India and Australia.⁸ The barriers are lowering fast. The world, as Thomas Friedman said, is getting flatter. These changes are happening all across the world. Can we keep up?

II

The health of the people, as Benjamin Disraeli said, is really the foundation upon which all their happiness and all their powers as a state depend. Few seem happy with the system designed to care for our health as it stands. Patients often say that the idea that the NHS is a patient-centred service is risible, and satisfaction levels with the NHS are depressingly low.⁹ Everyone has their own story to tell of their own experiences, some of them happy, which reveal the decency, compassion and commitment of doctors, nurses, and other carers. Many of them, though, reflect different slants. There are happy endings that have more to do with personal determination, connections, money, and the support of friends and family, than the services they've received. The good outcomes tend to owe less to the system than the people involved; indeed, the good outcomes often seem to have occurred in spite of the system. And of course there are the negative stories, stories of bad care and unhappy endings, sometimes because of treatment.

It is a peculiar feature of the NHS that nobody who works in it or uses it can be said to be happy with it. Pharmaceutical companies, manufacturers of medical devices and innovators of technology are frustrated, for despite introducing life saving drugs, treatments, therapies and devices they get blamed for driving up costs and are vilified for their profit motives. Moreover, managers are stressed about bureaucratic burdens and the ceaseless—to pilfer Alan Maynard's coinage—'redisorganisation' of NHS structures.¹⁰ The introduction and then merger of PCTs, the introduction, abolition and subsequent merger of various health and social inspectorates, the abolition of GP fundholding followed by the introduction of GP practice-based commissioning, have left managers working in 'an organisational shantytown in which structures and systems are cobbled together or

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thrown up hastily in the knowledge that they will be torn down in due course'.¹¹ Another effect of the hyperactivity in policymaking has been a simultaneous decentralisation and recentralisation of power, which has mangled market incentives, destabilised hospitals and institutionalised inefficiency. The attempt to performance-manage a competitive market has created a paradoxical situation where a lot has been done but very little has changed.

Of all the providers the medical profession is the most miserable. Doctor satisfaction has been the collateral damage of all the changes taking place. It is one thing that the reconfiguration of interests has required greater levels of accountability from the medical profession—accountability promotes professionalism even as it is challenging too—but the government's reforms also seem to have created a vampiric NHS that sucks the professionalism out of the profession. Doctors who want to care for their patients feel they haven't the time to do so. Targets have cut across clinical decision-making, and the joke—though it's not a very funny one—is that clinical issues such as the availability of Herceptin or IVF end up on ministers' desks. Whereas the public sector used to be preferred against the private sector because of job security, that, too, has now gone altogether. In conversation and in print, medical professionals in every corner and at every level of the service complain of the lack of respect and lack of understanding—and therefore lack of trust.¹² 'The job I loved,' one doctor has said, 'is now a job I hate.' Another familiar phrase is 'I just hope *I'm* never ill.'

The irony is that the monopoly on provision—and therefore on labour—in the NHS systematically disempowers and disincentivises the most important producers of all, the healthcare professionals. Unable to go elsewhere—as has been starkly exhibited in the fiasco over the training and

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appointments scheme for junior doctors—a doctor in this country generally either has a job in the NHS or no job at all. In a labour-intensive industry like health care, doctors, nurses and other healthcare professionals are the key resource—managerially as well as clinically—which means greater ownership and engagement is needed, but the public sector ethos amounts to little more than the obligation of doctors and nurses to work as hard as they are told to, with limited professional discretion. It is time to blow apart that most unfathomable of accepted myths, namely that public provision ensures decent terms and conditions for staff. The older generation of doctors are wedded to the NHS despite the conviction that it isn't working. But the younger generation, my generation? Why should this generation be loyal to an outdated conception, a relic of postwar planning?

Most deliciously of all, the NHS is a nightmare for the government. It has tried to divest itself of this responsibility, but because of its ultimate political accountability for the service it is unable to let go. Every time they intervene in the NHS, politicians deepen an already widespread belief among the public and in the media that they are personally responsible for everything that happens in the health service. The Secretary of State is in the impossible position of running one of the largest organisations on the planet and being criticised personally whenever anything goes wrong. There can be no worse job in government. Having told us that 2006 was the 'best year ever' for the NHS, a complacent political message, not a statement of fact, Patricia Hewitt found herself being ritually humiliated. Not only did a survey find that she was the least popular of Tony Blair's many health secretaries,¹³ but, alongside marches across the country, in March 2007 she was strangled in effigy in Crawley, West Sussex, by campaigners complaining about NHS job cuts and service closures.¹⁴

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III

In 1994, a commentator noted with more than a touch of irony that the NHS might no longer be the envy of the world, but it was certainly the envy of the world's finance ministers.¹⁵ That is no longer true. For many years the argument held that an advantage of a tax-funded system is that it keeps costs down. Then the current government responded to claims that the NHS was underperforming because it was underfunded by going on a massive spending spree. Between 2000 and 2005, total healthcare spending increased by 43 per cent in real terms, with the result that UK healthcare spending per capita is now around the EU15 level.¹⁶ Now those that said the NHS's problems were all about money look rather silly; the cry that goes up is not 'Show me the money!' but 'Show me where the money's gone!' No one can argue that quality has improved at a rate commensurate with spending. Productivity has been static. There are unexplained and unacceptable variations in performance. And while in areas where there have been targets there have been outcome gains, these gains come *at the expense* of other standards in other services. To say the NHS isn't working is hogwash; but it isn't working as well as it could or should be, and a patient may experience within one day, even in one hour, disorganisation and indifference alongside excellent care and illuminating kindness. For every tale of horror is another of exceptional service. The aleatory nature of the care makes criticism of the NHS difficult, yet it is also part of the pathology of the system.

And the system is a vast bureaucratic monopoly, the largest public healthcare service in the world. Although the present government has tried to modernise the system, making it operate as a market does, so that competition drives efficiency gains and promotes more choice and better quality for the patient, this has had only the most marginal

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of impacts. Inflation, which is a product of the way the system is arranged, has gone stratospheric, while innovation is repressed by vested interests and a lack of financial wherewithal. Nor does the NHS even achieve its core ideals. Although in international terms its performance hasn't been that impressive, defences of the *status quo* have always been made on the grounds of it being equitable. Okay, so it's nothing like the best in the world, the argument goes, but at least it provides health care of the same standard to everyone comprehensively and free at the point of delivery. That no longer stands up either. Now it is expensive, relatively mediocre and inequitable to boot. As has repeatedly and conclusively been demonstrated, the poor and ethnic minorities are significantly disadvantaged in their access to, and use of, the NHS.¹⁷

What's more, the NHS isn't comprehensive. Unprecedented sums of money have been ploughed into the service but astonishingly the gap between supply and demand is growing by the day. An increasing number of services, medications and technologies that are available are not being provided by the NHS, and there has finally been an amnesty on the withheld truth that the NHS has to ration treatments.¹⁸ But in our consumer age people don't want to be told they can't have health care, as we have already observed, and those with money are buying a rapidly expanding range of services from the private sector. For over half a century a two-tier healthcare system has operated in this country, with the rich able to buy care from the private sector and thus bypass the long queues within the NHS. These healthcare inequalities in Britain are becoming more, not less entrenched. And what are we to make of the fact that more than half of the nation's top consultants have private medical insurance? Presumably that those with

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money who really know what they can expect of the NHS avoid it like, well, the plague.

People are beginning to talk about formally casting off treatments to define a core package of care, so that what is not covered by the NHS would be covered by any one of a variety of private payments. This creates major problems if decisions have to be made nationally, which under the current system they would. The ethicality of trying to decide what is core and what's not, what's life-saving or 'merely' life-enhancing, will become devastatingly complex. This is not a solution to the funding gap. It would reduce NHS obligations to fund health care, but it wouldn't remove demand overall. What's more, it would do nothing to safeguard a principle that we should regard as non-negotiable, namely the principle of social solidarity. Solidarity in this country is crumbling. As the NHS becomes a core service for the poor, while the rich go private completely or supplement their NHS treatments with private treatments, it will increasingly, as the adage goes, become a poor service.

IV

Change is hard, and it's hardest on those who find it hard to change, but change is also important, and it brings opportunities as well as pain. Some systems are coping better than others. Satisfaction levels are rarely as low as they are in the UK, and in some countries, such as Switzerland, high levels of satisfaction are recorded. So many things affect outcomes that aren't directly attributable to health care that it's difficult to compare countries, but on those measures that we do have the UK doesn't fare very well. A study carried out a few years ago into mortality amenable to health care, which attempts to capture the actual quality of health services by using mortality data

related to specific conditions that should be preventable through appropriate medical intervention, found that the UK has one of the highest levels of avoidable mortality in Europe.¹⁹ On Potential Years of Life Lost, a measure of deaths that are *a priori* preventable, the UK also scores poorly, with improvements relative to other countries desperately lacklustre.²⁰

It would be irresponsible not to ask why this might be and search for changes that could make the NHS better value for money and turn it once again into a source of pride. To this end, the second half of this essay examines what's wrong with the way that the NHS is structured and suggests lessons that might be learned from abroad. It's often assumed that general taxation and public service provision are a proxy for equity, yet this commitment to equity is by no means unique to the NHS. Most OECD member countries have long achieved universal comprehensive coverage that is equitable using insurance arrangements. In this country, people say that to consider alternative ways of structuring the system is to signal a willingness to depart from these ideals. In fact, to *not* consider alternatives is to show a lack of commitment to these ideals, while to defend the *status quo* is to endorse inequality and societal division. There are, if you'll forgive the pun, no panaceas in health care, but there are models, such as the Dutch and the Swiss, that may be able to offer us ideas for how we could structure health care in this country to better effect. People are now willing to consider alternatives. For too long we have been caught in a tight, restrictive ideological trap. This is a good time to—in Wittgenstein's pithy phrase—show the fly out of the bottle.

Market-driven consumer-orientated health reform is the only way forwards. This is not because markets are an end in themselves, but because they are what the political

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theorist Friedrich Hayek termed a discovery process, and the most efficient means yet found for allocating resources, driving down costs and driving up quality. Those who object to markets say that they involve risks, but there are ways to minimise these risks, and the tragedy will be to fail to open health care up properly to the market, to reverse the government's supply-side reforms rather than take them forwards. So why, after all the government's noble efforts, does the system remain inherently unsustainable and ultimately unworkable, unable to deal with all the new and rapidly changing pressures of the modern age? The problem, simply put, is a lack of *real* choice and a lack of *real* competition.

If there are alternative providers, then hospitals cannot ignore patients' criticisms with impunity. By giving patients a choice—the freedom, that is, to take their business from one hospital to another, to exercise the power of exit—healthcare providers will in turn be given a powerful incentive to improve. But competition cannot thrive in a captive market and choice is nothing but an illusion unless money follows those choices. To date, all attempts to simulate the flow of money *as if* it were a market haven't worked. The causal nexus of the NHS's problems is that government has control of the purse strings. This is why it has been able to meddle so much with the system. This is why there is such a peculiar relationship between supply and demand; namely, that the supplier would like less demand. What needs to be done, then, is to change the demand side so that, as in any normal market, the correlative of an increase in buyer autonomy isn't a decrease in seller autonomy, so that the patient is not a burden but a benefit.

To be sure, even in countries where they have worked much better than in Britain, healthcare markets haven't been

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as successful as might be hoped. Changing financing to create the conditions for a healthcare market to thrive is a crucial precondition for changing behaviour in the system, but the system changes need to go further than changing financing alone. We need to decide what we want and work out how to pay for it. We need a system that requires and supports changes in the arrangement and delivery of health care in this country, with better integration—between prevention and cure, primary and secondary care, in-patient and out-patient services—and re-engineering of the patient pathway. Research by American academics searching for ways to explain and correct the failure of competition in America, where healthcare markets are relatively advanced, offers a way forwards. The fundamental nature of competition in health care must be redesigned. By changing the way that health care is measured to focus on patient value—the quality of outcomes per unit cost expended—across the whole cycle of care, rather than discrete interventions, we should be able to change the incentives of all participants in the system. It will mean that we move from paying for services to paying for outcomes. Paying, that is, for better health. What's more, by making these outcomes measurements public—indeed, making their publication mandatory—efficiency and productivity should improve and costs fall.

With all the people involved, with all the resources involved, with people's goodwill and commitment, health-care provision in this country should be outstanding. But it isn't, and good enough isn't good enough. Only the British still cling to the belief that it is a disgrace to ask anyone to pay for health care through anything other than taxation. Such thinking is nothing more than antiquated dogma. A commitment to the health of the nation, to national health, is not the same as a commitment to the NHS, or every country

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would have an NHS—which they don't. The NHS doesn't have the wherewithal to deal with these unprecedented pressures; that is, to deliver the founding aspirations of making all necessary health care available at high quality to everyone, irrespective of the individual's ability to pay. Surely the aspiration—and the adherence to the aspiration—is undermined if we aren't prepared to assess the actual results that are achieved in practice and to compare them with other nations and consider how we might improve, how we might get there. To make a moral commitment and then not consider alternative ways of reaching it is, as Nick Bosanquet, Professor of Health Policy at Imperial College London, has said, 'paradoxical and irresponsible'.²¹

What is becoming clear is that, as health care changes, the way that we understand it will have to change. Our system is full of dynamic and committed individuals. What we need to do is unite all the interests and participants in a common purpose. When the NHS was set up, Aneurin Bevan said that such a chance to make a health service 'the admiration of the world... comes but once, perhaps, in a generation... if it is not done now it will not be done in our time.'²² That opportunity has come round again. Are we going to be protectionist or progressive? Will we stay in the past or find a way into the future?

1

The Move to a Market

The NHS is the public service most valued by the British people... Yet despite its many achievements, the NHS has failed to keep pace with changes in our society.¹

The NHS Plan

The National Health Service

Established on 5 July 1948, the NHS was founded on three core principles. It was to be universal, that is, to provide health care of the same standard to everyone across the UK; it was to be comprehensive, covering all health needs; and it was to be free at the point of delivery, available to all citizens on the basis of need, not ability to pay. A remarkable achievement, it was 'a unique example of the collectivist provision of health care in a market society',² but it didn't come into existence without serious conflict. A major part of this was the feud between Labour and the Conservatives, and Aneurin Bevan, the man usually associated with its foundation,³ precipitated something of a firestorm by describing the Conservatives as 'lower than vermin' for opposing the legislation which created the NHS.⁴ But more important than the party political spats was the fact that the medical profession was powerfully antagonistic to the proposals.

'We must not yield on any points which collectively or individually spell the end of the doctors' freedom,' declared the BMA,⁵ and for seeking to make doctors salaried professionals within the service, Bevan was caricatured as a 'medical Fuehrer'.⁶ As for trying to nationalise the hospitals, many felt that this represented 'the greatest seizure of property since Henry VIII confiscated the monasteries'.⁷

Without Bevan's pugnacity, not to mention the finesse with which he wooed the presidents of the Royal Colleges of Surgeons, Physicians and Obstetricians, the NHS might never have come into being. The detailed and tortuous course of the battle, with its many skirmishes, has been told elsewhere,⁸ but in the end the medical profession won major concessions—GPs retained their independence as private contractors, for example, and consultants secured the freedom to practice privately—but Bevan was happy. He had his NHS and a decade later famously boasted that he'd 'stuffed their mouths with gold'.⁹

One of the assumptions underpinning the NHS, and which had been made by William Beveridge in his 1942 report, was that there was a fixed quantity of illness in the community which the introduction of a health service, free at the point of consumption, would gradually reduce. He reckoned that the NHS would raise the general level of health and fitness of the nation and would therefore increase national prosperity through a reduction of sickness absence that would in turn raise productivity, and in his 1942 report he had argued that 'there will actually be some development of the service, and as a consequence of this development a reduction in the number of cases requiring it'—a view which led him to assume that the NHS wouldn't be any more expensive twenty years later.¹⁰ Far from declining, however, expenditure increased steadily in the years after the establishment of the NHS, and in the years immediately after 1948 it was 'much greater than parliamentary estimates had allowed'.¹¹

'One would think the people saved up their illnesses for the first free day', complained one GP, not, perhaps, without some insight. After the old system of mixed social and private insurance brought in by Lloyd George earlier in the century, where coverage was patchy and the poor often

went without, the free new service felt like a bonanza. Dentists, of whom there was a shortage anyway, were soon booked solid for months ahead, while a five-month wait for spectacles rapidly developed.¹² 'The result of vast unmet need and recent medical advance', Nicholas Timmins shows in his magisterial biography of the welfare state, 'was an almost instant example of one of the NHS's recurring preoccupations—an expenditure crisis.' Indeed, while the original calculations of the annual cost set it at £130 million,¹³ by the end of the first year the total came to £276 million, and for the next year £449 million.¹⁴ 'I shudder to think of the ceaseless cascade of medicine which is pouring down British throats at the present time,'¹⁵ Bevan himself was admitting within eighteen months. 'We shall never have all we need. Expectation will always exceed capacity.'¹⁶ He could hardly have been more prescient.

Within five years, the first official study had been commissioned which confirmed the general impression that more resources were needed.¹⁷ Charging was introduced, for prescriptions and dental treatments, to curb costs. Although merely marginal savings for marginal activities, the NHS could no longer be said to be comprehensive and free at the point of delivery, and Bevan quit in outrage. Critics argued that at a time of booming economic growth NHS spending was growing at a much lower rate, hospital capital expenditure was less than a third of the pre-war levels, and doctors were having to practice twentieth-century medicine in nineteenth-century buildings.¹⁸ The 1960s saw significant extra capital expenditure with the advent of the District General Hospital, a specialist hospital of between 600 and 800 beds,¹⁹ but as the 1960s went on new difficulties emerged to do with coordinating different parts of the NHS, and there was growing recognition of the inequity of the provision in different parts of the country.

Well into the 1970s it was being observed that there was a 25 per cent variation in spending per head between regions,²⁰ but the inequalities weren't just geographical. Accusations about inequalities had particular force where the poor quality of care for certain patient groups was concerned. They came to a head in what Keith Joseph called 'Cinderella' services—services for the elderly, mentally ill and physically disabled, none of whom had ever been to the NHS ball. Starkest of all was the scandal of staff cruelty to patients at Ely Hospital, Cardiff, which caused Dick Crossman, Secretary for State for Health and Social Security, to say in 1967 that he was 'responsible for the worst kind of Dickensian Victorian loony bin' and that the NHS was confronted by a 'first-rate crisis'.²¹ A decade long catalogue of horrors on long-stay wards around the country ensued.²²

The picture that develops in these years is of a service lurching from crisis to crisis. In 1974 the government initiated a major reorganisation of the service intended to unify health services and improve coordination and management, but perhaps ironically there were delays in taking decisions, problems establishing good relations between administrative tiers, and widespread feeling that there were too many tiers and too many administrators, a point even the government of the time acknowledged.²³ This reorganisation incurred unexpectedly high costs, but as well as financial costs it had an awful impact on staff morale and it is around this time that we start to hear the now familiar refrain about morale being at an all time low.²⁴ Committees sat and reported, one after another, but nothing seemed to diffuse the tension. With low morale came 'the virus of industrial action',²⁵ and strikes served to worsen the problems.

During this time people started talking about the now familiar triumvirate of challenges, namely that costs were rising, expectations were rising, and the population wasn't

getting any younger. Acute medicine in particular began to experience the paradox of what Rudolf Klein has dubbed 'growing scarcity in an era of growth'.²⁶ From 1958, not only was the government getting less bang for its buck, a consequence at least partly of rising staff costs, but new drugs and treatments like valium, the contraceptive pill, and powerful antibiotics and treatments for asthma started jostling for a share of the spending.²⁷ They were effective; but they were also expensive. Technology, as well as pharmacology, was also making greater claims on the public purse. Now there were things like kidney dialysis and, from 3 May 1968, liver transplants. Much of this was of course great news for patients, though it contributed to an emerging sense, in Rudolf Klein's phrase, 'of the NHS at the mercy of the technological imperative'.²⁸

What's more, by increasing life expectancy, the NHS created increasing numbers of the malignant and degenerative diseases that many had previously avoided by premature death, leading to browbeating about the paradox of a health service that was creating more problems for itself by doing what it was supposed to do. 'The idea entered currency', as Nick Timmins has said, 'that the NHS was a bottomless pit into which any amount of money could be poured without satisfying the demand for health care.'²⁹ Enoch Powell was one of the most prominent proponents of this pessimistic view. Arguing that there was 'virtually no limit to the amount of medical care an individual is capable of absorbing', because with 'the range of treatable conditions huge and rapidly growing' society was witnessing 'a multiplier effect of successful medical treatment',³⁰ he directly contradicted Beveridge's optimism. The idea that there was a definable amount of care which was 'needed' and which, once met, would result in no more demand was, he said, 'absurd'. Rather, there was an 'infinity of demand'.³¹

Making the system more efficient

The history of the NHS is littered with the acronyms of administrative reorganisations, the debris of commissions and reports, the shrapnel of media headlines and countless political casualties. If Labour governments struggled to find extra resources to meet the demand from every angle, usually unsuccessfully, Conservative governments tended to go for restructuring, also largely unsuccessfully. By 1979, the system was organised into regional health authorities, which looked after tertiary care, ambulances and the workforce; district health authorities, which looked after secondary care and primary care; and general practices, independent contractors. The election of the Thatcher government in that year led to the consideration of more radical alternatives. Worried about the capacity of the NHS to absorb real increases in resources and then come back to ask for more if catastrophe was to be averted, Thatcher had come to believe that the health service was impervious to the sort of curbs imposed in other public services where staff had been cut and efficiency targets used to hold or reduce spending.³²

With a widening gap emerging between the money provided by the government and the funding needed to meet increasing demands, there were calls for alternative ways of funding the NHS.³³ However, irrespective of what was suggested—whether hypothecated taxes or an insurance model—it soon ‘became clear that there was little enthusiasm for a major change’.³⁴ Simply put, the public was so attached to taxation as the principal method of funding that to suggest anything else was seen to be political suicide, and the medical professions that had been such an obstacle to the formation of the NHS now opposed any tinkering with its design as a nationalised industry. As the Chancellor of the Exchequer of the time, Nigel Lawson, wrote in his memoirs, the NHS ‘is the closest thing the English have to a

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religion, with those who practice in it regarding themselves as a priesthood. This made it quite extraordinarily difficult to reform'.³⁵

With all alternative financing options ruled out, the government looked at how the money currently spent on health care could be spent better. The solution was to search for efficiency savings in improved management and the implementation of efficiency initiatives. 'If Florence Nightingale were carrying her lamp through the corridors of the NHS today,' ran the memorable verdict of Roy Griffiths, managing director of Sainsbury's who had been commissioned to compile a report for the government, 'she would almost certainly be searching for the people in charge.'³⁶ Griffiths' report, published in 1983, offered a critique of NHS management—specifically the absence of general management—and its failure to ensure that resources were used either efficiently or with focus on patients' needs.³⁷ The recommendations were that professional managers should be appointed at all levels in the NHS to provide leadership, drive ongoing change and cost improvement, motivate staff and develop a more dynamic management approach.³⁸ And, with a literary flourish rarely seen in policy documents, it called for immediate action: 'the Health Service', it said, 'can ill afford to indulge in any lengthy self-imposed Hamlet-like soliloquy as a precursor or alternative to the required action.'³⁹ The advice was heard by a government that was more like Othello than Hamlet, and changes were brought in with a promptness that couldn't be improved upon.

At the same time, a raft of efficiency initiatives were introduced, which were renamed 'cost improvement programmes' in 1984, and by the end of the decade it was estimated that these programmes had achieved annual savings of almost £1 billion.⁴⁰ Outsourcing catering and cleaning services introduced the private sector for the first

time directly into the provision of NHS care, and it was estimated that the first round of competitive tendering achieved annual savings of £110 million,⁴¹ with a further £10 million yielded in 1988-89 through income from private patients, car parking charges, and the use of hospital premises for retail developments. In addition, a number of other policies were pursued, chief among them the introduction of performance indicators covering clinical services, finance, manpower and estate management, enabling health authorities to compare their performance with what was going on elsewhere. What's more, medical audit, to which all doctors are now accustomed, was made into 'a routine part of clinical work in both general practice and hospitals'.⁴²

However, even allowing for savings from cost improvement programmes, the cumulative shortfall by 1987/88 amounted to £1.8 billion,⁴³ and the impact of underfunding became starkly apparent. Waiting times were soaring, premises were dilapidated, and a survey conducted by the National Association of Health Authorities reported that authorities were cancelling non-urgent admissions, closing wards on a temporary basis, and not filling staff vacancies in order to cope with financial pressures.⁴⁴ The BMA called for additional resources to help meet the shortfall, and in an unprecedented move, the presidents of the Royal Colleges of Surgeons, Physicians and Obstetricians issued a joint statement claiming that the NHS had almost reached breaking point and that additional financing had to be provided.⁴⁵

Yet again the NHS had absorbed the money and demanded more. The same time bomb that the government had so determinedly set out to diffuse was once again exploding. So in 1987, as well as wearily committing more money, Thatcher set up another review to scope new measures aimed at boosting efficiency. Although *Working for*

Patients, the White Paper published after Thatcher's departure in January 1989, gave the impression that ministers and civil servants were 'making it up as they went along',⁴⁶ it was of major importance for the future of the service. As well as further suggestions for making doctors more accountable and strengthening general management, it proposed that hospitals should compete for resources, instituting what came to be known as the internal market.⁴⁷ Of course, as at the inception of the NHS, the medical unions opposed the changes. The BMA presented it as a privatisation of the NHS and spent £3 million on an advertising campaign designed to discredit the Secretary of State for Health, Kenneth Clarke. Clarke, an adherent to the school of conviction politics, was not, however, to be cowed, and aided by a parliamentary majority, he got the main tenets of *Working for Patients* enshrined in the 1990 NHS and Community Care Act.⁴⁸

So what did the internal market look like? The plans relied heavily on the ideas of an American academic, Alain Enthoven, who in the mid-1980s had drawn up a blueprint making money follow the patient as a way to encourage hospitals to treat more people by offering them extra resources immediately.⁴⁹ At least in theory, the 1990 Act devolved responsibility from central government. Whereas under the old integrated system district health authorities both held the budget for health care and managed hospital and community health services, in the new system responsibility for purchasing and provision was separated. In other words, health authorities would become commissioners or purchasers, estimating need and determining priorities and then buying services for their areas from the hospitals; while hospitals were turned into healthcare trusts that provided care in the hospital and community by competing to offer the best deal in terms of cost, quality and

convenience. Because the financial viability of trusts depended upon their ability to gain contracts, health care was for the first time costed.

Management functions within the NHS were strengthened, with trusts having to develop business plans, cost healthcare interventions and negotiate contracts. What's more, managers were needed to monitor and report a variety of output and outcome measures to meet government performance targets. The 1990 Act also took a further step towards promoting primary care by encouraging them to develop their facilities at practice level and undertake more preventive health checks, and by giving GPs a role in purchasing secondary care from hospitals for their patients.⁵⁰ The other major changes during this time concerned capital planning and NHS property, and the Private Finance Initiative—essentially a consortium of private bodies come together in a joint venture to design, build and operate NHS premises, which NHS trusts effectively lease back by paying an annual fee to the PFI consortium⁵¹—was introduced in 1992 as an alternative way of mobilising capital for public investments.

For all its strength as an idea, there lies at the very core of the internal market a fundamental problem, implicit in something said by William Waldegrave when he was Secretary of State for Health in 1991. The NHS 'isn't a market in a real sense', he said, 'it's competition in the sense that there will be comparative information available. It's not a market in that people don't go bust and make profits and all that, but it's using market-like mechanisms to provide better information.'⁵² The truth is that the notion of the internal market equates to a managed market founded on an uneasy combination of devolved competition and central planning. Accordingly, as time went on, hospital trusts found their freedoms as self-governing organisations constrained by

guidance from government. Indeed, by intervening to determine the future of care, ministers were acknowledging the realities of a health service in which the ultimate responsibility for decisions and its performance rested with themselves. Yet, in so doing, they ran the risk of weakening the competitive incentives designed to drive down costs and raise standards.⁵³ This fundamental contradiction, that of a system that is simultaneously centrifugal and centripetal in its distribution of power, has troubled the NHS ever since.

The transition to a market

If people thought the election of the Labour government would herald quieter times in the NHS, they couldn't have been more wrong. The Blair administration's plans for the modernisation of the NHS have been just as radical as anything drawn up under the Conservatives. Indeed, there has been, as Chris Ham has observed, 'a strong element of continuity between the latter stages of the Conservative government and the approach pursued by the New Labour government'.⁵⁴ Not that this was apparent at the outset. To begin with Labour revolted against the Conservatives' policies, seeking to distance itself from the system it inherited and its associated vocabulary of the market. 'We will save the NHS', ran New Labour's 1997 election slogan, and among other things the party pledged to abolish the internal market—but retain the separation between purchasers and providers—and do away with GP fund-holding.⁵⁵

In tune with the tensions within the party between the traditionalists and modernisers—nowhere was this more apparent than in the appointment of a traditionalist, Frank Dobson, as Secretary of State for Health, and a moderniser, Alan Milburn, as Minister of State—the government's first White Paper at the end of 1997 outlined the Third Way.

'There will be no return to the old centralised command-and-control system of the 1970s', it announced. 'But nor will there be a continuation of the divisive internal market system of the 1990s.'⁵⁶ So, again, there was emphasis on decentralisation; yet, in the aspiration to develop a 'one nation NHS', also on centralisation.⁵⁷ And the emphasis was on a pragmatic approach—'what counts is what works'⁵⁸—but what this actually meant was really anyone's guess. It would be true to say that 'the new government was clearer about what it was opposed to—the fragmentation of the NHS market—than what it was for.'⁵⁹

At any rate, what became immediately clear was that getting rid of competition would be a great deal harder than expected. In fact, it started to look increasingly futile to try to do so, for 'with the competitive genie out of the bottle, politicians experienced difficulties in squeezing it back in, at least in those parts of the NHS where there was both scope for competition and an inclination to use the levers that had been introduced to bring about improvements'.⁶⁰ The residue of competition was most evident in the commitment to collect and publish data on the comparative performance of providers,⁶¹ and in the end the dissonance between the policy message articulated in government and practice within the NHS had to come to an end. The government put the NHS through a vastly disruptive process of trying to get rid of things which it was then to bring back, and to date its steering of the NHS has been one of radical shifts in direction, continuing the 'process of continuous revolution' initiated by the Thatcher government.⁶²

The reversion to the idea of the market was also a matter of political expediency because before the end of Labour's first term in office things were looking bleak. The difficulties came to a head in the winter of 1999/2000 when hospitals found themselves under considerable pressure from an

outbreak of flu. Media reporting of patients being forced to wait on trolleys for beds brought to public attention the consequences of capacity constraints. The plight of Mavis Skeet, a patient with cancer whose operation was cancelled until the point when her condition was inoperable, came to symbolise the shortcomings of the NHS. Influential figures like Lord Winston, a Labour peer, expressed their dissatisfaction with government policies, with Winston drawing on this mother's experience of using the NHS to compare the United Kingdom unfavourably with other countries. The claim that the NHS could cope with the demands of demography, technology and rising expectations appeared increasingly untenable.⁶³

Spending

Those who champion the taxation-funded NHS point out that it is 'an effective mechanism for controlling expenditure on health care'.⁶⁴ The NHS budget is shaped by the state of the economy and government decisions on the priority to be attached to different spending programmes. But the corollary of this is shortage, as when a series of years of expenditure constraints require staff in the NHS to cut back or delay the provision of services in order to balance their budgets. This is precisely what had happened in 1987, when crisis in the system forced the Thatcher government to set up the review that led to the internal market, and at the end of the 1990s it is what prompted the Labour government to make commitments to sustained increases in NHS funding. The comprehensive spending review had already led to a planned increase of £21 billion between 1999 and 2002, but in a television interview in January 2000 the Prime Minister made a commitment to increase spending on health care in order to bring it up to the average of the European Union,⁶⁵ and in March 2001 the then Chancellor of the Exchequer,

Gordon Brown, announced a review of the long-term funding needs of health care led by Derek Wanless, former chief executive of NatWest Bank.

The interim Wanless report in November 2001 concluded that the original reasons given for funding the NHS through general taxation were sound, including that 'it makes health care one of the things that binds society together, on the principle that we all take care of each other when things go wrong',⁶⁶ but it went on to note that the UK lagged behind some countries in health outcomes and argued that this was in part because of the relatively low level of expenditure on health care in the UK. In 1998 total health expenditure in the UK was 6.8 per cent of GDP compared with an un-weighted EU average of 7.9 per cent and an income-weighted average of 8.4 per cent.⁶⁷ The interim report stated that relative to the EU average spending on an income-weighted basis, the cumulative underspend between 1972 and 1998 had been £267 billion.⁶⁸

The final report was published in April 2002 and largely confirmed the conclusions of the interim report. In addition, it offered estimates of the costs of achieving the vision of a health service better able to meet the public's expectations of accessible, convenient and high quality care. It argued for higher rates of spending increases between 2003 and 2008 to *catch up* with other countries. Beyond those five years, lower rates of spending increases were recommended to enable the UK to *keep up* with other countries. That is, as of 2008 NHS funding is set to slow down: the increases are set to decrease. The report emphasised the importance of resources being used effectively. It also said that while 'the current method of funding the NHS through taxation is relatively efficient and equitable ... there may be some scope to extend charges for non-clinical services. This would potentially help provide more choice for patients.'⁶⁹

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There wasn't anything revolutionary about the Wanless Review, except that it served to make the case for sustained increases in healthcare funding. The government accepted the findings, and this was reflected in the outcome of the 2002 spending review. What followed was an injection of financial resources that was unprecedented in the history of the service, securing funding increases of over seven per cent per year in real terms between 2002/03 and 2007/08.⁷⁰ Whereas in the first full year of operation the NHS cost £437 million to run, the gross cost of the NHS rose to an estimated £104 billion in 2006, an 88 per cent increase in real terms on expenditure compared to just ten years earlier.⁷¹ In 1949 expenditure on the NHS was 3.5 per cent of GDP. By 2006 this figure reached an estimated 8.2 per cent of GDP.⁷² Per person the NHS gross cost in 2006 was estimated to be £1,720, and £4,504 per household,⁷³ roughly eight times the per capita cost of the NHS when it was first established, allowing for inflation.

It's perhaps worth mentioning at this stage that spending on the NHS doesn't constitute the entirety of UK spending on health care. When we compare the UK with the rest of Europe, one of the major differences that immediately becomes apparent is in the composition of health service spending. The proportion of health care financed publicly in the UK is higher than in most EU and OECD countries, standing at around 87 per cent in 2006.⁷⁴ Although private health care spending expressed as a proportion of overall spending has declined, reflecting the government's decision to inject more resources into the NHS,⁷⁵ the absolute figure is substantial and rising.⁷⁶ From just over a million subscribers in 1975, the number insured rose steadily into the 1990s. It reached a peak of 6.9 million people in 2000,⁷⁷ around 11.5 per cent of the UK population,⁷⁸ and since then has been declining very slightly, though numbers climbed again in

2006 for the first time since 2000.⁷⁹ Adding together private and public funding to give us a figure for total expenditure, we get £120 billion in 2006, representing 9.4 per cent of GDP.⁸⁰ This means that UK healthcare expenditure per capita is now around the EU15 level.⁸¹

Reform

While it was felt that the NHS was underperforming in part because the UK spent a significantly lower proportion of its national wealth on health care than its counterparts, the government also came to realise that the system would need changing if it were to make optimal use of its investment. There is ample evidence from international comparisons that the best outcomes are not always linked with greatest resource use or volume of services and there may be opportunities to simultaneously reduce costs whilst maintaining or even improving system performance.⁸² In retrospect, it has been possible to observe three phases.⁸³ First, new resources were injected and capacity was expanded, with an emphasis on providing cleaner hospitals, better pay for staff, new contracts for GPs and consultants, and the delivery of 'a health service designed around the patient.'⁸⁴ Second, targets were employed as a lever for improving performance, a trend most evident in the targets to reduce maximum waiting times for inpatient, outpatient and primary care appointments. Third, there was a recognition of the need for better systems to enable the efficient use of the additional resources invested. This has entailed attempts to embed incentives in the system to enhance performance automatically.

In the new NHS, the government would set national standards and put in place a framework to support delivery of those standards, but it would supposedly assume a more restricted role, 'steering not rowing',⁸⁵ as its functions

progressively transferred to the market, with the shift to market forces in place of government as the prime determinant of what health services are offered. With this shift, standards would be enforced through monitoring, inspecting and auditing NHS organisations. Successful organisations would be rewarded with extra funding and greater autonomy. Failing organisations would be given additional support and would be subject to a rising scale of interventions. Clinical services would be opened up to the market in order to provide much-needed capacity, although in due course the policy rationale shifted from providing extra capacity to giving patients a wider choice of service providers in a pluralized market.⁸⁶ The idea was to ‘move the NHS from a hierarchically managed to a regulated healthcare system’,⁸⁷ devolving power from the centre to Primary Care Trusts, NHS Trusts and Foundation Trusts and creating new regulatory roles for NICE and the Healthcare Commission, among others, at arm’s length from the state.

It is important to stress that how things function in theory doesn’t always apply in practice—there is often a slip betwixt cup and lip—but that is for later chapters. The model that gradually emerged from a somewhat ramshackle succession of policy statements was of the NHS as ‘a sort of holding company’⁸⁸ or ‘insurance purchasing organisation’,⁸⁹ franchising health services out to various providers, public and private. This willingness to use the private sector has, incidentally, signalled a marked departure from Labour’s early period in office, suggesting that the modernisers triumphed over the traditionalists, although significant—and perhaps, for the market, debilitating—concessions were made. At any rate, at least on paper, the NHS can be seen as the state-funded payer, but less and less the direct provider, of health services. The emphasis placed on patient choice,

payment by results—in which money follows patients to providers—and foundation trusts, shows the extent to which this has been envisaged by the policymakers in government as ‘a reactivated internal market’.⁹⁰

The structure of the new NHS

It’s neither possible nor desirable in this paper to outline comprehensively how the NHS now operates, but a brief guide to the theory is necessary. The healthcare system in England can be broken down into three main sections: organisations with strategic roles, those commissioning services and those providing them.

Resource allocation and strategy

At the top of the apex are bodies with a primarily strategic function, determining the overall direction of the NHS and overseeing and coordinating the work of other organisations. Ultimate responsibility for the NHS remains with Parliament, through the Secretary of State for Health, whose Department of Health (DH) is directly responsible for providing health services through the NHS. The DH no longer runs the NHS, since responsibility for this is being devolved to frontline organisations like PCTs and hospital trusts, and responsibility for managing, inspecting and regulating services is being increasingly devolved to Strategic Health Authorities (SHAs), arm’s length bodies and other organisations, such as the Healthcare Commission and Monitor, which are now responsible for inspecting and assessing the performance of NHS organisations and foundation trusts respectively. What the DH does do is secure and distribute resources, make major investment decisions, set national policy, ensure that national standards are set and maintained, and provide advice and guidance.

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Reporting to Parliament, it also oversees the performance of NHS organisations.

SHAs are regional bodies responsible for ensuring that government policies are followed by NHS purchasers and providers across the country. Varying hugely in size and scope, there are ten in total, and they can be seen as the local headquarters of the NHS, acting as a link between the DH, PCTs and NHS hospital trusts, mental health trusts and ambulance trusts. It's their job to look after the planning and development of healthcare services in the area, build the capacity of local services and manage the performance of NHS organisations. The other major group of strategic organisations are dubbed arm's length bodies, and they're paid by the DH to do various things on its behalf. There are three executive agencies of the DH, supposedly independent units of the DH; there are the eight special health authorities which are supposed to deliver particular services to the NHS or the public, the best known being NICE; and there are the eight non-departmental or arm's length public bodies, which include the Healthcare Commission and Monitor.

The purchasing side

Although the model is being extended, commissioning, or purchasing, or buying healthcare services, most prominently applies to Primary Care Trusts and GP practices at the moment. Accounting for 80 per cent of the NHS budget, there are 152 PCTs buying health care for geographically defined populations. The bottom line is that PCTs have to ensure the volume, quality and accessibility of services in their area. It's their job to negotiate primary care contracts with GP practices and secure the provision of out-of-hours services, such as NHS Walk-In Centres and NHS Direct. They also coordinate other family health services such as pharmacists, optometrists and dentists, and ensure the

provision of community health services, such as family planning, screening, chiropody, physiotherapy and rehabilitation services. Due to the growing emphasis on reducing hospital admissions and encouraging services in high street locations, they're also being asked to use alternative providers to deliver care closer to home.⁹¹

PCTs also buy secondary care services. So far this has been almost entirely from NHS trusts and Foundation Trusts, but the intention is that PCTs should be commissioning secondary care services in such a way that patients can choose from at least four or five different providers of elective care, including private providers. There's been a good deal of fretting in some quarters about PCTs buying care from independent institutions, but as we shall see the extent to which this has really happened has been extremely limited.⁹² They can also buy tertiary services—like cancer or neurosurgery—provided in a relatively small number of specialist centres.

The other major commissioning bodies are GP surgeries, or groups of them. In due course, the idea is that GPs will take over much of the commissioning currently done by PCTs, which will make PCTs little more than agencies, checking that GPs stay within budget, carrying out consultancy work for GPs and monitoring contracts. In effect, GPs are told the budget they're going to have for the coming year. With the money they're given, they are supposed to work out what their patients need and how to meet those needs, so they determine the type and level of services that are going to be required, who they're going to buy them from, and if they have any cash left over from their budget they get to keep it. The theory is they've got an incentive to manage referrals to secondary care more effectively, and any savings they make will be used to improve patient services.⁹³

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The hope is that competition for contracts will increase efficiency and improve the quality of services. Whether or not this works will depend on payment by results (PbR). PbR is, essentially, a payment for every treatment given, and providers will only be paid for what they do. In this respect, it's a bit of a misnomer, since it's not payment for results (outcomes), but simply payment for procedures (activity). Price competition is out. Instead, the aim is that competition be based on quality and efficiency, and the idea is that the tariff, a list of fixed prices set by the government for every treatment or procedure, will safeguard this. Providers are supposed to compete to attract patients, who are to be able to choose where they have their treatment, and the providers that operate more efficiently will cut their costs and make and keep the surplus, or profit.

The provider side

Healthcare providers basically fit into two categories—those outside the hospital setting, mainly primary providers, and acute hospitals, which deliver mainly secondary services. Acute hospitals may also provide tertiary care. Historically, hospitals have drawn more than 50 per cent of the NHS budget for service provision,⁹⁴ even though they only account for 19 per cent of the daily contacts people have with the NHS,⁹⁵ and this partly explains the drive to provide alternatives to existing hospital services, towards a greater variety of service providers in both secondary and primary care, and the quest to offer secondary care outside the traditional hospital setting. As a result, the money spent on hospitals has now fallen to 45 per cent.⁹⁶

Primary care services—services outside the hospital setting—account for 81 per cent of daily patient contacts with the NHS, with over 300 million patient contacts a year.⁹⁷ For most people, most of the time, the first point of

contact with the NHS is through the local GP. Whereas hospital doctors are salaried, GPs are independent, and have been described as 'small businessmen in the for-profit category'.⁹⁸ GPs are the gatekeepers of the NHS, because, since referral is required for elective or non-emergency access to hospital care, they control access to secondary care. They cover a vast range of roles, from dealing with minor ailments like colds to more complex secondary care procedures like endoscopies, and the plan is to accelerate the transfer of one million appointments, which would in the past have been done in hospital outpatient clinics, into primary care.⁹⁹ Most primary care services are on the NHS, but some are available outside the NHS.¹⁰⁰ In addition, there are alternatives to GPs if you don't want to go to a GP or can't get to one. These include walk-in centres, providing open access to advice and treatment for minor injuries and ailments, and NHS Direct, a 24-hour helpline that acts as a triaging system by directing people to the appropriate healthcare provider.¹⁰¹

The other three main areas of primary care are NHS dentistry, ophthalmic and pharmaceutical services. Officially, all treatment necessary to maintain oral health is, or should be, available on the NHS, but dentistry isn't free at the point of delivery, and although some groups are exempt from fees, most patients currently pay 80 per cent of the cost of treatment.¹⁰² Dentists, like GPs, operate as independent practitioners, but the proportion of dentists' time spent treating NHS patients has fallen. Indeed, there's a severe undersupply of NHS dentists in many areas, and it's predicted that by 2011 that the shortfall of practicing dentists will stand at 5,100.¹⁰³ When it comes to ophthalmic services, similar conditions apply, and most people's experience of eye care in Britain involves walking off the street and paying for the service. Most people's experience of pharmaceutical

services is, likewise, to pay towards the cost in the form of a prescription charge—not only for drugs but also for appliances such as syringes or devices to monitor blood glucose levels—at one of the country's 10,000 pharmacies.¹⁰⁴

The traditional model of secondary care was of specialised services, both inpatient and outpatient, provided in a hospital setting. It encompasses medical specialties such as dermatology and cardiology, surgical specialties such as urology and orthopaedics, as well as paediatrics and elderly care. Patients are generally under the care of a consultant and, unless admitted through A&E, require referral from a GP. A number of hospitals also offer tertiary services, for which patients require referral from a hospital consultant. We can roughly break secondary care provision into NHS hospital trusts, Foundation Trusts (FTs), specialist treatment centres and a range of independent sector alternatives. By 1996, all hospitals had become semi-autonomous trusts, but New Labour brought them back under the control of the Secretary of State for Health in 1999. NHS trusts provide acute and elective secondary care, earning their income by selling their services to PCTs and GPs, which means they mainly cater for geographically localised populations. All NHS trusts are supervised and inspected by the Healthcare Commission, which gives NHS trusts annual ratings for their quality of care.

As of 2003, NHS trusts have been able to become FTs, which more or less represent a return to the trust model espoused by the Conservatives in the early 1990s. All successful trusts can apply for foundation status. If the independent financial regulator, Monitor, deems them financially ready to fend for themselves, it will grant them foundation status, at which point they cease to be subject to the supervision of the SHA and are supervised instead by Monitor. There are a number of important differences

between NHS trusts and FTs. FTs are theoretically free from the meddling of the DH, which means they can set out their own priorities for service delivery on the basis of need, not national targets.¹⁰⁵ They're free to provide private health services, to borrow money on private financial markets, to buy and sell land and buildings, and, most importantly, to keep the proceeds for their own ends.

Before 2000 NHS purchasers were only allowed to buy secondary care from the independent sector when it was absolutely necessary to supplement mainstream NHS provision, such as to reduce waiting lists and ease capacity constraints. Now the idea is that the independent sector is a means to increase the choice of providers available to patients. PCTs and GP practices can buy mainstream NHS services from independent outfits,¹⁰⁶ but while the DH hopes that by 2008 the independent sector will be carrying out as much as 15 per cent of NHS procedures every year, this is extremely unlikely to be realised.¹⁰⁷ Borrowing from the models of polyclinics in Europe and day surgery centres in the USA, treatment centres were introduced in the UK in 1999 with the opening of an ambulatory care and day-case unit at the Central Middlesex Hospital in London. Treatment centres carry out planned or elective work, both diagnostic and therapeutic, in separate premises and with separate staff, and because they perform a high number of procedures as day cases or short stay cases, they reduce the need for hospital admissions. They can be situated in existing hospitals, at independent sites or in mobile centres.¹⁰⁸ Since 2002, the NHS has also block contracted such services from the independent sector, in the form of Independent Sector Treatment Centres (ISTCs).

With accountability for the NHS residing with the Secretary of State, responsibility for failures as well as credit for successes gravitated towards a single point in the system.

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Clearly one of the drivers behind the Labour reforms has been the high political cost involved in running the NHS as a centralised system. The new system, at least on paper, employs the theory of the market—competition and choice—in the quest for improved performance and more efficient services. These changes have been accompanied by a long term commitment to increase NHS funding, at levels not achieved in the past. Between 2000 and 2005, total healthcare spending increased by 43 per cent in real terms.¹⁰⁹ Has quality improved at a commensurate rate? Now that UK healthcare spending per capita is around the EU15 level, have we got value for money? This is a significant moment in the history of healthcare provision in this country. The public have, quite literally, paid their money and must now decide how much they have got for it.¹¹⁰

2

The State of Health

The quality of medical care is an index of a civilization.¹

Ray Lyman Wilbur

So cash spend on the NHS has more than doubled—an increase of around £55 billion—since 2000, but what has happened to all this money? Is the NHS delivering a better service? The answer, in short, is that it's difficult to tell. Some aspects of the service have improved, and some have deteriorated. The only statement that can be made uncontroversially is that the money spent on the NHS has not brought about commensurate improvements. But in all honesty, things are rather worse than that.

Financial crisis

For a start, despite the increase in funding, the NHS has struggled to balance its books over the last few years. It first registered a deficit in 2004/05, which then more than doubled to £570 million in 2005/06.² This, as we shall see, is not surprising. Pay increases were in many cases overgenerous and, with market reforms lagging behind the increase in spending, the NHS displayed a typical monopoly response to higher resources, overbuilding capacity, taking on too many extra staff and incurring lots of fixed costs.³ Nor was the market allowed to work. Micromanagement—such as top-slicing profits made by financially sound PCTs, and giving windfall payments in the form of contingency funds to those in deficit—has created perverse financial incentives and inhibited local management. As 2006 wore on, there was an increase in the number of bodies with a deficit or overspend, more of these deficits and overspends were

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significant in size,⁴ and a number of organisations acquired 'super deficits' of more than £15 million.⁵ Towards the end of the year, unaudited figures indicated that there had been a 'significant deterioration' in the overall finances of trusts in five of England's ten SHAs,⁶ and in February 2007 third quarter results showed that gross national deficit had risen to £793 million,⁷ enforcing the Audit Commission's view that management capability and incentives to promote sound financial health were lacking.⁸

Then, suddenly, in June 2007 Patricia Hewitt announced that the NHS had achieved a £510 million surplus. It looks an impressive achievement, but in fact hides the detail that 22 per cent of NHS organisations remained in deficit, with a combined gross debt of £911m.⁹ Significantly, the DH has classified 17 Trusts, that have consistently run large deficits, as 'financially challenged', to be subject to rigorous review of their financial and operational performance. Hillingdon PCT is the extreme example, with a massive £52.1m deficit. Also, how was the surplus achieved? The turnaround came at a cost: it is estimated that £1.8bn in extra funding due to the NHS in 2006-7 was held back to pay off previous deficits and to form a contingency fund for any deficit this year. This has ramifications for the services delivered to patients. 'Dealing with financial pressure diverts resources away from normal strategic operational priorities', the March 2007 report by the all-party Public Accounts Committee said.¹⁰ A recent survey of NHS trust chief executives showed that three out of four trusts were restricting patients' access to treatment as they struggle to control deficits.¹¹ The question that we have to seek an answer for throughout this chapter is: where has the money gone?

Rising costs

To the implicit accusation of having squandered the resources, one glib response frequently given is that the

money is being used to compensate for historic underfunding, a stance given force by the Wanless Report when it stated that the cumulative underspend by 1998 was £267 billion.¹² Likewise, this is the line taken by the NHS Confederation, which has pointed out that because expenditure growth was often less than healthcare costs, by 2000 it was running at high rates of activity, beyond what was affordable or sustainable. A culture developed in which NHS organisations were expected to report that they had 'broken even', which, combined with sustained underfunding, led to many key developments being put on hold or scaled back. Consequently recent funding increases, initially earmarked for new projects, have sometimes been required to deal with the results of previous under-investment.¹³

This will not really do. It may be a partial explanation, but it does not get the NHS off the hook. For a start, the NHS's ability to limit healthcare spending has regularly been described as one of the strengths of a centralised tax funded system, so it seems slightly disingenuous to use as an excuse for weakness an aspect that in other contexts is touted as a strength. What's more, justifying present failings on past failings can only be credited as an excuse for so long, and after a while it starts to sound like whinging. Ten years is a long time: if this government can't sort out the problems of the system, you have to wonder if any government can.

The costs of the goods and service purchased by the NHS have increased by considerably more than the price of goods and services across the entire UK economy, which has implications for what the government's money can buy and therefore for its ability to improve the service.¹⁴ Unless they stimulate extra productivity from existing resources, these cost pressures reduce the amount of the budget increase that is available for additional activity. To take one example, the cost of drugs has gone up. The NHS spends £8 billion a year

on prescription drugs in primary care in England; the number of items dispensed has increased by 55 per cent over the last decade, expenditure by 60 per cent.¹⁵ On top of these cost pressures, NICE has been preoccupied principally with improving the cost effectiveness of drugs and medical procedures employed in the NHS. Its recommendations have been largely cost increasing.¹⁶ In 2006/07 NICE appraisals accounted for an estimated cost increase of £291 million.¹⁷

Alongside these extra expenditures, a large programme of reform has been implemented, not least in working patterns and contracts for NHS employees. In addition to these employment reforms, which have substantially increased NHS costs, some of the increase in NHS resources has been consumed by annual pay awards to staff and by increased employer pension contributions.¹⁸ The DH's own estimate of how the extra money was spent over a single year—2004/05—showed that of the extra £6.7 billion in the system 30 per cent went on pay rises for existing staff; 18 per cent on training and capital; five per cent on the increased cost of goods and services purchased; and 48 per cent on extra staff, activity and drugs, leaving just £1 billion to spend on 'additional activity'—developing services, improving the quality of care, and so on.¹⁹

These calculations should be regarded with caution, since some of these elements are a mixture of inputs, such as extra staff, and outputs, such as activity.²⁰ The employment reforms were designed precisely to secure productivity gains. If additional pay were made available to stimulate and facilitate extra activity, then these additional costs can't be said to detract from the resources available for extra activity. The NHS, a virtual monopsony and therefore theoretically able to control what it pays for labour, shouldn't try to have its cake and eat it. The NHS

Confederation takes the same line, arguing that the additional expenditure on pay is 'a crucial part of the NHS reform programme. High quality patient care can only be delivered by valued and motivated staff who are paid a decent wage.'²¹ Still, if activity has not risen along with pay—the average pay for newly qualified consultants is 68 per cent higher than in 1997, and GPs are now paid double what they got in 2000²²—then it would be reasonable to complain that the marginal costs of extra activity in the NHS have been enormous and injecting all the extra cash into a capacity-constrained system has inflated costs.

Productivity

Productivity measures, in theory at least, allow organisational performance to be tracked over time and provide insight into the central question of the extent to which we're getting value for money. Productivity is in essence the volume of outputs divided by the volume of inputs. Perhaps the most authoritative source of research is York University's Centre for Health Economics. In July 2006 it found that 'there is considerable evidence of growth in both the volume and quality of NHS activity. However, this has not in general kept pace with the growth in expenditure. On most measures, therefore, NHS productivity is either static or declining.'²³ This has major implications, which explains why considerable effort has been devoted to improving the measurement of NHS productivity, and attention has mainly focused on incorporating appropriate adjustments for the quality of NHS outputs.

Until recently, NHS productivity was calculated by estimating output growth as a weighted average of the growth in 16 broad categories, such as inpatient admissions and outpatient attendances, and setting this against inputs equal to NHS expenditure. By this measure, the latest ONS

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estimate is that NHS productivity fell by an average of between 0.6 per cent and 1.3 per cent per year from 1995 to 2004.²⁴ Many commentators complained that this was crude and simplistic, prompting the ONS to publish two reports which made provisions for more accurate inputs and outputs estimates.²⁵ Input changes have been mainly technical in nature, but there have been significant developments on the output side, most importantly in attempts to generate estimates of changes in quality. These attempts have concentrated on the extra length and quality of life secured by medical intervention, the health gain element of NHS outputs, which recognises a cluster of interacting factors including survival rates, the before and after change in health status, and so on.²⁶ By this measure, productivity grew between -0.5 per cent and 0.2 per cent per year over the period 1999-2004.²⁷

In evaluating productivity, therefore, the most important distinction is now between outputs without quality adjustments and outputs with quality adjustments. A third measure is occasionally invoked. The DH has pushed for a measure of outputs that takes into account the 'value of life', adjusted to account for earnings growth of patients in the economy on the basis of the argument that health is valuable in a growing and increasingly productive economy.²⁸ This measure generates a productivity growth rate of between 0.9 per cent and 1.6 per cent per year from 1999 to 2004.²⁹ However, since the NHS has no control over earnings growth in the rest of the economy, and since it's difficult to control for lifestyle and attribute the credit for improvements to the NHS in such a formula,³⁰ there are powerful objections to this approach.

Each calculation for output affects the calculation for productivity, and a debate is raging about which is best; in the meantime, we'll just have to accept that there's no

definitive measure of productivity and work with this uncertainty.³¹ What we can say is that, at best, estimates of productivity growth suggest an average annual improvement in productivity of 1.6 per cent since 1999/2000, and at worst they suggest a decline of -1.3 per cent. Considering all the available evidence, it is difficult to conclude anything other than that at best productivity is slightly up, at worst slightly down. Productivity cannot be said, then, to have kept pace with NHS funding. 'For all the extra money, all the extra staff and extra patients treated,' as Patricia Hewitt said in a speech on 19 September 2006, 'NHS productivity has remained almost unmoved.'³²

Resources

Facilities

Capital spending has been substantial. There's been significant investment in the primary care sector, with just over £1bn in public funding already approved as part of the government's initiative to shift more services into primary care.³³ An estimated 3,000 GP practices have either been refurbished or re-built since 2000, and there has also been an emphasis on building new NHS health surgeries and refurbishing community hospitals, with the private sector being utilised to provide extra funds. Much of the modernisation and building of primary care infrastructure has been carried out via the Local Improvement Finance Trust (LIFT) initiative. By the end of 2005/06 LIFT schemes had attracted nearly £775 million of private capital and £210 million of public capital.³⁴ Although there is some disquiet about the variable quality and content of this work, in general people regard the execution of these schemes as successful.³⁵

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Spending on acute facilities has been rather more controversial. The majority of new hospitals have been built under PFI schemes.³⁶ As of May 2006, 50 PFI schemes were operational, 31 were currently carrying out building work, with an additional 49 either nearing financial close or in the pipeline. A further 12 public schemes were either completed or awaiting construction.³⁷ Serious concerns are, however, being raised about the sustainability and appropriateness of these projects, and a fierce debate is raging about the long-term implications and cost benefits of PFI.³⁸ The Audit Commission has found 'capital building projects being blamed for driving unaffordable long-term expenditure levels',³⁹ and there is evidence that PFI schemes have cost overrun where the initial cost increases considerably, in some cases over four times as much. Notable examples include a £432 million overrun (82 per cent increase) at Barts & The London and a £405 million overrun (139 per cent increase) at University Hospitals Birmingham.⁴⁰

How these new hospitals are designed is of critical importance, a point acknowledged in Labour's 2001 manifesto. 'Nightingale wards for older people and mixed-sex wards', it announced, 'will be abolished.' However, in marked contrast with the rest of Western Europe and the US, most patients are still being placed in large wards and many of these are mixed-sex. The Healthcare Commission's 2005 survey found that a fifth of patients had shared accommodation with the opposite sex at some time during their hospital stay. In some hospitals the proportion was well over a half. A survey carried out in February and March 2007 showed that a quarter of patients at mental health establishments had been required to share a bay and toilet with the opposite sex.

Anecdotal evidence suggests the problem is widespread. Joyce Robbins, director of watchdog group Patient Concern,

says mixed wards and lack of privacy are a source of continual complaints, so much so that professionals can become oblivious to the levels of discontent. 'In hospital your most private functions are the most public they have ever been', she recently told nurses at a conference on improving privacy on wards. She quoted a case of a 70-year-old woman spending weeks on a mixed Nightingale ward where a man with dementia tried to get into her bed. 'Nobody came when she pressed the buzzer so she took him back to his bed. And when she told staff in the morning they seemed to think it was a huge laugh. When it comes to dignity and privacy, it's perception that counts—and patients don't see single sex bays as single sex wards.'⁴¹

Roger Ulrich, professor of architecture at Texas A&M University, who spent several months in England in 2005 and 2006 advising the DH on healthcare design, has argued that large wards and mixed accommodation make privacy impossible. 'No other country inflicts this on their patients to the extent that the UK does. There is no privacy in an open bay. A curtain creates no verbal privacy.' It is regrettable, according to Ulrich, that PFI hospitals in the UK consist primarily of shared accommodation. 'These hospitals are being put up with 20 per cent, or less, single rooms—and they will be in place for decades. But single rooms reduce infection and provide privacy and dignity.' Brian Lawson, dean of architecture at Sheffield University, agrees. 'On patient satisfaction, reduced infection and ease of management, single rooms win hands down.'⁴²

Encapsulating the contradictions in the system has been the simultaneous drive to build massive PFI hospitals and move out into the community into smaller and more local units. Overall, in terms of beds, the picture is mixed. While the number of all specialty beds fell between 1991/92 and 2004/05, the number of acute beds has recorded a small

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increase in the years since 2000.⁴³ At the same time as the total number of hospital beds has fallen over the last 20 years by 31 per cent, hospitals have seen a 57 per cent increase in inpatients and a 341 per cent increase in day cases'.⁴⁴ Accordingly, day-only beds have increased dramatically by 170 per cent—from 3,400 in 1991/92 to 9,160 in 2004/05—reflecting the move away from overnight stays in hospital to day-case admissions.⁴⁵ Perhaps the best news for patients has been the drive to increase the number of critical care beds in the NHS. The shortage of critical care beds—which are intensively staffed and expensive to maintain—has been an important bottleneck in the NHS, a cause of cancelled operations, and rationing these beds has cost lives.⁴⁶ Seeking to remedy this, the number of intensive care and high dependency beds has been increased by 44 per cent from 2,240 in 1999 to 3,233 in 2006.⁴⁷ Beds remain scarce, and the figures for cancelled operations remain alarmingly high—132,000 were cancelled in 2004/05⁴⁸—but this should nevertheless be regarded as a considerable achievement.

Still, it is difficult to derive conclusions about quality from the total resources at the disposal of the NHS in England. Scanners are a perfect example of this. By June 2004 the NHS had been provided with 113 new MRI scanners and 223 new CT scanners,⁴⁹ increasing the numbers per million of the population to five (from 3.9 in 2000) and seven (from 5.5 in 2000) respectively. The number of imaging and radio-diagnostic tests undertaken by the NHS in England has also increased markedly; by 61.3 per cent for MRI scans and 57.5 per cent for CT scans since 1999/2000.⁵⁰ Relative to past resourcing, it's reasonably safe to assert that the NHS is better kitted out than it was when Labour came into power.

But OECD data shows that we should be careful not to get too excited. Even back in 2002, the OECD average for

MRI was 7.3 units per million of the population, with—to take a couple of recognisable examples—the Swiss clocking up 14.1 and the Americans 8.6 per million. And our relative standing was far better for MRI scanners than CT scanners, where we were down at the bottom of the table with the Poles and the Mexicans. The OECD average in 2002 was 17.6 per million of the population. As for mammographs and radiation therapy equipment, the UK's resources are lamentably poor, languishing right down near the bottom of the table, uncomfortably close to Turkey and Mexico on both counts.⁵¹

Another key facility is information technology. It would be unthinkable in the technologised age not to use an IT system in the NHS which would bind information together for all involved, shortening waiting lists, streamlining the prescription process, making patients' records and doctors' analyses available wherever people want to access them. The core of the National Programme for Information Technology in the NHS (NPfIT), the NHS Care Records Service, plans to enable any healthcare professional treating a patient to access that patient's medical record. The programme is thought to be the biggest civil IT scheme in the world, planning to link 30,000 GPs in England and 50 million sets of patient records to 300 hospitals by 2012. For a while things seemed to be going well,⁵² but in 2006 Lord Warner, then a health minister, said that NPfIT's costs could run to £20 billion over the next ten years,⁵³ much more than the £12.4 billion predicted by the National Audit Office (NAO). In 2007 Andrew Rollerson, an executive with Fujitsu, one of the system's providers, said that the system 'isn't working and isn't going to work',⁵⁴ an opinion shared by the Public Accounts Committee which has concluded that it is 'not looking good' and that 'urgent' remedial action is 'needed at the highest level'.⁵⁵

There are many glitches in the system. The take-up of the airline-style system, Choose and Book, to help patients book elective hospital appointments online from their GP surgeries, has been less than enthusiastic. By 3 April 2006, only 12 per cent of appointments were booked in this way.⁵⁶ A BBC 'File on 4' survey in May 2006 revealed that half the 340 GPs interviewed thought the system was either 'poor' or 'very poor'.⁵⁷ Then, in one of those priceless media moments, the system crashed on air while a supporter, Dr Andrew Langton, a GP in Avon, was explaining how it worked.⁵⁸ In January 2007 a report from the King's Fund also found that 93 per cent of GPs felt the consultation process for Choose and Book was inadequate.⁵⁹ Proper consultation is a problem concerning NPfIT as a whole. Sir John Bourn, the head of the NAO, has publicly criticised the DH for 'failure to take the NHS with the system'. That the government's record on IT is hardly impressive—remember the debacle over spiralling costs for the GCHQ system, not to mention the latest scandal of the exposure of weaknesses in the MTAS application process for junior doctors, with the embarrassing lack of security over doctors' confidential details—is unpropitious: one of the crucial roles for government in a healthcare system is the promotion of information sharing and the updating of technology.

Staffing

There are now more people working in the NHS than at any point in its history, and this has a lot to do with the government's commitment to increase staffing levels. In September 2005 there were over 1.3 million people employed in the NHS, which represents an increase of nearly a third of a million since Labour came to power. As well as encompassing a massive hike in the number of non-clinical staff—administrative and clerical staff, for example,

increased by 58 per cent between 1997 and 2003⁶⁰—the total number of doctors employed in the NHS increased by over 32,700 between 1997 and 2005,⁶¹ with consultant numbers rising from 10,520 to nearly 32,000.⁶² Whatever else is true, the increased staffing levels are likely to have a major impact on funding in the future. The maximum annual salary of a consultant is now approximately £96,000, plus any extra payments for clinical excellence, which means that an extra ten consultants on the payroll will cost over £1 million a year.⁶³ Similarly, many GPs now earn in excess of £100,000 per annum.⁶⁴ The DH has yet to publish its own estimates of the long-term cost pressures, although in 2005, Richard Douglas, Department of Health Director of Finance, told the House of Commons Health Select Committee that on the consultant contract ‘the forecast we produced has not proved to be absolutely correct’.⁶⁵

Without a ‘productivity miracle’, the gap between cost pressures and available funding could reach a total of £7 billion by 2010, which implies that there will be recruitment freezes and job cuts in years to come.⁶⁶ Already, medical graduates and junior doctors are facing severe obstacles to getting jobs, and this is unlikely to be relieved as funding slows after 2008. In oral evidence to the Health Select Committee in 2006, the Secretary of State for Health at the time, Patricia Hewitt, said that the NHS had taken on more staff than had originally been planned, to the extent that some organisations could not afford current numbers and there would have to be reductions:

The reality is that the NHS has spent more of the growth money on additional staffing than was planned and has taken on significantly more hospital doctors and significantly more nurses and somewhat more GPs than the NHS Plan intended. That is why some individual organisations around the country are now having to make some very difficult decisions on their staff, including in some cases redundancy, in order to get back into a position where they

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are employing the right number of staff they can afford and using them in the most effective way possible... the NHS took on more staff faster [than stipulated] and that is clearly a reason why some organisations are in real financial problems. They employed more staff than they could afford.⁶⁷

Ward staffing illustrates this perfectly. In 2006 there were roughly 400,000 nurses in the English NHS—and 493,000 in the UK NHS⁶⁸—an increase of 70,000 since 1999.⁶⁹ Yet there appear to be redundancies going on at the same time as recruitment drives, with ward staffing cuts in March and April 2006 suggesting that there isn't the money to pay all the new recruits.⁷⁰ The bad news, however, is that the new recruits *are* needed. Not only did a 2006 Healthcare Commission survey reveal that 12 per cent of patients believe there were 'rarely or never enough' nurses on duty,⁷¹ but in January 2007 a leaked DH document—the draft Pay and Workforce Strategy for 2008-11—estimated that, following further job losses, by 2010-11 there would be a shortage of 14,000 nurses.⁷² Janet Davies of the Royal College of Nursing complained that it 'demonstrates a yo-yo attitude to workforce planning'.⁷³ The DH has itself admitted that staff numbers are 'very volatile'. Few would quibble that it hasn't handled the NHS workforce at all well. But this is not a fault that better central management would resolve. The central planning of the workforce results in inefficient resource allocation that manifests itself as oversupply and under-supply in different areas of the country and parts of the service.

The difficulty, of course, is that there is only a limited link between sheer numbers and the performance of the system. The traditional way to beat the government over the head has been to compare country statistics on workforces, but on this front we've got masses of nurses. In 2005 the UK had a ratio of 9.2 nurses per 1,000 of the population, above the OECD average of 8.3.⁷⁴ This might give us clues to other

elements of the system. Given a finite cash pot it may explain why the UK is below the OECD average for the number of practicing physicians per 1,000 of the population, ranking 24th out of the 27 countries on this statistic,⁷⁵ and well below the average, which is a worry since OECD research shows that the number of physicians is inversely associated with avoidable mortality.⁷⁶

However, there are many confounding factors, not least the fact that the quality of nursing staff is the key variable for quality of care rather than simply quantity. The Healthcare Commission has found a statistically significant relationship between patient turnover, improved patient satisfaction and lower numbers of accidents and incidents with higher levels of registered nurses.⁷⁷ Bank staff and agency staff just do not produce the same results: the NAO has also found that employing experienced permanent staff leads to vast improvements in cost, efficiency and patient care.⁷⁸ Spending more per employee represents better value for money.⁷⁹ Perhaps most significant of all, the government has failed to incentivise nurses—or anyone in the NHS—by ‘making pay increases conditional on productivity gains’, as Alan Maynard has argued.⁸⁰

Process Outcomes

Patient satisfaction

The main way that patients’ views of performance have traditionally been collected is through the measurement of patient satisfaction, and it’s assumed that various performance indicators can be constructed from population and patient surveys. Care is required in the interpretation of survey data: satisfaction is a relative concept. It is multi-dimensional and influenced by many variables. The patient’s attitudes towards the actual care received will

reflect perceptions both of outcomes—such as health status following treatment—and processes—such as the way care was delivered. These in turn will be affected by expectations, which are moulded by the media, experience elsewhere in society, and their opinions of government policies.⁸¹

Here, too, the picture is mixed. According to results from the British Social Attitudes Survey, the Rolls Royce of surveys, general practice is the most highly rated NHS service, with satisfaction ratings of over 50 percentage points in 2004, but this is a marked decline from over 70 percentage points in the early 1990s. Satisfaction with dentists has plummeted, from just under 60 per cent in the early 1990s to four per cent in 2004, possibly due to the well-publicised difficulty of finding an NHS dentist. Satisfaction ratings for A&E are only available since 1999; here, levels have improved.⁸² Ratings for inpatients have been falling since 1999 to reach an all-time low of just four per cent in 2004. The ratings for outpatients were some 25 per cent below those for inpatients in the early 1990s but are now only a few points below, indicating that ratings for inpatients have fallen much faster than those for outpatients.⁸³

Overall survey figures for patient engagement register an ambivalent attitude. The WHO states that ‘engaging patients in their health care and encouraging patients to take responsibility for protecting their health is the best way to ensure the sustainability of health systems’.⁸⁴ Although patients generally have high opinions of clinical staff, and feel that they are treated with dignity and respect, a survey by the Picket Institute found that care is still too often delivered in a paternalistic manner, with many patients given little opportunity to express their preferences or influence decisions about their care,⁸⁵ and that transitions between different healthcare providers, and between hospital and home, are not as well coordinated as they should be, and many patients

need better help with recovery and rehabilitation.⁸⁶ The 'quality of NHS care is improving', the report concluded—but 'not as quickly and as comprehensively as many of us would like'.⁸⁷

A similar conclusion can be derived from overall satisfaction ratings, which are a key barometer of the public's opinion on government health policy. Results over the past decade from the British Social Attitudes Survey reveal a general pattern of rising satisfaction in the early years of the Labour government, some disillusionment setting in around 2000/01, and then a revival since 2003. In 2004, 44 per cent registered as satisfied against 37 per cent dissatisfied, giving a net satisfaction rating of plus seven.⁸⁸ Although there have been some improvements in satisfaction, the changes are relatively small compared with the rise in funding and the absolute figure is still very low. Interestingly, there's a difference in satisfaction ratings between those members of the public who have had recent contact with the NHS and those with no recent contact, with the former tending to be more satisfied than the latter. Yet—and this is highly suggestive—those with *a lot* of recent contact with the NHS tend to be more dissatisfied than the others.⁸⁹

Access and waiting times

Waiting times and lists are considered a serious barrier to access, and since the rich can bypass them while the poor cannot, these barriers 'appear to fall disproportionately on those least able to surmount them'.⁹⁰ At its birth in 1948 the NHS inherited a waiting list of around half-a-million patients, which rose year on year, and surveys show that for 'both the public and patients, waiting has consistently been seen as a (if not the) problem with the NHS'.⁹¹ Waiting is not just an inconvenience: it can make you ill. One study found

that 21 per cent of lung cancer patients became unsuitable for curative treatment during the wait for their radiotherapy.⁹² When Labour came to power it promised to cut lists, but waiting lists shot up, with the number of outpatients waiting over 15 months or over 12 months for inpatient admission more than doubling.⁹³ 'Patients were supposed to live up to their appellation,' as Julian Le Grand has put it, 'and be patient.'⁹⁴

It was for this reason that the NHS Plan specified several ambitious targets. As well as cutting the inpatient waiting list by 100,000, a maximum waiting time of 15 months was to be implemented by March 2002, with further reductions to 12 months by March 2003, to nine months by March 2004, and to six months by December 2005. The figures show that—on this measure—the targets have indeed been met: for example, there were fewer than 1,000 patients still awaiting admission after six months at the end of 2005, whereas in 2000 more than 270,000 were waiting longer than six months for admission.⁹⁵ The improvement has been sustained. Despite the increased pressure—in 2005/06 there were 10.4 million general and acute admissions to hospital, for example, against nine million in 2000/01⁹⁶—in April 2006 the number of patients waiting longer than six months for inpatient treatment stood at 144.⁹⁷

Similarly ambitious targets were also set for first outpatient appointments, with a maximum waiting time of 26 weeks by March 2002, down to 21 weeks in 2003, 17 weeks in 2004, and 13 weeks in 2005. These targets have also been met.⁹⁸ As of March 2006, only 126 people were waiting longer than 13 weeks.⁹⁹ The median outpatient waiting time witnessed a parallel decrease; from 7.46 weeks to 6.13 weeks.¹⁰⁰ In fact over 83 per cent of outpatients were, as of March 2006, waiting under eight weeks for a first outpatient appointment. This is despite outpatient activity, measured

as the number of first outpatient attendances, increasing by an average of 2.1 per cent per annum between 1999/2000 to 2005/06 to 13.7 million.¹⁰¹ As for A&E, where the target maximum waiting time is four hours, while 23 per cent waited more than four hours in 2002, this figure was down to three per cent by the end of 2004.¹⁰²

Waiting times are widely regarded as having been one of the Labour government's triumphs, but there are a few reasons for not popping open the champagne just yet. More people are waiting longer than it might at first seem. For a start, the statistic on waiting times for an outpatient appointment measures the number of people waiting for an appointment at that given point in time. In fact, across the year 2006/07, 32,914 people waited longer than the 13 week target. Another factor is that while the longest waits have been eliminated, there has been far less change in the mean time waited, and median waiting times have actually increased. In 1999/2000 the median waiting time for inpatient treatment was 43 days; the median in 2005/06 was 51 days.¹⁰³

Further caveats abound, but the most important concerns what has been termed the hidden wait. The idea here is that while inpatient and outpatient waiting time targets measure the time from a GP referral to the first outpatient appointment, and the time from when a patient is placed on a surgery waiting list to inpatient treatment, this does not represent the entire patient 'pathway' because it neglects time taken in between for diagnosis; that is, for tests and scans, the analysis of results and decisions about treatment plans. This is the hidden wait. In 2004, the former Liberal Democrat health spokesman, Paul Burstow MP, showed that in two out of five NHS Trusts patients were waiting up to six months or more for routine MRI scans.¹⁰⁴ Patients are

waiting a lot longer for hospital treatment than the inpatient and outpatient waiting times suggest.

In response, the government subsequently introduced an expectation that by the end of March 2007 patients should receive diagnostics within 13 weeks of their first outpatient appointment as part of the wider goal to ensure that by 2008 no one will have to wait longer than 18 weeks from GP referral to hospital treatment (RTT). The first set of data on this '18 week pathway' was released in June 2007, and it showed that 52 per cent of patients still wait longer than 18 weeks between a GP referral and their admission to hospital, and that 12 per cent are waiting over a year.¹⁰⁵

We also need to temper our excitement because waiting times in other developed countries are frequently much shorter. According to research conducted by the Commonwealth Fund, merely six per cent of primary care physicians in the UK think their patients 'rarely or never experience long waiting times for diagnostic tests', compared with 76 per cent in Germany. In addition, 60 per cent of UK patients reported waiting longer than four weeks for a specialist appointment, way above the figures of 23 per cent for the US and 22 per cent for Germany, while 41 per cent of UK patients waited four months or more for elective surgery compared with less than ten per cent in Germany and the US.¹⁰⁶ Not surprisingly, the British public is not too impressed with the performance of the NHS on this front. Results from the British Social Attitudes Survey show that on this front levels of dissatisfaction are still very high, with over three quarters still feeling improvement is needed.¹⁰⁷

Finally, while targets have acted as containment measures, they have not addressed the underlying causes of waiting in the NHS. Although there have been significant improvements in waiting times, the improvements have levelled out in the past year.¹⁰⁸ In some specialties slowing

improvement has been followed by stagnation and then deterioration, and this has been most notable in trauma, orthopaedics and ophthalmology.¹⁰⁹ 'The slight increase in waiting lists and times in the Q1 2006-07 is due to the recent initiatives put in place by PCTs and Trusts to negate the financial deficit', the Secretary of State noted in relation to ophthalmology waiting lists at the end of 2006. 'This has included the setting of minimum waiting times for patient referrals, diagnostic tests and treatment in some areas.'¹¹⁰ Some specialties have seen a dramatic increase in waiting lists in recent years. It is noticeable that these have been in areas of low profile and of little political importance. For example, the waiting lists for gastroenterology and dermatology have increased dramatically between Q1 2004-05 and Q2 2006-07.¹¹¹ Time will tell whether targets will be able to keep the lid clamped on the pressure cooker.

Gaming

The problem with targets is the problems they create. 'They discourage continuous innovation and improvement,' as Le Grand has said; 'once the target is achieved there is no incentive to go further.'¹¹² They also distort priorities when what is not targeted is ignored. Reported performance against targets may seem to be fine, but not if actions are taken to meet the goals that are at odds with them—what an article in the *BMJ* has referred to as 'hitting the target, but missing the point'.¹¹³ Targets can also lead to gaming. Gaming is a playful word for a serious problem. It is a term applied to the inappropriate ways in which targets are met to the detriment of patient care. There are the blatant forms of gaming—fiddling the figures, the deliberate manipulation of data¹¹⁴—and there are more subtle changes of behaviour—juggling patients around wards to keep target priority beds free—which can have undesirable consequences in the

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long run.¹¹⁵ To talk about gaming is therefore to talk about the law of unintended consequences.

It is in meeting waiting time targets that gaming has most frequently been observed. Despite the dramatic reduction in A&E waiting times, 'stays of longer than four hours for those who are admitted can be masked within the overall measure', according to the Healthcare Commission, and in the worst performing hospitals as much as 40 per cent of patients still spend over four hours waiting.¹¹⁶ It is also common to hear stories of patients waiting in ambulances outside A&E until staff are confident they can be treated within the four-hour government target,¹¹⁷ and it is well known that across ambulance trusts both the definition of a Category A ('immediately life-threatening') call and the time when the 'eight-minute' clock starts varies widely, and somewhat conveniently.¹¹⁸

These are, quite literally, high risk games, and in 2005 the BMA found that 82 per cent of A&E staff worry about the adverse effects of targets, such as discharging patients prematurely or treating those waiting the longest rather than those with the greatest clinical need.¹¹⁹ The problem is not just confined to A&E. In 2006 the Healthcare Commission criticised managers at Stoke Mandeville Hospital for 'putting NHS targets above outbreak control' measures for *clostridium difficile*, leading to the deaths of 33 patients.¹²⁰ According to one junior doctor:

When I worked in neurosurgery, I had to clerk for cancer patients with brain tumours who were being admitted for scheduled surgery. The psychological build up to something like this—having to sign a form acknowledging that you wish to proceed despite a substantial risk of dying on the table—is something that few can appreciate. Every week, one such patient would have their operation cancelled the morning of surgery because their bed had been filled overnight by a drunk or by a nervous wreck with a headache admitted from A&E, courtesy of the priority given to

admitting patients from casualty, however well, because they were in danger of breaching the government's four-hour-wait target.¹²¹

The same sorts of games go on in primary care. PCTs report virtually 100 per cent success in offering patients an appointment with a GP within 48 hours, and have done since March 2004.¹²² However, the DH acknowledges discrepancies with patient survey results. For example, in 2005 only 74 per cent of people surveyed by the Healthcare Commission were seen by a GP within the government's target of 48 hours, not for want of trying.¹²³ Patients are also finding it harder to contact their general practice than they were a few years ago.¹²⁴ It doesn't take a detective to deduce that these are strategies to achieve the government's 48-hour waiting time target.

Equally as insidious is the manipulation of elective waiting times. In 2004, the Audit Commission discovered patients being removed from waiting lists once they had been provided with a future date for an appointment, given immediate appointments that they were not able to attend, then classed as refusing treatment.¹²⁵ By 2006 this practice had been quashed but new tricks had been learned, such as using time taken for diagnostic tests or rehabilitation services as time deducted from the official waiting times, in order to meet government targets—the hidden waits that we encountered earlier.¹²⁶ The devil, as the old adage goes, is in the detail. Similarly, the high number of cancelled operations has been disguised because the DH only counts procedures called off within 24 hours of the scheduled operation in its calculations. This means, for instance, that while Worcestershire Acute Hospitals NHS Trust called off 1,791 operations in 2003, only 856 of them were officially registered as cancelled.¹²⁷ 'This is not uncommon', said Jonathan Fielden, chairman of the BMA's consultants' committee. 'When managers are faced with losing their jobs

if they miss a target, they will find any way to get round that target.¹²⁸

To be fair to the government, it is wising up to gaming, with, for example, statistics now published on general practices' advanced booking and the issue (along with that of closed lists) received specific attention in the 2006 White Paper *Our Health, Our Care, Our Say*.¹²⁹ In theory, of course, when a patient-led NHS becomes a reality, top-down targets will be obviated and incentives to cheat—for gaming is often just a euphemism for fraud and dishonesty—will be a thing of the past. We await the day.

Patient safety

Patient safety is both a means to an end and an end in itself. Florence Nightingale's dictum was that hospitals should first do no harm, and it's not just for patient comfort but also for restricting the spread of hospital acquired infections that wards need to be clean.¹³⁰ The main methods of evaluation have been either surveys, which ask patients to rate their impressions of cleanliness during their stay in hospital, or inspections by independent auditors.¹³¹ By and large survey evidence shows that the public is unimpressed. Given a choice of hospital, 67 per cent of the public say that information about hospital safety would be useful in guiding their decision,¹³² yet the Picker Institute has found that only about half of inpatients regard the ward they have been treated in as clean,¹³³ and British Social Attitudes Survey data tells us that satisfaction with the general condition of hospitals has fallen to its lowest point for 15 years.¹³⁴

As for observation data, the reviews of the government inspectorate for cleanliness have reported progressive improvements in England over the past few years, though in line with a recent inspection carried out by the Healthcare

Commission the higher number of hospitals scoring high across the board was matched by a higher number of hospitals scoring poorly.¹³⁵ According to research by Dr Foster, one of the least improving hospitals for hospital standardised mortality ratios over the five years between 2001/02 and 2005/06 was West Hertfordshire Hospitals NHS Trust. Its medical director, Professor Graham Ramsay, who has worked in the Netherlands, is working with his team to tackle hospital acquired infections. 'You want care that is easily accessible, but you want to know when you come into hospital that you won't get worse. Patients deserve a clean environment. In Holland and Scandinavia, if an incidence of MRSA does crop up in a hospital all staff on the ward and all other patients are screened and the ward is closed down until the results are known.'¹³⁶

Worryingly enough, given that infections such as MRSA and *clostridium difficile* cost the NHS an estimated £1 billion each year,¹³⁷ and that more general adverse events in which harm is caused to patients may cost as much as £2 billion a year,¹³⁸ data about infection rates and adverse incidents is inconclusive and extremely patchy because reporting has not been standardised.¹³⁹ Nevertheless, the picture of hospital hygiene reflected in NHS trusts' declarations on standards to the Healthcare Commission is a grim one: the number of trusts reporting non-compliance with standards on infection control, decontamination and the healthcare environment/hygiene actually increased by 6.8 per cent, 1.7 per cent and 2.5 per cent respectively in 2006/07. In total, nearly a third of all trusts declared non-compliance with one or more of these standards in 2006/07.

This grim picture gets decidedly grimmer if we glance at the overall statistics for the number of deaths from the best known superbugs. MRSA infection rates have declined slightly since 2001/02, but the number of deaths linked to

MRSA rose by 39 per cent. Moreover, NHS trusts have completely failed to contain the increase in the number of patients contracting *clostridium difficile*. Between 2003/04 and 2005/06 the total number of recorded cases rose from 47,034 to 66,005 and the number of deaths linked to *clostridium difficile* increased by 69 per cent.¹⁴⁰ From the available research, it is clear that hospital acquired infection rates are exceedingly high in the UK compared with other European countries,¹⁴¹ and Sir Ian Kennedy, chairman of the Health-care Commission, has criticised the government for not giving patient safety the attention it deserves.¹⁴²

Clinical outcomes

Any assessment of a health service ought to examine indicators of the *value* of its output, pre-eminently the improvement in health outcomes that result from its activities. Some health outcomes indicators are available. However, improvements in these are a function of many factors over which the NHS often has little influence. Life expectancy, for example, is a widely used indicator of the state of a nation's health. Large improvements have been seen over the past century, and by international standards the UK is just above the OECD average,¹⁴³ but this tells us more about the health culture and personality of our country than about the NHS. The relative scarcity of readily accessible outcome data specific to the NHS forces any analysis to rely heavily on process indicators, on the assumption that they provide a reasonable proxy for health outcomes.¹⁴⁴ This, as Julian Le Grand has pointed out, complicates any interpretation of improvements in outcomes.¹⁴⁵

In some areas the NHS has a more direct influence, such as over hospital death rates, and post-admission and post-operative death rates, yet here again things have got both better and worse, depending on where you look. If we

examine death rates within 30 days of admission or operation, we find that since 1998/99 the rate has fallen for Coronary Artery Bypass Grafts, but the rate following admission with a fractured femur has increased.¹⁴⁶ Another case in point is hospital standardised mortality ratios (HSMRs). HSMRs are an internationally standardised measurement of mortality which is calculated from in-hospital deaths by comparing the number of expected deaths with the number of actual deaths that related to a wide range of diagnostic groups and is expressed as a relative risk. HSMRs are getting better, which is encouraging,¹⁴⁷ but the considerable geographical variation is less encouraging. If all those trusts 'with higher than expected mortality rates were to reduce these in line with the expected rate', Dr Foster found, '7,400 deaths would have been avoided in 2005/06.'¹⁴⁸

On another measure, Potential Years of Life Lost (PYLL), a summary measure of deaths that are *a priori* preventable, the UK scores poorly. Improvements relative to other countries have been lacklustre—only four countries out of 26 registered a lower percentage improvement—and the two other nations registering an equivalent increase in expenditure, Australia and Canada, improved nearly twice as much as the UK.¹⁴⁹ Another study carried out a few years ago into mortality amenable to health care, which 'attempts to capture more precisely the actual quality of health services by using mortality data related to specific conditions that should be preventable through appropriate medical intervention', found that the UK has one of the highest levels of avoidable mortality (ages 0-74) in Europe.¹⁵⁰ None of these indicators are particularly encouraging, though it might be objected that they are also limited in what they can really tell us. We therefore have to take a look at a representative selection of specific conditions.

Targets are, officially at least, on the way out, which is to be welcomed. We observed earlier how in areas such as inpatient and outpatient waiting times, targets led to gaming, exhibiting the law of unintended consequences. If we pan out and broaden the perspective, we get a picture of this happening across the service. 'Regulation by targets assumes that priorities can be targeted, the part that is measured can stand for the whole, and what is omitted does not matter', the authors of an article in the *BMJ* noted wryly. 'But most indicators... provide an incomplete and inaccurate picture.'¹⁵¹ Concentrating on high-profile targets may mask what is going on elsewhere, and the Healthcare Commission has devoted much attention to the notion that 'there has been *much less progress [in the NHS] in areas not so thoroughly covered by targets*'.¹⁵² Of the 'out-of-view' services not subject to high-profile targets (or indeed any targets at all), the Healthcare Commission has singled out sexual health and maternity services for particularly lacklustre performance.¹⁵³ Other areas deserve consideration too, as we shall see.

The good news

Circulatory diseases (including heart disease and stroke) have remained the most common cause of death among males and females in the UK. As with all countries in the developed world, circulatory diseases cost the economy billions as things stand, and this looks set to rise. As the DH acknowledges, obesity 'poses serious concerns' in terms of 'its long term impact on the health of the population', with research showing that 'it is strongly linked to increased risks of stroke, angina, heart attacks and type 2 diabetes',¹⁵⁴ and WHO estimates ascribing around a third of CHD to excessive body mass index.¹⁵⁵ In the UK obesity is rising at an alarming rate. In 2004 nearly 25 per cent of the adult population was clinically obese, an increase of almost 500

per cent since 1980.¹⁵⁶ Prevention, then, as everyone is coming to recognise, is better than cure.¹⁵⁷ Even so, the government's record on the curative front has been impressive, and deaths from circulatory diseases have shown the greatest decline, particularly among males.

In fact, in this area the NHS is delivering some of the best outcomes in the world. In 1971, age-standardised death rates for circulatory diseases were 6,900 per million males and 4,300 per million females. By 2005 these rates had fallen to 2,600 per million males and 1,700 per million females.¹⁵⁸ The treatment of CHD, which was specifically targeted for improved care, stands out.¹⁵⁹ Between 1995-97 and 2002-04 the baseline figure for overall mortality due to CHD for people aged under 75 figure had been cut by 31.4 per cent.¹⁶⁰ This surely reflects improvements in measures specific to CHD care. The number of CHD patients receiving thrombolysis within 30 minutes of arriving at hospital increased from 39 per cent in March 2000 to 82 per cent in March 2006, although the rate has levelled off since 2004.¹⁶¹ The number of statins dispensed across England rocketed from 9.4 million in 2000 to 33.8 million in 2005, suggesting an improvement—at least on NICE guidance—in treating CHD after a heart attack.¹⁶² And the Healthcare Commission has commended the NHS on its performance in the treatment of heart attacks, faster diagnosis of angina and reduced waiting times for revascularisation.¹⁶³

Inequalities in the incidence of CHD suffering between socio-economic groups have also improved. Government statistics show that average rates of CHD have fallen faster for lower socio-economic groups, from a baseline absolute difference of 36.7 deaths per 100,000 of the population in 1995-7 to 27.6 in 2002-4; a fall in the inequality gap of 24.7 per cent. This is particularly good news, as is the fact that international comparisons for CHD show that the UK has

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witnessed the greatest reduction in PYLL due to myocardial infarction (heart attack) and ischaemic heart disease in the OECD.¹⁶⁴

After circulatory diseases, cancer is the second most common cause of death among both sexes in the UK.¹⁶⁵ The results of a 2003 MORI poll indicate that it also represents overwhelmingly the most important national priority among the British public, both in absolute terms and compared with other illnesses and diseases. Its importance as a national priority is reflected in the wide support for national funding for cancer, and for the idea of a dedicated budget to tackle the disease.¹⁶⁶ The government has specifically targeted cancer for improved care.¹⁶⁷ The targets are highly ambitious and there is no doubt that the NHS has gone a long way towards achieving them.

Since Tony Blair took office, cancer mortality rates for people under 75 have dropped by 14 per cent,¹⁶⁸ which means some 47,000 lives have been saved since 1997.¹⁶⁹ Other targets, particularly those on cancer waiting times, have also been met. Although in 2005 an NAO survey has found that 'a significant minority of patients diagnosed with cancer are not referred urgently',¹⁷⁰ in 2006 the Chief Executive's Report to the NHS announced that 99.9 per cent of suspected cancer patients urgently referred by their GP were seen in outpatients within two weeks in the fourth quarter of 2005/6, compared with just 63 per cent in 1997.¹⁷¹ Moreover 98.9 per cent of cancer patients are now treated within a month of diagnosis, and 91.1 per cent are treated within two months of being urgently referred by their GP.¹⁷² However, not everyone is wholly convinced.

A report co-authored by Karol Sikora, former chief of the WHO Cancer Programme, has argued that cancer care has been severely hampered by staff shortages in radiology, radiotherapy and histopathology, leading to severe 'hidden

waits'.¹⁷³ Then in August 2007 the *Lancet Oncology* journal published results of the EURO CARE-4 study of cancer survival rates. In a league of 22 European countries from 2000-02, England came out seventh bottom in terms of the number of patients alive five years after diagnosis—much closer to the performance of Poland and the Czech Republic than the best, Sweden, Finland and Switzerland. Cancer survival rates in these countries are some 10 to 15 per cent higher than in the countries that make up the UK. The same trend is observed for individual conditions—survival rates from stomach cancer, for example, are as much as 86 per cent higher in Germany than in England.¹⁷⁴

Moreover, comparisons with a similar study conducted from 1995-99 show that while cancer survival rates have improved across the board in Europe, those in the UK remain 'stubbornly low', and the UK seems to be the exception to the broad trend that those countries that spend the most on health care generally get the better survival rates. The study only refers to patients treated in the early years of the Cancer Plan, but even so, survival rates in England are 'noticeably similar to some eastern European countries that spend less than one third of the UK's per capita health care budget'.¹⁷⁵ Although a review by the NAO has commented on how patient involvement in cancer care networks has been 'good',¹⁷⁶ and concluded that the treatment of cancer should be seen as one of the major success stories of the NHS in recent years,¹⁷⁷ survey evidence suggests that 'patients are becoming less satisfied, probably because expectations are rising'.¹⁷⁸ The authors of the EURO CARE-4 report describe 'the considerable challenges that now face the UK government if it is to make the NHS work efficiently and effectively'.¹⁷⁹

Even the good news doesn't look so good.

The bad news

Targets, as we have said, prioritise one field at the expense of another. As one performs better, another performs worse. It is a seesaw vision of healthcare provision. Audiology is an area of the service that is neglected and consequently poorly performing.¹⁸⁰ It is clear that digital hearing aids give much superior service to older aids: but in spite of a strong endorsement from NICE there are very long waiting times. The latest British Society of Hearing Aid Audiologists survey into hearing aid waiting times found that the average wait facing someone seeking their first NHS hearing instrument in England had risen for the third year in a row to between 45 and 48 weeks (compared with 43-47 weeks in 2005). There are wide variations across the country with patients waiting on average between 73 and 74 weeks in the South East. Four hospitals in England have waiting times of 117 weeks, that is two years and three months, the longest waits in the UK. Users wanting to upgrade their hearing aids from analogue to digital have to wait on average 68-72 weeks. At one hospital in England the wait is 260 weeks—five years—and at another five hospitals there are waits of over 200 weeks.¹⁸¹

Services for citizens with mental health problems are also disappointing, especially considering the scale of the need. Mental health problems are widespread; 16 per cent of people at any one time in the UK have a common mental disorder, and it is estimated that between one and three per cent of people will have a psychotic illness such as schizophrenia or bipolar disorder.¹⁸² Mental illness causes huge suffering to patients and their families, and imposes heavy costs on the economy to the tune of an estimated £25 billion per annum.¹⁸³ The OECD has noted the growing importance of mental health and in particular its effect upon the economy, 'The magnitude of this change,' it pointed out,

'raises a large challenge for the health service about how to better help this group with treatment and rehabilitation.'¹⁸⁴ Yet there have been accusations of under-resourcing, problems associated with dilapidated buildings, difficulties with recruitment and staff retention, and inequities in provision that particularly affect people with mental health problems from ethnic minority communities.¹⁸⁵

Observing that mental health services 'fall short of national standards', the Healthcare Commission calculated that 'only half of people with depression were receiving treatment, only eight per cent had seen a psychiatrist and only three per cent had seen a psychologist'.¹⁸⁶ In fact, for 80 per cent of people who visit their GP with mental health problems, treatment went no further than this level. Furthermore, although there's a broad consensus that GPs should be referring patients for psychological therapy or to a Community Mental Health Team depending on the seriousness of the condition, rather than just prescribing drugs, the vast majority of sufferers receive no treatment except drugs.¹⁸⁷ In May 2007 it was reported that over the previous year 31 million prescriptions had been written by doctors for anti-depressants, with the use of drugs such as Seroxat and Prozac increasing by ten per cent. The exact number of people taking pills for depression is not known but is thought to be several million.¹⁸⁸

For those who do get referred by GPs for secondary care treatment, there are often substantial delays and long waits. Although 'information on waiting times for mental health care is not collected nationally', the Healthcare Commission has found evidence to support the claim that 'people are waiting a long time for appointments with psychiatrists and other mental health professionals'.¹⁸⁹ The OECD has claimed that 'people still have to wait for six to nine months to access psychotherapy while conditions often become more

entrenched'.¹⁹⁰ According to Angela Greatley, chief executive of the Sainsbury Centre for Mental Health, in 'many cases waiting times of over a year are reported'.¹⁹¹ Those that do finally manage to access treatment experience substandard inpatient care—only 63 per cent of patients said they were given enough time to discuss their condition or treatment with a psychiatrist—and there are streams of complaints about the continuity of care, supporting the general impression that, overall, approaches to mental health are poorly focused and coordinated.¹⁹²

Ultimately, despite significant investment—£7.2 billion—'there has', as the King's Fund's *Independent Audit of the NHS under Labour (1997-2005)* concluded, 'been no striking shift in performance'.¹⁹³ To put it another way, in the Audit Commission's words, more than 30 years after Keith Joseph criticised mental health services in Britain, 'mental health continues to be seen as the Cinderella of health service provision.'¹⁹⁴

Another service occluded by the penumbra of targets elsewhere is stroke care. Stroke is the leading cause of adult disability and the third biggest killer in the UK. While there have been significant improvements in hospital care, with most patients now being treated in special stroke units, there remain serious problems with longer term support. This is of particular concern as there are more than 900,000 people who have had a stroke living in England.¹⁹⁵ Despite the fact that stroke care is estimated to cost the NHS about £2.8 billion a year in direct costs, and the wider economy around £1.8 billion in lost productivity and disability, it wasn't subject to any specific targets,¹⁹⁶ which is especially surprising given that stroke care in the NHS has been the subject of heavy criticism for a number of years; most strikingly by the OECD.¹⁹⁷ Compared with other OECD countries, the UK is the only one to show no improvement in

the number of deaths per thousand of the population from stroke since 2000.¹⁹⁸

Not only is care poorly addressed relative to need overall, but it is also clear that there are 'some stark geographical inequities in provision'.¹⁹⁹ Upon admission for stroke, patients should be scanned as soon as possible in order to determine the best course of treatment, since 'time lost', as the maxim goes, 'is brain lost'. On average, 64 per cent of stroke patients in England are administered CT scans within 24 hours of admission.²⁰⁰ However, regional disparity in this area is high: in a number of trusts 100 per cent of patients are scanned on admission, but there are other trusts that scan as few as ten per cent of patients admitted as an emergency with a stroke.²⁰¹ What's more, while most hospitals are doing a better job of scanning patients soon after admission, three regions (North East, South West and Yorkshire and the Humber) have actually reduced the proportion of patients receiving early diagnosis since 2005.²⁰²

Moreover, as a leading specialist, Dr Anthony Rudd, consultant stroke physician at Guy's and St Thomas's, has put it, '[a]ll stroke patients should receive the best care from specialty doctors and nurses in dedicated acute stroke beds'.²⁰³ Outcomes for patients are better when this is the case: the NAO has estimated that achieving 100 per cent admission in stroke units would lead to a saving of 1,800 beds (approximately £82 million) and a 29 per cent decrease in death or dependence rates for patients.²⁰⁴ The British Association for Stroke Physicians recommends that a specialist-led, high quality, acute stroke service in England should employ around 430 whole-time equivalent stroke consultants; in 2005 there were just 86. Likewise, while in the North East 88 per cent of trusts reported that they employed a stroke specialist nurse, this figure dropped to 38 per cent in Yorkshire and the Humber. In three English regions all

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trusts reported that they did not employ a consultant nurse with specialist knowledge of strokes.²⁰⁵

There is considerable scope for improved continuity of care. The Royal College of Physicians has noted that 'a lot of progress... still needs to be made in the development of specialist stroke services outside hospitals' and that 'one of the common complaints of patients is that they feel abandoned when they leave hospital.'²⁰⁶ The Stroke Association has shown that many do not receive even simple information about their condition and recovery.²⁰⁷ In 2005, nearly half of stroke patients said they were not given information about dietary changes that might help prevent another stroke, over half said no one gave them information about possible side-effects of the medicines they had to take home, and half did not receive a care plan.²⁰⁸ Added to which, scant resources have been allocated to public health measures geared to prevention. An average of just 30 per cent of the general public surveyed by the NAO mentioned high blood pressure as a cause of strokes, even less mentioned smoking or high cholesterol levels or obesity.²⁰⁹

Money is not the solution

Back in 1998, John Willman warned that while hospital managers and doctors complain of a shortage of resources, Audit Commission reports indicated a systemic failure of hospitals to husband the resources they have. 'Extra money', he said, 'is no guarantee of a solution to the NHS's problems.'²¹⁰ He could hardly have been more prescient. The current government has achieved something momentous: it has shown that money really, really isn't the problem. Or, at the very least, that if it is, no government has the capacity through general taxation to deal with it. James Johnson, erstwhile chairman of the BMA, has commented:

THE STATE OF HEALTH

Don't assume there's anything automatic about the system we have at the moment continuing into perpetuity. I know that ministers will want to look very carefully at what they do next. If you get nine per cent of GDP spent on health and you still can't make it work, people will be saying—do you want to carry on doing the same thing or should we be trying something fundamentally different?²¹¹

The Universal and Comprehensive Myth

The great enemy of the truth is very often not the lie—deliberate, contrived and dishonest—but the myth—persistent, persuasive and unrealistic.¹

John F. Kennedy

Universal

No one would doubt that providing an equitable service is a major aim of the NHS. Indeed, it would be hard to find a government document or academic study concerned with the underlying principles of the NHS that did not include some reference to equity or one of its close synonyms, fairness and social justice. The idea is that people should be able to access the service and get the same quality of provision irrespective of social status or group. Oddly enough, it's often assumed that general taxation and public service provision are a proxy for equity, yet this commitment to equity is by no means unique to the NHS. Most OECD member countries have long achieved close to universal coverage of their population for a fairly comprehensive package of health services. In most of these countries, this is achieved as a result of a variety of public insurance arrangements aimed at ensuring equitable access.²

However, any serious consideration of doing anything different always comes up against a great shibboleth, namely the notion that the NHS achieves its ideals. Okay, so it's nothing like the best in the world, the argument goes, but at least it provides health care of the same standard to everyone across the UK, comprehensively and free at the point of delivery. To consider alternatives is treated as a sign

of willingness to depart from these ideals. In fact, *not* to consider alternatives is to show a lack of commitment to these ideals, while to defend the status quo is to endorse inequality. As has repeatedly and conclusively been demonstrated, ‘there are social groups such as the poor or the ethnic communities who are significantly disadvantaged in their access to, and use of, the NHS, and that the present combination of bureaucratic allocation and professional authority actually favours the better off’.³

Health inequalities

Before we go any further, we need to be clear about two things. One is that there are marked and entrenched inequalities in health in the UK, and that they are widening; the other is that these very often are not—and certainly not solely—the result of the healthcare system. This was pretty much the finding of Sir Douglas Black, who delivered a report into health inequalities in 1980 which showed, unmistakably, that the death rates for many given diseases were higher for the lower social and occupational classes than for the higher classes, and that overall the health gap between rich and poor seemed to be growing.⁴ ‘It was a shock to find that health inequality not only existed,’ as one commentator puts it, ‘but also seemed... to have increased in a situation where everyone could get health care without payment at a time of illness.’⁵ Black and his group did not, however, blame the NHS for this state of affairs. The real problems, in so far as they could be established, seemed to lie in issues such as ‘income, work (or lack of it), environment, education, housing, transport and “life-styles”’.⁶

Nearly 20 years later, the *Report of the Independent Inquiry on Inequality in Health* prepared for Tony Blair’s government in 1998—known as the Acheson report after its chair, Sir

Donald Acheson—found that ‘unacceptable inequalities in health persist’, that these ‘inequalities affect the whole of society’,⁷ and that ‘the gap in health between those at top and bottom of the social scale has widened’.⁸ The Acheson report, like the Black report before it, highlighted the link between social and economic disadvantage and health outcomes, and rather than blame the NHS its recommendations focused on things like education, employment, benefits, housing, the environment, and ‘living standards’.⁹ The government is faced with the dispiriting fact that not only have health inequalities not improved, but they have got worse, as the DH found in 2006. Not only are lower socio-economic groups less healthy,¹⁰ but the relative gap is growing. Between 1997-99 and 2002-04, for example, ‘the trend shows a widening in the relative gap between infant mortality in the routine and manual group and in the total population’.¹¹

It is wishful thinking, then, to assume that because we have a *National Health Service*, health outcomes must be broadly similar across the population. More to the point, while inequality may be the result of multiple factors for which no health system can be directly blamed or credited, it is becoming increasingly clear that the NHS often does little to combat inequality—and may even make it worse, by providing an inequitable service.

Unequal provision

For various acceptable reasons (for example, varying individual preferences), those in equal need and with equal opportunities to access health care may not make an equal use of those opportunities. These acceptable reasons should not be confused with unacceptable reasons for differential use of health care.¹²

Inequality and inequity are not the same. Inequality is a factual matter, largely outside the control of the NHS, while inequity is a moral matter. When talking about the NHS, it is inequity that is unacceptable. There are numerous ways that equity and inequity in health care can be defined, but the principle one concerns access. An equitable service offers equality of access to health care to individuals in equal need. This is generally referred to as horizontal equity, and it contrasts with vertical equity, when individuals with different levels of need consume appropriately different amounts of health care.¹³ To put it another way, the treatment available to individuals should depend only on their need for treatment, not on factors that are irrelevant to that need.¹⁴

There are abstruse debates about how all of these things are defined. The difference between access and utilisation, for example, means that if someone *chooses* not to use the service for whatever reason then it's not fair to then say that resultant inequalities in utilisation relative to need were inequitable. There are also tricky problems connected with defining need, such as whether it is in terms of health status or capacity to benefit.¹⁵ Generally, however, it's so hard to attribute outcomes to choices that inequality in utilisation is used as a proxy for inequalities in access, though different studies pitch for different qualifications of need based on a combination of detailed information about patients and carefully justified 'value judgements'.¹⁶ When all is said and done, numerous studies have shown that 'lower socio-economic groups use services less in relation to need than higher ones',¹⁷ which means, as Tony Blair himself acknowledged, the NHS does not provide equitable access to services.¹⁸

Horizontal inequity

Hip replacement is a common, effective, low risk and long established health technology, which is why it has often

been used as a test of the horizontal equity of healthcare provision in the NHS. In 2006 the York University Centre for Health Economics reported that studies of elective total hip replacement in the NHS between 1991 and 2001 have yielded striking examples of the unequal delivery of specialist health services across socio-economic groups.¹⁹ Survey data for people living in deprived areas suggests that they may be more likely to need hip replacements. The evidence for this includes higher rates of consultation for osteoarthritis—the primary cause of hip problems—in deprived areas and a great prevalence and severity of hip disease among individuals with low income and education.²⁰ By setting this against administrative data which show that people living in deprived areas are less likely to receive hip replacements,²¹ the York study was able to conclude that there is ‘substantial socio-economic inequality in use of elective total hip replacement’.

This is by no means an isolated case. Indeed, an article in the journal *Rheumatology* in 2006, found that while need for hip and knee joint replacements was three times as high in the poorest quintile of the population as the wealthiest quintile, the number of operations were no more common.²² When it came to discussing the findings, although the York team recorded that inequity ‘appears to have decreased slightly between 1991 and 2001’,²³ they went on to acknowledge that their study ‘did not include independent sector utilisation’, and ‘about a quarter of hip replacements in England are undertaken in the independent sector.’ Relevantly, ‘[t]his non-NHS utilisation is concentrated among individuals and areas of high socio-economic status, particularly in the South East of England. Inequality in NHS utilisation therefore underestimates overall socio-economic inequality in utilisation’.²⁴ So it’s bad enough within the

NHS, but take into account the two tier nature of health care in this country and inequity will be a lot worse.

Geographical variation in treatment

Geographical variations in access and quality do not offer definitive evidence of systematic horizontal inequity, but the service is patchy and there are signs that it is better in richer areas of the country. Recent statistics on meeting the 18-week target show that there are wide variations in performance across the country with some PCTs managing 50 per cent of patients meeting the target while others manage only 20 per cent.²⁵ Where diagnostics—MRI and CT scans—are concerned, there are massive variations in waiting times. Whereas patients in Wales can expect to wait only 47 days for an MRI scan, those in the North East can expect to wait 100 days. And while there are a small number of hospitals, such as South Warwickshire General Hospitals NHS Trust, where you can get a routine MRI scan in less than ten days, there are equally a small number where you have to wait more than 170 days, such as the Royal United Hospital Bath NHS Trust.²⁶ Similarly, patients are waiting just three days at University College London to receive a CT scan—but 141 days at Norfolk and Norwich University Hospital NHS Trust.²⁷ Where you live therefore determines how long you have to wait to access NHS services.²⁸

Likewise, within specialties there are wide variations in provision. This means that a deaf person in one part of the country is likely to have more rapid access to a hearing aid than someone with the same condition in another part of the country.²⁹ The same applies to stroke victims, too, and wide variations are also reported in the diagnosis and treatment of urological cancer, and in the treatment of multiple sclerosis.³⁰ Where you live also determines the quality of the orthopaedic treatment you receive. As well as identifying

variations in quality and efficiency in hip and knee replacements, Dr Foster has found that in one emergency procedure, fractured neck of femur, if all trusts were up to the standard of the best performers then in the past three years more than 1,500 deaths could have been averted.³¹ This is surely a failure for a system that purports to be uniform in its provision. Geographical variations are only a crude indicator, but it's clearly true that where you live—and often where you can afford to live—will affect the quality of care that you as a patient are entitled to receive. Similarly, 'there is still a four-fold variation in mortality rates between organisations' for coronary artery bypass graft (CABG) procedures.³² Variations in CABG treatment have consequences for equity. Julian Le Grand has shown that intervention rates of CABG or angiography are 30 per cent lower in the lowest socio-economic groups than in the highest.³³

Vulnerable groups

It's not just your class, income, education or employment status, nor where you live in the country, that matters; your 'fashionableness' as a sufferer also impacts on the quality of care you receive. Despite the fact that the UK population is ageing, and there is a higher proportion than ever before of older people in the community, the elderly depend on out-of-hospital care run by PCTs overloaded with responsibilities. It is, as the think-tank Reform notes, 'the poor cousin of the acute sector'.³⁴ In the treatment and nursing of medical emergencies for the elderly there appears to have been little general improvement. The vast amount of money spent in the system has had a curious way of bypassing these wards. The NHS is a long way from being able to offer an assurance of a high standard of care for admissions of frail elderly people, who then tend to stay for a long time. A

recent study by the OECD has demonstrated that the elderly, the largest users of the NHS, suffered substantial inequities, especially in hospitals or for specialist treatment and dental health. In terms of visiting GPs, the UK drops from first (for overall equity) to ninth (for equity for over 65-year-olds) in a list of EU countries.³⁵ If you are old *and* mentally ill things are even worse, as the Healthcare Commission found in 2006:

There are poorer and less integrated services for older people with mental health needs compared to those people with mental health needs aged under 65. The out-of-hours services for psychiatric advice and crisis management for older people were much less developed, and older people who had made the transition between these services when they reached age 65 said there were noticeable differences such as poorer quality, fewer services and less support.³⁶

This brings us onto mental health in general, where services vary widely across the country.³⁷ There are large disparities in spend by PCTs, from less than £75 per head per year to over £300 in 2004/05.³⁸ An enquiry by the King's Fund raised serious questions about variations in levels of investment and gaps in information, and the Audit Commission's analysis shows that this variation cannot be explained entirely by differences in levels of need, differences in volumes of activity, or differences in efficiency.³⁹ In addition, the Healthcare Commission has reported serious problems with variations in care, including a wide gap between the north and the south;⁴⁰ further evidence of which has been gathered by Reform. Following a review of postcode rationing in the use of new anti-cancer drugs by the National Cancer Director, which showed considerable concern about the differences in access to new therapies,⁴¹ Reform conducted its own study of prescribing in mental health. By looking at the use of atypical anti-psychotics—relatively inexpensive drugs that are recommended in NICE's guidance—it showed

QUITE LIKE HEAVEN?

that differing rates of prescribing in mental health are greater than in the case of cancer therapies. When it looked at the bottom performing PCTs, 14 of the last 20 were in the East Midlands and East Anglia, but only one in the South East. By way of contrast, 16 of the top performing PCTs were in the South East and London area and only four in the North or the Midlands.⁴²

So mental health is less well served than other conditions, and the quality of the service varies widely, with the relatively affluent south doing better than less prosperous parts of the country. In September 2006, the Healthcare Commission published its first national review of adult community health services, which noted that 'some disadvantaged groups are more likely than others to fail to receive services'.⁴³ As well as the elderly, there are also inequities in provision that particularly affect people with mental health problems from black and minority ethnic communities.⁴⁴ So do not be poor, black, old and depressed in England right now, because you're very unlikely to get treated.

Access and voice

It is now widely acknowledged that the system militates against lower socio-economic groups. Since there is much evidence to show that the provision of primary care services in deprived areas is getting worse,⁴⁵ there is strong evidence to suggest that 'the inverse care law' operates, which is to say that areas which are poorer and therefore have greater health needs are less well served by the health service than wealthier and healthier areas.⁴⁶ Curiously, the utilisation rates tell a different story. Most studies show that those of lower income and education status and ethnic minorities have higher use of primary care than those of higher income and education status, but that this is reversed in access to

secondary care,⁴⁷ where 'the rich are significantly more likely to see a specialist than the poor'.⁴⁸ Seen from another angle, under-utilisation of secondary care by lower socio-economic groups doesn't appear to be caused by a reluctance to seek an initial consultation with a GP, despite barriers to treatment.⁴⁹ Having made it to their GP, the poor, it is argued, 'experience another set of *difficulties*, which manifest themselves in lower rates of referral to secondary and tertiary care, lower rates of intervention relative to need, and lower and irregular attendance at chronic disease management clinics'.⁵⁰

It is always difficult to establish which barriers to access operate differentially—which ones are more significant for disadvantaged groups—and this applies to all manner of considerations, such as transport and travel, but one widely accepted reason that the system hinders relative access for the poor is the mechanism of 'voice'. Voice is simply a catchall term for communication difficulties, language, literacy, assertiveness, articulation, self-confidence, ability to deal with professionals and so on.⁵¹ This line of thinking holds that the middle classes get more out of the health service because they are better at expressing their needs.⁵² The idea of voice in its broadest sense is highly suggestive; when it comes down to it, the NHS is so vast and complex that a certain degree of canniness is required to exploit it successfully. Information is not transmitted freely—as would be expected in a properly functioning market—and standards vary wildly. Unofficial forces prevail, like learning, manners, 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. Certainly, higher socio-economic groups are more likely to have family or friends who work in the health services, and even if these contacts are not directly used to

gain access to services they act as an important source of advice on how to work the system.⁵³

How pushy people are also counts: at least one study—of hip replacement utilisation—has found ‘evidence of the effectiveness of the “sharp elbows” of the middle class in the welfare state’.⁵⁴ 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. As Frédéric Bastiat pointed out in the nineteenth century, when everyone directs their efforts toward ‘contributing little to, and taking much from, the common fund of sacrifices’ it is not the poorest and most unfortunate, ‘but rather the most influential and calculating’ who will do best out of the system.⁵⁵ We begin to get a sense of irony, though it isn’t very funny: an arrangement which attempts to remove the role of money in the system, far from abolishing inequality, reinforces it by being inequitable. The ability to get the most out of the NHS becomes a matter of survival of the fittest—or richest and most educated—yet this was surely what the NHS was designed to avoid. The system offers different services to different people in different parts of the country, quality and access vary widely; and, as we shall now see, because it is certainly no longer comprehensive, an increasing range of services are becoming available only to those with the money to pay for them.

Comprehensive and free at the point of delivery

It’s worth clearing out the most obvious misconception, which is that the NHS is free. It’s not. It’s ostensibly free at the point of delivery, but it certainly isn’t free. Being paid for through taxation, the gross cost in the UK was estimated at £1,720 per person and £4,054 per household in 2006, which represents approximately eight times the per capita cost of

the NHS when it was first established, allowing for inflation.⁵⁶ When we break these costs down, we find that in 2004, 76.5 per cent of NHS funding came directly from taxes, NHS contributions paid by employers and employees via the National Insurance Scheme accounted for another 21.5 per cent, and contributions from patient payments two per cent, or £1.7 billion.⁵⁷ Although this makes up only a small proportion of NHS funding, it proves that a certain amount of what people receive on the NHS is not even free at the point of delivery—nor has it been almost since the inception of the NHS. The extent to which this is true is growing all the time. More importantly, these figures do not account for a growing volume of out-of-pocket or direct payments made by patients supplementing NHS services with private care. In 2006 Allyson Pollock argued that the NHS ‘no longer provides truly comprehensive care’,⁵⁸ a point echoed in 2007 by the BMA, which said starkly: ‘...the NHS is not fully comprehensive’.⁵⁹

Rationing

The National Health Service was the child of scarcity, conceived at a time when Britain was still recovering from the ravages of war. It has remained a monument to institutionalised scarcity ever since.⁶⁰

As we’ve seen, the founding misconception of the NHS was that there is a finite quantity of need for health care which the government could meet with taxpayers’ resources. Bevan 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 could only work if this was true. But it was not. From the outset, the idea proved hopelessly optimistic. As a result, the NHS has always been under financial strain, however generous the proportion of public money allocated to it has been,⁶¹ and it ‘has never since the early days been able to fully cope with

the rising demands'.⁶² One solution was to introduce charges. The Chancellor of the Exchequer, Hugh Gaitskell, was determined to get a grip on spending and in 1952 he introduced charges for teeth, spectacles and prescriptions, leading to Bevan's resignation and dividing the Labour party for the next decade.⁶³ Within a few years of its birth, as Nick Timmins has put it, 'the completely comprehensive and free health service had ceased to be.'⁶⁴

In practice, charging didn't play a massive role—it never made up more than five per cent of NHS spending—so most of the pressure on a health service free at the point of delivery was relieved through rationing. One of the most obvious forms of rationing was rationing by queuing. Accustomed to wartime rationing, people accepted the conditions and saw queuing as a necessary restriction, 'a positive element which bound people together across classes'.⁶⁵ There was a lot of talk of sacrifice at the time—Beveridge for example talked of the need for 'equality of sacrifice'—and it was assumed that those who could afford to buy themselves better treatment would practice restraint. Yes, it was tight, but the pressure on resources wouldn't last forever, extending the benefits of medical science to all the people of Britain would undoubtedly resolve the problems of illness and disease, costs would go down, everyone would get just what they needed.⁶⁶

Sixty years on and the features of queuing and privation, seen as part of the culture of solidarity and shared hardship after the war, are now an anomaly; 'a sign of failure'.⁶⁷ Times have changed. The number of manual workers as a proportion of the workforce has fallen. Home ownership has more than doubled. Average and disposable incomes have shot up. We are used to possessions and lifestyles that Bevan couldn't have conceived of—cars, consumer durables, holidays, personal services—and ordinary people have

become accustomed to choice, variety and responsiveness to their demands. Patients are increasingly reluctant to accept rationing. Those who can afford to—or who have private health insurance provided by their employers—vote with their feet by moving into the private sector. Yet rationing is no less a part of the NHS than it was in 1948; indeed, it is even more prominent.

Before the internal market, doctors made decisions about whether and how to treat patients which reflected the shortage of resources, but this was fragmented and unrecorded in the transactions between doctors, patients and their families.⁶⁸ The internal market reforms gave responsibility for deciding what treatments should be available to purchasers of health care to health authorities. The information had to be made public, and with mounting demands on treatment they started to focus on priorities. By switching the emphasis to priorities in terms of the particular procedures to be carried out, the issue of rationing could no longer be avoided, for as John Willman has pointed out in *A Better State of Health*, priorities are simply 'another form of implicit rationing, since doctors and nurses who are busy on heart surgery or hip replacements have less time for other activities such as plastic surgery'.⁶⁹ It is a point rarely recognised that setting targets is about setting priorities, which involves rationing elsewhere.

Rationing is also done by 'dilution', where the funds have been spread so thinly that some parts of the service are just inadequate,⁷⁰ and simply by denial, as the NHS attempts to reconcile growing demand with limited funds. The introduction of kidney dialysis treatment in the 1960s marked the first occasion on which explicit decisions were taken to withhold treatment on the grounds of cost—it was effective but expensive, so a policy of restricted access to regional centres funded from Whitehall was introduced.⁷¹

This approach has been duplicated with other medical developments like heart and liver transplants,⁷² but the NHS has tended to resist declaring any form of treatment outside its remit at a national level.

However, while the DH divests itself of responsibility, it's a good deal harder for trusts to disguise what they're doing when they cut back the services they can offer on the basis of funding. Rationing is becoming more obvious to a public that is ever less likely to accept the consequences. This actually started as far back as 1991, when the North East Thames regional health authority issued guidance on minor surgical procedures which wouldn't be offered on the NHS unless there was an 'overriding' need. These included the removal of non-malignant lumps, extraction of wisdom teeth unless they were causing problems, varicose vein operations, in vitro fertilization, tattoo removal, and cosmetic surgeries like breast enhancement and liposuction.⁷³ Then in 1992/93 a survey by Bath University of the first wave of purchasing plans found that around 10 per cent of the 100-odd authorities were planning to deny or limit particular treatments. As well as a variety of cosmetic procedures, the list also included sex change operations and homeopathy.⁷⁴

More and more PCTs are denying patients services, and the range of services being denied is growing all the time. A 2007 survey of chief executives carried out by the *Health Service Journal* discovered that restricting access to treatments has become widespread, with 73 per cent of PCT leaders reporting this, while 50 per cent said they had delayed operations, and 83 per cent of acute trusts had closed wards.⁷⁵ In January 2007 Norfolk PCT told hospitals not to treat patients who had waited less than 17 weeks, formalising rationing by queuing as well as rationing by denial. It also said the trust would not pay for elective

operations on smokers.⁷⁶ Six months later, Leicester City West PCT told hospitals to run blood tests on smokers to prove they had quit before putting them on the waiting list and admitting them for elective procedures.

It was in this charged atmosphere that the BMA published its May 2007 report, *A Rational Way Forward for the NHS in England*, which amounted to a bold public renunciation of the taboo which had surrounded talking about payments for healthcare services in this country. Outlining a long list of procedures in jeopardy, it declared that 'in the future the NHS will not be able to provide all services.'⁷⁷ At last we are witnessing an amnesty on withheld truths. 'Rationing of health care in one form or another has always existed but has not been discussed', wrote Michael Wilks, one of the BMA's senior office holders, in a letter to the BMA's 139,000 members: 'While agreeing that an open and honest debate on rationing is needed, the nature of that debate needs to be clarified. It might, for instance, address whether current inequities in care caused by pressures to balance the financial books are preferable to one alternative, which is to set a limit on the availability of some procedures.'⁷⁸

These words encapsulate many of the issues of the debate. Do we want a system that tells us, from the top, what we can and cannot have? The list of procedures going off the NHS gets longer year by year. Expectation continues rising, while delivery is falling. As the financial ceiling on the NHS comes down, and the demands made on health care press upwards, more and more treatments could be squashed out of the service, with unfortunate consequences. People have always believed that money is the problem, that if we pour in enough cash the rationing will stop, but that can now be viewed as a fallacy. We will have to examine this in more detail in the next chapter, but as cost increasingly

determines provision, rather than need, who is going to make the decisions—the market or the government, the patients or the providers? In a properly functioning market, rational competition and choice, accompanied by information about quality and effectiveness, ensures the best possible allocation of resources. The direction in which we are going severely limits individual choice by making one-size-fits-all decisions on behalf of everyone in a catchment area.

Some rationing is unavoidable and occurs when treatments are intrinsically expensive or rare. Organ transplants are the best example of the former. Given the limited supply of available organs and the great demand for them, there is a ceiling. Priority setting is unavoidable. Scarcity is the major determinant of price on the open market and short of farming organs in a laboratory, decisions will inevitably have to be made about which patients are to receive transplants. This is not the same as the rationing which happens as a result of the way that the NHS is organised, which ensures a permanent shortage of capacity. These shortages, resulting from unnatural blockages in the supply chain or decisions about what can and cannot be afforded, lead to precisely the kinds of ‘resource allocation by decibel count’⁷⁹ that we saw with the under-resourcing of mental health services. 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. Do we want a system where one person’s gain is another’s loss?

It’s easy enough if the procedures that are rationed are of dubious merit. A key basis for removing procedures and treatments from NHS provision is that they are ineffective, and providing them is a waste of time. In this case not

offering the intervention doesn't constitute rationing because there is no benefit to the patient's health. In November 1984, the government introduced a 'limited list' of medicines that could not be prescribed under the NHS. This included proprietary cough and cold remedies, antacids, laxatives and mild painkillers,⁸⁰ and the list was lengthened in 1993 to include appetite suppressants, pesticides, toiletries, products for diabetics and foodstuffs such as evening primrose oil.⁸¹ As the junior Health Minister who announced this measure, said: 'The NHS should not be paying for items which have no therapeutic or clinical value.'⁸² The same goes for grommets, a treatment for glue ear. In the early 1990s, the NHS was spending more than £30 million annually on this,⁸³ but despite the apparent efficacy of the operation, research evidence suggests that it's unnecessary in most cases. If left alone, glue ear usually clears up of its own accord—within about three months in most cases. It is rarely, however, this simple.

The rationale behind the exclusion of some forms of treatment is that there are other healthcare services the NHS must provide in all circumstances. If resources are limited and outstripped by demand, funding must be preserved for this basic core of treatments because they are, in some sense, essential to the health of the individual. This makes lifestyle an emotive criterion. Is a treatment worthwhile—should services be rationed—to people who have brought their problem on themselves? PCTs like Norfolk increasingly seem to think so. Many people find the idea that treatment should be focused on those who are most likely to benefit from it more persuasive when a condition can be attributed to behaviour thought foolish or dangerous by informed opinion. But rationing on this basis carries risks. For every smoker you deny treatment, there would, for example, be someone with an STI acquired through sexual promiscuity.

‘These measures are clearly being driven by finance and not clinical need’, said Michael Summers of the Patients Association, responding to the news that Norfolk PCT is refusing to treat smokers who won’t attend clinics. ‘It’s a way for hospitals to save money and it’s very wrong.’⁸⁴

IVF is another classic. Many cash-strapped health authorities are refusing to pay for IVF treatment, leading to accusations of postcode rationing, and in many parts of the UK fertility treatment is only available privately.⁸⁵ Those who oppose IVF on the NHS cite its cost in comparison with other forms of treatment—they point out that the cost of a hip replacement is roughly the same as the cost of a single cycle of IVF, or that it is cheaper to treat heart disease—along with its relatively limited success rate. Comparing the benefits of one treatment against those of another and focusing on the one that produces the best health gain per pound has great intuitive appeal when resources are capped. But should these choices be made by individuals in consultation with doctors, or should decisions be made on behalf of everyone by the politicians? Those who advocate IVF on the NHS say that that is to set the birth of a baby and the happiness of a family against the improvement in quality of life for an entirely different patient. Others say that the cost of funding IVF is outweighed by the economic contribution the resulting child can make. A Sheffield University research team has calculated that while it costs £13,000 to create a baby using IVF, each child contributes £147,000 in taxes and insurance to the UK economy,⁸⁶ and Rand Europe believes that ‘it is a false economy not to fund it’.⁸⁷

There is surprisingly little evidence in wide circulation about the effectiveness of various treatments, and at present many decisions are based on the budget, not value for the patient. It is not that an operation doesn’t work, just that

when judged against the cost of another treatment, one patient's life is considered more or less valuable, which is why capacity to benefit—which has in the past resulted in the denial of physiotherapy, kidney dialysis, stroke care, hip operations, and many more treatments to the elderly—seems to have gathered traction. The practice of medicine is supposedly the application of medical knowledge to particular patients in the light of their circumstances. The only requirement is that two cases in identical need—whatever that means—be treated identically and preferably by ways that are proven to work. This sends us scurrying off in search of a set of explicit principles to ration the health care budget fairly, but such a search is futile because the needs of individual patients are so different. No rationing principle yet found really faces up to the question of the gap between supply and demand in the NHS.

That is because the principle of rationing is axiomatic in our healthcare system. The amount of taxation that people pay is practically and politically limited, and therefore so too is the amount of money available to spend on health care in England, with concomitant restrictions on the service that is available. Having imposed the expenditure ceiling, the government then passes responsibility 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. For a public that wants to be able to access the services to which it believes it is entitled, the NHS is an anachronism. The NHS remains as the last relic of socialist post-war planning, its entire approach redolent of a bygone age when consumer choice was an irrelevance. And this despite all the so-called market reforms. In 2003, Tony Blair said that the NHS had become a 'deeply unequal' system where the most affluent

in society opt out while the poorest too often receive the worst health care.⁸⁸ It is to the opting out that we now turn.

Under-the-table payments

We have already spoken about how the middle-class ‘voice’ has a major impact on their ability to derive better health care from the current system. An under-acknowledged facet of this—under-acknowledged because it is illegal—concerns under-the-table payments. These are informal out-of-pocket payments. Out-of-pocket payments are formal when they apply to the private sector, informal when encountered in a public sector which is supposed to be free, and in the latter instance have come to be known colloquially as under-the-table payments. Data on their extent in a range of eastern European countries suggest they are widespread in both ambulatory and hospital care, and that in a small number of Newly Independent States of the former Soviet Union they form the largest source of funding. Informal payments made by patients and families to supplement formal coverage are common. For example, approximately 38 per cent of average salaries received by physicians in Hungary compromised official income; the remaining 62 per cent was from informal payments.⁸⁹ Informal payments are a response to the lack of financial resources in a system that is unable to provide adequate access to basic services.⁹⁰

Nothing on this sort of scale occurs in England, but there is anecdotal evidence to suggest that what in polite society we call gifts and presents often get passed from patients to doctors or surgery administrators. One consultant surgeon interviewed in the course of researching this study said that at his private practice a few patients gave a bottle of champagne to make sure that they could see him rather than his registrar. Another spoke of theatre and concert tickets as the lubricant in the system. A handful of other figures

confirmed that they have encountered this in the NHS, with middle-class patients giving presents to foster better relations with the medical staff and encourage them to ensure that they access the best treatment available. Two other senior figures in the healthcare establishment in this country, along with one academic, all of whom spoke strictly off the record, said that they were aware that GPs and consultants are in collusion about referral patterns, a phenomenon that may well happen much more than has been surfaced to date. Money speaks even louder than words.

Top-up payments

The NHS was established to make sure that the quality and range of treatments available to those in need was not dependent on their ability to pay. The obverse of this is a two-tier system where patients have differential access to services according to what they are willing or able to pay, threatening the very foundations of social solidarity. To some extent, because public and private healthcare systems exist in parallel, this has been the case for a good many years.⁹¹ Since the early 1990s, about 11.5 per cent of the UK population has had some form of private medical insurance, either personal or corporate cover.⁹² Others are bypassing the blockages for specific treatments, and anecdotal evidence suggests that this is happening with increasing regularity. There has been no official attempt to map the scale of this trend, but there is a growing body of material which shows that patients are beginning to develop sophisticated approaches to purchase upgrades to their basic NHS care. As Allyson Pollock has written:

As is already the case for NHS dental services, routine and ophthalmic services, and long-term care, a 'half-way house' is beginning to emerge where NHS patients are invited to

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supplement their NHS care by paying a ‘top-up’ fee. Recent examples include maternity care, where patients can opt to buy a ‘superior’ package of care, covering services which were once free to all women in labour, and MRI scans and dermatology, where patients bypass the waiting list by paying for them privately.⁹³

It doesn’t take a genius to identify why. With PCTs struggling to balance their books, the range of treatments available on the NHS is being cut, creating hidden waits and postcode lotteries; but in our modern consumer age, people don’t want to wait or suffer delays and they don’t want to be told they can’t have a life-saving or life-enhancing treatment by politicians who they don’t trust at the best of times. It is also possible that all the rhetoric of choice in the NHS has stretched people’s expectations even further, and as some private treatments become cheaper and more accessible in the marketplace, attitudes are becoming more amenable to using them. Unlike informal—under-the-table—payments, these formal payments—formal because they are paid to the private sector—aren’t illegal. But they are making it harder to credibly argue that health care in this country is comprehensive and available to all irrespective of the ability to pay.

All of which means that we’re moving closer to continental systems of mixed funding than many would think, as a recent paper for Doctors for Reform has argued, but with a critical area of difference: ‘we are far behind in terms of the coherence of our funding system and in terms of equity. We run the risk of achieving the worst of all worlds: inequitable NHS provision combined with inequitable provision outside the service. In both worlds the least well-off are disadvantaged.’⁹⁴

Patients find themselves at the frontiers of this ethical debate on a daily basis. If you have recurring tonsillitis so severe that you have to take a week off work every time it

strikes, surgical removal is not only necessary but urgent as well. Yet if you manage to get a referral from your GP, the waiting list to see a consultant is likely to be six months, and after that you could wait another eight months for the operation. Or you could self-pay and go to a specialist. That way, for £95, you'll see a consultant in two days, and for a further £1,400 you'll cut months of the waiting time for the operation.⁹⁵ Or imagine you're a 76-year-old widow whose hearing is diminishing in the left ear and who's completely deaf in the right ear. You can't localise sound, you feel disorientated and you find it difficult to communicate. Your ENT consultant tells you that he can implant a new bone-anchored hearing device to improve your hearing; the bad news is the PCT limits the number of devices he can implant to five per year, which means his waiting list is already five years long. If you've got the cash, the £2,500 to get the device installed on the private sector is quite simply a no-brainer.⁹⁶

It's in cancer care that these issues become most complex—and unavoidable. Medical innovations are advancing far faster than the NHS can raise revenues to supply these innovations to the patients who need them. Despite all the talk of choice, decisions are being made for individuals about the treatments they can and cannot have. For more than 60 years, most cancer treatments have been based around chemotherapy, of which over 200 types are available. As was mentioned in the Introduction, chemotherapy is a carpet bombing approach: in laying waste to a tumour, the drugs also wipe out the body's entire immune system, causing numerous side-effects and leaving patients susceptible to opportunistic infections. In the last decade, however, advances have led to the creation of new types of cancer weaponry such as monoclonal antibodies which, like mini guided missiles, target the tumour itself rather than the surrounding tissue.

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These advances offer enormous potential, but they are expensive. If administration and medical care costs are factored in, then estimates for the yearly cost for cancer drugs now set Herceptin (Roche) at £60,000, Glivec (Novartis) at £50,000, Avastin (Roche) at £70,000, Tarceva (Roche) at £65,000, and Sutent (Pfizer) at £40,000.⁹⁷ There's more to come, too. Quite apart from predictions that monoclonal antibodies will double the number of intravenous infusions required for cancer by 2011, the availability of powerful tyrosine kinase inhibitors as straightforward tablets without the need for complex administration systems is bound to change the dynamic. Personalised medicine for choosing the right therapy through genomic and proteomics is likely to become available as an over-the-counter diagnostic service through emerging independent providers.⁹⁸ We now possess—and are developing—powerful weapons in the fight against cancer, but with NHS budgets in chaos can we afford to use them?

Distilled down, this becomes a straightforward payoff, system versus individual. Should the system make the decisions or should the individual? According to Mark Sculpher, Professor of Health Economics at York University, there is an issue of whether such drugs are worth paying for. At £30,000 a year, Herceptin exceeds NICE guidelines for the upper limit at which a drug is deemed cost-effective for the NHS. So when a PCT allows an expensive drug like Herceptin to be widely prescribed, other services within the community will suffer—typically mental health services and care for the elderly. 'There is simply no moral case', Sculpher has argued, 'for one individual to say, "I am justified specific and special treatment" if the system doesn't think they are. That's not how it works.'⁹⁹ Not everyone agrees. John Toy, medical director of Cancer Research UK, is not sure that

NICE, good as it is at examining the science, is the best body to determine quality of life. 'It is a very difficult equation to calculate', he has said. 'Quality of life is an important and justifiable part of the equation.'¹⁰⁰ Centrally managed rationing and patient choice are on a collision course.

What implications are there for the citizens of this country? Mark is a 47-year-old father of three. After having a colectomy for colon cancer three years ago, he presented with upper right abdominal pain and was found to have multiple liver metastases on a CT scan. He was offered chemotherapy at his local hospital using three drugs—5 fluorouracil, folinic acid and oxaliplatin—but had heard about a drug called Avastin which when added to the above regimen improved both the percentage of patients responding and their survival. Although licensed for metastatic cancer in the UK, it is not available for financial reasons on the NHS. By contrast, it is covered for this indication by all major UK private medical insurers, and is a standard treatment in France, Germany and Italy as well as the US. Having been told that he would have to get all his treatment at the local private hospital if he wanted to receive Avastin, at a total cost exceeding £20,000 for six months care—when in fact he could've been given Avastin privately and the other drugs on the NHS—he decided to do so.¹⁰¹

And there's more. With regard to precision radiotherapy, there are 61 radiotherapy centres in the UK, of which 28 now have equipment to provide Intensity Modulated Radiotherapy (IMRT), and three provide it routinely to significant numbers of patients. IMRT is now standard in the US and most of Western Europe. Savvy patients are beginning to travel long distances for radical radiotherapy. While delays abound, with a three months waiting time for radiotherapy being common in the UK, a centre in Zurich, Switzerland, currently has a working group engaged in re-engineering

the time from first contact to radiotherapy delivery from five to three working days.¹⁰² Ironically, in a country that prides itself on equity in the system, as drugs become more expensive and more powerfully marketed by drugs companies with huge media budgets, the rich will get better cancer care than the poor as they will be able to choose and afford the care that they want. As Karol Sikora, former chief of the WHO Cancer Programme and an honorary consultant oncologist at Imperial College School of Medicine, has said: 'We need to face up to this situation.'¹⁰³

A growing number of commentators are beginning to argue that formalising these co-payments offers a solution to the NHS's crisis. Charles Clarke is one such. 'I do not believe that over the coming decades the combination of Gershon-type efficiency gains and the likely levels of increased allocations from the Treasury are likely to meet public expectations, and the consequent political pressures. The only way out of the dilemma which governments will therefore face is to permit some level of charging.' He accepted that it 'is likely to raise important issues of fairness and possible social division', but suggested that 'co-funding' of services through the tax system and some form of charging could be based on existing models, such as dentistry, where people paid set fees for the services they received.¹⁰⁴ Yet the appalling dentistry provision should be all the reason we need not to go in this direction, and it will certainly do nothing to alleviate concerns about social division. Day by day the comprehensive dream is coming to look more like a shabby illusion, and in a consumer society that cares passionately about its health and quality of life this is making social solidarity an historical artefact.

There may be ways to make top-up payments more equitable in a reconfigured system, but they will do nothing to resolve its fundamental faults.

4

Unhealthy Competition

How any individual will act under the pressure of competition, what particular circumstances he will encounter in such conditions, is not known before even to him and must be still more unknown to anyone else. It is therefore literally meaningless to require him to act 'as if' competition existed, or as if it were more complete than it is.¹

Friedrich Hayek

Nationalised monopoly

To really understand why the NHS exhibits so little improvement after the injection of such enormous wads of cash into the system we have to look at how health care in this country is arranged. The truth is that while on the one hand the problems facing the NHS are unbelievably complicated, on the other hand they are very simple. No longer can it be claimed that the problems facing the NHS are a result of underfunding, and that more money, accompanied by problem-specific instruments, initiatives, targets, plans and process reforms, mostly directed by or for the DH, will do the trick. The problem, starkly put, is monopoly; and, more to the point, nationalised monopoly. People have been saying this for some time. One of the more useful critiques was offered in 1999 by Nick Bosanquet, Professor of Health Policy at Imperial College, London. Coining the term 'triple nationalisation', he outlined how provision, funding and resource allocation are all state monopolies.² When we understand this, we will see that lack of money and inadequate management processes are symptoms, not causes, of the problem.

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- The provider or supply side is a nationalised monopoly. Patients receive their care in state-owned institutions and at the hands of state employees. The nationalisation of supply causes capacity restraints at almost all levels and eliminates professional autonomy. Despite concerted efforts by this government to introduce greater pluralism on the supply side, these have had only the most marginal of impacts.
- The purchaser or demand side is a nationalised monopoly. Virtually all the money in the system is collected by the Treasury through taxation, which then controls the flow of that money through the system. The nationalisation of demand means that money does not follow patients, who are denied choice and, as a result, are systematically disempowered by the system.
- Strategy and resource-allocation are nationalised. Despite all the talk of devolution, decisions about which services get what resources, and which patients get which treatments, and when and how, are made by state officials. As a result, the NHS fails to adapt its supply to fluctuations in demand; it takes power over health care away from patients and professionals, and gives it to managers and ministers.

Giving providers a monopoly has never been a good way to improve a service of whatever kind. 'History tells us that monopolies that are truly benevolent and effective are rare',³ and the best way really to understand the weaknesses of monopoly is to compare it with a competitive situation, namely a market. Now there's a lot of guff spouted by those who object to competition on the basis of the assumption that those who advocate it are simplistically wedded to the private sector, but it is not the strength of the private sector versus the weakness of the public sector which informs a

belief in the importance of markets, so much as a belief that competition improves supply. It has to be said that a monopoly that is achieved through possession of a unique skill, say, or superior performance of some other description, is not necessarily a bad thing. The problems occur when that monopoly position is achieved by excluding others, when it 'consists in a power of preventing others from serving the customers better', as the political theorist Friedrich Hayek argued,⁴ and therefore preventing competition.⁵

The advantages of competition do not depend on it being perfect. For it is not perfect and will not produce perfect outcomes or results. This would be the wrong way of understanding it. Against an ideal of perfect distribution with optimal use of all resources, which has never been achieved, competition has been shown again and again to produce results better than those of the existing procedures of monopolies. Competition shouldn't be judged against a utopia of what the NHS would be like if the distribution of resources were perfect and the system were arranged by some omnipotent deity, and nor should it be claimed that this is what it will achieve; but rather it will raise efficiency considerably above the existing level. Using an analogy of experimentation in science, Hayek calls competition 'a discovery procedure', since it 'leads, under favourable conditions, to the use of more skill and knowledge than any other known procedure'.⁶

Competition relies on the self-interest of the producers, but it is a self-interest which is in the long run to the benefit of the whole society, and although the system doesn't currently have a highly developed commercial spirit, such a spirit is 'as much the product as the condition of effective competition, and that we know of no other methods of producing it than to throw competition open to all who want to take advantage of the opportunities it offers.'⁷ That

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is, the spirit of enterprise and innovation will develop as people rise and are successful, and others imitate and go beyond them. Prices fall, quality rises. And it's crucial to add that properly functioning competition, if not prevented, works like this irrespective of whether or not people like it. One of the most important aspects of this process is that a minority make it necessary for the majority to do what they don't want to, whether that's working harder or changing habits—things they wouldn't do if it weren't for the fact that they're in competition.⁸

And this isn't just abstract theory either. The history of markets teaches us that, whatever their risks, they operate in precisely this way. For example, an examination of the data on all UK manufacturing plants between 1980 and 1982 has shown that productivity increases as efficient new entrants join the market and inefficient producers exit. The author found that there was a considerable spread—up to four times or more—of productivity between plants, even with like inputs in like areas. The movement of plants within this distribution was of great interest. Almost 50 per cent of plants at the top of distribution still existed a decade later; the rest had slipped to lower in the distribution. More than 70 per cent of those that started at the bottom of the distribution exited within the same period, and less than one per cent managed to improve their relative productivity and move up the distribution. The conclusion was that the entry of new providers and the exit of old ones generates efficiencies, and increases productivity by 50 per cent; that competitive pressure ensures ongoing productivity growth; and that change of ownership affects productivity positively.⁹

It is an accepted economic principle that competition will at least reduce the growth of costs, if not the costs themselves. As productivity increases in the health economy all

providers will be able to disperse their overheads over a greater number of episodes and consequently reduce overall costs per episode. Providers who set prices too high, or give slow or unattractive services, risk losing customers to competing providers that offer lower prices, higher quality and better services. In this way competition benefits patients and society in general. Competition happens when there are many consumers and providers of similar products and services, and it improves productivity by encouraging all suppliers to be the best that they can be in order to qualify to provide care and attract patients. The level of competition in an industry is affected by the ease with which new producers can enter the industry and by consumers' information about the availability, price and quality of substitute goods and services.

The same general economic dynamics should be equally applicable to the provision of health care. The introduction of new products and service methods by entrepreneurs is an important form of competition and is a source of technological progress and economic growth. Within the context of healthcare reform, it is not sufficient to ensure that a large number of providers exist within the health economy: there also needs to be competition between them, which means that providers must be independent, entrepreneurial and innovative. Politically this is a highly sensitive supposition, since it also implies that some providers may be forced out of business, resulting in hospital closures, a point to which we shall return in Chapter 6. There we shall also deal with the assertion that health care is somehow 'different' and that competition cannot work where there are complex care pathways, for this depends substantially on how outcomes are measured and how information is transmitted through the system.

Choice and competition

Choice has an inherent value, since it is what people want in a consumer society, especially when they have the information available to them to make choices, which makes it desirable in and of itself because it directly empowers users. But its most important purpose is functional. Competition cannot happen unless the users of the service, the patients, are able to exercise choices. Successive governments have envisaged choice as an important system-reforming mechanism, a way of breaking down the provider monopoly in the NHS. In a functioning market, users of services compliment and complain about those services to the providers, which gives those providers feedback for improvement in the future. Demand drives supply. In the UK, however, although the middle classes exercise choice more effectively than the poor by going outside the system, in absolute terms they have little influence over providers.¹⁰

The reason for this is that patients are unable to exploit that most powerful form of choice—and therefore of provider incentive—which is to take their business to another provider. That is, the power of exit. ‘If a provider has a monopoly on the supply of a service,’ as Julian Le Grand has argued, ‘it can ignore the complaints of its users with relative impunity. Only if it knows that the dissatisfied can go elsewhere does it really have an incentive to improve.’¹¹ But choice can only mean anything if there are alternative providers in the system and money follows the patient. Choice alone will not make people free unless there are different choices to choose between, and as things stand choice seems to be more honoured in the breach, as it were, than in the observance; in other words, there is a divergence between the government’s mantras of choice and the public’s experience of choice. ‘The illusion of choice’, as Le

Grand has warned with characteristic concision, 'is worse than none at all.'¹²

Still, there are those who claim that the public don't want choice, and we have to take this point seriously. For where choice has been tried it does seem to have had marked effects. The London Patient Choice Project reduced waiting times in the specialties in which it was piloted, improved performance and reduced waiting times in a way that benefited all patients, not just those who opted for an alternative.¹³ Sixty per cent of patients who were offered a choice took it and of those that did 97 per cent said they would recommend the scheme to others.¹⁴ Significantly, satisfaction levels appear to have been high: more than three quarters of those who were offered choice were satisfied with the approach, with half very satisfied.¹⁵ In more general terms, the British Social Attitudes Survey reveals that choice is high on public priorities in healthcare provision. Not only have a majority stated that there should be 'a great deal' or 'quite a lot' of choice, but very few believe that the NHS currently provides choice, making it reasonable to conclude that 'the NHS does not appear to be meeting the public's expectations on choice.'¹⁶

We now have to address one of the most pernicious arguments made against choice, which is that those who champion choice are simply trying to make life easier for their chums in the middle classes. This line of thinking rests on the assumption that the desire to make choices in life is in some way the preserve of richer and more educated members of society.¹⁷ It is an assumption that is belied by the facts. As the British Social Attitudes Survey has found, manual workers are actually *more* pro-choice than those in professional and managerial occupations—67 per cent as against 59 per cent. Similarly, those on low incomes tend to be *more* enthusiastic about choice than those on high

incomes—70 per cent as against 59 per cent. And those with lower educational qualifications are *more* supportive of choice than those with higher educational qualifications—69 per cent as against 56 per cent.¹⁸ What's more, lower socio-economic groups also make choices and exploit the opportunities when they are open to them.¹⁹ So it is precisely those whom the critics of the choice programme think will be disadvantaged that will benefit most.

Not that this should be surprising. As the DH's National Patient Choice Survey found in late 2006, choice is not experienced uniformly across the service or by all patient groups, with significant geographical variations.²⁰ People will exercise choice once their expectations of what they can have—if they want it and know how to get it—rises to a certain point. If they find their choices within the NHS curtailed, those that can afford to will go outside and beyond the system, as the increased appetite for private co-payment signals. As John Appleby of the King's Fund has put it, 'those on high incomes see themselves as having the choice to go private if the NHS does not deliver what they want'.²¹ The middle class already do well out of the unreformed no-choice NHS.²² The people worst served by this state of affairs are the poor, those who cannot afford choices outside the system. Creating more choice and competition will therefore make the NHS 'not only more responsive and more efficient, but also—contrary to popular belief—more equitable and socially just'.²³

A final point before we move on. While extensive surveying shows substantial majorities in favour of choice in the NHS among all groups, some surveys show that the public would rather have a good local service than a choice of services. On the basis of these findings, some commentators object that the public is less interested in choice than in quality. However, not only are the aims of choice

and good local provision not mutually exclusive, but in the absence of uniformly good local services right now, and in the absence of any blueprint for how such uniformly good local services might be delivered, it's disingenuous to regard this as anything other than a false option. As Le Grand has put it, 'that is a nonsense question: if you were offered a perfect television or a choice of televisions, you would obviously choose the former. The real question is how to obtain a good local service.'²⁴ We return, of course, to Hayek's discovery process.

Plurality of provision

Since 2000 patient choice has emerged as an important policy in the English NHS. Following experiments such as the London Patients Choice Project and the National Coronary Heart Disease Choice Scheme, the plan from January 2006 has been that all eligible patients referred by their GP for elective care should have been offered clinically appropriate choices from a list of four or more providers commissioned by their PCT, including—and this shows how considerable New Labour has changed its attitudes towards the private sector since 1997—one independent provider.

This is likely to be popular. Although people believe that government is best at making sure that services go to the people who need them most, they also believe that the private sector is better than the public sector at running services cost-effectively and providing a quality service.²⁵ As a matter of fact, it is not a conviction that the private sector is superior that should motivate change, but rather the knowledge that competition is the best way to raise quality in services. It is too simplistic to think that the public sector is full of knights and the private sector full of knaves, that one or the other has a monopoly on nobility of purpose, or self-interest, or, for that matter, on efficiency of practice or

lumpish wastefulness.²⁶ It is not difficult to find impressive characters in the public sector—people like Robert Naylor, chief executive of University College London Hospitals, or Mark Goldman, chief executive of Heart of England—while some in the private sector in this country show little impetus to improve their docile monopolies.

None of this means very much, however, if between theory and reality there is a slip between cup and lip. And the truth is, for all this theorising about markets, we do not have, nor have we ever had in this country, a properly functioning healthcare market. This, it will be argued, is a direct result of two main faults in the way the reforms have been introduced. One is that they have been pushed from the centre without getting frontline organisations onside; another is that the centre holds the purse strings, and all attempts to pluralise provision have been, and will always be, stymied by an absence of any corresponding liberalisation of purchaser side or funding arrangements.

Foundation Trusts

In theory FTs should give us cause for hope. The DH's own press release announcing the launch of FTs promised that 'the best hospitals will be freed from excessive Whitehall control'—a remarkable confession of the Department's assessment of its own approach. Building up FTs is vital to creating freedom and ensuring that the reform programme goes ahead, and their performance has been impressive. Monitor has reported that 56 out of 59 trusts ended the financial year 2006/07 in surplus, the combined total of which was £130m. An operating surplus and healthy cash balance is as important for a foundation trust as it is for any successful enterprise, because it allows the trust to invest in improving facilities and services for patients. True, the FTs were the best performing NHS Trusts before they gained FT

status, but their relative performance has continued to improve. Significantly, they achieved efficiency improvements of an estimated three per cent in 2006/07, equivalent to over £270m. This is reflected in the EBITDA operating margin—a metric used to evaluate a company’s profitability—which improved from 5.6 per cent last year to 6.7 per cent. Forty-four FTs also experienced higher levels of activity than they planned for. By contrast, the supposed efficiency gains across other NHS organisations are not well quantified and are vague to say the least.²⁷

Encouragingly, at least for their long-term prospects, FTs are showing commercial acumen and a desire to sustain visionary enterprises—and attract visionary individuals. Aware that not every hospital can be the best at everything, or even needs to provide everything, UCLH, for instance, has rationalised its resources to concentrate on core specialties. ‘We aspire to be the best at what we can do, not the best at everything’, says Robert Naylor, its chief executive, ‘and we seek to collaborate with other hospitals so that patients can receive the best care at those institutions if we do not provide for their specific need.’ As we shall see, the incentives to make money by aspiring to be excellent are being undermined by the government’s actions, especially top-slicing; but there is some potential in the model for genuine and significant change in the future.

There are also limited signs that the market in health care is gathering pace. Independent organisations can bid for the franchise or management of persistently failing NHS trusts or PCTs, as can FTs. Among recent cases, much attention has focused on the purchase of Good Hope NHS Trust by Heart of England NHS FT. There are problems here, however, such as that the deficits are quite probably simply being written off, which does little to foster an ethos of accountability in the sector. Under the terms of its deal Good Hope’s £17.5

million debt is being turned into public divided capital owned by the DH, and it has been reported that 'Heart of England will have to pay a dividend of about 3.5 per cent on money that is technically repayable but is rarely in practice repaid'.²⁸

A notable trait among more visionary institutions is that they have increased their own provision of private facilities and services, exhibiting an increasingly entrepreneurial attitude. In 2001, UCLH acquired a private hospital, the Heart Hospital, providing cardio-thoracic services; in 2003 it entered into a joint venture with Sonic Healthcare, an Australian pathology company, resulting in rapid turnaround times for pathology tests, down from 24 hours to four hours; and a floor of the hospital is currently being leased to HCA, the biggest private provider in the US, in a joint collaborative venture. Other examples include the Hammersmith Hospital, which in 2002 acquired the Masonic Stamford Hospital on a 15-year lease,²⁹ and the University Hospitals Coventry and Warwickshire NHS Trust, which has formed a partnership with BMI healthcare for the joint management of a new NHS private patient unit.³⁰ The General Healthcare Group currently operates six partnership projects on NHS sites, taking on development costs, paying rent and purchasing services such as pathology from the NHS trust, and in return selling clinical services to the NHS trust. Most recently, Salisbury NHS FT formed a company, Odstock Medical Limited, to market its own treatments and devices.

Overall, however, progress has been limited. The government's target was that all acute and mental health trusts would be in a position to apply for FT status by 2008. 'We expect there to be 70 NHS FTs, including up to 15 mental health trusts, by spring 2007,' the DH has declared, 'and potentially up to 100 by the end of the year.'³¹ There are indeed now 70 NHS FTs, but Monitor, the FT regulator, is

very sceptical about the chances of meeting the government's expectations for 2008. Achieving the ambitious target, Monitor has said, 'will require substantial national action and leadership on issues such as the specialist tariff and service reconfiguration'.³²

Independent Sector Treatment Centres

The history of markets, as we have observed, tells us that completely new entrants are also needed. To this end, the government formulated the policy of using independent sector treatment centres—or ISTCs, to add to the bewildering almanac of healthcare acronyms—to treat NHS patients free at the point of delivery. ISTCs do planned, non-emergency operations and diagnostics, often on stand-alone sites away from local acute hospitals. Despite being in their infancy, these glossy new institutions seem to be doing a good job. Although it criticised ISTCs for incomplete data that was not of comparable quality to that presented by NHS organisations, a report by the Healthcare Commission was generally complimentary about the standards of care. Emergency re-admission rates—a handy indicator of treatment quality and of discharge processes—are significantly lower in ISTCs than the NHS. What's more, patients are more positive about their care in ISTCs: 96 per cent of patients surveyed rated their overall care as 'excellent' or 'very good', consistently better than the NHS on the vast majority of issues. Patient safety is also impressive, and there hasn't been a single case of MRSA detected in an ISTC.³³

The picture of their impact is far fuzzier. There is some anecdotal evidence to suggest that the arrival of an ISTC in an area can affect the behaviour of local surgeons, NHS managers and private providers: competition, they assert, usually off the record, has forced them to raise their game.

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When an ISTC was set up in Exeter, for instance, waiting times for hip replacements dropped suddenly, more than could be accounted for in the additional capacity provided by the ISTC, suggesting greater productivity in the local NHS. However, any enthusiasm was choked by the Health Select Committee's July 2006 report finding that ISTCs are poorly integrated into the NHS, which undermines their competitive worth.³⁴ Added to which, as the Department of Health has admitted, the number of procedures performed by ISTCs is a tiny fraction of the NHS's total capacity, and there's nothing to suggest that NHS facilities are adopting in any systematic way techniques pioneered in ISTCs.

So while the potential impact is massive, the actual impact has been minimal. In a 2005 memorandum, Ken Andersen, the then Commercial Director of the NHS, said that without significant further growth the ISTC market would collapse:

There is an emerging IST market which is not sustainable with the current volumes and number of players—it needs to grow and/or consolidate, otherwise in 4-7 years' time it is likely to stagnate and ultimately collapse. In order to create a pluralistic, highly innovative and competitive market across all levels of the value chain, the market needs to grow by at least 450,000 additional procedures per year.³⁵

This is worrying since the independent sector will only be able positively to contribute to the service and improve performance when there is enough competition to drive innovation and productivity. Expenditure in cash terms on health care for non-NHS bodies has increased by 227 per cent between 1997/98 and 2004/05, but as a percentage of the overall NHS spend it has only risen from 3.2 per cent to 5.3 per cent over the same period,³⁶ which implies that the impact is likely to be limited. Currently, only 170,000 patients a year are being treated under the first wave of independent centres,

not the 250,000 originally intended. Now the word on the street is that the second wave of surgical centres, also intended to treat 250,000 patients and to be conducting roughly seven per cent of elective operations performed by the NHS, is being scaled back.³⁷

In July 2007 the DH confirmed that it had pulled the plug on one of the biggest second wave schemes, a £35m contract that would have provided a new surgical centre at Queen Mary's Hospital in Sidcup, with existing facilities receiving varying degrees of refurbishment. Clinicenta, the preferred bidder, was to have provided clinical services including ear, nose and throat, general surgery, ophthalmology, urology, trauma and orthopaedics from April 2008. 'If the capacity is already there we don't need them', said Alan Johnson of ISTCs when he was merely days into his new job as Secretary of State for Health. Concerned that this would signal a change in direction, the King's Fund warned he should not 'reverse important reforms to the service'.³⁸

Not surprisingly, ISTC providers, many of whom represent significant capital investments from abroad, are also getting nervous. As Adrian Bull, managing director of Carillion Health, which saw one of its big schemes pulled in June, put it: 'It is very important that the government does not allow serial cancellation of these schemes to undermine the confidence of the private sector in future investment in NHS work.'³⁹ David Loasby, spokesman for NHS Partners Network which represents ISTC providers, said: 'We are disappointed that wave two programmes have been scaled back. Inevitably it shakes investor confidence and our willingness to bid for future schemes.'⁴⁰ With more cancellations expected, shrinking the market for private sector operators at just the time when it needs to expand, the worry is that the ISTC project might run out of steam before

it's even had a chance to show us what it can do and where it can take us.

Of course, the theory is that enabling patients to choose to have their operation in private facilities could keep ISTCs in business, but some dramatic changes will have to take place for this to be a realistic aspiration. To date the extent to which patients have been going private with NHS funding has been extremely limited. Partly this is because of a paucity of information—many don't know they are entitled to a choice of providers and hardly any have even heard of an ISTC—and partly it is because of the gap between central policy makers and local NHS managers. For if at the centre the enthusiasm for competition is genuine, at the local level competition is seen as a threat, and the use of ISTCs has not been taken up enthusiastically by PCTs.

The pathology of this resistance is tricky to trace. To some extent, it is cultural. The majority of GPs are either sceptical about choice and doubt that it provides benefit for patients, or oppose it on principle. A study by the King's Fund has found that many don't offer their patients choice unless their patients ask for it.⁴¹ PCTs, too, display marked hostility towards the independent sector, refusing to see it as a partner in providing services, as a report by NHS Alliance has described.⁴² Not that this is entirely surprising, given that PCTs have been bypassed by the contracting process: virtually all the throughput in the first wave of ISTCs was paid for through centrally-negotiated block contracts which guaranteed volumes of patients and often paid as much as 15 per cent above the NHS price list, or tariff, for procedures.⁴³ The corollary has been that very few patients have been treated with funding drawn from a local area as a result of local decision-making. Indeed, the King's Fund has found out that just two PCTs awarded a contract to organisations outside the 'NHS family' in primary care last

year, and GP-owned businesses continue to exercise a virtual monopoly over provision.⁴⁴

A lot has been done, but little has changed. For all its strength as an idea, the problem inherent in Labour's healthcare market has been that it isn't a market in any real sense. It is a managed market founded on an uneasy combination of devolved competition and central planning. Nowhere is this more the case than with block contracts, which weaken the competitive incentives designed to drive down costs and raise standards. 'The government's choice policy is excellent', Ali Parsa, founder and managing partner of Centres for Clinical Excellence (CCE) has said, 'but it's stymied by block contracting. Block contracting was never going to bring results.' He goes on: 'Imagine buying 80 per cent of a restaurant's meals beforehand. The food's never going to be that good until each individual customer can demand quality for themselves.'

Accordingly, Parsa is among those who believe that less government sponsorship of the independent sector will actually give it a better chance of success. CCE, the largest commercial partnership of healthcare professionals, recently acquired Nations Healthcare, an ISTC network which was awarded one of the largest contracts in the first wave of the ISTC programme. Nations ISTCs include two newly built facilities in Burton-upon-Trent and Bradford. A third facility is currently under construction in Nottingham.⁴⁵ The CCE model of healthcare delivery is all about re-engineering the care pathway by empowering clinicians through their ownership of the service. The acquisition of Nations Healthcare demonstrates UK healthcare professionals' readiness to take ownership of healthcare services. One of CCE's ophthalmology leads, Jonathan Boulton, is sure that there's more hope for ISTCs if there is local clinician to clinician engagement—not to mention contracting—as

hospital consultants go out and engage with GPs in a 'progressive partnership'. We shall have to wait and see.

Demand side reform: market simulacra

The government has realised that, for choice and competition to work, money has to follow the patient. But rather than search for a system in which this can happen naturally, it has attempted to *replicate* the functions of the market. The two main ways in which it has sought to do this are practice-based commissioning and payment by results.

Practice-based commissioning

Practice-based commissioning has been introduced as a way to bring about changes in the purchaser side without making any of the changes to the funding arrangements that would be needed to create real market conditions. This is largely because of the government's ideological attachment to funding the NHS through taxation, as well as a belief that the public is antipathetic to alternatives. Although the government claims that 85 per cent of general practices are starting to engage in practice-based commissioning, this actually only shows the number of practices taking up an incentive payment.⁴⁶ The fact is incentive payments can be taken without doing any commissioning or re-designing of services. James Kingsland, chairman of the National Association of Primary Care, has said: 'Surveys and straw polls I have done at conferences in the last two months show that practices with actual active devolved budgets and data is as low as ten per cent—don't get complacent about government figures.'⁴⁷ Numerous other studies have exposed the failure of commissioning to be effective and so bring about significant shifts in the pattern of healthcare delivery, finding its impact to be marginal at best.⁴⁸

One such was a report by NERA Economic Consulting. This found that while the intention was to allow those nearest to patients to design services that would be more responsive to their needs, 'it remains difficult to understand how proactively it is possible for a relatively small practice to engage in practice-based commissioning. Prioritising, budgeting, managing need, contracting and monitoring are all functions to which PCTs have devoted substantial dedicated resources. Clearly it will not be realistic for all of that work to be replicated in every practice.'⁴⁹ The 'gaps in capability' identified by the NERA team were also identified by the Healthcare Commission, though its criticism was even more swingeing: even PCTs weren't up to it. 'Many PCTs lack the skills and confidence to commission services efficiently', it reported in 2006.⁵⁰ Among its recommendations, the NERA team suggested that non-NHS bodies take over responsibility for commissioning services.

Payment by results

Payment by results is an ingenious attempt to enable commission by making money flow through the system *as if* the NHS were really a market. Seeking 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 where each patient commands a separate account, payment by results is an initiative designed to make it seem as if the money is following the patient who seems to have choice—though notably, at least at the moment, for a designated number of providers, not whoever they want, and only for elective care. The Audit Commission has said that 'there is little evidence at the system level that the new incentives have generated the positive behaviours intended'.⁵¹ Instead, there are signs that the system has experienced greater 'financial instability',⁵² leading to tension within and

between organisations, and the King's Fund has warned that 'perverse incentives may result in hospital trusts resisting collaborative working across care networks'.⁵³ To date all that has been achieved is an increase in the complexity and volume of NHS paperwork without releasing any gains for patients.⁵⁴ Ultimately, the implementation of payment by results has been patchy. The 2006/07 tariff was withdrawn at very short notice and only published in final form a few weeks before its introduction, so trusts and managers had very little time to prepare for it,⁵⁵ and the King's Fund has reported that the 'direct impact' of the reforms 'has been marginal'.⁵⁶

The critical error underpinning payment by results is that every procedure is set at a fixed price, the national tariff price. The idea behind ruling out price competition is to stop providers from offering cheap poor-quality services. Instead, by keeping price standardised, providers won't seek to cut corners. All the same, there will be a significant onus on them to attract patients, since 'patient choices will reflect the dimensions of quality that patients find to be important. These could be clinical quality, timeliness of treatment or possible other "patient experience" factors.'⁵⁷ And as providers cut their costs, finding ways to deliver the service at a lower cost than that stated by the tariff, they will be able to keep the difference. That's the theory anyway.

The most obvious flaw is that this involves the government setting prices. Allyson Pollock has argued that in time some treatments are likely to prove profitable, while others won't, the result being that providers will want to do more of the former and fewer of the latter. 'If this is not to lead to services being unavailable for some patients who need the less profitable treatments, the prices will have to be constantly adjusted, a task that would appear to call for a lot of information and expertise in business planning, which the

DH will have to maintain.⁵⁸ Actually, it's worse than this, since the very idea that the government will decide on the tariff price is unworkable. There have already been many complaints about the appropriateness of cost to product or service. In 2007, there were protests from almost every quarter. The *British Journal of Dermatology*, the Royal College of Physicians and the British Society for Rheumatology all complained about the inappropriateness of costing to product/service. Colin Holden, president-elect of the British Association of Dermatologists, said 'the tariffs are incredibly crude'.⁵⁹

The issue of clinical quality is critical (how is this to be measured and quantified or qualified?) or would be if payment by results really was payment for *results*. But it is not. It is payment for *activity*. There is no specification for quality in outcomes. Properly functioning markets depend absolutely on suppliers being able to undercut the competition on price—so long as this is accompanied by accessible and reliable information about quality, which tells the consumer whether the reduced cost buys the same, better or worse quality products and services. It's all well and good talking of 'a system with incentives for reform embedded within it' so that 'providers will automatically provide a high quality service without having to be told to by the top',⁶⁰ but the history of markets tells us that these incentives are not easily redesigned. Until such a system incorporating real market mechanisms is considered, '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.'⁶¹

The government's efforts to simulate a market have incorporated measurement indicators and delivery mechanisms, not to mention pilot schemes which are an attempt to do by artificial means what the market does naturally, which is

innovate. Added to which, attempt after attempt has been made to achieve the effects of freedom and choice, but each limits those mechanisms further. 'The result is more, not less, bureaucratic sclerosis.'⁶² The idea of patient empowerment is essentially impossible in a structure which systematically confounds such attempts. It is not through the wishes of the professionals responsible, and it is not even due to anything other than good intentions in government. It is all about the nature of the system. Even user groups only really empower representative customers, when what we need is to find ways of empowering the individual. There are ways to bring into play the wants and inclinations of every patient in the system—but they will require a wholesale rethinking of it.

Resource allocation: unable to let go

Partly a cause and partly a consequence of there being neither real choice nor real competition, much of the government's effort has been concentrated on putting pressure on what are still largely monopoly providers by telling them that they have to provide a good service, setting targets for that service, and telling them off when they fail. In other words, top-down performance management. It is a politically managed market—less market than monopoly—in which competitive incentives are severely attenuated by the controls exercised by government.⁶³ Targets distort and redefine priorities. In fact, targets, with their blunt emphasis on uniformity, absolutely contradict consumer choice and abrogate attempts to make the service responsive to individual needs and wants.

No organisation with 1.3 million employees can be run efficiently from the centre, yet this is precisely what the DH attempts to do, micromanaging every hospital and surgery across the country with a blizzard of circulars, edicts and directives. Many of these have been inconsistent and

permanent revolution has imposed huge costs.⁶⁴ Hyperactivity is a good word for all of this. Paradoxically, the result has been organisational paralysis and a vast increase in bureaucracy, with funds diverted from patient care into self-serving administration. It is a truth universally acknowledged that bureaucracies seek to perpetuate themselves: instead of liberating the NHS, the government's traditional response to any crisis has been to indulge in another round of organisational tinkering, such as replacing regional health authorities with SHAs, collapsing the number of PCTs, or getting rid of GP fundholding, reverting to it in the form of PBC, then bringing in the GP contract, then rewriting it to make GPs work harder for their money.

One chief executive complained of the fact that before the new reforms his hospital had to achieve twenty targets—'and we were pretty clear what the big ones were.' But since then performance targets have risen to 'a ridiculous level'. At any one time he might now be responsible for achieving 420 targets. Another has complained that, among the 40 human resources targets he has to meet, he must give the percentage of his staff who have received an appraisal for their personal development plan. 'That is part of my job. If I don't do it then I am a bad manager. But why insult me by checking? If the DH doesn't trust me, why did they give me the job in the first place?' The NHS is above all an organisation subject to political pressure. In the peculiar NHS world where, as Frank Dobson remarked, 'everything is a priority and nothing is a priority', the chief executive of an NHS hospital asks himself one important question: 'I can't afford to fulfil all these targets. So which five can I be sacked for?' The five, to do with access and waiting times, therefore immediately take priority.⁶⁵

Following the market oriented reforms, there was in 2006 a reassertion of central power. The effect of this, according to

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think-tank Reform, has been that the 'behaviour pattern of the NHS now resembles that of the British economy in the era of stagflation ("stop-go"). An inflationary increase in costs and spending ("go") leads to a drastic "stop" which threatens investment and innovation for several years.'⁶⁶ It's easy to find examples which support the notion that central planning has remained the dominant mode. The reform programmes remain bolt-on additions to a centrally planned monopoly rather than drivers of competition. A recent operating framework from the DH called for a reappraisal of capital spending based on a stronger role for the centre:

SHAs will need to have conclusions ratified by the Department before proceeding. This exercise will be prioritised to ensure that resources are applied to the more developed schemes and the Department will provide support to the NHS if it requires it. In addition, in future, trusts will be required to seek formal approval, under the usual delegated authorities, before they can appoint a preferred bidder. This process will help to ensure that plans are robust and viable in the context of the reformed NHS, and deliverable once they are put to the market.⁶⁷

The appearance of local decision-making is constrained by the reality of central priority-setting and the need to have everything ratified by the DH. This skews investment decisions towards central priorities rather than local initiative. Those central priorities may include short-term and potentially short-sighted decisions simply to reduce the costs of schemes instead of a reviewing of each scheme's individual merits in the new reformed service. Perhaps the ultimate example of this centralised meddling in the affairs of the NHS has been the recent fad for top-slicing. Top-slicing is what happens when money is moved around between PCTs, so that those that have made a surplus effectively subsidise those that have accumulated deficits. Many commentators consider it a remedial and reactive way of dealing with the deficits that have been found in many

trusts. This is David Stout, director of the NHS Confederation PCT Network:

More than £1bn has been taken from PCTs during this financial year through the top-slicing regime. This money is then held by the SHAs in their reserves to offset the region's deficit. The impact of this top-slicing has been to throw a large number of PCTs into apparent deficit, when without the top-slice they are delivering a surplus. When the effects of top-slicing are taken into account, the number of PCTs in deficit falls from 71 (47 per cent of PCTs) to 29 (19 per cent of PCTs). Or, to put it another way, 42 PCTs have been sent into deficit because they have been top-sliced.⁶⁸

With the money taken from them sitting in the reserves of SHAs, rather than being reflected as PCT surpluses, there is a negative impact on frontline patient services. The overall effect of this has been highly punitive. A survey of chief executives carried out in 2007 found that restricting access to some treatments was widespread, with 73 per cent of PCT leaders reporting this, while 50 per cent said they had delayed operations. At acute trusts, 83 per cent had closed wards. So, not only is it bad for a PCT to be portrayed as a poorly performing trust when it isn't, so devaluing its reputation at a local and national level, but 'because PCTs are subjected to resource accounting and budgeting... the fact that an organisation is presented as being in deficit means that its available funding for the following year will be reduced unless top-slices are returned to PCTs'.⁶⁹ It certainly seems bizarre for the best performing and best managed PCTs to be punished for their success.

This is profoundly destabilising for trusts and has a negative effect on management. The Audit Commission has also expressed concern along these lines. Both the action of taking away the surplus from a successful organisation and bailing out of an organisation in deficit 'can dilute accountability'.⁷⁰ Indeed, actions taken by the DH and SHAs, which 'can also be influenced by expediency, can cut across

accountability of individual organisations for their own performance'.⁷¹ When it comes to running the finances of their organisation, because money cascades from the top, managers are ultimately indifferent to the routine of accounting. Doubts have been raised about their 'financial capacity and capability' as well as about 'the nature of incentives within the system to promote sound financial health'.⁷² Of fundamental importance in a competitive environment is the fear of going bust. If market forces imply anything, they imply failure as well as success, which means the NHS needs 'a clear failure regime'.⁷³

Pathologies of the NHS

We have now considered extensively how Treasury budgets impose a ceiling on NHS expenditure: without *intrinsic* restraint on demand, an *extrinsic* restraint on demand has become essential, attempting to constrain need by force.⁷⁴ Rationing is not only a general principle underlying the NHS, but also a consequence arising from the crisis confronting the monopoly provider, the government. One of the main criticisms of the commercial sector is that it's only concerned with short-term profit and fails to make investments necessary for services to improve and costs to fall in the future. The real pity is that this is exactly what the NHS is like. Government after government has come into power and reorganised the NHS, desperately trying to find a way to make an unwieldy and ultimately unworkable system function for long enough to placate the electorate, and as a direct consequence of this people of vision have been stifled.

The bottom line is that no effective mechanism has ever been found to achieve the right balance of freedoms and incentives for the local management of nationalised industries. When it comes down to it, you just end up with a

system that is run from the centre through targets; and whether they're called targets or priorities or initiatives or anything else, they always leave local managers, not to mention individuals dependent on the services, feeling that the system is unresponsive to local needs and opportunities. 'The current reform programme is less a coordinated plan to develop the NHS', wrote the then chairman of the BMA, James Johnson, in a May 2007 report, 'and more a series of discrete initiatives that are not easily related and often seem contradictory.' He went on to complain of 'a constant wave of initiatives with little connecting them, [and] a resultant incoherence' in the reform programme.⁷⁵

Waste and inflation

No aberrant characteristic of the current government's approach, the questionable value for money achieved by the NHS results from the aspiration of every government since 1948 to deliver all care for all people through its own providers and finances. The NHS is subject to, in Hayek's words, 'the political coercion to make uneconomic use of resources'.⁷⁶ A study a few years back 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 costs 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'.⁷⁷

Drugs prescriptions offer a perfect example of the inefficient allocation of resources without the natural

economising effect of market pressures to contain costs. The NHS spends £8 billion a year on prescription drugs in primary care in England, and expenditure has increased by 60 per cent in real terms over the last decade.⁷⁸ In May 2007 the NAO found that drugs wastage by PCTs costs the NHS at least £200 million a year, and that there is considerable scope for efficiency savings without affecting clinical outcomes.⁷⁹ It also cited DH estimates that as much as 10 per cent of all drugs prescribed are wasted—which would mean up to £800 million-worth of drugs are wasted annually. Moreover, the full cost of wastage is not just the cost of the drugs themselves, as PCTs have to pay for returned drugs to be destroyed.⁸⁰ According to a list drawn up by the NAO, the level of wastage varies widely across the country: Surrey PCT could save almost £7m each year if its GPs prescribed more efficiently, while GPs in Redcar and Cleveland PCT could only improve by £371 a year.⁸¹

This is just one aspect of the inflation which produces the curious paradox at the heart of the NHS, namely that the Treasury imposes a limit on NHS expenditure and yet also has to give way to a constant escalation of costs.⁸² The NHS's chronic and escalating inflation—estimated by the DH at 6.5 per cent in 2006/07—severely restricts the amount of money available for activity spending.⁸³ It might have been expected that as the main buyer of services the NHS would be able to dictate prices to its suppliers. But this has not proved to be the case. Likewise, while for many categories of staff the NHS is 'a virtual monopsony buyer and therefore (at least to some extent) able to control the "price" it pays for labour',⁸⁴ it has struggled to control pay costs. The inflationary problem is not so much that pay rises have absorbed a third of the increase in additional funding to the NHS⁸⁵—with consultants earning 68 per cent more than they did in 1997 and GPs double what they got in 2000⁸⁶—but

that productivity has not kept pace with cost increases. A feature common to all of the pay deals was that they were negotiated centrally and that 'increases were not linked explicitly to changes in working practices or higher productivity'.⁸⁷ As the NAO has found, the 'lack of effective links between performance and outcomes' means that the consultant contract, for example, 'is not yet delivering the full value for money', with the bizarre consequence that 'some consultants are actually working the same if not fewer hours for more money'.⁸⁸

Another way in which the NHS wastes money is through bad management. The Gershon Review found that the DH could oversee efficiency savings in 2007/08 of £6.5 billion, more than any other government department.⁸⁹ To achieve this, it needed to make better use of staff time, for example in the implementation of a modern IT structure for the NHS. It also needed to make better use of NHS buying power at a national level to get better value for money in the procurement of health care, facilities and medical supplies.⁹⁰ Day surgery is another area where major productivity gains are possible: procedures can be carried out more predictably and with shorter waiting times, bed time is saved and there is less disruption to patients' lives, with a reduced risk of cross-infection because patients are not mixed with the critically ill.⁹¹ Yet OECD data revealed how day surgery actually decreased in the UK from 73.9 cases per 1,000 in 2000 to 72.7 in 2005.⁹² In 2006 the Healthcare Commission found that more than a third of NHS acute trusts were failing to manage their finances adequately,⁹³ and that 24 per cent of operating time was lost to delays or excessive gaps between operations. Restricting comparison to day surgery units, weighted activity per member of staff fell by 24 per cent, primarily due to staff increases without corresponding increases in surgery output. Overall, the Commission

concluded that productivity gains could result in increases in the total number of patients treated on a day surgery basis of 44-49 per cent.⁹⁴

In this context, it is highly relevant that no mechanism has ever been successfully identified for establishing marginal utility in the NHS—that is the relative usefulness, and hence the cost, of an extra unit of service. This means that other methods must be employed to relate paying power to the amount of services bought. The overall expenditure is the only means available; and it is not a very good one. There is no natural way in the NHS for supply and demand to adjust and respond to one another, even though they have to be approximated somehow, so the only method used is a centralised guesstimate, given force by the Treasury. While it has been argued in the past that the monopoly nature of the NHS has resulted in apparently good value for money in terms of its average costs, its marginal costs—the key determinant of economic efficiency—are exorbitant.⁹⁵ This goes some way to explaining why at the core of the NHS's problems lies a paradox: the expenditure ceiling rises constantly, never effectively controlling costs, yet it always, at any given time, limits treatment artificially. So we arrive at the great irony of a supposedly comprehensive and universal NHS that would like as few patients as possible. Each new patient is not another opportunity to be welcomed, but another burden to be shouldered, which is hardly how supply should regard demand.⁹⁶

Lack of innovation

Despite there being a widespread consensus, including in both the government and the DH, that 'the UK lags behind other countries in the use of technology in the health sector',⁹⁷ the root cause of this lack of innovation is all too

often glossed over: monopolies, and particularly nationalised monopolies, stifle the rate of change by reducing the pressure to innovate in the first place, as well as slowing down the diffusion of innovation. In open markets the threat of entry by newcomers not only puts pressure on prices; it also acts as a pressure towards innovation because if, say, a hospital pioneered new techniques that provide higher quality, more cost-effective care, it should both attract more patients and make greater profits. This incentive structure—and culture—simply doesn't exist in the NHS at present.

Moreover, what opportunities there are for managers to innovate—to say nothing of their inclination to do so—have been summarily stymied by the combination of financial pressures, targets and constant re-organisation the NHS has been subjected to. Even semi-autonomous organisations such as FTs—at least in theory free from performance management—are severely affected in such a climate. Indeed, Monitor recently revealed that FTs are currently sitting on a huge £995 million in cash balances largely because 'in the absence of greater certainty about the long-term requirements of commissioners, FT boards continue to demonstrate a reluctance to invest in major capital projects [and develop new services]'.⁹⁸

Of course, there are cases of innovative practice in the NHS, but they are comparatively few and far between, often occurring in spite of the system rather than because of it, and with low rates of diffusion. Statins, the lipid-busting drugs used to treat raised blood cholesterol, are one notable exception: after being pushed heavily by NICE and the DH, their uptake rocketed from the 9.4 million dispensed in 2000 to 39.7 million in 2006.⁹⁹ The use of percutaneous transluminal coronary angioplasty (PTCA), coronary stents and CABG have also registered fairly rapid growth.¹⁰⁰ But too often innovation follows the experience of John Petri, a

consultant orthopaedic surgeon at James Paget NHS Foundation Trust, who battled against the DH to build a new operating theatre, which allowed him to introduce a 'dual-surgery' technique that is commonplace in France but alien to the NHS. His waiting times subsequently fell from being over a year to being non-existent. John Petri did feasibility studies, won the Medical Futures Innovation Award in 2005, and met Tony Blair and DH officials who promised to spread the best practice. Nothing happened.¹⁰¹

International evidence is also revealing. A cross-country study of technological change associated with heart attack care, such as the use of catheterisation in the year after a heart attack, bypass surgery and primary angioplasty, found uptake in the UK to be both 'slow' and 'late'.¹⁰² In a separate report, Dr Adam Fitzpatrick, a Consultant Cardiologist and Arrhythmologist at Manchester Heart Centre, showed how the UK only fits 430 new pacemakers per million of the population, compared with 900 per million in France, Germany, Belgium and Spain, despite cardiac arrhythmias being among the top ten causes of unplanned hospital admissions. Treatment of diabetes shows the same pattern. In Germany, for example, over 40,000 patients use insulin pumps compared with less than 2,000 in the UK—yet type 1 diabetics, if not managed effectively, will more than likely incur both personal suffering and significant costs to the NHS later in someone's life.¹⁰³

The picture is no better when we look at pharmaceuticals. Evidence collated in 2001 showed how the uptake of new drugs in the UK is at best half that in Germany and a third that of France,¹⁰⁴ and a comprehensive report carried out recently by the respected Swedish outfit, the Karolinska Institute, found this trend had not abated. The UK—along with the Czech Republic, Hungary, Norway and Poland—was 'consistently identified as a below-average adopter of

new cancer drugs for the treatment of breast cancer, colorectal cancer, lung cancer, non-Hodgkin's lymphoma and supportive care' out of 19 European countries.¹⁰⁵ For the uptake of certain drugs, such as trastuzumab for breast cancer and gemcitabine and vinorelbine for non-small-cell lung cancer, the UK is described as 'well below average'—in fact for trastuzumab, usage in the UK has consistently been as much as 50 per cent less than the average, and is currently 66 per cent less than the best performer, Spain.¹⁰⁶

Only the most complacent of ideologues could fail to be concerned by the consequences for patients of the inadequate uptake of new medical technologies and drugs. Evidence abounds to illustrate the point. To take a couple of examples: a low-cost monitoring device that assists GPs in early diagnosis of atrial fibrillation for stroke prevention and other life-threatening heart rhythm disturbances has been estimated to have saved over 150 patients' lives, yet it has been taken up by less than one per cent of GPs;¹⁰⁷ likewise, research highlighted by the Karolinska Institute has shown that an increase in the number of available cancer drugs is associated with an increase in both one-year and five-year cancer survival rates by as much as 50-60 per cent.¹⁰⁸ Despite this we hear report after report describing 'a tendency by managers to see innovation as purely a cost pressure, without looking to the full potential for efficiency gains'¹⁰⁹ and health benefits for patients. All of this seems to fly in the face of reason, until one realises that such attitudes —at best described as 'conservative'¹¹⁰ at worst 'Byzantine'¹¹¹—are less the result of individuals' obscurantism and more a direct result of the way the healthcare system is organised.

It is important to recognise that new technology and new ways of working can be expensive in the short-term, even if they are cost-saving in the long-run. Put another way, it may take a few years for benefits, such as a reduced drugs

budget, lower admissions/re-admissions to hospital and increased quality of life, to be realised. This is why a long-term perspective is imperative. Yet this is nigh on impossible in such a consensual body as the NHS, where individual organisations are performance-managed to the hilt and budgets are centrally constrained and time-specific.¹¹² As the chief executive of Rotherham PCT, Andy Buck, has said: 'I think we [are] encouraged to focus on this year's targets—get the finance right, deliver the targets and don't drop any clangers. That encourages a short-term perspective, a focus on in-year delivery and nothing else. It is very hard in that context to think and act strategically in the long term. But that is what we should be doing. We can try to rise above it, but it is very difficult.'¹¹³ All this goes some way to explaining such apparently baffling decisions as that taken by the Dudley Group of Hospitals NHS Trust in 2004 *not* to take up a new medical device called CardioQ, despite the fact that experimentation at the trust found that CardioQ patients saw an average reduction in length of stay of 3.75 days, or 26 per cent, and that the first NHS Trust that implemented the new technology had already announced savings of more than £1 million.¹¹⁴

Rather ironically, too, the so-called market reforms have probably made the situation worse. The crux of the problem here is that price competition has been ruled out. It is the DH, not the market, that 'works out' the national tariff for each hospital episode, with the unsurprising result that some tariffs set under PbR 'appear to be so inadequate they would fail to cover the cost of the technology alone'.¹¹⁵ Revolutionary new technology is often expensive at first—think of flat-screen TVs, laptops or hi-fis—but as demand pressures increase and production expertise improves, the price falls. Under PbR we have a perverse situation where if

the DH doesn't account for the initially higher price, it is very unlikely the technology will be brought in at all.

Yet *disruptive* technologies are precisely what the NHS must become more open to. As John Wilkinson, director general of the Association of British Health Insurers, said in evidence to the House of Commons Select Committee: '[Using] an industry analogy: companies that do not invest in technology and look at new ways of doing things, get drowned with trying to do the same thing over and over again more effectively more often.'¹¹⁶ In a competitive situation, the NHS would probably have drowned: time and time again across its history the procurement of technology across trusts has typically resembled a 'creeping mix' of equipment, rather than necessarily more clinically efficacious and cost-effective systems.¹¹⁷ Nowhere is this more evident than with DGHs, many of which have overshot the level of care actually needed by the vast majority of their patients. The public never stops clamouring about hospital ward closures, and they make for emotive headlines, but if the hospital has managed to make care efficient enough to get rid of redundant space then this is an achievement, not a failure.

The problem is that disruptive innovations need competition in an open market to develop, because they, like George Eastman's camera, Bell's telephone, the personal computer, photocopiers or iPods, generally 'sneak in from below' while the market leaders of the time have their attention focused on developing existing products. This is a rarity in the NHS because, despite efforts at supply-side reform, there is no meaningful 'below', there is no 'openness', and there is no prospect of there being so as things stand. Hospitals and PCTs are making such huge deficits at least partly because they are digging in and tightening controls on existing ways of doing things. For those enlightened few who fight against the system, who innovate

and by doing so provide better quality and more cost-effective care, there is no competitive impulse to induce change in others—it is left to central bodies to try to force best practice on risk-averse actors who are inclined towards the status quo. Of course, there are always risks associated with a new technology and not all innovations will be cost-effective, but as John Petri found out, vested interests tend to move to discredit even proven innovations and they all too often get dumped. We should be seeking to cultivate a different attitude altogether, one that says ‘let’s find a way to deal with those risks’.¹¹⁸

Organisations are, in fact, lining up to challenge the old ways of doing things, but they are being hampered by the system, relying on the independent-sector-shy ‘patient choice’ agenda being flexible and accommodating enough for them to treat NHS patients in the future. In late 2006 Karol Sikora outlined how CancerPartnersUK, an organisation which aims to revolutionise cancer services across Britain by creating a unique partnership between private, public and voluntary sector organisations, is aiming to open a network of strategically placed centres providing the latest high quality treatment and diagnostics. Funded by private equity, they would provide a patient-centred, integrated service—including chemotherapy, radiotherapy, complementary therapy and some diagnostics on an outpatient basis.¹¹⁹ Further examples are the Bridgewater, a £13 million stand-alone private hospital opened in Manchester in June 2006, and CCE, the private hospital co-ownership capital venture we encountered earlier that is set to open its first unique new-build hospital by 2009,¹²⁰ both of which are co-owned by groups of consultants in a joint venture with private equity houses and banks. In fact, CCE looks specifically to back consultants who want to operate new or

redeveloped hospital facilities in areas of strong local health-care demand.

These are exciting new developments, but both they and innovative organisations within the NHS will only achieve their true potential if the conditions are right: if space is created for genuine competition in health care. The UK is already a world-leader in healthcare research; with properly designed competition our healthcare system could become one of the most innovative in the world. But the odds are set against it. As Andy Goldberg, who helped set up the Medical Futures Innovation Awards four years ago, has said: ‘The NHS is [like] the interfering mother-in-law who keeps ringing up to see what’s going on. Risk is a swear word. You walk down any hospital corridor and see a complaints box, but no ideas box.’¹²¹ It is time for this to change.

The Providers

No one is happy with the status quo. We have a system characterised by producer capture—a system which delivers far more power to the producers of the service than the users, therefore creating little real incentive for the providers of health care really to worry about the patient—but where the producers are miserable. Clinical distortion—which simply means that clinical decisions made by health professionals are distorted by operational requirements of management—is endemic and all attempts to meliorate it—like targets for waiting times, pressure on clinical priorities—fail to do so and illustrate further the limitations of the model. But if managers are more powerful than clinicians, they are nonetheless frustrated because they have their hands tied by politicians.

Disconnected hierarchy

‘There is a culture of fear in the NHS’, declared Jonathan Fielden, chairman of the BMA’s consultants’ committee, in

March 2007, 'and doctors are under severe pressure to meet targets and keep their mouths shut.'¹²² It isn't just doctors. When a survey revealed that the majority of chief executives believe care will suffer as a consequence of money troubles, David Nicholson, chief executive of the NHS in England, was blunt. Local chiefs were appointed to deliver the government's policies, he said, and not to pass comment on them.¹²³ However, the lack of freedom for local managers results from the way that the entire system is organised. Politics and health care in this country will remain inseparable while the NHS is funded out of general taxation, because no government will relinquish control while it is accountable to the electorate. Many a misleading comment has been made about the travesty of having managers in the NHS, but managers are necessary if a hospital is to be well run. To run a hospital you need to be an excellent manager. Many are excellent, and would stand out in any form of enterprise. Sadly, many are not. The Healthcare Commission found in 2006 that more than a third of trusts fail to manage their resources adequately,¹²⁴ and in the same year the Audit Commission found that 'the origins of financial failure in the organisations we reviewed typically lay in ineffective management and weak or inadequate board leadership'.¹²⁵

The NHS Confederation has also outlined the weaknesses of senior management, but pointed out that even a good chief executive has a particularly hard task in the NHS.¹²⁶ A 2007 survey of NHS chief executives reported that tough cost-cutting measures have caused half the trusts to delay operations and three-quarters to restrict access to treatment. Seventy per cent think that the NHS is 'hidebound by bureaucracy' and 86 per cent feel battered and bruised by reorganisations,¹²⁷ which impede continuity and make the NHS an unattractive place to managers from other sectors of the economy. With job security extremely poor—the typical

tenure of an NHS chief executive is 700 days¹²⁸—it is difficult to get the best candidates to apply. A vicious cycle develops. That this bureaucracy stifles enterprise is beyond doubt. ‘People of vision’, said one senior non-executive director, ‘are not at liberty to implement that vision.’¹²⁹ The frequent complaint of Whitehall’s overbearing presence reflects the contradiction of a service that is supposed to be acting competitively even as it is performance managed from the centre. This connects, as we have seen, to another contradiction, namely that government both imposes great pressures on chief executives and ultimately bails them out when things go wrong, so eroding accountability. ‘The effect is for the organisation and its management to believe they are not in charge of their own destiny,’ the Audit Commission has said, ‘waiting for external solutions rather than searching out internal improvements.’¹³⁰

Another factor is that at the same time as chief executives are subject to the ‘capricious and demanding authority’ of central government, ‘they are unable to exert the same authority over their staff’.¹³¹ The NHS contains powerful professional groups, particularly in the medical field, with a long history of influence and independence whose primary allegiance is to individual interests rather than collective or corporate objectives set by management. The Bristol Royal Infirmary Report found complex relationships within the NHS and noted: ‘a chief executive and a trust’s board can be disempowered by strong professional groupings, apparently beyond the chief executive’s control to manage’. They also observed that doctors ‘do not respond to senior management’ but to professional peers whom they respect and ‘who may even be in the same organisation’.¹³² The chief executive of one North London hospital who has worked in the private sector expected to find ‘the pulls and levers you have

in industry'. Instead they don't have the power to, as Sir Stanley Kalms has put it, 'hire, fire and kick butts'.¹³³

So Whitehall control, which is a function of the nationalised monopoly arrangement of the NHS, prevents organisations from ordering themselves as they see fit. Another connected consequence is a bloated middle management structure. A 'Kafkaesque situation' has been created in which '[h]ospitals are recruiting more and more managers to monitor care which fails to improve partly because of their appointment'.¹³⁴ Damagingly, middle management does little to link senior management to clinical staff. Indeed, senior and middle management are so busy looking upwards to their masters in government that they don't have enough time to engage with the clinical staff. This is what the NHS Confederation has called the 'disconnected hierarchy' of NHS management: the top of the organisation 'is not effectively connected to the front line and may not even share the same objectives and priorities'.¹³⁵ When people hark back to the golden age of the matron what they're really talking about is a structure where clinical and management roles are integrated. The engagement of frontline clinicians in planning and finance is the best way to represent patients' needs at the highest level, husband resources and foster a positive working environment. In the best hospitals in the country, such as Guy's and St Thomas' NHS FT, there is a highly integrated management structure. Conversely, a disconnected hierarchy is 'a reliable indicator of impending financial trouble' since it is the 'clinicians who spend most of the NHS's money'.¹³⁶

Unhappy doctor syndrome

The best of the system is achieved by the professionalism of the clinical staff working in the NHS, often against the odds of the system, and the staff who work around the clock

around the country for the health of its population are the NHS's most important asset. To be sure, they can be a troublesome bunch. They haven't always sought to maintain clinical control over their work in a way that has been in the public interest. As a group, doctors' strongest tendency is to resist change. They resisted the move away from more market-oriented healthcare to the NHS and they have resisted the move away from a nationalised monopoly to a more marketized system. And clinical autonomy has always been the rallying cry. A 1946 poll of doctors found, for example, that 66 per cent were implacably opposed to what they saw as the consequent loss of their independence, and in 1971 the DHSS complained that 'the existence of clinical freedom undoubtedly reduces the ability of the central authorities to determine objectives and priorities and to control individual facets of expenditure'.¹³⁷

The tussle has implications for the power structure in the NHS: within the medical profession some interests are stronger than others. 'In the hospital services it is the consultants in the acute specialties such as surgery and general medicine who have been most influential. In contrast, consultant psychiatrists and geriatricians have wielded less influence.'¹³⁸ The loudest voices jostle to the front of the queue. Competition for resources gets sharper as specialisation increases and medicine fragments into myriad departments and disciplines, and in time groups also become more assertive, encouraged by greater unionisation. 'After the foundation of the NHS, the proportion of its unionised workforce rose steadily from 40 per cent in 1948 to 60 per cent in 1974. The mere fact of union membership raised pay levels during this period, particularly with the growing willingness of NHS staff to threaten industrial action.'¹³⁹ Rudolf Klein has even gone so far as to say that they are encouraged to 'denigrate the service... and to

advertise their own claims for extra resources by drawing attention to the NHS's shortcomings',¹⁴⁰ a point that echoes Enoch Powell's dictum about the tax-funding of the NHS, that it endowed 'everyone providing as well as using it with a vested interest in denigrating it'.¹⁴¹

The epitome of this is what Nicholas Timmins has called 'the standing NHS refrain'¹⁴²—namely that morale is at an all-time low. It was echoed in 1987 when in an unprecedented move the presidents of the Royal Colleges of Surgeons, Physicians and Obstetricians and Gynaecologists issued a joint statement claiming that the NHS had almost reached breaking point and that alternative financing had to be provided,¹⁴³ and indeed it has been heard more times since than need enumerating. So we should be wary of putting the medical profession on a pedestal. The truth is that doctors are neither saints nor sinners. They are people like everyone else, and just as fallible, which explains why there are examples of negligence as well as of nobility.

All the same, staff dissatisfaction is part of the pathology of the service. Doctors and nurses are often treated in a manner that would not be tolerated—would hardly be legal—in the private sector. In 2006 70 per cent of staff in acute trusts reported regularly working unpaid overtime and countless reports point to abnormally high levels of stress and sickness absence.¹⁴⁴ Not only, as patients gain power, are healthcare professionals having to come to terms with their diminished power; but in addition, betrayed by a government unwilling to relax its control, they are having to accept their reduced autonomy. There are changes on all fronts: targets are supplanting clinical priorities and diverting work into bureaucratic form-filling; rapid advances in medicine make it necessary always to be up to the minute, and streams of guidelines and protocols denude clinical decision making.¹⁴⁵ Fiona Godlee, editor of the *BMJ*,

claimed in 2006 that 'the spirit of medical professionalism' is 'quietly dying'.¹⁴⁶ And this was the splenetic wowl of Lucy Chapman, a junior doctor, writing in the *New Statesman* in December 2006:

Doctors feel undervalued and overworked because they are. We are routinely coerced into submitting false time sheets to underpay ourselves, in order not to breach the legal limit for working hours on paper and so incur fines to the hospital. Trusts across the country, including my own hospital, have cancelled study leave and funding for training courses for medical staff... My rage is not your concern: it becomes relevant only when you consider that sometimes my choice is between staying with a patient who is haemorrhaging, or going to another building to collect the blood they need, because no one else will go.¹⁴⁷

In the past it has been true that in return for a high degree of job security NHS staff relinquish all other perks which employment should bring: respect, flexibility, decent pay and conditions, responsibility and professional development. Now they don't even have job security. The increase in staffing in the NHS, which is the direct result of centralised planning and a silo management approach that failed to concentrate properly on cost and economics, has created an unsustainable workforce. In all likelihood, as the DH has confirmed, there will be a surplus of 3,200 consultants in three years' time, and in August 2007 thousands of junior doctors found themselves out of work. This has been a particularly remarkable illustration of the problems of central government being in charge of employment in the service. With the cost of training a doctor to this stage estimated at around £250,000, the potential waste runs into the billions.

James Johnson, who resigned as chairman of the BMA over the whole affair, criticised the government for its 'appalling lack of workforce planning'.¹⁴⁸ The outrage has been widespread. In March 2007, out came the banners, the

placards, the campaigners in their thousands, to march on the streets, all organised by NHS Together, an alliance of organisations representing staff working in the health service, along with the TUC, and Health Secretary Patricia Hewitt was even strangled in effigy in Crawley, West Sussex.¹⁴⁹ In a joint letter to *The Times*, more than a dozen leading specialists, led by Morris Brown, professor of clinical pharmacology at the University of Cambridge, wrote to complain about the ‘junior doctor saga’. They said that a ballot of 3,500 doctors had revealed majority rejection of the current plans and a 90 per cent no confidence vote in the Secretary of State and CMO, Professor Sir Liam Donaldson.¹⁵⁰

In harmony with this dissonance, a massive survey by the Healthcare Commission found that fewer staff in acute trusts were satisfied with their job than in previous years,¹⁵¹ and only two fifths were able to answer positively to the question: ‘As a patient of this trust, I would be happy with the standard of care provided’.¹⁵² A 2007 poll carried out by doctors.net, Britain’s busiest medical website, revealed a profession disillusioned with central control, angered by the growth of bureaucracy. More than two fifths of respondents were young, having graduated since 2000: 56 per cent said there’d been no improvement in the NHS since 2002; 72 per cent said they didn’t think the extra money had been well spent; 72 per cent said there’d been no improvement in quality of care.

The doctors and nurses in the NHS are among the best in the world, but their skills—their human capital—are being squandered. Centralisation leaves too little freedom for staff in the workplace, and the problem is monopoly, or more precisely monopsony, which is to say that the NHS is the only buyer of healthcare labour. In theory staff should be able to move into the private sector, which is made possible

by the new training rules and the relaxation of the additionality rules in more recent contracts for ISTCs. This would mean that the healthcare system wouldn't lose the considerable investment in training. Unfortunately, because of the limited impact and spread of the private system this looks unlikely to be anything more than a tiny drop in the ocean unless something radical happens. So the small size of the private sector means that the labour market is dominated by a single huge employer. This means that staff have little power of exit if they wish to remain in the profession, which in turn severely restricts their power of voice or bargaining power. Indeed, it is natural that when pressures are exerted on the system it is the interests of the staff that suffer first.

For some unfathomable reason, the belief persists that public provision ensures decent terms and conditions for staff. An objection of some to increased competition is that NHS staff will be subjected to the uncertainties and pressures of markets, with a corresponding loss of the 'public service ethos' and its replacement by the 'profit motive'. In fact, the public sector ethos amounts to little more than the obligation of doctors and nurses to work as hard as they are told to, with limited professional discretion. The dedication and perseverance of NHS staff ensures that some patients get good treatment, some of the time. But it is in spite of, not because of, the system. The debate is not whether we need better management, or more efficient strategies and systems, but how we get there. Surely it is now obvious that the system won't work better just because government tells it to. Reforms to break down the monopoly have been ineffectual: the main buyer of NHS treatments is the state, the main provider of NHS treatments is the state, and all strategy and resource allocation decisions are made by the state. And the main advantages traditionally touted

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for this arrangement—comprehensiveness, universality and equity—are being weakened all the time.

Only the British still cling to the belief that it is a disgrace to ask anyone to pay for health care through anything other than taxation. Such thinking is nothing more than dogma. Back in 1999, Nick Bosanquet, wrote of the ‘important human commitment’ the NHS represents, a commitment to the founding aspirations of making necessary health care available at high quality to everyone, irrespective of the individual’s ability to pay, overlaid with the modern pressures of consumerist expectations and demands and the pressures of technological and medical advances. Given that the NHS doesn’t have the wherewithal to deal with these pressures, ‘surely such an aspiration will be devalued, even hopelessly compromised, if we are not prepared to assess the actual results that are achieved in practice.’ To make a moral commitment and then not consider alternative ways of reaching it is, he said, ‘paradoxical and irresponsible’.¹⁵³

Better Healthcare for All

A reform is a correction of abuses; a revolution is a transfer of power.¹

Edward George Earle Bulwer-Lytton

The bottom line is that the market isn't working because there has been no liberalisation of the demand side—of the way that money flows through the system, or of the way the system is funded overall. This has prevented the real consumer choice that is necessary for competition to work. Not only does this mean that the reforms have not had the desired effect, they have had a perverse impact, creating instability without improvement, which has resulted in a reassertion of centralised control, in turn reinforcing some of the old problems and precipitating a few new ones to boot. The system needs to change so that money follows the patient, so that patients are set free to choose, so that competition can be turbo-charged, and greater quality and productivity achieved for all.

Ready for change

There is entrenched resistance to change, but the voices calling for a rethink are getting louder and more numerous. 'If people begin to believe it's a terribly inefficient service, they may begin to question what they are prepared to pay for,' warned Sir Derek Wanless in 2006 following the announcement that he would be conducting a review of the performance of the NHS five years on from his famous 2002 report, in collaboration with the King's Fund. 'There will be pressure to improve delivery and that could lead to a

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reduction in services or a change in the method of funding. It could herald the social insurance revolution; who knows?² Certainly the time has come to renew the debate about how we organise and finance health care in this country. Recently Bernard Ribeiro, president of the Royal College of Surgeons of England, revealed that he believes a tax-funded NHS is unsustainable and should be replaced with an insurance-based system.³

Even the BMA's consultant conference debated a motion calling for the NHS to be funded through a means-tested compulsory form of national insurance, such as in Germany or France. 'The continued failure and multiple attempts to re-organise the NHS are missing the point', said David Wrede, a consultant gynaecologist and author of the proposal, in July 2007. 'The fact that the system is tax-funded and so centralised has led to something which is totally dysfunctional and increasingly unsustainable.'⁴ A 2007 doctors.net poll, which revealed a profession disillusioned with central control, angered by the growth of bureaucracy, and deeply sceptical of government initiatives, also reported that 79 per cent of respondents doubted that the highest standards expected of the NHS could be sustained through taxation alone after 2008.⁵

Public opinion is also coming to accept that the NHS will not do and that alternatives must be found. There's no doubt that for many years the tax-funded NHS has been popular with the public, a generalised impression which hides the glaring paradox of a public which professes to be wedded to a healthcare system that it spends so much time deriding. The same NHS that is lambasted by the press and in opinion polls has also been presented by pollsters as part of our inescapable national destiny. The findings of the British Social Attitudes Survey should surprise nobody. Throughout this paper it has been argued that the principle of

solidarity and universality should be non-negotiable. The public mostly concurs. Consistently since 1983 around three quarters have opposed an NHS system that is available only for those with lower incomes, making contributions and taxes lower for most people, who would then take out medical insurance or pay for health care.⁶ Yet, in recent years support for increased taxation and spending on health care, education and other services has fallen to its lowest point for 20 years.⁷

By asking more specific questions, a 2006 ICM poll revealed that two thirds of voters believe that in its present form the NHS is unlikely ever to meet public demands, however much is spent on it. Three quarters believe politicians ought to be removed from the daily running of the service and there is growing support for the idea of a decentralised and pluralistic health service. Eighty per cent agree it shouldn't matter whether hospitals or surgeries are run by public, private or voluntary organisations, so long as everyone including the poorest has access. Sixty-five per cent agree that the NHS was the right idea when it was introduced 60 years ago, but Britain has changed and we need a different system now. Almost half agree that instead of paying taxes for the NHS, we should have a European-style system where everyone takes out health insurance and the government tops up the payments for people who can't afford the premiums.⁸

Another manifestation of this deepening dissatisfaction has been the call for an independent NHS. There are a number of reasons for regarding this as a reactive and unsatisfactory stop-gap measure, rather than a positive step in the right direction. Those who take this line want to detach government from the management of health care by making the NHS constitutionally independent. However, this fails on accountability measures for public money—the NHS would

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be run as a quango, but wouldn't be depoliticised, since it would remain fully funded by taxation. At best the board running the service would still be managing this behemoth from the top, which means none of the problems with top-down management would be overcome. At worst, ministers would both claim a lack of responsibility and submit to the temptation of micromanaging from a distance as a reaction to political pressures.

Calls for an independent NHS are a diversionary tactic. They are a desperate attempt to return to doctors some of the professionalism and autonomy they feel they've lost, and loosen the stranglehold of government, without unbundling the NHS from the state properly. The truth is that there is immense resistance to any changes to the financing of the NHS. In interview after interview, any mention of such a measure elicited droning sighs of disapproval. Those who wearily reject suggestions of liberalising the purchasing of health care in this country fall into two broad camps. There are those who have heard some of the arguments many years previously and are unwilling to reconsider. They haven't realised that thinking elsewhere in the world is moving on in terms of how insurance systems can be managed to offer universal and more comprehensive cover, and how market competition within these systems can be organised so that it is more effective and delivers greater value for patients. The other group consists of those who want to shut down the debate because their vested interests lie in sustaining the system.

What, for example, are we to make of the opposition of the unions to reforms in health care when they currently do so well out of the unstructured private sector? While trade unions passionately defend the NHS and denounce even the modest market reforms by government, they are more than happy to take advantage of private sector privileges denied

to most. The leader, Bill Morris, and General Secretary, John Monks, of the TUC have both in the past enjoyed private insurance. A quick look at the Unison website reveals that for the likes of an NHS porter one of the perks of joining is membership of Medicash.⁹ Other trade unions have also done deals with BUPA, Benenden Hospital, Medicash, SimplyHealth and Standard Life. They acknowledge the shortcomings of the NHS, not by supporting its reform, but by offering private health care to members. More than 3.5 million of the TUC's 6.8 million members now hold some form of PMI. It is an unusually proportion for any socio-economic group in the UK.¹⁰ Not dissimilarly, the results of a 2007 survey of 1,700 GPs carried out by *Hospital Doctor* magazine found that 28 per cent of GPs have private medical insurance, and 33 per cent would prefer private treatment if they fell ill,¹¹ and a survey commissioned by BUPA found that for hospital consultants the figure rises to 55 per cent.¹² Few advocate the same for the general public.

So it is that whenever anyone talks about changing the system, the BMA screeches about the iniquities of markets. When *Working for Patients* was published in 1989, introducing the internal market,¹³ doctors were united in attacking the government for leading the system 'inexorably towards treatment determined by financial considerations rather than need'.¹⁴ Yet as Rudolf Klein rightly pointed out, the idea that the practice of medicine was divorced from money is 'perhaps the most important founding myth of the NHS'.¹⁵ 'Discussion revolved around a mythologized past (an NHS in which money did not matter) and a demonised future (an NHS in which medical practice was driven by money).'¹⁶ The BMA launched a £3 million advertising campaign against the Secretary of State for Health at the time, Kenneth Clarke, that included the memorable slogan: 'What do you call a man who ignores medical advice? Mr

Clarke.¹⁷ Afterwards Clarke described the BMA as ‘just another trade union, actually one of the nastiest I had ever dealt with’.¹⁸

The fact is that the likes of James Johnson, erstwhile chairman of the BMA, and incidentally a beneficiary of BUPA private insurance, know all too well that competition would not line the pockets of NHS consultants who currently practice privately. Rather it would destabilise the boundaries of a two-tier system from which they have profited so handsomely. Long before 2000, the NHS had been buying somewhere between 60,000 and 80,000 procedures annually from the private sector, at a cost of around £100m.¹⁹ Although the BMA strongly contests this, there’s good evidence that, working in their own time in private practice, NHS surgeons and anaesthetists were charging the highest fees in the world per procedure.²⁰ More, that is, than countries where insurance systems operate. Although there would be many advantages for doctors in a market-oriented approach to healthcare delivery, particularly in terms of elevated levels of professional autonomy, they would be very unlikely to gain financially.

Pluralising the purchasing of health care

Fairness for all

Real change cannot be achieved without liberalising the demand or purchasing side of the healthcare market; without, that is, greater pluralism of funding. Moving towards an alternative financing system will not be some sort of magic bullet—other shifts in system behaviour will be needed at the same time—but the insurance model proposed here is a prerequisite for genuinely competitive conditions. Those who oppose alternatives do so by employing the emotive accusation that an insurance system would undermine the comprehensive and universal values of the

NHS. Quite apart from the fact that the NHS is by no means perfect in this regard, this argument simply does not stand up to scrutiny. The challenge is to find new means in a consumer age with limitless expectations to deliver what the NHS once promised to deliver: if we believe that no citizen of this country should go without high quality comprehensive care, regardless of their income status, we are no different from the rest of Europe.

Although OECD countries organise, manage and finance health care in a variety of ways, since each national system was created in its own particular way, the systems share some common principles. All seek to deliver high quality care, with most realising that to deal with the pressures of the modern world this must harness the efficiency and competitiveness of markets. The best seek to synthesise this with universal access to an equal standard of care. The principle of universality is a governing one. It is captured in several country constitutions and health service founding documents, and has been incorporated into the EU Charter of Fundamental Rights.²¹ This priority reflects the belief that access to health care is a precondition for active membership of society.²²

The Swiss system demonstrates that government need not be the single buyer of health care on behalf of the population, and that financing and administration can be decentralised, with many concomitant plusses. Using an insurance system, high quality health care can be delivered comprehensively and universally, with equitable access according to need to a broad range of services. Although, like every other country, it hasn't managed to combat rising costs, the Swiss healthcare system is, according to the OECD, excellent. Measures of health status compare well with other countries.²³ The Swiss generally regard their health status as good, with around 86 per cent of the population claiming to

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be in good or very good health, compared with 75 per cent in the UK.²⁴ Although rising, the share of the population considered overweight or obese is well below the OECD average,²⁵ life expectancy is rising steadily, way ahead of the UK,²⁶ and it has improved faster relative to other countries. This improvement has been accompanied by a large reduction of potential years of life lost (PYLL).²⁷

In fact, Switzerland does better than the UK on every measure where comparisons are made, from health outcomes indicators to resource provision. Up-to-date medical services are widely available, the technology is in good condition and, partly as a result of the generous supply of acute care beds, there are no waiting times for elective surgery.²⁸ Yes, that's right, *no waiting times for elective surgery*. And that's not just for some of the population. Health coverage is, the OECD has confirmed, not just comprehensive but universal.²⁹ Everyone resident in Switzerland has access to health services. And not only is it universal, but inequalities in health are less pronounced than in most other countries,³⁰ which, as the OECD has pronounced, is a 'considerable success'.³¹ Access is not only prompt, but distance to care facilities is not an impediment to obtaining care even in rural areas, and responsiveness to patients' demands is impressive. The Swiss system offers a very high degree of choice. Patients enjoy mostly unconstrained freedom of consulting with any doctor and of being treated in the hospital of their choice.³² Not surprisingly, surveys consistently find higher levels of satisfaction in Switzerland with the system than in other countries, better than Germany, Sweden, the US and the UK.³³

How have they achieved this? Well, for a start, Swiss health care doesn't come cheap. As a share of GNP, Switzerland devotes more resources to health spending than any other OECD country apart from the United States and

Germany. In 2003, Switzerland spent 10.7 per cent of GNP on health, compared with 15 per cent in the US and 11.1 per cent in Germany.³⁴ Clearly, we need to be aware of the high national expenditure. Value for money is contentious and while competition has brought many benefits to patients, it hasn't significantly brought down costs. This is a fundamental, rather than an incidental, point, and we shall address it in some detail soon enough. All the same, the high levels of spending on health care are accompanied by high levels of satisfaction, which suggests that people are able to obtain the care they want. The system is recognised to be more responsive and also more comprehensive than the NHS.

One of the problems with a tax-based system is that there is a weak link between contributions and consumption. The state is the guardian of the funds, which leads among other things to ceaseless controversy about their disbursement, particularly given that the fiscal ceiling results in restrictions. No one would argue for limiting spending on any other consumption good, however, whether it was computers or chocolate. The same goes in Britain for those forms of health care that people meet themselves—if individuals want more analgesics because they are less tolerant of pain than they used to be, and they bear the cost of such demand themselves, then their spending decision is theirs alone—but in Switzerland not dissimilar principles apply to a whole range of treatments. There will always be cost-benefit considerations, taking into account sacrifices they make in other parts of their lives in order to gain the benefits of those treatments, but it is fair to say that the Swiss spend more on health care and get more health care.

High levels of satisfaction and high quality outcomes also imply that it's not just the total spending that matters, but also how payment is arranged and ordered in the system.

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Switzerland's 1996 reforms 'secured population-wide access to a comprehensive range of modern health services by mandating the take up of health-insurance coverage offered by competing insurers'.³⁵ Coverage is achieved through a combination of mechanisms. A third comes through compulsory health insurance premiums. Each individual residing in Switzerland is required to purchase basic health insurance from one of a number of competing health funds. This mandatory cover is defined by insurers operating under community risk pooling arrangements rather than on the basis of earnings or income. Those who cannot afford to pay, or can only partly afford to pay, have their coverage supplemented on a sliding scale by state funding. A further third of the system is financed by individuals out of their own pockets. The rest comes from government, other social insurance schemes and voluntary health insurance.³⁶

Principles of social health insurance

Health systems are in constant transition, and all over the world face similar financial pressures. The key argument made in favour of social health insurance (SHI) over tax financing is that a tax-based system like the NHS is inextricably linked to a model of healthcare delivery that produces poor quality at an unnecessarily high cost. In the case of the NHS this entails a ministry of health delivering health care through its own network of facilities, which are paid through a mixture of budgets and salaries, and whose degree of autonomy is severely limited. The core concept of SHI, at least in countries like France and Germany, is that wage-earners make mandatory contributions based on their wages, with the employer and the employee sharing the costs, and crucially this is paid not to the state but to insurance funds. In the French system, premiums are charged as a percentage of income and the total cost is

nearly 20 per cent of payroll, including employer and employee contributions, and compulsory insurance covers the whole population thanks to a government-backed subsidy for the poor.

Among the advantages ascribed to an insurance system over a tax system, the payee is able to see how much is being paid into the healthcare fund, and to vary the amount of money being allocated. This endows the patient with more choice and enables the system to be more responsive to those choices. Similarly, whereas under a tax system the patient pays a compulsory amount into a general pot and so has no bargaining power when dealing with a bad practitioner or hospital, under an insurance system the patient becomes a paying customer who can go elsewhere. This makes the power of exit that we have seen is so critical for the functioning of a market into a reality.

Not only does SHI offer greater accountability for spending, but it also offers the prospect of wresting some control of the delivery out of the hands of the ministry of health by forcing an institutional separation of the purchasing of health care, administered by insurers or an SHI agency, and the delivery of health care, run by the public sector, the private sector, or both. In theory—and it's a theory the British government has been testing—it should be possible to achieve separation of purchasers and providers within an integrated system. In practice, this is not the case. 'There may be political economy reasons why such a purchaser/provider split is hard to engineer in a tax-financed system', a recent World Bank report argued, 'and why it is hard to grant public providers the necessary autonomy to be able to respond to the incentives a purchaser/provider split generates, such as civil service regulations, treasury rules on investment, etc.'³⁷

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In France there's no distinction between public and private hospitals—public hospitals provide about 65 per cent of beds and the remainder are private—and patients have complete freedom of choice. When in need of consultation or treatment, they typically pay their doctor a fee and then claim back 75-80 per cent. Recognising that payment might deter the poorest people from seeking care, six million people aren't expected to pay. All patients, whether exempt from co-payments or not, may go directly to a specialist outside or within a hospital. This pragmatic blend of consumer choice, professional autonomy, central regulation and a government-backed guarantee for the poor has resulted in traditionally high standards of care with waiting lists, for instance, virtually non-existent. Many have championed the European social insurance model as the best way forward for the future in Britain, especially since France, as well as consistently performing well on most health status measures, was ranked first by the WHO in 2000.³⁸

Yet for all their strengths there is one feature of SHI systems that is to be avoided, namely funding them through employer and employee contributions. The Swiss have developed a social insurance model that does just this; the French and the Germans have not. The French and Germans have traditionally offered high quality, but in both countries costs are soaring,³⁹ leading commentators to argue that when it comes down to it *'tax finance and social insurance are simply different ways of raising revenues'*.⁴⁰ That in both Germany and France the proportion of general taxation financing the system is increasing betrays the fallibility of their versions of SHI. That something is that the success of SHI depends too closely on the economic vicissitudes of a nation; more specifically, it depends on the balance of people in and out of work, and revenue is therefore likely to be diminished by an ageing population and rising unemployment.

Accordingly, the World Bank found that 'Germany's current healthcare crisis has occurred partly because SHI revenues fell as unemployment rose (the contributions paid by Germany's workers also pay for cover for the unemployed) and as the population grew older'.⁴¹ Germany has seen the number of uninsured individuals climb to 200,000. With no obligation to buy or sell health insurance coverage, both state and private health insurers have been able to reject individuals who have no coverage or have lost their insurance due to unemployment.⁴² This has now changed, and public insurers are required to offer at least a basic benefit package to these people,⁴³ which explains the rise in tax spending on health care in that country. The German health minister has described the exclusive linking of health finance to earnings as 'the Achilles' heel' of the country's social insurance system.⁴⁴ For this reason, and because of the qualitative gap between what the rich get on private insurance and the rest get on state insurance, the main parties in Germany are committed to changing the way health care is funded.⁴⁵

France isn't faring that much better. Health expenditure is creeping up, seemingly inexorably, and leading to sizeable budget deficits for the social security fund. Although it reduced from €11.2 billion in 2004 to €9.1 billion in 2005, the health insurance budget deficit remains substantial.⁴⁶ In 2004 new laws were introduced that gave Parliament a role in priority setting, and these new reforms have significantly altered the governance and regulation of the health system.⁴⁷ At the same time, tax spending on health care has been rising. While the system isn't the same as Germany's, employer and employee contributions are a point of vulnerability, as the ageing population reduces the proportion of the population in paid employment and contributes to uncertainties over the ability of SHI to meet

future cost pressures. Interestingly, one of the ways in which the country has responded to its problems has been to move closer to the British gatekeeping function.⁴⁸ Although the French GP function isn't the same as that in the UK, in that there aren't compulsory patient pathways and there's been a heavier emphasis on patient choice, it nevertheless represents a major concession.

Despite the advantages of these systems—reduced role for government, leading to less politicisation and micro-management, greater plurality of provision and financing, leading to more patient choice, more efficient allocation of resources, fewer capacity shortages and less rationing—it would clearly be difficult to persuade people that the merits sufficiently outweigh the demerits of the upheaval of system change. However, by detaching insurance cover from employment, the Swiss have headed off many of the problems currently being experienced in France and Germany, and the Dutch have managed the same feat. Indeed, the newest and most visionary model for the organisation of health care comes from the Netherlands, where they have found a way of pluralising the purchasing mechanisms in an insurance framework without tying payments to employment, demonstrating that the merits of the market can be harnessed without undermining social solidarity.

New frontiers for health care

On 1 January 2006, a major reform of the Dutch health insurance system came into effect, the most recent stage in a long process of reform. The former system, a combination of a statutory sickness fund scheme for the majority of the population and private health insurance for the rest, not dissimilar to the French and German models, was replaced with a single universal scheme. Despite its relative success—

the OECD reported that there were ‘few differences in the health services or providers available to the privately and socially insured’, which meant that the ‘mix of health financing has not resulted in a “two-tiered” system’⁴⁹—it was widely felt that the Dutch system was fragmented and there had for a long time been calls to end the dual structure of health and replace it with a single mandatory scheme covering the entire population. In the end what has been achieved is a more unified and coherent system than even the Swiss have devised. The aims of the reform were to make the health system more efficient, to improve the quality of health care and to make it more consumer-driven, while at the same time keeping it accessible to everyone.⁵⁰ Indeed, it has been said that the values of solidarity in healthcare financing and equal access in healthcare delivery have evolved as the cornerstone of Dutch health care.⁵¹

Characteristics of the new Dutch system

A defining feature of the new system is its concerted attempt to promote market competition. Health insurers, which may operate for profit, are required to compete on premiums, types of health plans and service levels. The new system grants consumers greater freedom of choice. Consumers are free to choose any health insurer and type of health plan anywhere in the country, which gets rid of the kind of postcode lottery that we have in this country, and they can change to an alternative insurer or plan once a year. The government hopes they will vote with their feet if insurers fail to live up to expectations. All legal residents of the Netherlands are obliged to purchase a basic health plan, but are free to purchase a complementary voluntary plan, of which there is a wide variety available, covering additional health services such as physiotherapy, dental care for adults, psychotherapy and various forms of preventive care. The

basic insurance package covering essential health care is defined by the government, but health insurers have some freedom to decide, for instance, which providers to contract, what types of care to cover and whether or not to offer benefits in kind or reimburse subscribers. This allows for some differentiation among health plans in order to give consumers choice.⁵²

Market competition is expected to encourage health insurers to negotiate favourable contracts with providers. The idea is that they will negotiate on the basis of price, volume, quality of service, such as waiting times, as well as on clinical quality. Quality will be particularly important for them to attract and keep customers. In order to help consumers to make informed choices when selecting an insurer or healthcare provider, considerable energy is now being spent on the construction of websites and other facilities that provide comparative information about health plans and provider performance (waiting times, patient satisfaction and so on). The introduction of market competition is being accompanied by a rapidly expanding information industry in which not only the government but also a growing number of private agencies participate. There are good reasons to believe that the way that quality and value for patients have been measured in supposedly competitive markets—along with the types of information available about these measurements—have been responsible for the dysfunctional nature of most healthcare competition around the world. Changes here are needed if choice and competition are to achieve the potential gains claimed for them, as we shall see shortly.

In a completely free insurance market, where clients have freedom of choice and there is sufficient transparency, various tools are available to insurers to enable them to optimise their activities—risk selection, premium definition,

efficient commissioning of healthcare services and organisational efficiency⁵³—and one of the principles on which such a market operates is that insurers can charge a client a premium that reflects the risks associated with the client. This is known as the equivalence principle,⁵⁴ but will of course come into conflict with the equity principle, the principle of the level playing field. For this reason the Dutch system doesn't create a *completely* free insurance market. It is a carefully regulated market, with parameters imposed to ensure equitable access to care.⁵⁵

This brings us to a further element of the health insurance reform, which relates to what the government terms 'public constraints'. Several of those constraints have already been mentioned. The new system is mandatory and covers the entire population. An axiom of the new legislation is that health insurers must accept every applicant, an attempt to guarantee consumer choice.⁵⁶ So insurers aren't allowed to deny access to applicants with pre-existing medical conditions or to charge them a higher premium.⁵⁷ Insurers must set a single flat rate premium for each type of health plan they offer. They are forbidden to vary premiums with age, sex, or specific health risks. The government pays the premium for those under 18. Low-income groups receive an income-related government subsidy or 'healthcare allowance' to purchase a health plan.

The law has, then, suspended the equivalence principle. But an insurer with an unhealthy client would be at a disadvantage compared with a rival with healthier clients. The ban on risk selection by insurers can only be enforced when insurers have no financial incentive to select risks.⁵⁸ To prevent insurers seeking to avoid less healthy clients—which would compromise accessibility for the poor—and to facilitate fair competition, an extensive system of risk equalisation has been developed that compensates health

insurers for major differences in the profile of their clients.⁵⁹ The most important element of this system is the risk equalisation or solidarity fund. The fund pools income-related insurance contributions and government contributions. Each employed person pays a contribution of 6.5 per cent of their income. As in the Swiss system, employers do not pay any contributions, circumventing many of the problems being experienced in Germany and France. For the self-employed, retired persons and some other specific categories, the contribution rate is set at 4.4 per cent. It is from this fund that insurers receive risk-adjusted capitation payments.

Efficiency gains are expected from increasing individual responsibility. More individual responsibility also implies greater financial responsibility. While low-income groups are compensated for the increased nominal premium by an income-related government subsidy, for the rest the nominal premium rate has risen significantly. The government assumes that high nominal premiums are necessary to make people more cost-conscious, and a no-claims bonus system has even been introduced in which people who do not use health care or spend less than €255 a year receive a no-claims bonus refund at the end of the year.⁶⁰ The nominal premium rate was €320 before the new system in 2005; after the first year it came to €1,038.⁶¹ While this leap in direct insurer payments has unquestionably been big, it was lower than the average premium of €1,100 predicted by the state, and lower still than the sceptics thought it would be. What's more, this is offset by the lowering of the income-related contribution, and the average household is no more out of pocket than they were in the old system.⁶²

Crucially, the relationship between insurer and subscriber is an arrangement under private law. The system incorporates a private approach to health insurance regulated by law, but

with strong statutory safeguards. It ‘amalgamates the social tradition of the health insurance fund and the market tradition of private insurance’,⁶³ according to the Dutch government. That ‘the new scheme is fundamentally based upon the notion of solidarity’⁶⁴ is enshrined in the ruling that health insurers are forbidden to vary premiums with health risk and must accept each applicant; in the mandatory nature of the scheme for all citizens, putting an end to the traditional dividing line between social and private health insurance; and in the comprehensiveness of the basic package. ‘We conclude’, say Yvette Bartholomé and Hans Maarse of Maastricht University, ‘that the new scheme should be considered as a hybrid arrangement combining a public function with a private structure. It is a public arrangement under private law.’⁶⁵ The Dutch model is, in effect, a private insurance system which covers everyone. The Dutch have found a way to make the private insurance arrangements function for public benefit.

Preliminary results

The principles are clearly sound, but if success ‘would imply that the competitive changes enhance value and efficiency in purchasing health care’⁶⁶ then it is too early to determine whether or not the reform has been a success. Health outcomes dated to the old system show the Netherlands was already performing well. Although health spending is high, so is life expectancy, well above the OECD average—and the UK—while infant mortality is low.⁶⁷ Access was among the best in the world, with the highest proportion of people with uniform proximity to hospitals and GPs.⁶⁸ The transition from SHI to a universal mandatory private health insurance (PHI) model was smooth and well managed, and ‘the implementation of the new health insurance scheme has caused fewer problems than some had originally feared’.⁶⁹

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The costs, as we have seen, have not been as high as some warned.

Consumers appear to have made the best of their choices with alacrity.⁷⁰ Since the new legislation has come into effect, many more people than expected have changed insurer. According to the latest data available, about 18 per cent of the insured have switched from one insurer to another, a much higher percentage than expected by most experts, including the Minister of Health.⁷¹ While some insurers have grown significantly larger, one insurer has lost almost a quarter of its subscribers.⁷² Further consolidation within the insurance market is likely. Two mergers were announced in May 2006 and each covers about 25 per cent of the Dutch population.⁷³ Initial observations of insurer behaviour indicate that the broader scope for market competition is making all insurers, including the not-for-profits, act more like market agents. They are becoming more market-focused and client-driven than ever before, and adopting the management style of commercial agents.⁷⁴ Consumer choice is a dynamic element, driving market competition which is expected to encourage insurers continuously to innovate their policies and providers to improve their quality and efficiency performance, though these changes will only happen if there is transparent information on quality. From preliminary findings 'it is becoming clear that the position of consumers and patients has already been significantly strengthened by giving them more choice'.⁷⁵

National health insurance system (NHIS)

The British system has always been a two-tier system, but the gap between rich and poor is widening at an alarming rate. As core NHS services are cut in the drive to reduce costs, with various other interventions having to be funded through co-payments or insurance, the poor are denied an

increasing range of services because only the rich can access them privately. We have entered a transitional phase. The Dutch system offers itself as a potential alternative way forward. It's never wise to transplant foreign systems wholesale; but there are some lessons we can learn. The changes have come into being gradually in the Netherlands, and there is no reason to believe that it would be possible or desirable to introduce them here overnight. But there is also no reason to believe that a long-term strategy couldn't be devised that envisaged moving to such a system at some point in the future. Our own hallmarks would need to be stamped on it, adapting rather than erasing as many as possible of the structures and institutions that are already in place to a modernised system that will fit the modern consumer age.

In searching for a more adequate way of delivering health care in this country in the future, we need to find a system that binds everyone together rather than one that is fragmented. But in a consumerist age where costs are rising, we need to find a system that is capable of dealing with the huge pressures of new cancer drugs and better ward facilities, for instance, the top quality cardiothoracic surgery and requests for expensive fertility treatment. By harnessing many of the incentives and efficiency mechanisms of competition for the public good, the Dutch have also found a way of dramatically reducing government interference, making money follow patients who exercise real choice, and using private individuals' money both to cover the costs of their own expectations and the needs of poorer and more vulnerable citizens. It is within this context, then, that we should as a country consider the advantages to be gained from moving towards a universal mandatory health insurance system.

Mandatory and universal

What we have seen in the case of the Dutch and the Swiss systems particularly is that it is possible to deliver high quality responsive health care through different models of financing that promote competition and stay true to the principles of fairness and equality. Having competing health insurers is the only way to make money really follow the patient, which means that it is the only way to begin to deal with the rising expectations and costs of health care in our consumer orientated century. The rules governing the operation of health plans would need to be carefully negotiated, but this is also the only way to reduce the government's control of providers—the medical professions—and handling of the allocation of resources. Instead of a hierarchy of power, there will be competing interests who will have to negotiate in a more mature and more equal manner. Making insurance mandatory and therefore universal is the only way to restore fairness—not to mention value, cost-effectiveness and efficiency—to a society of competing interests which has in recent years become increasingly incohesive and segregated by class, ethnic boundaries and income.

One of the key precepts set by two American authors, Michael E. Porter and Ellen Olmsted Teisberg, in their seminal study *Redefining Health Care*, is that when an individual can impose costs on society, the need for mandatory insurance is common sense. Everyone who wants to drive a car, for instance, is required to have insurance so that they won't inflict costs on other citizens if they have an accident. Making insurance mandatory also means that individuals pay their share of the costs of the insurance system every year, not just the year in which they think they might have an accident. The case is even stronger for health coverage. You might choose not to drive, thereby

avoiding crashes, but it's not so easy to avoid being ill or injured. Given that the cost of treating an illness or injury can be immense, and can continue for years or even decades, Porter and Teisberg remind us, 'the cost that an uninsured person can impose on others is substantial'.⁷⁶ Unless everyone is bound into the system, making everyone pay their fair share, the average costs of insurance will only spiral out of control, as they have in the US.⁷⁷

The fresh perspective that Porter and Teisberg bring concerns not the exclusion of the poor from insurance schemes but the noncommittal behaviour of the rich. One of the major problems facing the American private insurance system has been that high income individuals often don't take out insurance. That is, many of those without insurance *choose* not to have it. In Massachusetts, for example, an estimated 168,000 people without health insurance—37 per cent of the state's uninsured—have annual incomes over \$56,000.⁷⁸ These people who can afford insurance—or part of its cost—opt out in the hope that they won't need care. When they're injured or fall ill, they seek care and are charged list prices, which are frequently twice those charged to patients with insurance. In many cases, the resulting bills are beyond their means to pay. Inability to pay medical bills is a leading cause of bankruptcy in the United States.⁷⁹ When uninsured patients can't afford to pay, the cost of their treatments is shouldered by those who are insured, often in the form of higher insurance premiums.

Making insurance mandatory is therefore a means of cost containment. Making everyone pay a premium holds down the cost per person. If those who opt out join the system later on, they will not have contributed their fair share of the costs that they are likely to impose on the system. Mandatory coverage would end this cost shifting and free riding by people who can afford—or can afford to contribute to—

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insurance but prefer to take the risk and go without it because they are young, currently healthy, or have other financial priorities. Everyone should be required to have core coverage for life. Otherwise, even if uninsured citizens remain healthy, they deprive the system of revenues, which means that the solidarity principle—the principle of covering the poor within the same system as the rich—would be undermined. The money of those who have money is needed to provide subsidies for those who don't have money. In so far as it is possible, it is desirable for everyone to become a paying customer and contribute what they can to the costs of the system.⁸⁰

The mechanisms by which we could bind everyone into the same system have already been considered in our examination of other systems: universal mandatory subscription to competing private insurance plans, with subsidies drawn from a solidarity—or risk equalization—fund for those on lower incomes, based on a sliding scale where individuals pay what they can and everyone pays something. Laws would be needed to stop insurers finding ways to avoid, disenroll, or deny coverage to unlucky subscribers who become ill, but any policy of forcing insurers to have on their books certain proportions of high risk individuals and patients with expensive diseases or conditions comes up against the incorrect assumption that there is a fixed amount of illness or injury in a population.⁸¹ A solidarity fund financed by government and the revenue levied from the premiums of those that can afford them would be the best way to ensure that insurance coverage is truly universal, guaranteeing, as the OECD has said, 'cross-subsidisation among individuals of different risk status'.⁸² In time insurers may even find ways to make profits by enrolling greater numbers of high risk individuals.

Before moving on, it's worth observing that a single system, albeit comprising competing insurers, unifies all participants. The asymmetry of voice exhibited in the system that we have at the moment would be substantially redressed. Right now, those with the loudest voices are increasingly exercising choice by opting out—putting their money where their mouth is—and this can only denude the NHS in the future. As is often remarked, a service that is only for the poor will inevitably become a poor service. A distinct advantage of mandating insurance coverage and locking the rich into the system is that it gives the loudest voices an incentive to improve it, which is likely to lead to better care for all. If everyone is covered for emergency, primary, secondary and tertiary care, there would be continuity of care for rich and poor alike. It would also mean that results could be recorded effectively for the whole nation, not just a portion of it. And indeed results measurement should be mandatory, exposing substandard care for any group, including minorities and those with low incomes and low educational attainment, promoting competition and raising quality across the board.⁸³

Managing the transition

Taking as a starting point a relatively integrated NHS, combining insurer, purchaser and provider functions, the government has attempted to move towards making delivery more independent—involving the private sector, aiming to make all secondary care trusts autonomous FTs, and changing the accountability structure so that providers are accountable to regulators, not the Department of Health. A growing body of commentators is beginning to argue that if a competitive, independent provider market were to become a reality in coming years, then this would leave the NHS 'in effect, as largely an insuring-purchasing organisation'.⁸⁴ Given that, as we saw in the preceding chapter, these reforms have not had

anything more than a marginal effect, any enthusiasm or fretting, depending on your perspective, would be premature. However, the reforms could start to have an impact if people come to realise that demand-side reforms could set the providers free.

‘The historical experience of countries, their national culture and popular customs all help shape expectations of the health care system and responses to proposed reforms’, as a group of academics from the European Observatory on Health Systems and Policies has argued. ‘The ideological dimensions of national politics and of government policy will clearly shape reform content and will also have an impact on approaches to implementation.’⁸⁵ It may not be conducive to stable and sustainable reform to design plans for system reform that rely for inspiration on the big bang theory of change, but then much of the groundwork has already been done. In seeking to manage carefully the transition from a single insurer NHS to a pluralised insurer NHS, it would be wise to strive for as much coherence with our history and traditions as possible.

Opportunities are presenting themselves for new thinking. We may be able to learn from the vision espoused by a recent report which sees a *potential* role for private insurers in a reformed NHS purchasing arena. This report, by NERA Economic Consulting, identified gaps in the ability of NHS bodies to undertake commissioning activities. What they suggest is that purchasing be carried out by a wider range of bodies than at present, ‘new bodies that draw on skills from across the NHS, or bodies that also draw on private sector expertise’.⁸⁶ If such a situation came about, and there are signs it is beginning to—in June 2007, for example, Hillingdon PCT issued an invitation to tender part of its commissioning function to the private sector⁸⁷—there is scope not only for private insurers to act as purchasers, or to be otherwise

involved in purchasing, for tax-financed patients, but also for the same insurers to introduce restricted packages of supplementary insurance that would cover, for instance, access to better amenities within the context of publicly financed health care.⁸⁸ This is particularly true given the degree of independence that is supposed to characterise the healthcare provider sector, and the weakening of the separation of public and private income streams.

Paradigm shifts in the purchasing and provision of health care would still be required for any of this to become a reality, but it is no longer a far-fetched proposition. Private insurers could be encouraged to take on the developing market for co-payments and top-ups, which many commentators are calling to be formalised and regulated in a manner redolent of the mixed funding systems of Europe.⁸⁹ In the short term that could quickly turn into a vibrant market, and in time these insurers could expand to take on the role of funding the entire system, as has happened in the Netherlands. Mutuals could provide insurance and pay providers, which could be a combination of public, private and voluntary sector bodies. PCTs could be converted into these mutuals or into American-style Health Maintenance Organisations, though it would be preferable for them to be abolished and replaced with non-geographically-based insurers. It is not, let us restate, that private is better; just that competition is better. There are many ways forward, but we must be clear about where we want to go, and it is difficult to envisage a model that more soundly harnesses the efficiency and competitiveness of markets while synthesising this with universal access to an equal standard of care.

The place of government

Reducing the influence of government absolutely does not mean disengaging government. The WHO World Health

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Report 2000 on health systems performance identified *ensuring effective stewardship* as fundamental to health systems. Stewardship is defined as having three main components: health policy formulation—defining the vision and direction for the health system; regulation—setting fair rules of the game with a level playing field; and intelligence—assessing performance and sharing information.⁹⁰ The first of these is addressed in the determination to move to a mandatory universal insurance system, the National Health Insurance System. In system terms, the state would also play a role in contributing to the financing of the solidarity or risk equalization fund. As for the second of these, although the state would lose a good deal of its influence over the purchasing and provision of health care, and the general allocation of resources, it would acquire greater responsibility for the regulation of the system and public health policy. The third of these forms the subject of the final chapter of this report.

Regulation

The market carries risks. It should be clear by now that taxation funding of health care carries perhaps greater risks, but the introduction of market incentives could result in a series of perverse incentives that will require monitoring and regulation. Government regulatory frameworks and inspections would be needed to prevent the system being a shambles, and many such have been considered in reference to the regulation of the Dutch system. State policies can set rules and regulations that would affect the nature of competition in health care, as well as incentives and constraints for all participants in the system. Government has a broad role in setting healthcare policy for insurance. It can set basic guidelines for who is covered by health insurance, how health plans operate, how insurance is paid

for. It should do everything it can to eliminate barriers to entry—price discrimination to different groups in society has to be eradicated—and ensure that insurance is universal.

Government also has a role in directing the scope of policies. This means prompting debates on what services insurers, and society, should be responsible for covering and how—including leading the debate on what should be discretionary and what the responsibilities of patients participating in their health care should be—since what is covered by insurance is a major determinant of the costs of plans. Such things to address would be how comprehensive the mandatory insurance package is, whether or not it includes treatments such as IVF, and what should happen, if, for example, you refuse to be screened. Should you then pay more for your health care?

Added to this, government can be an ombudsman curtailing anti-competitive buying practices, preventing cartels and so on, which could linger when there's been such a powerful single buyer in the form of the NHS. One of the things that the government has tried to do is pass the regulatory role on to other bodies like Monitor and the Healthcare Commission, but in truth this is one of the few key roles that it should retain in a healthcare market. Rather than have a government run system that is regulated by arm's-length bodies, we should be moving towards a market system that is regulated, if not by statutory bodies, then certainly by legally enshrined institutions.

Public health policy

If the government were forced to play less of a day-to-day role in the purchasing and provision of health care in this country, it would have more time to concentrate on promoting better health in the nation at large. This could prove to be important in an insurance system, for there is

increasing evidence that many diseases are lifestyle-related, which would create pressure on individuals to take greater responsibility for their health. Public policy has important roles to play in the development of public health measures to encourage the population to take more responsibility for health at the level where it often starts—the individuals. Indeed, if there is one function everyone must agree should be the responsibility of government, it is preventative health care: epidemiology, the promotion of healthy living and the maintenance of a safe environment.⁹¹ ‘The ultimate reform strategy’, as the designation from the European Observatory has said, ‘would be to ensure that populations were healthy and that there was no need for health services.’⁹²

The NHS has sometimes been referred to as a national sickness service because of an insufficient focus on preventative care, for one of the impacts of the short-term horizons imposed by the constant cost pressures on the NHS has been the neglect over decades of public health. The criticism is justified from an historical perspective although there have been welcome shifts towards a greater focus on funding in the last five years. Speaking in 2005, the CMO, Professor Sir Liam Donaldson, made it clear that the emphasis was shifting in this direction, with particular emphasis on smoking, obesity and sexually transmitted diseases. He said that ‘a lot of the attention has turned to the sort of health problems facing us as a population. Many of them are man-made diseases rather than diseases of the past which were nature’s diseases. The challenges for us are not just to help and support people with chronic diseases but also to get upstream and prevent them.’⁹³

Recent concerted efforts to reduce smoking rates have culminated in the ban on smoking in public places, although measures to reduce binge drinking and obesity have to date been less effective at changing attitudes and behaviour in the

population. The growing prevalence of overweight children has, the World Health Organisation tells us, now reached epidemic proportions. It is a particular concern in this country. Across Europe, England and Poland display the sharpest rates of increase over the last 20 years.⁹⁴ Diabetes, cardiovascular diseases and certain forms of cancer are some of the conditions associated with overweight and obese individuals. Whatever the causes—snacking, fast food, high calorie drinks, high fat and salt diets, substandard food in schools with poor canteens and vending machines, reduced exercise levels, selling off school playing fields, sedentary jobs and so on—there needs to be a concerted effort to confront this urgently through public health strategies. It might also be done through incentive payments in insurance packages. But as Sir Derek Wanless put it in 2006: 'I have been saying for a long time that I think the secretary of state should be secretary of state for public health'.⁹⁵

Intelligence

This will be taken forward by the WHO's third component, performance assessment and information sharing, which largely forms the subject of the next chapter. Government has a role in mandating the collection and reporting of results information and facilitating the penetration of information technology. We have to find a system that is more than consumer-driven. No matter how much costs and decisions are shifted to consumers, unless providers and health insurers have to compete on results and the right information and advice, there will be no real choice for patients. Consumers cannot on their own cause competition to improve. With high uncontrolled costs, self-rationing, where consumers worried about costs opt not to get treatment, will take us back to the days before the NHS. The current system isn't working. Most people are aware of this

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irrespective of political affiliation or professional alignment. A fresh approach is needed to address the problems of a healthcare system that is consuming a larger and larger share of the national budget with questionable results. This is not a charter for eliminating government's involvement in health care, but for reconstituting its role.

6

Redefining Health Care

Come, give us a taste of your quality.

Hamlet

Making the market work

A universal mandatory insurance system in which demand as well as supply is liberalised would be a crucial precondition to changing behaviour in the system, but for a healthcare market to thrive we need to go further than changing financing alone. The truth is that even in countries where healthcare markets are relatively advanced, health spending has grown faster than GDP, and nowhere is this more the case than America.¹ In their book *Redefining Health Care*, Michael E. Porter and Elizabeth Olmsted Teisberg search for ways to explain and correct the failure of competition in America. They argue that the fundamental nature of competition in health care must be redesigned. By changing the way that health care is measured to focus on patient value—the quality of outcomes per unit cost expended—across the whole cycle of care, rather than discrete interventions, they show how we can change the incentives for all participants in the system. By making these outcome measurements public—indeed, making their publication mandatory—they show how efficiencies will improve and costs will fall. To borrow the motto of one of the more enlightened new entrants, we need to measure what counts and publish everything that we measure.²

Value-based competition on results

The trajectory of normal markets is well known. We have seen it happen in car manufacturing, information and

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mobile telecommunications technology, and in other sectors. Competition drives improvements in quality and cost. Innovation leads to the rapid diffusion of new technologies and better ways of doing things. Excellent competitors prosper and grow, while weaker rivals are restructured or go out of business. Prices fall, value improves, supply reacts to demand, and the market expands to meet the needs of more consumers. Equally as well known is that healthcare competition, in countries where it has been allowed, has not followed this pattern. Relentless attempts to control costs have failed to stop them rising. Performance remains patchy and different providers exhibit wide variance in both quality and cost for the same type of care. Poor providers don't go bust and good ones don't always get the credit. Technological improvements spread relatively slowly and often don't drive value improvement. Often technological change is actually blamed for many problems. None of these reflects what we would expect of a well functioning market. It is just not good enough when life and quality of life are in the balance.³

So Porter and Teisberg go back to the drawing board. Why is competition failing in health care, they ask, and why is value for patients not higher and improving faster? Their diagnosis is that it is not an absence of competition, but the wrong kind of competition that is the problem. Competition has taken place at the wrong levels and on the wrong things. It has gravitated to a 'zero-sum competition': the gains of one system participant come at the expense of others because everyone tries to shift costs to each other. The OECD has observed just such misaligned incentives in Switzerland, finding costs shifting between financing agents and buyers, rather than a collaborative focus on controlling and managing cost. 'Provider, insurer and patient incentives to enhance efficiency', it has said, 'are weak'.⁴ This kind of

competition doesn't create value for patients, but undermines quality, promotes inefficiency, and pushes up administrative costs. It doesn't have to be like this. Everyone should share responsibility for this dysfunctional competition. But limiting competition is not the solution. 'The only way to truly reform health care', say Porter and Teisberg, 'is to reform the nature of competition itself.'⁵

Competing on value

What's needed is to compete on *value* for patients. It sounds like a platitude, but so far this hasn't been the character of healthcare competition. Value, simply put, is a ratio of health outcome against the unit of cost expended.⁶ The aim, therefore, surely everyone would agree on: increased quality of patient outcomes relative to the money expended. To date—and this is the case in every developed country, irrespective of how it has been organised, but certainly more excessively in marketized models—the downward pressure on costs has been affected by trying to dissipate costs and pass them on to other participants in the system, a short-term vision that has often been characterised by squabbling over who pays for what. Value for the patient has been the collateral damage in this skirmish. 'Competition in insurance markets should be strengthened and aligned with incentives to increase quality and efficiency', said the OECD of Switzerland, 'insurers should purchase on the basis of quality and access to care as well as price.'⁷ Value in health care can only be understood by focusing on the level at which it is actually created, which is in addressing the patient's actual medical condition, such as asthma, back injuries or congestive heart failure, and doing so over the full cycle of care, from monitoring and prevention to treatment to ongoing disease management. We need to

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reconfigure the market so that each purchaser and provider competes on the right things.

If we're to move towards an effective and efficient healthcare market in this country, competition has to take place at the level of individual services. It is no good replicating the deficiencies of markets abroad where competition between providers is compared on broad service lines. The Healthcare Commission has moved in the direction of ranking hospitals—using the star rating—for their overall performance. Historically, this is understandable in the NHS. Providers were geared up to offer every possible service to the patient and handle anyone who walks in through the door. It's time to change. In an institution like University College London Hospitals FT, there has been a realisation that services can be streamlined in a market environment so that competition only takes place in the areas where the hospital has decided to concentrate—and excel. The fact that UCLH has been able to rationalise and scale services shows that this is not an implausible ask. This should be the model going forward.

A major flaw in NHS purchasing has been the use of block contracts, and where ISTCs and other independent sector providers have been commissioned to deliver services in this way, it hasn't been conducive to competition. Block contracting has largely been the model in other countries, too, with health plans in the US, for instance, contracting with providers across the board for every service. Yet sheer breadth of service doesn't in and of itself have much impact on patient value. We would do well to remember the analogy of the restaurant used by Ali Parsa in Chapter 4, where it was argued that block contracting undermines the accountability for quality. What matters is being able to offer value in the treatment of a condition for which an individual patient needs treatment. Sometimes one provider will be

good at this, sometimes another, but in insurance markets—and nascently in ISTCs—block contracts have promoted captive referrals within provider groups and suppressed competition at the level of the individual patient and the medical condition.⁸

If competition is to take place between providers, and insurers are to purchase from those providers, then the value for the patient must be measured not on discrete interventions but on the full cycle of care. Across the world, outcomes are measured not across the whole cycle of care but for an individual procedure, service, office visit, or test. In England, for example, payment by results generally involves block contracting for discrete interventions, and the range of information about even limited sections of the care cycle is therefore extremely limited. The cycle of care involves not only diagnosis and treatment but also rehabilitation and long-term assessment and management of a condition to minimise its recurrence. Value must be understood as the outcomes and costs over the whole cycle, not just for individual components. Providers can offer services for a range of medical conditions, but the value they create should be determined by how well they deliver care for each one, and this is the level at which they should compete.

Neither in the NHS nor anywhere else in the world is anyone taking such a long-term perspective, encompassing preventive steps to avoid the need for interventions in the first place and ongoing disease management to forestall recurrence.⁹ It is the patient who loses out. A cost saving in the immediate term that leads to a cost increase in the long term does not improve patient value and wastes money. A quick diagnosis that turns out to be a misdiagnosis leads to unnecessary treatment. There's little benefit to be gained from cheap surgery if it results in avoidable complications or leaves the patient blighted by recurrences in the future. For

example, if drug eluting stents are used to save costs in percutaneous coronary interventions, when in fact they result in a later complication—sudden thrombotic occlusion, known as late stent thrombosis—necessitating a more technically difficult and expensive open operation to unblock the artery, then the cost benefits of the drug eluting stent have to be questioned.

Conversely, a high-cost stroke intervention that avoids decades of nursing home care is a bargain. Sometimes low-cost interventions can be the way forward. The use of statins perfectly exhibits how the judicious use of drugs can bring down the costs of care further down the line. They are, as the York University Centre for Health Economics has pointed out, ‘highly cost-effective’.¹⁰ Another example is chronic kidney disease. A timely diagnosis and treatment for the early stages of the disease prevents or delays the evolution of the disease to end-stage renal disease, which must be treated by dialysis or transplantation. Early intervention improves the benefits of coaching patients in healthy living habits and the management of related health issues such as anaemia, bone disease, hypertension, dyslipidemia and malnutrition. Disease management also enables appropriate preparation for successful dialysis if the disease progresses. Competition over the care cycle will lead to more attention to the prevention, detection, and long-term management of illness relative to treatments and acute interventions.¹¹

A medical condition has to be defined from the patient’s perspective. It should encompass the set of illnesses or injuries that are best addressed with a dedicated and integrated care delivery process. Knee injuries and spine injuries, for instance, may be best treated as separate conditions because addressing each of them involves different monitoring, different diagnostic expertise, different interventions, and different forms of rehabilitation. As for

defining the care cycle, that will be something that providers will need to establish. How to measure chronic kidney disease across the care cycle will not be easy, and it's not clear that it should be in the same care cycle as, say, kidney dialysis. While there are clearly links between earlier renal stage care and dialysis care, and these links should be managed, the nature of the care delivery process is very different. Hence there are two separate medical conditions that will benefit from dedicated focus and a dedicated care delivery structure.¹² The point is that we need to decide what we want to pay for and find better ways to measure that than we have at present.

As for the providers, they should organise themselves around medical conditions, with integrated practice units housing all the services necessary to address that medical condition.¹³ Exactly how these will be defined will depend on individual providers. Competition has to be structured around the full cycle of care within these integrated practice units, rather than on discrete interventions, treatments or services. Value can only accurately be managed in this way. Providers will be assessed on how well they perform in looking after the patient through a cycle of care for specific medical conditions. This will demand that secondary and specialist providers work more closely with their patients and primary care providers. From diagnosis through treatment to aftercare and monitoring, there will be better interlinkage between bodies, better preparation before treatment so as to make treatment more effective, and more attention given to rehabilitation and hospitalisation.

At the moment, GPs have only the most piecemeal data about the re-admission rates, say, of a given hospital department, and little idea about whether what they pay for will deliver long-term value for the patient. Not surprisingly, there is also no systematic information to be had about how

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well GPs do on behalf of their constituents. In the market to which we are advancing this will have disastrous consequences for value and cost. Navigating the care cycle is challenging: who is looking after the patient? One of the great myths about the NHS is that because it has been run as a single-funder and single-provider system, the patient experiences care as more integrated than other systems. This isn't true. A report drawing direct comparisons between Kaiser Permanente—an American HMO—and the NHS, for example, attributed Kaiser's superior performance at least in part to the fact it had achieved real integration 'through partnerships between physicians and administration that can exercise control and accountability across all components of the healthcare system'.¹⁴ Instead, in the NHS, countless patients complain about being lost in the system or having transitions between primary and secondary or tertiary and rehabilitative care badly managed, and this is particularly serious with long-term and chronic conditions. An insurance system has the potential to make this much better—so long as it's in insurers' best interests to purchase health care across the whole cycle of care.

Among other consequences, insurers will find it worth their while to encourage greater integration of secondary and primary providers in the way that they look after the people on their books. Collaboration between providers and purchasers will maximise patient value. Given that insurers will be forced to accept all subscribers, they would not be able to avoid high-risk individuals. In this way, the incentive to cut costs in the short term is likely to be reduced. A patient's illness will be closely managed over an extended period of time, detecting impending problems early and initiating remedies and interventions in ways that keep their costs over the cycle of care down to a minimum. Insurers who are involved in the full cycle of care will strive to keep

their costs down by looking after their clients better than any other insurers. Some insurers will show themselves better and more eager to have their clients screened, say, or receive regular MOT check-ups, or use primary services more frequently, because that way they will save money in the long term. And they will be compared on their efficiency in this respect. Both purchasers and providers will shift from thinking of a single intervention as the product towards thinking of the patient's overall and ongoing health as the product of health care.

As well as competing at the level of individual services and doing so over the full cycle of care, purchasers and providers must be free to compete irrespective of geographical boundaries. As is the case in any other market, there's no reason why health care in England should not be regional, national, international, as well as local. National and international companies have found ways to scale operations so that they can provide services in a variety of locations. Banks do just this, profiting by providing services that customers trust and want to use. Supermarkets follow similar patterns. It is quality, not distance, that counts. Purchasers or commissioners, whether patients, GPs or insurers—and it's notable that in the Netherlands insurers must operate at a national level, therefore preventing local cartels and monopolies—should be interested only in the best care for patients across the cycle, not where it is located.

Despite being called the *National Health Service*, treatment has traditionally been delivered locally and managed locally, resulting in catchment-area politics and postcode lotteries. This is a distinct anachronism and it belongs to an era when medicine was less complicated and travel was more difficult; an era, indeed, when medicine was more about comfort than cure. Local referrals made sense when there was little difference in the quality that people got

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irrespective of where they went, so it came down to how well they liked and trusted their GP. Particularly in the NHS, where resources are allocated centrally, but also in a number of other countries' healthcare systems, the local bias in health care means that many providers offer services in which they lack the volume and experience to be truly excellent, and it follows that they often suffer from excess capacity and the tendency to supply in order to create demand. With the growing sophistication and complexity of medicine, variations in quality have become substantial.

Yet still some argue that every city, town or even borough should have all services and specialties. Indeed, it is a case often made by neighbouring hospitals that duplicate each others' services. This defies logic. No one institution needs to provide everything, especially if two streets away there is another providing the same services. Even rural hospitals needn't offer everything. Certainly they need A&E departments, routine and preventative care, disease management services, and so on, since no one wants to have to travel far for a routine check up or a simple prescription; but there is no pressing need for them to have more services unless that hospital has developed sufficient experience, scale and expertise, and meets standards of excellence. It is worth mentioning that internet-based integrated information systems could make it possible for trained professionals in rural institutions to provide basic care based on best practice—and it would help if they had access to the patient's entire history at the click of a mouse.

Those in need of specialist care can travel. Funnily enough, this often elicits howls of anger from people who happily travel from their village or town into the nearest city centre every weekend to do their shopping. If they can make such a journey to buy groceries and a new dress, they can make such a journey for an elective operation. While

travelling some distance to the best facility in a county—or even country—may sound expensive and inconvenient, the cost savings and the long-term life improvements in terms of quality care far outweigh this and make travel worthwhile. The costs and inconvenience of travel are easily justified by avoiding other, higher costs that arise with inferior outcomes such as longer or incomplete recovery, chronic pain, complications, and mistakes. No one is being forced to travel, and some may choose not to. But while it's frequently asserted that patients will always choose convenient local care rather than seek out or utilise more distant providers, current patient behaviour is the result of an absence of choice and of proper information about quality and value. Many patients assume the quality of care they receive at every hospital will be the same, but it is not. The established patterns of behaviour need to change.

Competing on results

So far so good, but competition on value cannot become a reality unless value is measured, which means that there has to be an agreed way of evaluating the unit cost of outcomes at the medical condition level. It also means that these results have to be published. If providers, insurers, and suppliers have to compete on results, those who achieve excellence will be rewarded with more business, while those who don't won't. When providers can demonstrate that they deliver superior patient value, it will be good news for patients, but also for insurers who will be able to purchase better care at lower costs. When insurers can demonstrate that they are the best at coordinating care, and that they contract with the best providers, it will be good news for patients, but also for excellent providers.¹⁵ In short, everyone's a winner. The whole thrust of my argument has been that top-down micromanagement is failing to create the

right incentives for increasingly demoralised providers and that such a system is unable to keep up with the rapidly evolving pressures and complexities of the modern age.

One of the symptoms of this, as we observed in Chapter 3, is unexplained and unacceptable variations in performance. In the absence of reliable information about the outcome of care, practice varies wildly, and the same patient might be prescribed very different treatments by different doctors. Speaking in confidence, some surgeons admit that they do a mastectomy with breast reconstruction, say, rather than a wide removal, simply because reconstruction surgery is more interesting. That is to say, they do it because they can. There is a gathering body of evidence to suggest that many common interventions either have an insufficient evidence base or are delivered despite there being better alternatives available.¹⁶ This wobbly evidence base has troubling implications for the quality of care in the UK. For instance, in 2007 the King's Fund reported 'good evidence that different consultants achieve different clinical outcomes', but also noted that 'there is little routine data to describe these variations locally'.¹⁷

At the extreme end of the scale, the case of Rodney Ledward, a gynaecologist struck off by the GMC after being found guilty of bungling 13 operations, is instructive. Ledward was impugned for lack of care and judgement pre-operatively, failings in surgical skills, inappropriate delegation to junior staff, and poor post-operative care and judgement. In 2005 a retrospective analysis examined the obstacles to identifying Ledward as a statistical outlier. Much of the data was of 'variable quality and equally variable relevance', the researchers found, 'to the quality and outcomes of the care that the NHS provides'.¹⁸ Although that was some years ago, things haven't changed much.¹⁹ Consumers, hospital managers and clinicians need an open

flow of information, but the Health Select Committee has complained:

Trusts are required to... report adverse patient incidents which could affect patient safety. However the quality of reporting is fantastically variable, with some [NHS] Trusts returning a nil return, which means they have no adverse incidents and which beggars belief. *The quality of data submitted by [NHS] Trusts is extremely poor... So patients are not going to be able to exercise an informed choice, it is as simple as that.*²⁰

Another way of approaching this is to consider how GPs make referrals decisions. A study of GPs by the King's Fund found 'remarkably little consensus about the range of information' although consensus did exist that the 'Healthcare Commission star ratings were universally distrusted... partly as a result of the way they aggregate information such as financial performance with other more clinical markers, making the rating as a whole useless for informing GPs referral decisions'.²¹ 'The distrust of data produced by NHS organisations about their performance', the study found, 'was typically based on personal experience of the methods used to distort data (such as A&E figures) in order to meet targets.'²² Many GPs therefore make recommendations to patients based on a blend of formal and informal information.

This isn't always as sophisticated as some patients might like to believe, and it is not uncommon in focus group settings to hear GPs say that they wouldn't touch such-and-such a consultant 'with a bargepole' or that they 'wouldn't send a dog there'.²³ The fact is that in the absence of hard evidence patients and doctors fall back on a raft of euphemistic proxies like 'trying hard', 'doing everything they can', or even just 'caring'. But the heart surgery team whose patients consistently die at a higher rate than expected may well be trying just as hard as the team whose patients are more likely to live. The ICU in which a greater

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percentage of patients die may well be just as well equipped as the ICU where many more patients survive. Trying to help patients and actually helping them isn't the same thing. 'If medical quality, like beauty, is in the eye of the beholder,' asks Michael Millenson, 'then how can we judge between the doctor who advises bed rest for back pain and the one who recommends surgery?'²⁴

In direct contrast, there's every reason to believe that systematic measurement of outcomes would contribute to systematic improvements in care. Superior performance can't be rewarded unless it can be identified, but the combination of accountability and information in a competitive environment encourages excellence.²⁵ Just as in the world of business you can't compete unless you have the statistical process control, continuous quality improvement, benchmarking, and the capability to know how to do the right thing all the time, so the same principles apply to medicine. How long in this environment can people plead ignorance about the appropriateness and effectiveness of measures taken in the operating theatre? Designing software programs that can deliver outcome measurements is a major task confronting medicine in the modern era. To bring in sophisticated outcome systems requires sophisticated technology. Clinical data are needed by management and clinicians to see what works, both for internal management and to differentiate themselves from competitors.

The good news is that in this respect the UK is relatively advanced in international terms,²⁶ and this bodes well as we make the transition into a competitive market environment. The three best known solutions offer a range of assessments, monitoring devices and management tools. The POSSUM system is the clinical audit system of choice recommended by the Royal College of Surgeons, along with many other authoritative bodies, and used in 40 countries around the

world.²⁷ This has also given rise to the CRAB system, which is being developed by Elision Health. Two other established systems are based on Hospital Episode Statistics and being marketed by leading providers of healthcare information, CHKS and Dr Foster. They provide comparative data about hospital care, and in the case of Dr Foster provide that data directly to the public. Information about clinical outcomes is, according to Dr Jack Tinker, dean of the Royal Society of Medicine and chair of Dr Foster's Ethics Committee, 'an invaluable tool in our desire to deliver the best quality care'.²⁸

So to really compete on results, those results need not only to be measured but also to be made publicly available, and there is every reason to believe that the UK can be at the vanguard of this revolution. Holding every actor in the system accountable for the creation of value will drive performance improvements. Ways of calculating value-added and at the same time controlling for initial patient circumstances—risk adjusting—are being developed. In time hospitals will get better at collecting data at differing levels of granularity and sophistication, but government still has a key role to play in ensuring that the measurement and reporting of results becomes mandatory. Consumers will only be able to play a bigger role in their care, and make better choices, if providers and insurers re-align competition around patient value. When doctors are driven to compete on results—thus improving both quality and efficiency—and insurers are driven to compete on getting the best value for patients—thus demanding better information and advice—even the least informed patients will benefit.²⁹ We may live in the era of the expert patient, but you won't need to be an expert patient to gain from the new system.

This kind of competition has the potential to drive massive changes in health care. Changes by insurers and

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providers to compete on value will reinforce and magnify each other, and will spur technological and medical innovations. As consumers adopt these principles, providers and insurers will be more motivated, and more able, to improve the value they deliver. There will be money to be made for those providers and insurers that move early to engage in patient-centred, value-based competition.³⁰ There will be no need to predetermine the best way to structure the system, command standard practices, dictate how IT systems should be designed, or decide which new medical technologies should be adopted. If every participant in the system has to measure and report results, professional pride will motivate improvement; if every participant has to compete for every subscriber and patient, improvement and innovation will occur even faster.³¹

It is worth emphasising the point that although best practice guidance is helpful for doctors and clinical management, it isn't on the processes but the outcomes that health care should be judged. Substandard ways of providing health care will slide into obsolescence, not because of enforced process compliance but because, like not having the best IT equipment in business, it will be crippling for those who fail to keep up. Comparing providers and insurers on the value they achieve for patients in specific conditions over the full cycle of care will drive patients to the best competitors. For this to work, patients need to be free to migrate to excellent providers, which, to restate, is why insurance needs to be the funding mechanism. With greater patient throughput, organisations will get better, more efficient and more profitable. They will get better at making more money to make more money. Those providers that remain inefficient or fail to deliver quality will lose patients unless they improve, which will put an end to institutionalised inefficiency and a healthcare climate where

politicised interests champion the lowest common denominator.

Critically, of course, it doesn't necessarily follow that quality should be more expensive; indeed, good quality should be less expensive because of more effective prevention, more accurate diagnoses, fewer treatment errors, lower complication rates, faster recovery and less invasive treatment. More broadly, better health should be cheaper than illness. Better providers often earn higher margins at the same or lower prices, so quality improvement does not require escalating costs.³² In *Redefining Health Care*, Porter and Teisberg marshal a wide array of examples to show that the kind of continuous quality improvement that we can aspire to already exists in isolated institutions. St Luke's Episcopal Hospital, the home of the Texas Heart Institute, is one such. Because of its reputation for excellence, it attracts the most complex and demanding patients, whose needs propel more rapid learning opportunities and the uptake of the newest technologies: it has surgical costs that are one-third to one-half lower than those at other academic medical centres.³³

A good illustration of the axiom that value that can be added even as costs are reduced by scale and experience is diagnostics services. Numerous studies have shown that women benefit from more accurate diagnoses when the reader of the mammogram is highly experienced and when the original film is re-read every time a mistake is discovered in order to facilitate learning. The evidence suggests that women who have their mammograms read by a radiologist who reads at least 1,000 films per year, and perhaps over 2,500, get the best service. Now digital images can be transferred almost instantly, so high volume centres for reading tests can be contracted without inconvenience to patient or provider,³⁴ and it's more than likely that in due

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course such tasks will be outsourced across the globe to specialist centres.³⁵ The myth that there must inherently be a trade-off between quality and cost in health care has been allowed to hold sway for too long. By focusing on patient value and relentlessly recording and reporting results, the productivity frontier should be pushed further forward.³⁶ Catching up and moving to this frontier will enable providers to achieve current outcomes at lower costs, improved outcomes at the same cost, or better outcomes at lower cost.³⁷

Furthermore, eliminating mistakes and defects in care will lower the cost. The advantages of reducing errors are especially great where the costs of preventable errors and complications are high in terms of wasted or inappropriate treatments, repeat visits, delays, workforce time, drugs, surgery, and even the highest price of all, death. Likewise, by treating the right condition in the right way—‘doing the right thing’, as Millenson has put it, ‘and doing the right thing right’—there are opportunities to reduce cost while improving quality. In general terms this will involve moving towards addressing causes, rather than mitigating symptoms, which will make care more effective and less costly in the long term. And whether they are adopted without controversy since the value they add is easy to demonstrate and they cost less right from the start—this is true of new antibiotics and minimally invasive surgeries—or start out being expensive and risky to administer but improve over time—this is true of cataract surgery, which originally necessitated a week’s stay in hospital and is now a high quality low cost outpatient procedure—innovations will be a key generative force for change.

We come full circle, ending up where we began, with the epigraph quotation from Einstein: if you always do what you always did, you’ll always get what you always got. By

moving to a modified version of Porter and Teisberg's system of value-based competition on results, some of the more obstinate obstacles to better health could be overcome, such as the view that it's a bad thing to cure disease because individuals will just live to be sick for longer, so raising costs. It is time to get over the peculiar and unhealthy relationship between supply and demand that has suppliers wishing for less demand, otherwise we may as well just say the cheapest patient is the dead patient and be done with it. The truth is that in any other context people would laugh at you for saying that technology is detrimental to development, yet in health care people get away with arguing that innovations that cure diseases do nothing to increase value and simply raise costs. It's an attitude that survives only because people are content to confuse patient value in the treatment of a *specific* medical condition with the costs of treating other putative conditions, the conditions that a patient may develop later in the future. More to the point, it takes no account of the very real contribution that healthy individuals make to society and the economy, and it rides roughshod over the fundamental aspiration to a better quality of life.³⁸

Coda

The best measure of quality is how closely the result approaches the fundamental objectives of prolonging life, relieving distress, restoring functions and preventing disability. When all's said and done the proof of success is a happier, healthier patient. By liberalising demand and supply using a plurality of providers and purchasers we should be able to achieve a system that is less sclerotic and wasteful, and more flexible, efficient and innovative than the current NHS—one where healthcare professionals feel respected and are proud to work. What's more, the search is

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on for better quality and outcomes measurements so that evidence precedes practice, rather than the other way round; so that treatments are more consistently reliable and geography doesn't decide health destiny; so that the perverse incentives that push up costs are eliminated for good. Only then will providers be able to compete—and purchasers able to choose—on the basis of quality. We will need a debate about the minutiae of how this is to be achieved, but this has to be the overall strategy. Periods of transition and revolution are always difficult for the major parties involved. Anxiety is always experienced when we move away from the old paradigms and the old ways of doing things. Yet there are many, many reasons to be hopeful. Optimism, not despair, should be our mood and our mode of approach. The future promises longer, healthier lives for all of us. We are going through a revolution. The goal of the revolution is to introduce the health care that works best. The goal has to be the best care that is possible for the patient. The patient deserves nothing less.

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