Reforming the NHS in the UK

Stephen Pollard

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*What is the Labour government doing in its attempt to reform the UK National Health Service? **Stephen Pollard** analyses the history of NHS reform since its inception in 1948, and how the current government is seeking to adapt the old state-funded, state-delivered model to the new century's demands.*

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He has been described by the Sunday Times as a New Labour 'guru', and by the New Statesman as a leading "British neoconservative". His biography of the British Home Secretary, David Blunkett, will be published in January 2005. From 1998-2000 he was a columnist and Chief Leader Writer on the Daily Express. Before that, between 1995 and 1998, he was Head of Research at the Social Market Foundation, and from 1992-95 Research Director at the Fabian Society.

He was Research Assistant to Rt Hon Peter Shore MP 1989-92. He is the author of numerous pamphlets and books on health and education policy, and is co-author with Andrew Adonis (now the Prime Minister's senior policy adviser) of the best-selling A Class Act – the Myth of Britain's Classless Society (Penguin, 1998). He is also a senior fellow at Civitas, the Institute for the Study of Civil Society, in London.

Stephen Pollard

We are living through an experiment in Britain. For decades, the alibi for the NHS' failure to meet the expectations – and the needs – of patients has been a supposed lack of funding. Despite the evidence from across the Channel that almost any other method is more successful at giving patients what they require, the NHS' cheerleaders have been able to live in a political comfort zone. Since there appeared to be no realistic prospect of the NHS ever being handed a budget anywhere approaching the sums which they claimed was necessary for it to do the job successfully, they have been able to press their assertions with little or no chance of the evidence showing them to be right or wrong.

All that changed on 18th January 2000, when Tony Blair pledged that spending on the NHS would increase such that, within five years, Britain would be spending at the EU average – what would amount to a one third increase in the NHS budget. The pledge was met with scepticism. Then, in that July's Comprehensive Spending Review, the Chancellor, Gordon Brown detailed the specifics: an unprecedented real terms increase in NHS funding of 6.1 per cent over the four years to 2003-04, the longest period of sustained high growth in NHS' history. Since the foundation of the NHS in 1948, the average had been 3.3 per cent – substantial on any measure, but dwarfed by Brown's largesse.

The sceptics doubted that the government would be able to follow through. In fact, however, it has spent even more. When Labour took office in 1997, £35 billion was being spent on the

NHS. By 2008, that figure will have risen to £92 billion – a 44 per cent real terms increase from 2002, when the splurge began.

It is, of course, too soon to make a final judgement on the success or failure of this spending. We do know, however, that the political benefits so far to Labour are negligible. Opinion is evenly divided between those who think the NHS has generally improved (35%), those who think it has stayed the same (31%) and those who think it has deteriorated (30%). Indeed, 46% of the public do not even accept that the money has been spent – they believe that NHS spending has stayed the same or even fallen, outweighing the 43% who believe that NHS funding has indeed risen over the past five years.

Four days before Mr Blair's interview, in which he first announced the money, I had been talking to one of his closest confidants. The government was in the middle of a battering over the latest NHS 'winter crisis'. Headlines such as "Elderly patients left starving to death in NHS", "Consultants fear crisis over NHS bed shortage" and "Flu cases soar" were appearing daily. "What if we were to increase the NHS budget by a third; would that do the trick?" my companion had asked me. I wondered what 'trick' meant - dampening down the NHS as an issue, or genuinely improving the system? "Won't it do both?", came the reply.

I could, I suppose, have launched into a detailed explanation as to why simply throwing money at the problem was not the answer. But I was sick and tired of trying. For years, when Labour was in opposition, I had been trying to persuade its senior figures that the problems with the NHS weren't 'Conservative cuts' (there weren't any - only annual increases in spending), the internal market or bureaucracy (managers make up just 2% of the NHS' workforce - if anything it is under-managed) or sundry other explanations. The problem was fundamental: the NHS, as an exclusively tax funded, monopoly provider of health care, is simply incapable of delivering what the public wants from it. So I pointed out that, although the Prime Minister would no doubt get hurrahs from the NHS establishment, he would effectively be throwing away billions of pounds of taxpayers' money; it would have no worthwhile effect.

The adviser was nonplussed: "But that's what it needs, isn't it, lots more money?" I reminded my friend that the reason why the rest of Europe spent so much more on health was because of their extra private spending, not any more tax spending.

The adviser got twitchy: "Well, Tony's been looking at this, and he's realised that the only way to save the NHS is with an enormous dose of money, and a complete change in its working methods."

I had a sense at the time that the party venue where our conversation took place would one day seem appropriate: the Dome.

There are two ways of looking at such a vast increase in spending. One is to take heart that, at last, the NHS is getting the money it has always needed. The other is to note that lack of funding is indeed not the problem – and never has been. The real problem is more fundamental – the very notion of a state funded, state delivered health service is what is at fault. The outcome of this experiment – whether it is the former or latter interpretation of the spending increases which is correct - will determine if the government has been wise and

sensible or reckless and profligate. The evidence of the past suggests that, since the government's analysis is flawed, so will be its prescription.

Ever since the NHS' creation in 1948, health economists have argued that it is underfunded, and that if only it was given more money it could do the job expected of it: providing "a comprehensive service covering every branch of medical and allied activity", free to all at the point of use and to the highest possible standard, as the original White Paper put it in 1944. At no point has it succeeded in that aim; but in recent years it has fallen further and further behind. In all but two of its 53 years, funding has risen in real terms.

However many times the figures are given, it seems few people are prepared to look at them. The UK spend on healthcare for most of the past decade has been around 6.5 to 7% of GDP, compared with an EU average of almost 9%. Case proven, you might think - an underspend of over 2%. No wonder the NHS has been in such straits. Except that the figures are more complicated than that. The amount we spend on state-provided healthcare has been much the same as in the rest of the EU; the UK figure is less than half a percent below the EU average. The difference was made up in private spending, where our figure is tiny. The state element - the NHS - simply was not underfunded compared with the other European systems.

And yet on almost any measure of success, the NHS disappoints. There is no need to recite once more the NHS' litany of failure; on almost any measure of acceptability, from cancer survival rates to hospital cleanliness, the NHS forces us to accept conditions which would shame any of our neighbours. In a report for the World Health Organisation, the NHS came 24th, behind such giants as Andorra and Malta, as well, of course, as almost all our European neighbours. And Switzerland, which has a fully private system of competing insurers, beats the NHS hands down in its treatment of the poor.

The reasons why we have such a poor system are relatively straightforward. One, which does need to be confronted, is that we have so few doctors. We in the UK have 1.7 per 1,000 people; Germany has 3.4, France 2.9 and even Poland 2.4. For that, we have the British Medical Association to thank.

Decades ago, the BMA put a cap on the number of trainees to ensure a permanent shortage, and thus ever higher wages. But even if we were to have the same number of physicians, the structure of the system would mean that we still lagged behind.

The frustration is that the debate in the UK is so warped by ideology. Even the current Labour government, so free of ideological baggage in many areas, has retreated into its shell over the NHS, and decreed that as much money as possible must be raised via taxation to be allocated to the NHS, despite state health spending being no greater elsewhere.
On any rational analysis, politicians would have turned to alternatives years ago. But the NHS is, as the former Chancellor, Nigel Lawson once called it, the English religion.

Three new factors have all fed off each other to undermine for good the foundations of the NHS. Demographic change means not only that the tax base is shrinking but also that the demands placed upon the NHS are ever greater. In 1971, 13 per cent of the population were over 65, and 900,000 people over 85; by 2041, 25 per cent of us will be over 65, with 3 million over 85. Thus, at the very time when the costs of looking after so many more elderly are rising, so the proportion of the population of working - and so tax paying - age is shrinking.

The cost of constantly developing and improving medical technologies puts ever greater pressure on centrally controlled and funded budgets.

And, in some ways the most important of all, the rise since the 1970s of a new and strident consumerism means that the public is no longer prepared to put up with failure just because it likes the ideological cuddliness of the NHS. The NHS was introduced in 1948 into a system where open rationing was the norm, where doctors were demigods whose word was taken as holy writ, and where we humble patients were grateful for whatever we were given. Today, if Dixons – the UK's leading electrical retailer - told us we would have to wait a year for a TV we would take our custom elsewhere.

The government has introduced a series of reforms which are designed to inject more flexibility into the NHS, such as Diagnostic and Treatment Centres and Foundation Hospitals. The former is part of a new willingness to commission private providers to undertake NHS treatment, the latter intended to lift the dead hand of bureaucratic and central control within the NHS. The government maintains that the combination of extra spending and managerial reform is critical: the one without the other cannot work – but the two combined provide the answer to the NHS's problems.

That the government itself is wise to the public's changing perceptions of what the NHS is for, and where it might be heading, can be seen from the rise of 'health tourism' as an issue. 24% of the public cite as the NHS's biggest problem people using the NHS who have not paid into it. The phrase was almost unknown in 2002. By 2003, however, newspaper reports (often in tandem with reports about asylum seekers) had brought it to the front of the debate over the provision of healthcare. As the NHS operates at the moment, anyone can turn up at a hospital and expect to be treated. That means that they do. And this includes some people from abroad who come to the UK specifically to take advantage of a free NHS. The Health Secretary, John Reid, has some of the shrewdest political tentacles in the government, and could see the damage that such behaviour could do to the NHS model. Thus, in December 2003, he launched an 'initiative' to keep it in check. Although Dr Reid calculated that this 'health tourism' costs the NHS £200 million a year, money is not the real issue. In terms of the NHS' £68.7 billion budget in 2003, £200 million is, after all, chicken feed. And there is little evidence that 'health tourism' is any worse today than in previous years. What has changed is that, in the past, the idea of an NHS which was free – to everyone - was so widely shared that we put up with what we now think of as abuses, such as health tourism.

The real waste is not such headline grabbing issues but more prosaic problems such as bed-blocking, when the elderly are forced to stay in hospital when they are medically fit to leave. Every day, more than 3,500 older people remain in hospital simply because no follow-up care is available outside. Around one-third of those are stuck in hospital for over a month. This bed blocking accounts for 1.7 million lost 'bed days' every year. The Department of Health does not expect to be able to reduce the number of people delayed to less then 2,500 by the end of 2005. So Dr Reid is looking to the US, where elderly patients of Kaiser Permanente, a not-for-profit health insurer in California, spend a third of the time in hospital that NHS patients spend for such problems as asthma, bronchitis and strokes, and yet achieve far better clinical results. That is also why he has decided to give foreign health care providers most of the £2 billion programme to build fast-track treatment centres to cut the NHS waiting list.

Times have changed since the days when no one really cared whom the NHS treated. The government is now ploughing so much money in that the public is no longer prepared to put up with paying for the treatment of foreigners who come to the UK to mend their health on someone else's money. Dr Reid well knows that if he does not demonstrate that he is alive to such concerns, he risks undermining Labour's entire case for taxing and spending.

Once, however, it is accepted that health care should be made available not on the principle that everyone is always treated but only to those who qualify for it, then the entire debate about the provision of health care has been transformed.

The health debate in Britain is nothing if not ironic. Europhile Labour says we have nothing to learn from those weird, inequitable Continentals, whilst the Eurosceptic Conservatives go off on their Grand Tour and return with tales of wonder of how equitably the Europeans manage their affairs.

No one disputes that the total amount spent in Britain on health has been too small. But the difference between the UK and the EU has been in the amount spent privately. In terms of the state's spending on health as a percentage of GDP, the numbers are relatively similar. So this is the real question: should we do what they don't, and close that gap by increasing taxes to pay for spending ever-greater amounts of public money; or is there a better way to fund - and run - our health system?

Not according to Derek Wanless, the former banker asked by Gordon Brown to examine the alternatives. Mr Wanless' conclusion could have been written by Bevan himself: "The current method by which health care is financed through general taxation is both a fair and efficient one, with no evidence that any alternative financing method to the UK's would deliver a given level of health care at a lower cost."

Spending on the NHS in Scotland has consistently been among the highest in the EU, some 20 per cent higher per person than in England. The Scots have, relatively, 30 per cent more consultants, a third more GPs, 30 per cent more nurses and a third more acute beds. Yet far from outperforming the rest of the country, waiting lists in Scotland are even worse. And in terms of health outcomes, death rates for heart disease, cancer and strokes are worse than in any other Western country.

The problem has not been that the NHS has been under-funded but that we have a system which only permits tax funding, and which thus rules out any of the gains of competition, innovation and consumer responsiveness. The underfunding has been private, not public - and that has been because of the NHS, not in spite of it.

Ah well, you see, says Mr Wanless: "Success or failure will ultimately depend on how effectively the health service uses its resources." In other words, the NHS has not been properly run. It is a familiar argument: the line we have heard from Tony Blair, Gordon Brown, Alan Milburn and now John Reid almost every day since the launch of the NHS plan in July 2000. In other words, until now no politician, civil servant or manager gave a second's thought to making the NHS more efficient. How inconvenient then that, as Mr Wanless writes later: "The health service has been through many reorganisations over the past 20 years." The truth is that, over the NHS's 56 years there have been constant attempts to make it work, and none has cracked it. The reason is that there is a basic flaw in the model.

The Government's stated aim is to make the NHS more responsive to consumers. But there cannot be many people who seriously think that the most efficient, most convincing way to do that is by strengthening a public-sector monopoly (which the NHS remains, however much it contracts out some of its service provision).

There are characteristics common to all the most successful systems.

First, there is a large measure of taxpayer funding. No one seriously proposes ending that. Accusing those who point to the relative success European models of wanting "privatisation" might score cheap debating points, but it is nonsense. Even in the US, often cited as the most lunatic free market model, 45 per cent of healthcare is tax funded.

What make other systems different - and vastly more successful at delivering healthcare - are the final two common threads. Secondly, there is a much larger degree of private, non-tax, non-compulsory insurance spending than in the UK. And thirdly (in reality the same point), instead of a state monopoly, there is competition between providers - some state, some private, some profit making, some not-for-profit.

Most European systems are based not on paying taxes into a vast pool to the government, which then decides how money is spent, but on "social insurance", in which contributions go to independent sickness funds which are directly responsible and accountable to the payer. Depending on the country, there is a greater or lesser degree of choice as to which fund one joins, and as to which works best. Switzerland, for instance, has a system of competing insurers with an almost totally free choice. Far from this meaning the poor suffer, Switzerland has far better health outcomes than the UK, despite (ignore the mythology of Switzerland) a greater proportion of poor amongst the population; and the concept of waiting lists is unknown. If one’s premium exceeds between 8-10 per cent of taxable income, one is entitled to a subsidy from the state.

In Ireland, where one can opt for private cover, there is an equally successful method of guaranteeing good treatment for the poor. Insurers have to offer "open enrolment" where anyone can join a scheme, regardless of pre-existing conditions, with lifelong cover so that, as people grow older and pose a greater cost threat to the system, they are not cut off. Risks are spread among pools of insured people so that premiums for individuals are not unaffordable. And insurers in Ireland have to offer a minimum level of benefits to ensure that private patients are no worse off than the NHS patients.

In the same vein, Germany is steadily increasing the degree of choice of sickness fund available to patients, but to prevent cherry picking by the funds it has introduced a risk-adjustment formula to make those funds with healthier members transfer revenues to those with a greater share of more costly members.

In Gordon Brown’s 2002 Budget, he remarked that his intention was “to make our NHS the best insurance policy in the world”. The key word is “insurance”. It is no mere coincidence that the bulk of the revenue raised for the NHS in that Budget came from National Insurance. It is critical to the government's approach, which is to argue that the extra money will not disappear down a black hole but that it is, in effect, a premium which we pay for the NHS.

The NHS is paid for by the 27.4 million taxpayers. At the moment it receives £65.4 billion a year. That works out - the "premium", if you like - at £2,387 per taxpayer. By 2008, with NHS spending having grown to £92 billion, the premium will have risen to £3,358 per taxpayer. These figures are, of course, rough guides but they serve a purpose. Asked in the focus groups how much money is spent on the NHS for every man, woman and child in Britain, people are simply clueless. Estimates vary widely from "a couple of hundred" to "£50,000?" and "£80,000?". When told that the figure is in the region of £1,200 (the above 'premium' is for taxpayers alone) the reaction is mixed: "I'd never thought it would be that high, not for the service you receive"; "That seems excessive. What happens if you don't use it? Does it go back into the pot for next year?"

In Ireland and Australia, patients are now given the choice of opting out of their NHS-style healthcare systems in return for a rebate. Just as in Britain today, they all used to pay the same sort of notional premium because they were all supposed to receive the same level of care. Now they can get a rebate from their taxes and turn to a wide range of alternative providers who have sprung up to cater for this new market. Even those patients in the state-funded system benefit because the Government has far more options to choose from when it needs to contract out treatment for its own patients to the private sector. More money flows into healthcare because opted-out patients tend to choose to spend more. Everyone wins.

If the government's spending gamble fails, the talk of insurance and premiums will boomerang back. We may soon start to ask why we have to hand our dramatically increased premiums over to the government to spend for us, and why we cannot spend them where and how we would like.

The notion of the NHS as an insurance policy is politically advantageous but in reality no more than a ruse to justify vast spending increases. The idea of standing up and saying "Money, that's the answer, lots of it, and quickly," is anathema to the Prime Minister; but that is what he is, in effect, saying. So the talk is now of a "consumer-led NHS". And what could be more modern than that? The NHS may be a public sector monopoly, but if it is consumer focused, so what? So we'll reform it. How will we do that? An NHS Plan! Yes, a Big Plan. And we'll make sure it changes by doing it ourselves, running it from Whitehall. We'll set up Boards, full of people who know about these things, and we'll give them tough names, like Modernisation Agency, and that'll show how serious we are.

But it doesn't matter how much one talks about management incentives and the importance of "consumer focus": the NHS was created to serve a society where rationing was the norm and the state was viewed as the ideal engine for growth.

Contracting out the provision of services is all very well - and it is in its own way pretty sensational that a Labour health secretary can, from a party which despised them for decades, now describe private providers as "a member of the NHS family", as Alan Milburn did of Bupa when signing a contract for express surgery provision. But for all that, such agreements are nothing more than contracts for the supply of services, which are no more and no less significant than any other contract between the NHS and any other of its suppliers. It makes not the slightest difference to the big questions: how do we fund healthcare, and how do we structure its delivery to provide patients with what they want?

In this context, the most important of all the changes introduced under Labour is probably NHS Abroad, if for no other reason than that it demonstrates what can be done by other systems. Soon we will all know of someone who has benefited. And we will all be asking the same question: how come the rest of Europe can do it, and we can't?

Just as it makes perfect sense for the NHS to buy surplus services from the private sector, so too it is sensible for patients who cannot be treated in the UK to go abroad. Alan Milburn, who introduced NHS Abroad, was right to try to open up the NHS so that, as on the continent, services are delivered by many different types of organisations, from mutuals and charitable trusts to profit making companies. But it is missing one crucial part of the equation to look at the continent, see that they use all sorts of providers, and think that if we did the same, and increased spending, everything will come right. The differences in the two funding methods are equally critical. On the Continent, sometimes services are paid for directly and then reimbursed, sometimes they are paid for via the insurer. The point is that if they do not attract patients, they do not get revenue. The patient controls where his or her money is spent.

(NHS Abroad was a politically dexterous manoeuvre by Mr Milburn. He had resisted all calls for such a policy. In the summer of 2000, the European Court of Justice held that two patients were entitled to claim reimbursement from their own national systems for treatment they had had abroad. Mr Milburn saw the import of this ruling and gained political credit for an innovative move. In reality, he saw that his hand was about to be forced and stepped in before being presented with a fait accompli.)

For the first time in its 56 years, the NHS has the money which its cheerleaders have always said it needs. It is kill or cure both for the NHS and for the Government's reputation. If money is indeed the answer to the NHS's problems and we start to see clear, tangible evidence of improvements, Labour will reap the political rewards. But if, after two or three years, no one notices much difference then the electorate may soon decide that someone has to carry the can for an extravagant waste of billions of pounds. And, perhaps still more importantly, some thing will also have to carry the can - the NHS itself.

The reason why this is such a gamble for the government is because the evidence points to the latter. Since 1997, spending on the NHS has already risen by 40 per cent. Yet activity has increased by a paltry 6 per cent - a pretty awful return on any investment. Between 1999 and 2000, for instance, spending rose 9.2 per cent but the number of extra cases dealt with rose less than 1 per cent. Again, between 1995 and 2000 the number of consultants rose 20 per cent, yet the number of day cases rose only 5 per cent. Such examples - plucked at random - are the antithesis of efficiency. They represent productivity chaos.

The government's attempts to change this – to accompany the extra money with structural changes which will have a genuine impact on productivity and efficiency – reveal in their failure the futility of the task. Take Foundation Hospitals.

Foundation hospitals were to be the means by which entrepreneurialism could be introduced into a Stalinist NHS. Hospitals would be "set free", free to expand in areas in which they had expertise and a competitive edge, free to set their own priorities, free to set their own wage rates and employment terms, and free to respond to patient demands as they best saw fit. As Alan Milburn put it at the 2002 Labour Party conference: "we want the NHS not to be owned by me but to be owned by the local community".

An NHS of one million employees - the largest organisation in Europe, after the collapse of the Red Army - could not be run from a desk in Whitehall.

Fine words - so fine, in fact, that they were taken by many in the party as code for the break-up of the NHS, with lots of self-governing individual hospitals competing against each other, and ownership by "the local community" heralding a form of privatisation. They signalled the arrival of those two familiar bogeymen, “a two-tier NHS” and “creeping privatisation”.

As is almost always the case with this government, a promising idea was so neutered by battles and compromises that it lost most of its original purpose. For foundation hospitals to be truly independent, and truly entrepreneurial, they would need to be able to set their own wage rates and employment terms, and to be able to borrow - the means by which any business is able to expand. They can do none of this. Any borrowing must be approved by a regulator - in effect, by the Treasury.

Indeed, as Mr Milburn was delivering his thoughts in 2002, Gordon Brown was speaking in the next room, explaining precisely why he was going to destroy Mr Milburn's vision of foundation hospitals.

"What we've got to watch is that we don't have a situation emerge where commitments are made by organisations that are not the Government . . . and we have got to meet all those commitments," the Chancellor said, conveniently ignoring the fact that universities can already borrow off the balance sheet. But this is not an argument about facts, inconvenient or otherwise, but about ideology. For Mr Brown, the idea of competition - and, heaven forefend, entrepreneurialism - in health, even within a state-funded system, is anathema.
As he has put it: "What we say and do about the NHS is not just about the future of our public services, but about the character of our country. It is an affirmation that duty, obligation, service, and not just markets and self-interest, are at the very heart of our idea of society - at the heart of what it means to be a citizen of Britain."

Foundation hospitals are probably worth having - they do offer some independence, however limited - but they pose no threat whatsoever to the sort of NHS envisaged by the Chancellor. In this aspect of the battle between transformers and consolidators, the consolidators have clearly won.

That is why another promising development is most likely to end up similarly disappointing. As he came to the end of his 2003 Budget speech, the Chancellor proclaimed his ideological triumph: "To those opposite, who have advocated vouchers, fees, new health charges for medical services or basic accommodation, this is the Government's answer: we have not only rejected these charges but are abolishing hospital accommodation charges, not just for pensioners, but for all who have charges imposed on them through the social security system."

Yet in February 2003, in a speech which the Chancellor appeared not to have noticed, Mr Milburn announced that he was introducing the very essence of a voucher: "From December 2005, by when extra capacity will have come on stream, choice will be extended from those patients waiting longest for hospital treatment to all patients. They will be offered choice at the point the GP refers them to hospital. Patients needing elective surgery will be able to

select from at least four or five different hospitals, again including both NHS and private-sector providers."

Nowhere in the speech did the word "voucher" appear. One would not expect it to. Labour hates the word, which it regards as a horrible, right-wing construct. But the meaning of Mr Milburn's words was the same. All patients will be able to choose where they are treated, and by whom, including in private hospitals. The cost of their treatment will be quantified and made available to competing healthcare providers, who will then be free to offer an equal or better service than their rivals. The patient, not a bureaucrat, will decide who carries out the treatment.

Were that to come to pass, it would be the most revolutionary reform to the provision of health care since the introduction of the NHS in 1948.

In the July 2004 Comprehensive Spending Review, the Chancellor confirmed that by 2008 the NHS budget would be £92 billion (a rise of 7.1 per cent a year over the next three years). In other words, spending on the NHS will then amount to 0.35 per cent of the entire planet's measurable GDP, controlled in the end by one man sitting at a desk in Whitehall.

Put like that, it is little wonder that the Department of Health is taking a different tack, and is seeing how it can shift that spending away from Whitehall and into the hands of patients. Dr Reid's promise is that by 2008, patients will wait a maximum of 18 weeks from the time they see their GP and are told they need an operation, to the day when they are admitted for surgery. Another pledge is to allow all patients an unlimited choice of which hospital they are treated at.

And yet there are fundamental contradictions to the notion of choice within the NHS even on the government's own terms. The National Institute of Clinical Excellence, for example, exists specifically to reduce choice. NICE was set up with one of the most misleading launch promises in history: spreading excellence throughout the NHS, ending 'postcode prescribing' and ensuring that all patients received access to the 'best' treatments available.

In reality, NICE was set up by Frank Dobson in 1999 to provide an independent, expert justification for the rationing which has always been a fundamental and necessary part of the NHS' modus operandi. It was a thinly veiled attempt to provide medical cover for intensely political decisions. Not so much NICE as NASTY, as Roy Lilley refers to it: Not Available, So Treat Yourself.

The NHS website defines the service's aims as being "to bring about the highest level of physical and mental health for all citizens, within the resources available, by: promoting health and preventing ill-health; diagnosing and treating injury and disease; caring for those with a long-term illness and disability, who require the services of the NHS." That begs more questions than it even begins to answer: what is "the highest level of physical and mental health for all citizens, within the resources available"; what are "the resources available"; what if "the resources available" are not enough; what is "health"; what is "disability"; what (fill in your own question here…the list is endless)?

It is certainly true that, as new medical technologies emerge, so too our definitions of healthcare change. Viagra is perhaps the most obvious example. Erectile dysfunction can, in

some men, have debilitating consequences across many other aspects of their lives, and a cure can certainly be a clinical need. For others, of course, it is merely about pleasure. Again, cosmetic surgery can often be frivolous. But it can also be one of the most wondrous and necessary of treatments.

NICE employs a deeply flawed methodology known as 'economic analysis' in reaching its decisions. Economic analysis compares the costs and consequences of alternative treatments for any given condition and is promoted as a rational, scientific means of allocating resources and containing costs. But in reality it is little more than a spurious justification for imposing value judgements which are hidden from view and thus discussion.

Indeed, the very purpose of basing rationing decisions on the outcomes of economic evaluation is to provide an apparently objective alibi behind which intensely difficult, and usually unpopular, political decisions - what, and how, to ration - can be hidden. Subjective choices about which treatments to deny, and to which groups of patients, are thus disguised as objective decision-making, and given entirely bogus credibility, when in reality they are no more objective than any other political decision.

But be clear what NICE's guidelines mean: an issue which is fundamental to the critical questions of what we expect from the NHS, and what we mean by health, is being tackled not as the result of a national debate, not as the consequence of individual medical consultations, and not as part of a wider discussion of what we expect from the NHS.

Instead it is being dealt with by sham concepts such as economic analysis, without any consideration of the broader context of how such new medical technologies shape our ever-changing understanding of healthcare and good health. These are issues which cannot be avoided in a tax-funded system. Indeed, they need to be faced in any system. The critical difference is who makes the decision. To talk about consumer choice in a system which depends on organisations such as NICE is not so much sophistry as downright falsehood.

– Q&A –

Cécile Philippe
Thank you Stephen for what has been a very (provocative) talk, is there any chance that they will learn this lesson at Ten Downing Street?

Stephen Pollard
Yes, I think there is, because I think it is, as I characterised it at the beginning, it's an experiment – and like all experiments you discover at the end of that whether something works or something doesn't work. My problem with it is that I think we're taking five maybe ten years or whatever to learn a very expensive lesson but I think it will become clear after a while, but usually when policy wonks stand up and talk about something they are able to talk about things happening in the long term or even the medium term if they're feeling dangerous, well this is something that can be judged in the short term and indeed, you know it could be that I'm completely wrong, and that the money will actually do the trick and that within a matter of – let's be generous, say five years – it will be noticeable that the NHS is indeed delivering to patients what patients want from the NHS, in which case people like me

will have to shut up and go away because we'll have been proved wrong, but what if we haven't been, and that it hasn't made any real difference? Then I think the conclusion will be inescapable, even to this government.

Question 1

I'm Charles Bouchard of Merck and Company. Stephen, we as a pharmaceutical industry looked at this question of health system reform about twelve years ago intensively, examined all the countries of Europe and others worldwide and came to similar conclusions that health systems lack, one, the money, and two, the dynamism that a certain amount of competition private spending might bring, perhaps mixed with, you know, major public spending – but not necessarily so as the Swiss model and other countries may show. But in your remarks, you sited the chancellor who defined once again, as we've always heard all these years, the politics of this matter: Europeans and other countries and places with (social solitary) systems are justly proud that they have universal coverage. But universal coverage does not mean you have universal access and when the money begins to shrink and expectations rise, new technologies arrive and so on, what goes first in innovation and access, you know lines and queues and whatnot, services get denied and so on, and the sector that is the most dynamic, that is where people bring innovative products to the market, are those most likely to be squeezed. So basically we see a political question, how do you make it fashionable for us, even a labour government, to start introducing competition, and here I'm wondering about you know, one of the threats possibly presenting an opportunity.

The squeeze on government budgets has become all the more harsh since monetary union; the master criteria have imposed deficit targets and whatnot and, health spending being a major component of government, this has really helped bridle any increases for whatever reason. So I'm just wondering if in the context of Europe there are new ideas, new ways of looking at this that can be introduced, because I think the basic thrust of competition is correct, it's how you get this to be politically fashionable and acceptable.

Stephen Pollard

That's a nice easy question isn't it? Do what no politician in Europe has managed over the last fifty years. Let me give you one very – I'll come to Europe in a second, but just in a British context and I think in some ways one can extrapolate from this, without getting too detailed – if you look at foundation hospitals which were meant to inject a form of competition into a state system by giving local hospitals the ability to compete against each other, well you know, that was not, nobody was changing the ownership, nobody was talking about them making profits that would do anything other than go back into the state funding more generally, so this was just about competition, it wasn't about privatisation. The problem was that labour MPs, for all the new "labourness" of labour and Blair (I've always characterised Blair and New Labour as being a coup within the labour party), indeed even you can see from some of the remarks from Gordon Brown that even though these two great ideological soul mates are at the top of the tree, even within that great relationship they have their tensions and ideology, but for most labour MPs the idea of competition is anathema almost in any area, in the idea of health service it's almost immoral to have competition because somehow competition means winners and losers and if you have losers in health then you are being immoral.

Now the government couldn't even get through the house of commons something which didn't in any way involve a change in ownership, profits or anything like that, they couldn't

even get this tiny thing which was basically just saying to some hospitals that they could expand and offer greater services than others if they had a particular skill in a particular area. That's with a majority of over 170; the government couldn't get that through and had to water it down hugely. Now, just as it happens, just the accident of electoral geography in Britain is that the most, it just happens that the most supportive of Blair, that MPs who are the most supportive of Blair happen to be in the most marginal seats in the country, so after the next election in May the chances are that the majority will fall, which will mean that the labour party's even more hostile to competition than it has been at the moment, so the idea that somehow, even if people can come up with an idea that might work to reform the health service within the Downing Street policy unit they can't implement it.

Now I think, I mean this is a very sort of soulless, it's a very negative response, my colleague Tim Evans uses this phrase a lot which I think is one of the most evocative phrases that politicians are just corks bobbing on the tide of history, and I think you know in terms of healthcare for instance, you know after a while I think in the British context and eventually across the rest of Europe too, "people power" works. In the end, when people start to complain and when people start to get annoyed and to get anxious and to get angry, politicians respond. They don't lead - they respond more often than not because most of them are timid and I think it's a matter of time, but in time these arguments will come through, I think actually, perversely, the fact that the British system is so much more backward than many other European systems means that when the shock comes in (I would say about five years or so, maybe even shorter than that), it means the debate, paradoxically perhaps, will be much bolder, and bolder solutions become more implement-able because the public, it becomes a greater shock to the system and they're much more prepared to see radical reform, but anyway that's just supposition.

Question 2
Tim Evans from CNE. I'm mindful that we have ten new accession countries to the EU and I'm mindful that many people particularly in Eastern and Central Europe are enacting reforms of their health system, we've seen some quite radical reforms that I think are very sympathetic to a market view being pushed through, for example recently in Slovakia. Stephen what can our friends in Eastern and Central Europe learn from the continuing failings of the National Health Services, because in many ways we've tried through the NHS to introduce a Sovietised healthcare system which even outstrips the former Soviet bloc, but what advice would you give them as they now have a blank page and they have an opportunity to do something very radically different.

Stephen Pollard
Well I wouldn't presume to offer advice to countries who, even in the short time that they've been able to reform, have outstripped the NHS or outstripped Britain in their imagination and ability to sort of think things through, but I think there's one crucial, I think if you look at any healthcare system and especially if you look at the British system the one thing you have to bear in mind is you have to put the patient in control, because the patient will end up funding the system in the way that they think the system needs to be funded and that you will have a responsiveness from health providers to the demands that are placed on them by patients and that however you structure, and of course there's no such thing as a perfect healthcare system, each country has its own traditions, each country has its own sense of values and so on, but I think the one thing you can say is that the systems that work best are those that put the patient in control and give the patient a direct relationship with the provider.

Question 3

You say that the British Medical Association is to blame for the low number of doctors in Britain because of the caps it puts on recruitments. Why do you think so many doctors say that they want to leave the National Health Service altogether, either to go private, into the private sector or to leave the health system completely?

Stephen Pollard

I think that's because of two things really, one is a, one is brutal which is pay: they think they are working too hard for too little reward and they can get more money working in, either leaving medicine altogether or working privately. The other is, if you pardon my swearing, it's a blood awful job being a doctor in Britain because you don't have much reward, you're constantly having to work within budgets that are not controlled in any way by you, that you have no input in. If you want to introduce new treatments, you can't, because you have, well here's one example: the government introduced three years ago, four years ago, it sold this idea as being a way of the phrase was distributing excellence through the system which was an organisation called NICE, the National Institute for Clinical Excellence and it was sold as a way of distributing excellence throughout the system which was a fantastic piece of PR spin for the crudest piece of rationing that's ever happened in the NHS. In fact there's another health advisor who says it shouldn't be referred to as NICE it should be called NASTY: Not Available So Treat Yourself, and it's things like that where doctors themselves, it's not just patients who aren't empowered but doctors themselves.

That said, I mean this is a different tack to your question, but I do think that the medicine and doctors are the one last sort of real vested interest trade union in Britain that haven't been – well them and lawyers – that haven't been properly reformed and properly tackled, but that I think is beginning to change, much as I think, having said that doctors want to leave the profession because they're not paid enough and so on, the government is beginning to make doctors realise that they should be at the service of patients rather than patients at the service of doctors. Anyway that's another story, let's not go there.

Let me just say this one thing before I forget, there is just one thing I'd like to add to my talk. When I started I was a sort of classic labour party member, I believed in the NHS as being as Nigel Lawson called it "an article of religious faith", it did mean what it meant to be British and so on because it was by far the most equitable, it promised universal coverage and so on, and I started writing a book about ten years ago about class in Britain and about the fact that Britain was still a class divided society and I had a chapter on healthcare and I was fully prepared to write that this was the one exception to the rule that actually in healthcare we do have this wonderful system. And I started to look at it, and I started especially to look at some of the work of Professor Julian Le Grande at the LSE who, in fact, now works as Tony Blair's health advisor. Le Grande's work showed that far from us providing, as in fact Charles Bouchard said, you know universal access is not the same as universal coverage, that actually in the system that we have, and this is the same with any system of rationing it's especially true in the former Soviet Union and Warsaw Pact countries, where you have rationing the people who benefit, the people who are fine are the people who know how to work the system, and the people who know how to work the system are the middle classes, so what we have with the NHS is a system that is, it's not good but it's a lot better if you're middle class and know how to work the system than a system where all patients are empowered through their, through the system and that I think is the – for me, coming at it from a left of centre

perspective – that for me is the ultimate critical failing of the NHS, is that the people it lets down most badly of all, because if for no other reason that they can't afford to go elsewhere, it's the poor and that I think is the fundamental problem with it. Anyway, party political broadcast over.

Question 4
(Name unclear) European Commission. My question is about what you just mentioned about patients becoming in control. I would agree with you except that there are two...

[break in transcript]

...relied on the GP basically to take care of themselves and therefore it's a major shift to become empowered from becoming assisted. The other thing is that if you want to choose you need to have the transparency that goes with it. If I am sick and I want to choose between two GPs or hospitals, what type of information do I have, trustable information that is to give me the possibility to choose?

Stephen Pollard
On your latter point, I 100% agree with you. The two are inseparable, you have to have greater transparency of information, you have to have access to the fact that you know where as some doctors know that they wouldn't let their relatives be operated on by doctor X because he's a butcher, well the public aren't allowed to know that. In matters like this you have to have things that are as crude as well: success rates in operations, even just people who've been working on hip replacements for the last ten years, I'd much rather go to somebody who does five hip replacements a day that somebody who has done two in their life, those sorts of things are the information you need.

I think your first points about being empowered – Though I think we disagree on what "empowerment" is, it doesn't mean that you have to take the decision on every aspect of your treatment, I mean I don't want to, I have pretty limited medical knowledge, I would much rather place my care in the hands of a doctor who I trust, indeed that's what I do. It means, however, that I get to chose who that doctor that I trust is or who that insurance provider is or who that company is or whatever, but it doesn't mean having to take, for instance, when I drive a Fiat say it's because I understand that Fiats (or Porches or whatever) are the best cars to drive and that they would have built it in a way that I want to drive it, rather than me wanting to know about how the engine flows or what happens with the clutch and the accelerators, I just want to get in and drive it because I've been told that as a result of competition this is the car to get, it's pretty similar to that I think, I don't want to have to take every decision about my medical care but I want to be able to if I want to, I want to be able to chose who I trust to hand over those decisions to.

Question 5
My question is about the political implications of what has happened. I'd actually like to, my question [unclear] to what I call political atmospherics. If we were sitting here in the early 90s before Tony Blair became even leader of the labour party let alone Prime Minister, the fear in Britain then was that the conservative party's internal market reforms would be swept away by a future labour government, that much of the private sector would be threatened. I remember in 1994 sitting with a group of private healthcare executives in London and they asked me the question: If we have a future labour government how quickly will it be before

we're nationalised. But here we are now complaining that labour market reforms have not gone far enough. Now away from the policy realities and away from the failures of the British parliament to enable the Prime Minister and Milburn and John Reed to make the reforms they might like to make, the political atmospherics are very important because we now have a left of centre party that at least accepts a sizeable private sector, it accepts that reform means more private input and of course we have a conservative party that would like to go a lot further so the entire direction of the debate has shifted from those who would like to nationalise and those on the right who want to have what might be loosely called "partnership", to everyone coalescing at the minimum around partnership and those now in the conservatives who would like more private funding and more private reform. So the whole direction of the political debate, the conversation has changed, and I have a very good friend who is a very senior civil servant at the department of health in London, he's one of the most senior strategic civil servants in that ministry and he said to me recently, for all the labour party's failings, at least the rhetoric that labour has built into British politics, that rhetoric could at some stage in the future be built upon rapidly by a conservative government, that's not me suggesting that there will be a conservative government next year, I think they're many years away from getting a majority, but I think it's an important point labour has: Blair has at least succeeded in changing the debate and changed it in a different direction. I'd like your reaction to that.

Stephen Pollard
Yes, I think that's true, he's changed it in terms of – to give credit as I say there are, there have been reforms and I think the two most interesting reforms that I think are symbolic of a changed rhetoric and that are something that can only begin to have impact are, as I said, NHS abroad. which incidentally was a fantastic piece of political salesmanship because for about five years or so there'd been a campaign led mainly by a British newspaper *The Sunday Times*, to allow patients to be treated in the rest of the EU which the government, both the conservative government and this government steadily just repeatedly ignored and then you remember in, I think, June of 2000 or was it 2002, the case in the ECJ when a Belgian and a Netherlands citizen wanted to be treated out of the country and there was an ECJ judgement which upheld that right, within a week of that happening the health secretary announced a brand new initiative NHS abroad which will allow patients to be treated elsewhere, and nobody pointed to the fact that he had no alternative but to do that, but anyway it was a real change in what was happening, and I think that will have some impact.

Similarly, this idea of an NHS voucher that patients may, patients are in theory to be entitled to have a choice of five providers for every treatment that they get, now once patients get used to that it's almost impossible to imagine anybody reining backwards from any of this, so I think it's true that they've changed the political terrain in the sense that they've sort of, for me the problem is how they've come at it, they've not come at it by arguing, by thinking through how do we move to a healthcare system that would be the most efficient and most equitable system, what they've done is thought how can we make the NHS work, and the way to do that is to, well, on the one hand, people tell us it's about money so let's do money, and on the other hand clearly it's not efficient so lets change the mechanisms, which is, as far as I'm concerned, answering the wrong question: you're trying to make something that can't work work. Well okay, you might make it work a bit better but you won't make it work as well as another system might. So although the rhetoric's changed and they've implemented certain things, which, as I say, is impossible to rein back from, I still think in some ways they've changed the rhetoric in a bad way in that the conservatives are now offering – in some

ways some of their policies make a lot of sense, but the one thing they've just said politically they have to do is promise to match what labour is spending on healthcare, in other words, even though they explicitly argue because they want to change the system, even though they argue that they system's wrong and doesn't work, they're still going to spend the same amount of money on it, which doesn't actually add up, anyway, that's another point altogether.

Question 6
Okay, maybe we come back to history because I'm always very surprised by the fact that really, in Western Europe at least, the UK's certainly one of the most free markets of all the countries and suddenly because of the (unclear) revolution – I've always wondered why nothing happened on healthcare at that moment and why is it so difficult now for the people who seem to have accepted a lot of free marketers' reforms and seem to be much more familiar and happy to make profit – for instance, one comment was that "yes, people do not want to work for the NHS anymore, they want to get more pay"; you know in France this is absolutely not something that you will hear or see happen because more and more people want to become public servants. So this is not a trend that you see. So really there is a contradiction that I still cannot reconcile.

Stephen Pollard
I agree it's about history really, this will be about the third of fourth time that I've used it, but Nigel Lawson's quote about the NHS being the English religion. I mean, we don't go do church any more in Britain, but everybody has to have some kind of religious belief and that belief is in the idea of the NHS, as that quote that I read from Gordon Brown said that the NHS somehow exemplifies what it means to be British – which is a bit like the way Canadians define themselves as not being American by the fact of their healthcare system, well we define ourselves, we might be capitalist, we might be whatever, but we are actually really decent people because we have the NHS, and if you think I'm joking I'm not. I think it is very much like that and I think that's, which is why even, there were two things that Mrs Thatcher never considered really changing, although she did introduce the market, internal market into the NHS, there were two things she didn't consider changing, one was the NHS. Another was the British Broadcasting Corporation, and it was for exactly the same reason: that we think of the BBC as defining what it means to be British. Similarly we think of the NHS as that, well I think we're a long way closer to changing the NHS than we are to changing the BBC but then that's a whole other can of worms.

Question 7
I'm an assistant to MEP (name unclear) from Slovak Republic. I always wonder when we talk about healthcare reform, we always talk about the money and funding and this stuff but I would like to imagine that healthcare is about prevention and to make people not to fall ill so I think could you enlarge on the prevention measures.

Stephen Pollard
Well in fact last week the government announced or introduced a white paper, a discussion document on public health on precisely that, that the idea, that the phase that's often used is that "the national health service isn't a national health service, it's a national illness service" and that what it should be also about is investing money in public health and so on, but then, I mean there are, this is one of the problems if you have a state run, state funded system that when you then try to introduce measures which deal with things like obesity or smoking or

whatever, which have these enormous financial consequences, you're then accused of wanting to introduce a (nanny) state, that's the phrase that's used in Britain, because it's a state run service then of course the state has to introduce the measures to impact on that, and therefore why should the government tell me, for instance, that I shouldn't eat a Mars bar or something? Or that I shouldn't smoke? And we're now going to introduce a smoking ban in public places in Britain and there's a lot of criticism of that – as I say it's a national illness rather than a national health service and the government responded last week with a plan which I have to say I think in many ways is quite sensible, it's full of quite sensible, obvious measures like for instance I read in the newspaper today that they're going to put in extra money into schools so that kids who don't have any kind of physical education have the option of having two hours of physical education a week, or running round because a lot of kids don't get to do that anymore, I mean sort of obvious things like that, but again when it's part of the state then the criticism is why should the state tell me and some ways it's a justified criticism, why should the state tell me that I should make my kid run around for two hours if he wants to go and play football then that's fine, but I'm not going to do it because I'm told to. It's not a very good answer but still.

Question 8
I have two questions, the first and they may be a little bit contradictory. First question is: The UK introduced a few years ago "NHS direct" to try to improve the system. I don't know if it improved it well or not, if the system saved money or not with that, I would like to have your idea about the filling of this introduction of the NHS direct. To remind everybody, the NHS direct is a system that people have a call centre and they have first to call at their call centre before going to see the emergency in the hospitals, that's one of the applications. And my second question is more related with what was said with prevention, like for example you have in UK a system that worked very well on dental which is "DenPlan". DenPlan is a pure private system working [unclear] on prevention and you have all types of population in this system from rich people to poor people, that means that people consider that their teeth are something important and if you talk with a British dentist they will tell you that the [unclear] of the people is divided for them sometimes in three parts. One part is for dental repairs under the NHS system; prevention is under DenPlan, and for some very special repairs it can be purely private. Would a system like that, working very well on the dental, because I think there are 1.2 million or 1.5 million people in the UK in a system that can be working in certain areas with the GPs for example.

Stephen Pollard
In a word yes, it's very interesting – I think partly to answer your question as well, one of the problems is that there's no incentive in the system as it stands at the moment for people to look after themselves. You've paid your taxes – or you haven't but you're still getting treated – and that's it. All the responsibility has gone. It's nothing to do with you anymore, it's up to the state to look after you. So if you want to drink eight pints a night and you want to smoke 60 a day and you want to do whatever then fine, so there's no incentive at all. Very interestingly last month a firm of insurers, The Prudential, introduced a healthcare insurance plan which – I can't remember the exact name of it – but it's built up on the basis of you get refunds for, or your premium is determined by whether you run, whether you smoke whatever, and you get premiums, you get incentives to look after yourself, you get money back if you've done certain things that will help you to look after yourself better, and literally they introduced it last month. So it will be very interesting to see how it works, but I think things along those lines are very sensible, where there is a – as I say, the fundamental problem

with the NHS is that you have no incentive whatsoever to look after yourself because that's it, it's not down to you, it's down to the state.

In terms of NHS direct, I don't know actual evidence, actual figures about cost savings and so on, but there are anecdotal stories. Take these with a pinch of salt, but I have spoken to people who say that all it's done is to give people who aren't even necessarily patients another vehicle by which they can moan and grumble. In the past people who might have rung 999 for a moan about something rather than for an emergency now switch to NHS direct, and that it doesn't actually have much impact. That said, I find it difficult to object to a service which offers information to patients, it seems to me a thoroughly sensible idea but whether it has had a direct impact in terms of saving money I simply don't know.

Question 9
What do you think about the Belgian system?

Stephen Pollard
I would much rather be treated under the Belgian system than I would under the NHS, it's a "no brainer" as they say.

Question 10
[Inaudible]

Stephen Pollard
The difference is that if I got seriously ill would I get treated and the answer is yes, my father had cancer under the NHS and he wasn't – they didn't even begin the treatment for seven months.

Question 11
I'm a French national and I work for the North East of England office here in Brussels so I'm under a UK contract under the NHS. But because I'm working here in Belgium under the E106 I'm also under the Belgium health system, so obviously I know these three systems very well, try to understand them, and I think there are some advantages in the NHS that are not in the Belgium system and the dental treatment was a point within the NHS system where you're better protected than in Belgium in a way. And there's another thing as well which, like I've been hearing, and within the commission they are looking at bridging gaps between old member states and new member states under health system but with the – I would say – gloomy picture you're giving of the NHS I'm a bit scared about what is promising for this kind of programme.

Stephen Pollard
Be afraid, be very afraid.

Question 12
I don't think we can just let that go by, you didn't mention an important component, at least for us, is financing of medicines. We do regard the UK system as one of the best in Europe at the PPRS, that means that if you're going to compare Belgium and the UK you might be better off say if you are having a baby in Belgium or being hospitalised in Belgium, but if you wanted a new medicine you'd be much better off in the UK because this country is one of the worst in Europe in terms of delaying access to new medicines, it's hugely bureaucratic, very

difficult to bring in innovative products to this market, so it's a mixed bag and when it comes to innovation in medicines in particular the UK for all its problems is one of the better countries in Europe.

– end –

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