

# Why the NHS needs real reform

## Executive summary

**The NHS isn't working.** The NHS budget has risen by a third in just four years, but hardly any additional patients are being treated and waiting lists remain above one million. Cancer care and accident & emergency services are getting worse. Political targets distort doctors' priorities and give a misleading impression of overall performance. Up to a fifth of NHS resources – £10 billion a year – are lost through waste, fraud and inefficiency. More patients are paying for their own operations to avoid waiting lists, creating a two-tier system.

**Why other systems are better.** Other countries are able to spend more by raising health funds from a variety of sources. Under social insurance systems, premiums are paid to third party insurers who, unlike governments, are under an obligation to serve customers. Patients enjoy shorter waiting times, better standards of care and real choice.

**How the NHS lags behind.** Detailed comparisons of the healthcare systems of Britain, the USA, France, Germany and Switzerland show that Britain spends less on health as a proportion of GDP than nearly every major country. Other countries have far more doctors and no waiting lists.

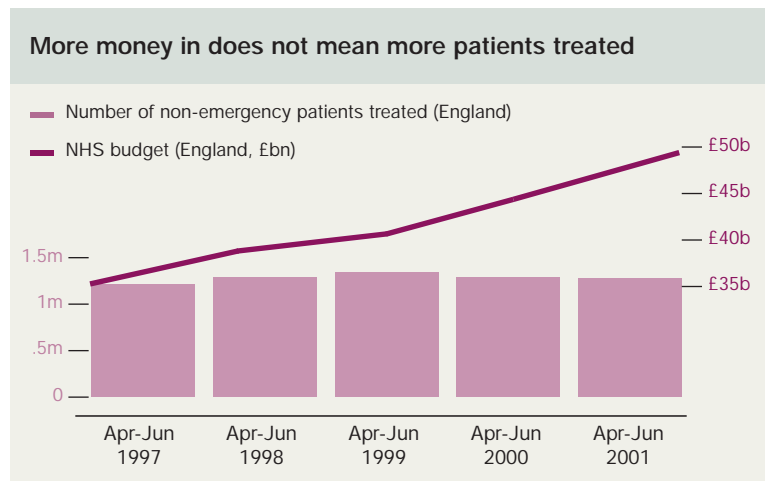
**Attacks answered.** Ministers have begun to attack other countries' healthcare systems, so as to persuade the public that there is no alternative to a taxpayer funded system. But every one of their claims is misleading.

**The Government's 'ten year plan' is not real reform.** Patients will still wait; they won't have real choice; the system is still centralised and there is little diversity of provision.

# The NHS isn't working

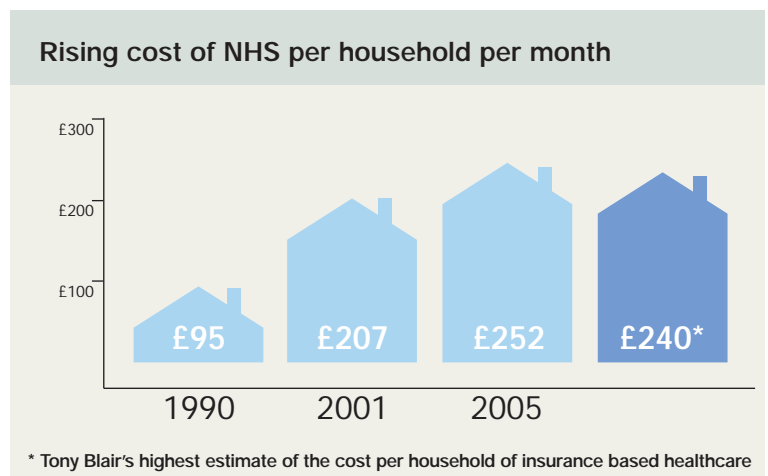
## Spending increases haven't worked

- Money has been poured into the NHS. In just four years, between 1997-8 and 2001-2, the total health budget in England has increased by a third – from £35.3 billion to £49.8 billion. But there has been little impact on performance. In fact some services have got worse.
- Hardly any extra patients have been treated. For the second quarter of 2001, the NHS treated 1,276,000 waiting list patients, compared to 1,211,000 in the second quarter of 1997.<sup>1</sup>



- The latest figures compare the number of waiting list patients treated between April and December for 2000 and 2001. These show that, despite an increase of nearly £5 billion in total health spending, only 2,000 extra patients were treated. As John Yates of Birmingham University commented: "We are putting a lot more money in, and appointing a lot more consultants, but we are not getting any productivity increase".<sup>2</sup>
- The Adam Smith Institute has estimated that only 17 per cent of new health resources reach front line services. This is supported by a recent report from the NHS Director of Finance. For 2001-2, £1.9 billion is being spent on higher salaries; £1 billion on more drugs; £800 million on new capital and training and £150 million on clinical negligence claims. Only £550 million went on new staff.<sup>3</sup>

- The failure to increase productivity means that waiting lists remain above one million. They have remained at over one million since 1993, despite an increase in spending of two thirds, from nearly £30 billion to nearly £50 billion.
- Scotland, Northern Ireland and Wales already spend at the European Union average on health. Yet they have poorer standards of health and, in the case of Northern Ireland and Wales, longer waiting lists than England. In Scotland the average wait for an operation has risen from 44 days in December 1997 to 57 days now.<sup>4</sup>



<sup>1</sup>Department of Health. <sup>2</sup>Financial Times, 16 February 2002. <sup>3</sup>The Times, 28 March 2002. <sup>4</sup>Sunday Times, 16 December 2001.

## Political targets

- Politically set targets give a misleading impression of overall performance. For example, the Government has set targets to reduce the number of patients waiting for extremely long periods. But, overall, hardly any extra patients have been treated. So a cut in the number of patients with extremely long waits can only be achieved by making more patients wait for shorter periods.
- Over the year 2001, the number of patients waiting for longer than 12 months fell by 15,000. But the number of patients waiting for between 6 and 12 months rose by 10,000 and the numbers of patients waiting for less than 6 months rose by 23,000.
- Artificial targets also distort clinical priorities. Over half of consultants admitted distorting their clinical judgements to meet a previous government target to reduce the waiting list by 100,000.<sup>6</sup>

## Resources are wasted

- The Department of Health itself has estimated that 16 to 20 per cent of the NHS budget – between £7 billion and £10 billion – is lost through waste, fraud and inefficiency.<sup>7</sup> Stuart Emslie, a risk control expert at the Department, listed the following major items of waste:
  - ▶ £1 billion to £3 billion lost through fraud such as patients falsely claiming free prescriptions.
  - ▶ £2 billion on mismanagement of hospital resources, such as “bed-blocking” by elderly patients who cannot be discharged from hospital because they have nowhere else to go.
  - ▶ £2 billion on sick pay and agency nurses.
  - ▶ £1 billion to treat hospital acquired infections.
- Cancelled operations are another example of waste. The number of cancelled operations has risen from 50,000 in 1994-5 to 80,000 in 2000-1.

## A two-tier system

- The failings of the NHS mean that Britain in effect has a two-tier system. A minority who can afford it resort to private care, but the majority have to accept an inadequate service. According to the Independent Healthcare Association, the number of people paying for their own operations rose in 2001 by over 25 per cent to over 250,000.<sup>8</sup> BUPA reported a 30 per cent increase in self-pay operations between 1998 and 2000.
- The Secretary of State for Health, Alan Milburn, has admitted: “The reason people go private is because ... they’ve got to wait so long on the NHS. I think a lot of people feel like they are forced to go private, somebody with a bit of savings who might be in their 50s or early 60s, they have saved hard all their lives and they’re suddenly told that they need a heart operation and they are faced with this terrible dilemma of either paying or waiting.”<sup>9</sup>

## Cancer care

Despite increasing resources, cancer services have actually got worse. Research has shown that, in 2000, only 32 per cent of patients were given radiotherapy within four weeks of being told they needed it, compared to 68 per cent in 1998. The author, Dr. Nick James of the Institute for Cancer Studies, University of Birmingham, said: “Tumours don’t get smaller while you wait – they get bigger. I’m sure patients are dying unnecessarily”.<sup>5</sup>

The extra money is not reaching the frontline. The Government increased cancer funding by £280 million in 2000-1. But a House of Commons Science and Technology Committee study concluded that the money had been lost in the system. Professor Gordon McVie, Director General of the Cancer Research Fund, said: “I think there is still some mystery about where some of the money is. I would have thought that seven-eighths of the resource has not yet got out there”.<sup>10</sup>

The same has happened in 2001-2. James Watson, a consultant radiotherapist at Addenbrooke’s, Cambridge, said: “We officially discovered we got £700,000 for cancer services, but we never saw it. I don’t know where it went.” An NHS official said: “There’s spin, there’s noise, there’s people saying it’s glorious – but it’s not. We’re exactly where we were five years ago.”<sup>11</sup>

## Accident and Emergency

The Government’s target is that, by 2004, no patient should wait longer than 4 hours to see a doctor in an Accident and Emergency unit. But, despite increased resources, fewer hospitals are meeting the target. In 1996, nearly 90 per cent of hospitals met the target. By 2000, only 75 per cent did so.

The Audit Commission monitors the performance of hospitals towards the target. Its last report in October 2001 concluded: “Waiting times have been increasing since first measured by the Audit Commission in 1996. The rate of deterioration has increased since 1998.” Sir Andrew Foster, controller of the Audit Commission, said: “It is clearly disappointing that there is extra investment and doctors yet waiting times are growing quite significantly.”

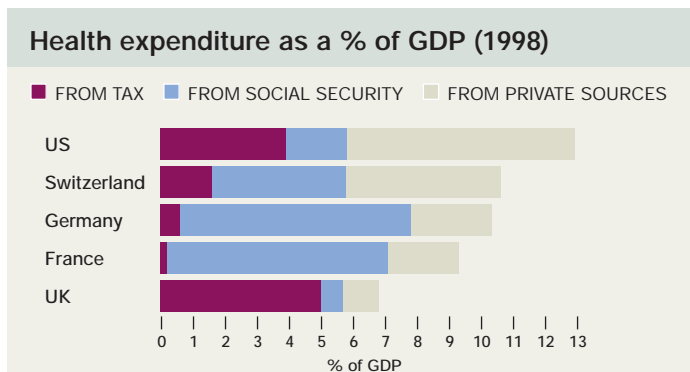
<sup>5</sup>The Observer, 3 March 2002. <sup>6</sup>National Audit Office, 2001. <sup>7</sup>Sunday Times, 2 December 2001. <sup>8</sup>The Observer, 31 March 2002. <sup>9</sup>The Observer, 31 March 2002. <sup>10</sup>Cancer Research – a follow up, House of Commons Select Committee on Science and Technology, March 2002. <sup>11</sup>The Observer, 17 March 2002.

# Why other systems are better

There is a debate on the provision of healthcare in every country, and no system is perfect. But any fair analysis of alternative systems reveals that the NHS, the only system paid for by tax revenues alone, delivers a significantly poorer standard of care. With more flexible systems other countries are able to spend far more and use resources more efficiently. Their patients enjoy higher standards of care and greater choice.

## More resources

- The NHS is one of the most underfunded health services in the developed world. For the period between 1972 and 1998, under-investment in the NHS compared with the EU average was £267 billion.<sup>12</sup>
- On the latest statistics Britain spends less on health as a proportion of GDP than nearly every major country. Other countries spend more by raising health funds from a variety of sources.



- Britain has fewer doctors per head of the population than most of the developed world. France and Germany have more than twice as many.
- The Government has announced that it is succeeding in increasing the capacity of the NHS, for example, by employing 10,000 more nurses over the last year. But experts at the King's Fund have estimated that the NHS would need an extra 100,000 doctors and 300,000 nurses to meet German levels.<sup>13</sup>
- The Association of British Neurologists has reported that while European countries provide one neurologist for every 20-30,000 patients, Britain provides one neurologist for every 177,000. The Royal College of Radiotherapists has reported that France has four times as many radiotherapists per head of population as Britain.<sup>14</sup> Britain has about half as many radiotherapy machines per million people as France or Germany, and only a third as many as the US.

## Shorter waiting times

- As a result of this lack of capacity, Britons wait far longer for treatment than people in other countries. Over one million people remain on the NHS inpatient waiting list alone. In a survey in 2000, a third of Britons reported that they had waited for longer than four months for a non-emergency operation. Only 1 in 8 Canadians and only 1 in 100 Americans had waited as long.<sup>15</sup>
- In Britain, the average wait for hospital treatment, once an appointment for surgery has been made, is 136 days.<sup>16</sup> For some conditions the wait is much longer: the average wait for heart bypass surgery is 266 days, and for hip replacements, 243 days.<sup>17</sup> In France and Germany, there are no waiting lists except for transplant operations.

## Better standards of care

- For nearly every cancer, Britons have a lower chance of survival than continental Europeans and Americans. Two thirds of women suffering from breast cancer here are alive five years after diagnosis, compared to four-fifths in France and America. If Britain achieved the European average performance in cancer care, 10,000 lives a year would be saved. If we met the best European performance, 25,000 lives a year would be saved.<sup>18</sup>
- New OECD figures have shown that Britain also performs extremely poorly in regard to treatment of heart diseases. Britain carries out the fewest heart bypasses of any developed country; for every 100,000 people, 35 Britons were given heart bypasses in 1999, compared to 60 in Greece, 90 in Germany and 202 in America.<sup>19</sup>

## Real choice

- British patients can only exercise choice over their GP. But other systems allow patients to choose the hospital and specialists to treat them.

"When we pay taxes in the UK the money goes to the Treasury which treats it as its own. It is not seen as an advance payment for services to be provided. Under social insurance systems premiums are payments to third party insurers which are under an obligation to serve customers. Perhaps the most important thing for Mr Blair to realise is that several countries have systems based on insurance which do not compromise social solidarity" (David Green, Director, Civitas, The Observer, 2 December 2001).

<sup>12</sup>Securing our Future Health: Taking a Long-Term View, Interim Report, Derek Wanless, HMT, November 2001, p37. <sup>13</sup>Health Service Journal, 1 November 2001.

<sup>14</sup>The Observer, 19 March 2002. <sup>15</sup>Health Affairs (2000). <sup>16</sup>Healthcare Navigator Patient Waiting Times Monitor, edition 6. <sup>17</sup>Dr Foster research quoted in The Mail on Sunday, 10 March 2002. <sup>18</sup>EUROCARE 2 Study, 1999. <sup>19</sup>Daily Mail, 19 February 2002.

# How the NHS lags behind

	UK	USA
Spending (as % of GDP, 1998)	6.8	12.9
Approx spending per head of population (1998)	£990	£2,460
Number of doctors per 1,000 population (1998)	1.7	2.7
Main system of funding	National Health Service. Contributions are made through general taxation. Funds collected and distributed by Treasury.	Most people are covered by private health insurance (see below).  35 million people over the age of 65, and 5 million disabled, are covered by Medicare, a federal government programme. It is funded from taxation and social security payments.  33 million people on low incomes can use Medicaid, a programme delivered by individual states and funded from federal and state taxation.  2 million children are covered by the State Children's Health Insurance Program, funded by taxation.
Charges	No payment at point of use.  Limited flat rate charges for prescriptions, eye and dental care. Exemptions apply.	In federal programmes limited charges are made. The least well off are exempted.  Different insurance schemes impose varying levels of charges.
Private insurance	Owned by 11 per cent of population.	71 per cent of Americans have private health insurance. However 39 million are not insured, including around 8 million children.
Choice	Very limited choice of GP within area of residency.  No choice of hospital or physician.	For the privately insured, the degree of choice varies by the insurance plan.
Waiting lists	1 million people waiting for hospital treatment.	For insured, no waiting lists.

In Britain, one million people remain on waiting lists. There are none in France or Germany.

Up to a fifth of the NHS budget – £10 billion a year – is lost through waste, fraud and inefficiency.

France	Germany	Switzerland
9.3	10.3	10.4
£1,390	£1,630	£2,350
3.0	3.5	3.3
<p>Assurance Maladie (Illness Insurance).</p> <p>Compulsory contributions are made by employees and employers. Employers pay 12.8 per cent of salary; employees pay 8.25 per cent.</p> <p>Contributions are paid into funds determined not by the choice of the employee but by their occupation.</p>	<p>Gesetzliche Krankenversicherung (Statutory health insurance).</p> <p>Compulsory contributions are made by employees and employers.</p> <p>c.450 insurers offer the same statutory package of care at different prices. Individuals can choose their insurer – the average contribution is 13.5 per cent of salary. Employees pay half and employers pay half.</p>	<p>Loi d'Assurance Maladie (LAMal Compulsory Basic Social Insurance).</p> <p>Compulsory contributions paid by employees only.</p> <p>93 insurers offer the same package of care at different prices on a non-profit basis. Individuals can choose their insurer. Premiums are set according to place of residency.</p> <p>Government pays the premiums of poor people.</p>
<p>Charges are levied at the point of use and then reimbursed minus a flat rate charge of 6 Euros (£4) (the 'ticket modérateur').</p>	<p>No payment at point of use.</p> <p>Three levels of prescription charge.</p>	<p>Some payment at point of use. Patients are billed up to a minimum of 230 SFr (£100) in any year. Thereafter patients pay 10 per cent of any charge.</p>
<p>87 per cent purchase private health insurance.</p> <p>It does not offer quicker treatment or treatment at a higher standard, but covers the cost of charges, upgraded hospital facilities, upgraded optical and dental care.</p>	<p>9 per cent choose to extend their GKV social insurance package to cover benefits such as dental care, optical care, spa cures and choice of the very best physicians.</p> <p>Above a certain income level it is possible to opt out of the state social insurance system. 10 per cent choose to do so.</p>	<p>30 per cent choose to extend their CBSA package, as in Germany, to obtain greater comfort in hospitals and choice of top physician.</p>
<p>Free choice of GP.</p> <p>Free choice of hospital or physician.</p>	<p>Free choice of GP.</p> <p>GP recommends hospital – but patients make choice.</p>	<p>Free choice of GP.</p> <p>Choice of hospital in canton of residency.</p>
<p>No waiting lists.</p>	<p>No waiting lists.</p>	<p>No waiting lists.</p>

If Britain met the best European performance on cancer care, 25,000 lives a year would be saved.

Only 17 per cent of new health resources reach front line services.

# Attacks answered

Ministers have begun to attack other countries' healthcare systems, so as to persuade the public that there is no alternative to a taxpayer funded NHS. But every one of their claims is misleading.

- At a press conference on 6 December 2001, Tony Blair claimed that any alternative to funding the NHS through tax would be more expensive for families. He alleged that "it would cost a British family between £130 and £240 a month to insure themselves". But the independent think tank Civitas has shown that the average British family already pays £207 a month towards the NHS, which will rise by up to £50 as Government health spending increases to the EU average. In 2001-2, the NHS will cost nearly £62 billion, divided between nearly 25m households.
- "In many countries, where private insurance or charging is the norm, the cost of catastrophic illness can be financially catastrophic. You can run up bills of £100,000, £200,000 or even £500,000 for serious operations and the necessary drugs and care." (Gordon Brown, 17 March 2002). The Chancellor is scaremongering by suggesting that an alternative to the NHS would mean people paying bills of hundreds of thousands of pounds for treatment. Social insurance schemes in other countries cover these costs.
- "Under France's social insurance scheme you have to rely not just on your own taxes but on your own employer paying a lot – even then you have to pay charges on top every time you visit a doctor or hospital." (Gordon Brown, 17 March 2002). Social insurance schemes do not necessarily involve burdens on employers – in Switzerland, for example, premiums are paid by individuals, with the government assisting people who are unable to afford them. In France, patients claim back nearly all of their charges, and in the German social insurance system, patients pay no charges at all.
- "In practice countries such as France are moving from social insurance towards greater use of general taxation." (Gordon Brown, 20 March 2002). This is misleading. A recent reform has increased insurance payments by individuals rather than employers. But the money is still paid into the central insurance fund, which is not controlled by government.
- "Rising knowledge of genetics also seems likely to further exacerbate the problems already present in private insurance systems. People with a predisposition for a particular disease will be open to discrimination and may face excessive premiums, reductions in coverage or find it impossible to obtain private insurance altogether." (Gordon Brown, 20 March 2002). This is also scaremongering. Social insurance systems do not levy costs according to the health profile of individuals. In France and Germany, premiums are a set percentage of salary. In Switzerland, premiums are 'community rated' – ie. set according to a particular location.
- "The choice provided between different funds within the social insurance system can, in practice, be constrained. In Germany, for example, there are over 400 different insurance funds but what they cover is strictly defined in law leaving little room for choice." (Gordon Brown, 20 March 2002). In Germany and in Switzerland, by law, insurance funds have to deliver a certain package of care to ensure that no patient is disadvantaged. But the funds compete on the basis of price and their service to patients.

"We have constructed for ourselves the most appalling health system. The time has come to totally rethink it...

It's amazing that we've got a system so bad that we consider a 10-month wait natural."

(Lord Desai, Labour peer and former Labour health spokesman, 3 February 2002).

"The variants of social insurance that are under discussion in progressive countries such as the Netherlands do introduce elements of patient choice that the NHS system does not presently permit."

(Peter Mandelson, The Guardian, 6 December 2001).

# The Government's 'ten year plan' is not real reform

The Government's ten year NHS plan aims to create an NHS "redesigned around the needs of the patient." But its reform programme actually falls far short of this ideal.

## 1. Patients will still wait.

According to the Government's NHS Plan, by 2005 no-one will wait longer than six months for hospital treatment. The "eventual objective" is that, by 2008, no one will wait longer than three months.

But patients in other countries already face far shorter waiting times. Patients in France and Germany do not face any waiting lists at all. In a 2000 survey, only 1 in 8 Canadians and only 1 in 100 Americans had waited longer than four months for hospital treatment.

## 2. Patients won't have real choice.

The NHS Plan states that for the "first time, patients will have a real say in the NHS". But, crucially, it does not envisage that patients will be able to choose a hospital or the specialist who will treat them – a choice taken for granted in other countries.

Patients will be encouraged to express their views on services rather than exercise real choice. Each hospital and Primary Care Trust must create a "Patients Forum", "to provide direct input from patients into how local NHS services are run."

## 3. The system is still centralised.

More of the NHS budget is being channelled through Primary Care Trusts (PCTs) – groups of GPs and other local health services. The aim is to allow front line doctors to mould the development of services.

But it is unlikely that the system will become truly responsive to patients since the NHS budget will still be distributed by the Department of Health. In other countries, patients or their representatives influence the distribution of funds.

Furthermore, PCTs (and hospitals) must respond not only to the many targets set by the Department of Health but also to the guidelines laid down by new central government agencies, such as the Commission for Health Improvement, the National Institute for Clinical Excellence and 28 new Strategic Health Authorities.

## 4. There is little diversity of provision.

The "Concordat" agreed between the Government and the Independent Healthcare Association in 2000 established the basis for working partnerships between the private and public sector in healthcare. Ministers have been keen to stress that, in principle, publicly-funded NHS care can be delivered by any provider whether public, private or voluntary.

But new partnerships have been very slow to emerge. A flagship scheme with a small BUPA hospital in Surrey was announced in December but has yet to be finalised. New hospitals are being built under the Private Finance Initiative (PFI) but the Government has agreed that their staff will remain employed by the NHS, reducing the opportunity to introduce new services and ways of working.

In other countries diversity is well developed. In Germany, for example, 50 per cent of hospitals are publicly run, 30 per cent by private not-for-profit organisations and 20 per cent by private for-profit organisations.

**Reform** is an independent campaign to promote new directions for public policy based on the principles of free enterprise, limited government, and individual liberty.

We do not believe that further spending increases on the NHS in its present form will be enough to solve its fundamental problems. Current reforms do not transfer power from an unresponsive monopoly provider to the patient.

We are campaigning for a proper national debate on the NHS and open-minded consideration of alternative ways to fund and deliver healthcare.

We believe that the ideals of the NHS could underpin a modern national healthcare scheme, offering higher standards of care and real choice to all patients, irrespective of their means.

REFORM  
45 Great Peter Street  
London  
SW1P 3LT

Tel 020 7799 6699  
Fax 020 7233 4446

e-mail: [info@reformbritain.com](mailto:info@reformbritain.com)  
web: [www.reformbritain.com](http://www.reformbritain.com)

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