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WASTING LIVES

**A statistical analysis of NHS performance
in a European context since 1981**

Matthew Sinclair
Foreword by Professor Karol Sikora

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Foreword

An enormous amount of tax in Britain goes into paying for the NHS. Are we getting value for money or is much simply squandered by a vast bureaucratic monolith out of touch with a consumerist, informed and demanding public? By using a sophisticated metric of the effectiveness of a healthcare system, the amenable mortality, this piece of research comes to the alarming conclusion that despite more than tripling NHS spending over the last decade we have not increased the pace of improvement in the most important measurement of its output – its ability to save lives.

Over the last twenty years public health researchers have put together the concept that certain deaths, at least in people under 75, can be avoided by effective healthcare. This measurement is gaining ground as a tool to compare different ways of delivering and paying for healthcare.

NHS spending is now at unprecedented levels. Over £105 billion is being spent this year alone. Yet this report clearly shows that the huge recent surge in NHS funding has not even caused a blip in the trajectory of amenable mortality. On our ability to save lives, on quality of service provision and on access to technology, we still lag far behind Europe which is far less dependent on public sector monopoly.

Further increasing the total budget spent on health is one solution. This can either come from increased taxation or by direct payment at the point of care. Far better would be radical reform of the entire system from its insurance function through to delivery. The choice is between a modern, consumer driven service for all or a decaying, bureaucratic system where those with resources manage to escape.

Real reform and not more money is the only rational way forward. Our universities are producing some of the finest graduates in the world to join the wide range of professionals crucial for the modern delivery of medicine. They have the education, skills, dedication and enthusiasm to let Britain lead the world if only we can get the funding model correct.

Politicians need to read this report carefully and determine the optimal strategy they can devise to put to a well informed public. Those that capture the best way forward will carry the British voter with them. The NHS is not a religion set in tablets of stone. It must be used as a powerful base on which to construct a dynamic, responsive and reformed service to benefit us and our children.

Professor Karol Sikora

January 2008

Executive Summary

This paper sets out the ongoing failure of the NHS to match European levels of healthcare performance and the inability of new money, since 1999, to rectify the situation.

The report uses mortality amenable to healthcare – the number of deaths from certain conditions, and at certain ages, that healthcare can reasonably be expected to avert – to compare NHS performance with that of four European peer countries: France, Germany, the Netherlands and Spain. Amenable mortality is a widely respected metric for healthcare performance described in the British Medical Journal and currently being studied for implementation by the Office for National Statistics.

Data from 24 years and five countries, sourced from raw data in the detailed World Health Organisation international mortality database, was filtered for deaths from those conditions, at certain ages, considered amenable to healthcare. The level of detail in the report has provided an unparalleled degree of context within which to understand the progress of British healthcare in recent years.

The key findings are:

- In 2004, the latest year for which data is available, higher rates of mortality amenable to healthcare in the United Kingdom relative to the average of European peers led to **17,157 deaths** in that year. This is equivalent to over five times the total number of deaths in road accidents and over two and a half times the number of deaths related to alcohol.
- The United Kingdom caught up with its European peers at a nearly constant rate between 1981 and 2004. This implies that **the massive additional spending since 1999 has had no discernable effect on mortality rates**.
- If NHS spending had continued to increase relative to European peers at its pre-1999 rate **£34.3 billion – £1,350 per household – less would have been spent between 1999 and 2004**. In 2004 alone, £9.8 billion less would have been spent, 9.7 per cent of total spending in that year. This extra money has largely been wasted.
- In the **last three years** studied (2002-2004) **amenable mortality convergence was slower** than the trend over the entire period. This suggests that, if anything, relative improvements in mortality amenable to healthcare could be slowing.

The pattern appears to be that incremental reforms in the 1980s and early 1990s achieved roughly the same results as massive increases in spending in the later years. Neither strategy is likely to be able to sustain improvements, however, as the returns from additional spending are likely to diminish



rapidly and incremental reforms are strictly limited if the fundamental structure of the NHS cannot be altered.

In order for British healthcare to match the performance seen in other European countries several key differences will need to be addressed:

- **Centralisation.** Local NHS organisations have very little room for independent decision making. In other European countries, in particular Switzerland and Spain, healthcare policy is highly decentralised.
- **Political management.** Healthcare provision in the UK is managed by politicians. Secretaries of State responsible for healthcare have rarely had management experience and none have had specific subject knowledge in healthcare. European healthcare systems, in Germany, France, Switzerland and the Netherlands, have genuinely independent providers of hospital care and social health insurance that are not managed by politicians.
- **Monopolistic.** The NHS is a monopoly. It not only has unique access to taxpayers' money but does not allow patients to receive part of their treatment for a certain condition for free while purchasing the rest from the private sector. In the Netherlands, in particular, insurance companies compete to offer the best value. In almost all of the European healthcare systems a diversity of hospitals competes to offer value to insurance funds.

The poor performance of British healthcare is not preordained. It is not a price we pay for ensuring that everyone gets the treatment they need, given that the other European countries this study has examined all look after the unfortunate. Failing to reform leaves British healthcare without the decentralisation, competition and professional management that it so urgently needs.

Ultimately, failing to reform the NHS costs lives.

1. Introduction

"There has been a 16 per cent reduction in cancer as a result of the new investment since 1997." – Gordon Brown¹

That statement is a good example of the message that the Government is trying to get across on the NHS. It is both correct and largely meaningless. If a similar argument were accepted on the economy nearly every government could boast of the greater incomes they left behind as technological progress drives up income over time. Both new technologies and the greater resources of a wealthier nation will mean that healthcare performance can be expected to improve without policy improvements.

The proper question is: has the extra healthcare spending in recent years led to an increase in the rate at which British healthcare is improving relative to that in comparable European countries?

Healthcare performance cannot be understood without a clear picture of the context. British healthcare benefits from all manner of global trends – whether new technologies or expanding incomes – just as surely as the economy does. This report should set the progress of recent years in context and make clear the extent of the challenge to achieve the performance that we should be demanding from our healthcare system.

¹ *Hansard*, 5 December 2007: Column 816

2. Method

Different measures

A number of different approaches to quantifying the performance of healthcare systems in different countries have been tried. However, these approaches all have important limitations:

- Life expectancy and variants such as disability adjusted life expectancy are, perhaps, the most common measure used to assess a nation's health. Disability Adjusted Life Expectancy was used by the World Health Report 2000.² However, as a measure of healthcare system performance, this will be distorted by mortality rates linked to conditions that healthcare systems cannot have a significant effect upon.³
- Surveys of public opinion provide subjective evidence of a healthcare system's effectiveness. However, there is no reason to think that public opinion is an effective gauge of a healthcare system's aggregate performance. The Picker Institute highlights⁴ the three variables that a patient will reflect in satisfaction surveys:
 1. The personal preferences of the patient
 2. The patient's expectations
 3. The realities of the care received

Disentangling the reality of care received cannot be done reliably. The public have limited evidence with which to assess the system beyond their own interactions with it and will only occasionally experience the healthcare systems of other countries that should provide a benchmark.

- Studying individual conditions can allow for a more detailed examination of how a healthcare system performs.⁵ However, if certain conditions are studied in detail and then taken as samples with which to build an aggregate picture of a healthcare system the result can be highly distorted. A common criticism of the National Health Service is that targets lead to high profile conditions being prioritised and others neglected. There is a huge risk of having either disproportionately prioritised or neglected conditions in your sample and coming to erroneous conclusions. While this can be controlled for such controls can only pick up the most acute anomalies.

This study's chosen measure for the performance of healthcare is aggregate mortality amenable to healthcare. This gives an aggregate measure of

² World Health Organization, *'The world health report 2000. Health systems: improving performance'*, June 2000, <http://www.who.int/whr/2000/en/index.html>

³ Nolte, E. & McKee, M. 'Measuring the health of nations: analysis of mortality amenable to health care', *British Medical Journal*, November 2003, Figure 2

⁴ Picker Institute, *'Survey Information'*, <http://www.pickereurope.org/page.php?id=21>

⁵ Gubb, J. *'Just How Well Are We?' A glance at trends in avoidable mortality from cancer and circulatory disease in England & Wales'*, Civitas, November 2007

healthcare attainment that does not rely on subjective opinions and separates out the conditions and ages where healthcare can expect to make a significant difference.

Mortality amenable to healthcare

'Mortality amenable to healthcare' is a measure of deaths that could realistically have been averted by the healthcare system.

- An international comparison using mortality amenable to healthcare was performed by Nolte & McKee.⁶ They found that when nineteen developed countries were ranked on healthcare performance the UK placed nineteenth. An update of this study showed some progress but still found the UK ranked among the worst performing developed countries.⁷ This can be compared to when they were judged on disability adjusted life expectancy where the UK placed tenth. They argue that the World Health Organisation ranking of healthcare systems would be improved by replacing Disability Adjusted Life Expectancy with mortality amenable to healthcare.⁸
- Public bodies are increasingly moving to report mortality amenable to healthcare. The Office for National Statistics is currently consulting on plans to create a series⁹ and the Scottish Public Health Observatory have created estimates for Scotland¹⁰.
- Mortality amenable to healthcare has been criticised for showing insufficient correlation with healthcare inputs.¹¹ However, this would seem to be a more telling comment upon the complexity surrounding healthcare productivity – we should only expect that greater quantities of healthcare inputs will reliably feed into better healthcare if we assume static and uniform productivity.
- Another criticism could be that by focusing exclusively on the mortality record our study neglects some other priority. This is a risk with any measure but mortality amenable to healthcare includes a wide range of conditions so should be taken as relatively robust with respect to this criticism.

⁶ Nolte, E. & McKee, M. 'Measuring the health of nations: analysis of mortality amenable to health care', *British Medical Journal*, November 2003

⁷ Nolte, E. & McKee, M. 'Measuring the health of nations: Updating An Earlier Analysis', *Health Affairs*, January 2008

⁸ Nolte, E. & McKee, M. *'Does health care save lives? Avoidable mortality revisited'*, Nuffield Trust, 2004, page 9

⁹ Office for National Statistics, *'Measuring premature and avoidable mortality: ONS proposals for national indicators; Response to the Consultation'*, September 2006,

http://www.statistics.gov.uk/about/Consultations/downloads/PAM_RespCon.pdf

¹⁰ Grant, I. et. al. *'Mortality amenable to Health Care in Scotland 1981-2004'*, June 2006,

<http://www.scotpho.org.uk/nmsruntime/saveasdialog.asp?IID=3751&SID=3206>

¹¹ Nolte, E. & McKee, M. *'Does health care save lives? Avoidable mortality revisited'*, Nuffield Trust, 2004, page 43

How the mortality amenable to healthcare figures were calculated

Detailed mortality data from the World Health Organisation Mortality Database¹² was extracted. This gave the number of deaths in each age group, in each gender, in each year within the set of causes identified as amenable to healthcare by Nolte & McKee.¹³

For each gender, for each country and for each year age-standardised mortality amenable to healthcare rates were calculated: the number of deaths for the amenable conditions, within the amenable age groups, were added up and divided by the relevant population (figures also from the World Health Organisation Mortality Database) to produce age-specific mortality rates. These were weighted by the European Standard Population to produce an age-standardised rate for that year.¹⁴

The weighted average of the two genders was then produced to give an age-standardised rate for a country in a given year.

Countries and years studied

The countries chosen for comparison – Spain, France, the Netherlands and Germany – are the largest nations in the EU-15 for whom sufficient mortality data is available. They are appropriate as they are big, reasonably wealthy and generally stable countries taken as Britain's peers in other policy areas. Italy, the other European country of a comparable size, is not included because it only has mortality figures as recent as 2002.

The years studied are, with some exceptions, 1981 to 2004. 2004 is the most recent year for which data is available. Starting in 1981 allows us a reasonable number of years with which to establish a trend that the later years can be compared to. Germany is replaced by the Federal Republic of Germany for the years before unification in 1990. Britain's data is missing for 2000 so that year has been left out entirely.

¹² World Health Organisation, 'Mortality Database', Updated 15th October 2007, <http://www.who.int/whosis/mort/download/en/index.html>. The World Health Organisation provided the original information but is not responsible for the analyses, interpretations and conclusions in this report.

¹³ Nolte, E. & McKee, M. 'Measuring the health of nations: analysis of mortality amenable to health care', *British Medical Journal*, November 2003, Table 1

¹⁴ NHS Executive 'Quality and Performance in the NHS: High Level Performance Indicators and Clinical Indicators', May 2001, Annex D1: Age-standardisation and calculating confidence intervals, <http://www.performance.doh.gov.uk/indicat/d.pdf>

3. How did the NHS compare in 2004?

The amenable mortality rates in 2004 paint a stark picture of the differences in performance between the British and European health systems.

- Amenable mortality in the UK is 26.9 per cent higher than the average in the European peer countries. It is 48.6 per cent higher than in the best performing country, France.
- This difference in mortality rates, when applied to the 2004 population, implies that there were 17,157 deaths in 2004 that could have been avoided if we had matched the average rate of mortality amenable to healthcare in the European panel.

This is equivalent to:

- Over five times the total number of deaths in road accidents.¹⁵
- Over two and a half times the number of deaths related to alcohol.¹⁶

Table 3.1: Mortality amenable to healthcare in the UK and selected European countries, 2004

	Population, 2004	Amenable mortality rate, 2004	Combined amenable mortality rate, 2004
United Kingdom			
Male	29,270,975	148.5	
Female	30,563,339	122.7	135.3
Netherlands			
Male	8,055,946	109.6	
Female	8,225,832	118.9	114.3
Germany			
Male	40,350,091	134.8	
Female	42,151,183	107.1	120.6
France			
Male	29,466,782	94.0	
Female	31,176,524	88.3	91.1
Spain			
Male	20,987,670	115.3	
Female	21,704,081	86.1	100.5
	Euro-average (excluding UK)		106.6
	<i>Difference between UK and Euro-average</i>		28.7
	Deaths per year in UK implied by difference from Euro-average		17,157

¹⁵ Office for National Statistics 'Road Casualties: Pedestrian deaths at 40 year low', July 2006, <http://www.statistics.gov.uk/cci/nugget.asp?id=1208>

¹⁶ BBC News 'Surge in alcohol-related deaths', August 2005, <http://news.bbc.co.uk/1/hi/england/4152772.stm>

This is a shocking number but fits with a pattern apparent from looking at the existing literature on mortality due to particular conditions. These studies do not relate exactly to mortality amenable to healthcare but do illustrate just how large some of the differences in mortality rates between the UK and other countries are:

- The EURO CARE-4 study found that England had one of the lowest cancer survival rates in Europe. 44.8 per cent of men and 52.7 per cent of women in England were still alive five years after diagnosis. By contrast, in Finland the respective rates were 55.9 per cent and 61.1 per cent. In the USA the rates were 66.3 per cent and 62.9 per cent.¹⁷ Cancers are responsible for a large number of deaths: 153,491 in the UK in 2005,¹⁸ 30 per cent of all deaths.¹⁹
- Male, under 65, premature mortality from all circulatory diseases in 2004 was 64.1 per 100,000 compared to the 57.9 per 100,000 EU-15 average.²⁰ For women the respective numbers are 23.6 and 20.1 per 100,000.²¹ Based on the populations used in our study of amenable mortality that difference alone equates to 2,885 lives.
- In 2000 the National Audit Office estimated that 9 per cent of hospital inpatients have a hospital acquired infection at any one time.²² The number of deaths where a *C. difficile* infection was mentioned on the death certificate reached nearly 4,000 in 2005.²³

There are, broadly speaking, three reasons why a country will have higher or lower mortality rates:

1. Lifestyle – people's decisions over whether to eat a proper diet, exercise regularly, smoke, drink to excess and pursue a host of other relevant behaviours.
2. Technology – new drugs, surgeries and vaccines and a better medical understanding of the process of disease are produced by businesses and universities and other researchers in the UK and around the world.

¹⁷ Berrino, F. et. al. 'Survival for eight major cancers and all cancers combined for European adults diagnosed in 1995-99: results of the EURO CARE-4 study', *Lancet Oncology*, Volume 8, Issue 9, September 2007, pp. 773-783

¹⁸ Cancer Research UK 'UK cancer mortality statistics for common cancers', May 2007, <http://info.cancerresearchuk.org/cancerstats/mortality/cancerdeaths/>

¹⁹ Office for National Statistics 'Mortality statistics, cause', 2006, Table 2: Deaths: underlying cause, sex and age-group, 2005: summary, <http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=618>

²⁰ Department of Health 'Health Profile of England 2007', October 2007, Chart 3.10: Male premature mortality from all circulatory diseases

²¹ Department of Health 'Health Profile of England 2007', October 2007, Chart 3.11: Female premature mortality from all circulatory diseases

²² National Audit Office 'The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England', February 2000, Figure 1, http://www.nao.org.uk/publications/nao_reports/9900230.pdf

²³ Office for National Statistics 'Clostridium difficile: Deaths increase in 2005', February 2007, <http://www.statistics.gov.uk/CCI/nugget.asp?ID=1735&Pos=1&ColRank=1&Rank=224>

3. The healthcare system – whether the healthcare system is adequately resourced and effectively run.

The first two causes of death will constitute statistical noise in any measure of healthcare performance based upon mortality. However, they do not endanger this study's conclusions. We must therefore look to the performance of the UK's health system.

Lifestyle

The importance of changing lifestyles is a common criticism of almost any measure of healthcare outcomes. Increases in obesity rates are set against falls in smoking rates. A detailed assessment of the effects on mortality amenable to healthcare would be a major undertaking but there are three reasons that this should not be seen as critical to this study:

- There is a large body of research – the EURO CARE study²⁴ on cancer survival is one example – which shows significant differences in survival rates.
- Through regulation and 'sin taxes' government claims a large measure of responsibility for people's behaviour when it will affect their health. Examples include the recent ban on smoking in enclosed public places and workplaces²⁵ and the £8.1 billion in tobacco duties that is charged, before VAT, on cigarettes each year.²⁶
- The structure of the healthcare system may affect lifestyle. People face a greater incentive to stay healthy if they bear all or part of the cost of treating unhealthy lifestyles.

All this means that differences in health due to lifestyle changes can be understood, in the UK at least, as a part of healthcare performance.

Technology

Technological growth will be an important explanation of changing healthcare performance over time but is unlikely to reflect differences in health policy between countries:

- Technologies, whether developed by pharmaceutical companies, universities or governments, are usually available globally to anyone who can afford them.
- Technological improvement is likely to lead to falling amenable mortality rates over time. It should also lead to convergence between better and

²⁴ Berrino, F. et. al. 'Survival for eight major cancers and all cancers combined for European adults diagnosed in 1995-99: results of the EURO CARE-4 study', *Lancet Oncology*, Volume 8, Issue 9, September 2007, pp. 773-783

²⁵ Smokefree England 'A healthier England from July 1st 2007', <http://www.smokefreeengland.co.uk/>

²⁶ HM Treasury 'Budget 2007', March 2007, Table C8: Current receipts



worse performing healthcare systems. A historical advantage is effectively wiped out when old investments, in scanners of a certain precision – for example – are made obsolete. Technological progress will only create differences in healthcare performance between countries if the health service is slow to adopt new technologies.

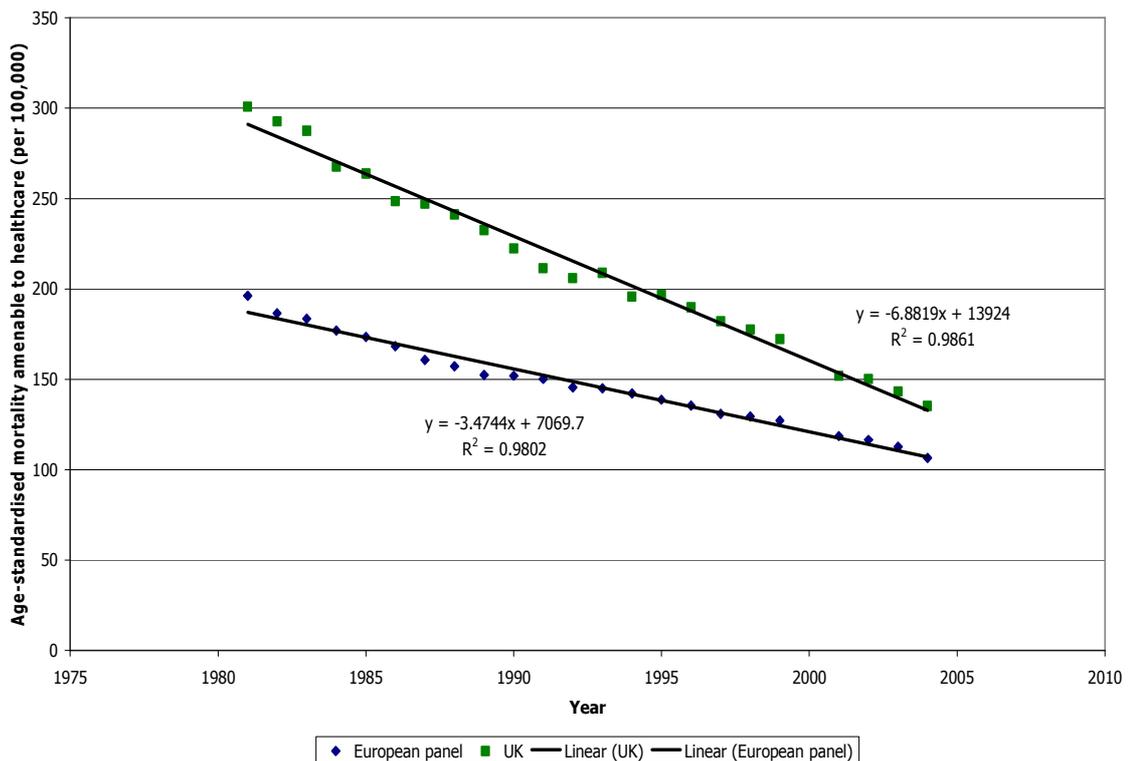
4. Have big increases in spending improved the health service?

This record is not, in itself, a case for institutional reform. There are two possible strategies to reduce the UK health system's underperformance and reduce amenable mortality:

1. Spend more money.
2. Introduce reforms that change the way healthcare is delivered.

To see whether the first strategy is tenable we can compare the five years from 1999 to 2004 – where significant extra spending was provided to the health service – with earlier years.

Figure 4.1: Mortality amenable to healthcare in the UK and selected European countries, 1981-2004



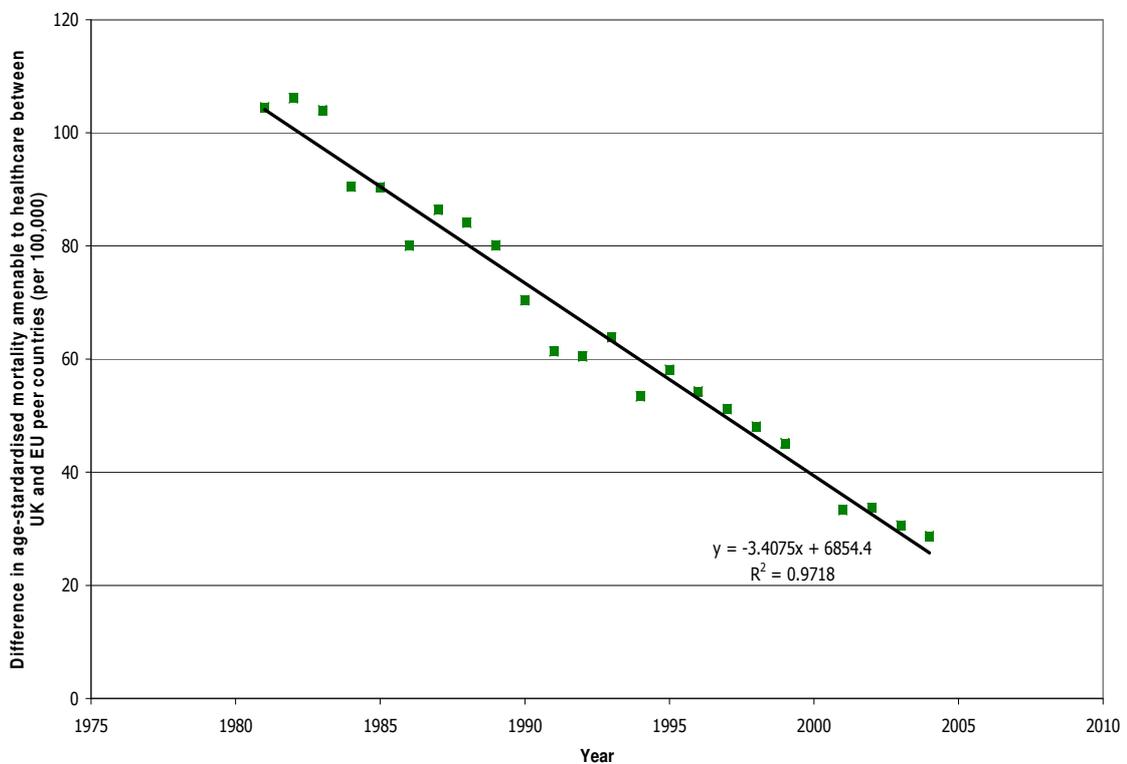
- This chart shows a consistent pattern across the 24 years of the sample. Mortality amenable to healthcare in the United Kingdom is falling and is converging with the European rate.
- There is a strikingly good fit. Nearly 99 per cent of the variance in UK mortality amenable to healthcare can be explained by the year and 98 per cent of the variance in European mortality. This is also a similar

pattern to that observed by less detailed and up to date surveys of amenable mortality over time.²⁷

- What this implies is that through the Thatcher, Major and Blair governments the performance of the UK healthcare system improved at a uniform rate.

The same pattern can also be seen when looking at the difference between the performance of the UK and EU countries.

Figure 4.2: Differences in mortality amenable to healthcare between the UK and selected European countries, 1981-2004

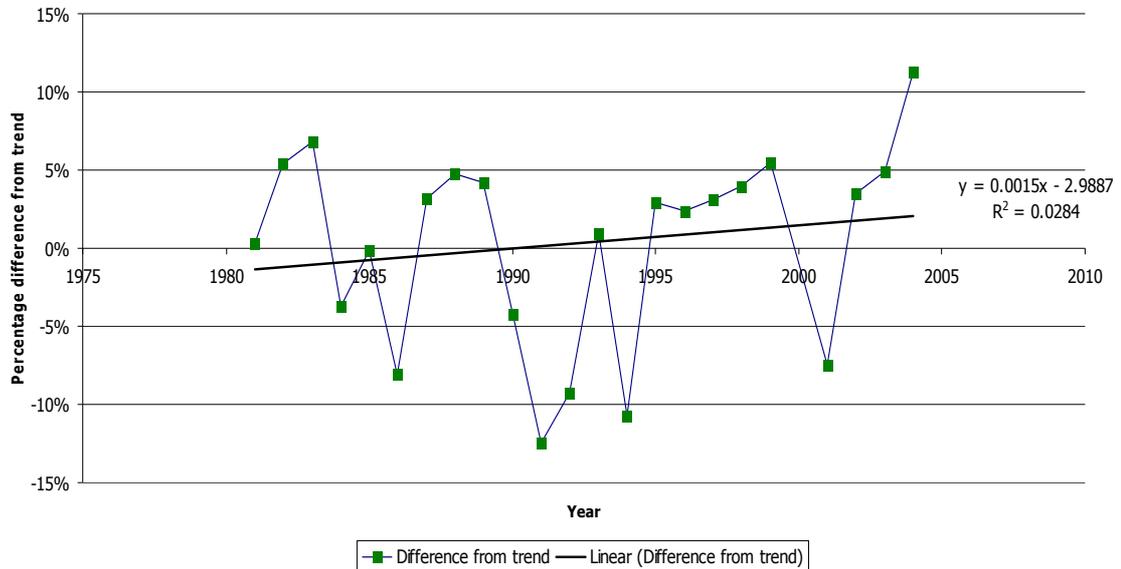


- This chart again suggests a uniform pattern across the period studied.
- There is again a strikingly good fit. Over 97 per cent of the variance in the difference in mortality amenable to healthcare, between the UK and the EU peer countries, can be explained by the year.

²⁷ Grant, I. et. al. 'Mortality amenable to Health Care in Scotland 1981-2004', June 2006, Figure 4 Male age standardised death rates (per 100,000) for amenable causes in selected EU countries, 1980, 1990, 1998, <http://www.scotpho.org.uk/nmsruntime/saveasdialog.asp?IID=3751&sID=3206>

The differences from the trend are not only insubstantial; they do not appear to have any pattern to them.

Figure 4.3: Differences from the trend in difference in mortality amenable to healthcare between the UK and selected European countries, 1981-2004



- The differences from the trend of convergence between the UK and European amenable mortality rates are highly unstable. There is no clear pattern in the differences from the trend.
- However, if anything, the difference from the trend is increasing over time. In the last three years studied there is a positive difference from the trend, indicating that convergence was slower than the average over the period studied. This means that the trend of convergence between the UK and European amenable mortality rates is, if anything, slowing.

By contrast, the pattern for spending shows a sharp upturn in 1999 (figure 4.4). This spending upturn can be seen clearly when it is compared with the relatively uniform improvement in mortality relative to that in EU-peer countries (figure 4.5).

Figure 4.4: UK health spending as a percentage of average spending in selected European countries, 1981-2004

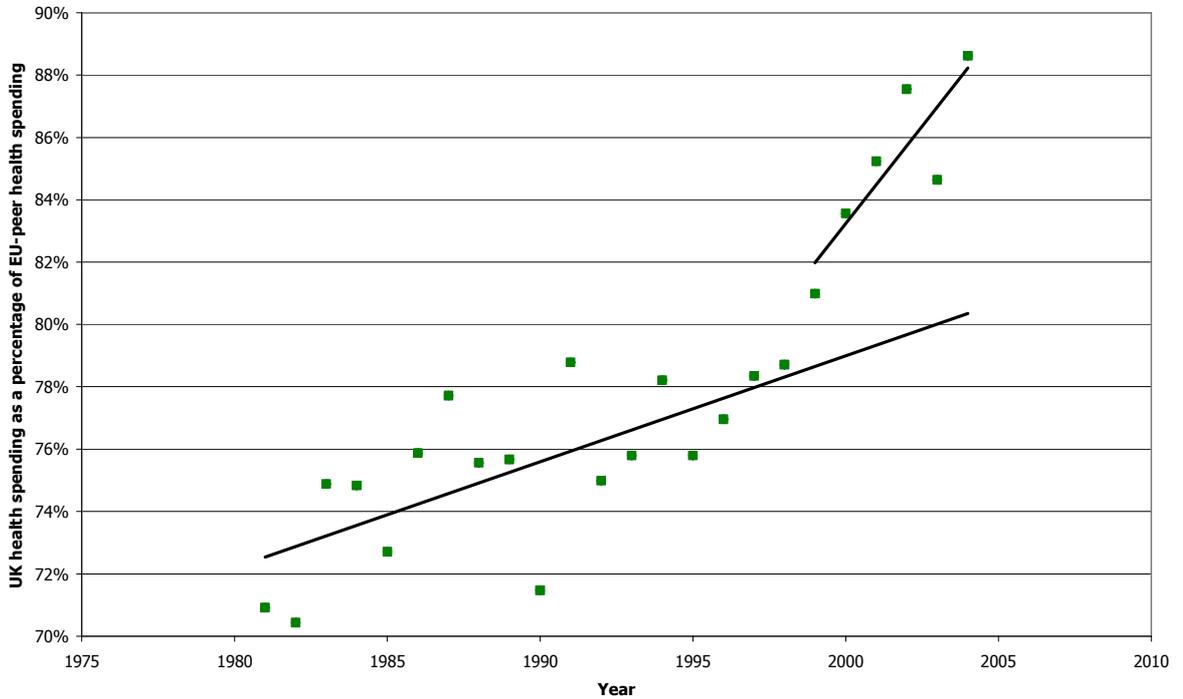
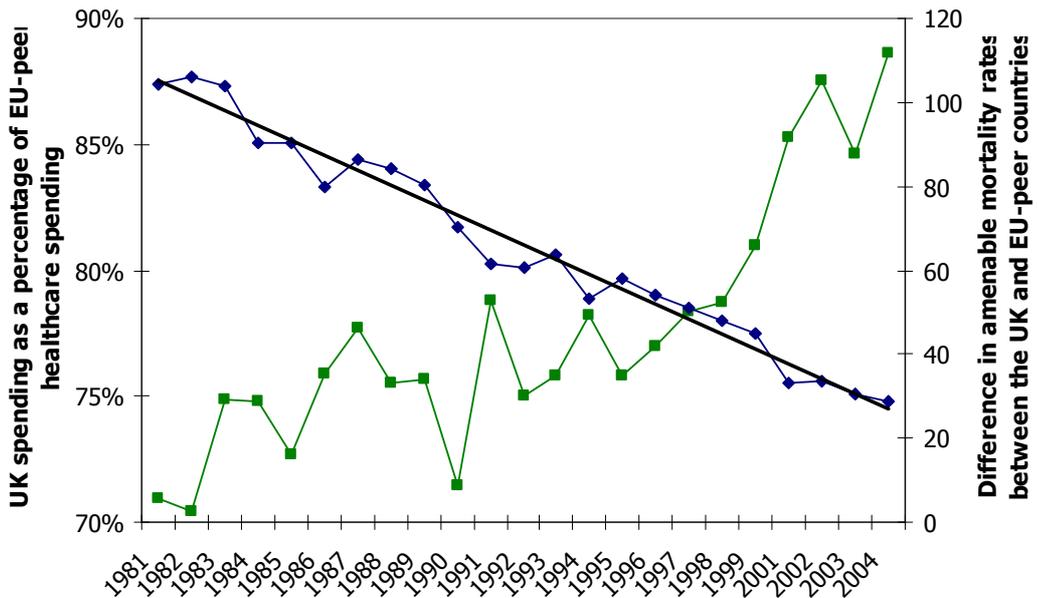


Figure 4.5: UK health spending as a percentage of average spending in selected European countries compared to differences in mortality amenable to healthcare between the UK and selected European countries, 1981-2004



- Again, it is important to see how much recent policy has diverged from the historical pattern and the experience of peer countries. Britain's healthcare spending was already slowly converging on European levels before 1999 but there is a significant increase in the pace of convergence after 1999.
- If health spending had continued to increase relative to European peers at its pre-1999 rate £34.3 billion less would have been spent between 1999 and 2004.²⁸ In 2004 alone, £9.8 billion less would have been spent, 9.7 per cent of total spending in that year. That extra money has had no discernable impact upon mortality amenable to healthcare.
- Some might argue that reductions in amenable mortality will lag behind improvements in healthcare. It might seem plausible that the effects of the spending will be seen in the years after 2004. An examination of a breakdown of NHS expenditure, however, suggests this is unlikely to be the case. 59 per cent is spent on staff and pay, 15 per cent on drugs, 10 per cent on medical equipment, catering and cleaning and 6 per cent on supplies. Almost all of this is expenditure that will be used to treat patients immediately. Drugs will need to be bought and staff paid again each year. Just 10 per cent of expenditure is on capital (buildings, equipment and training) that will improve NHS performance over a number of years.²⁹

How did so much additional money produce no improvement?

It might seem radical to suggest that such a large increase in spending has produced no improvement in healthcare outcomes but that conclusion is supported by a number of inefficiencies identified elsewhere in the literature. There are several factors that could be driving poor performance:

- Additional money led to significant cost inflation, particularly in staff pay, which has produced significant pressures within existing spending. The Kings' Fund estimated that 73 per cent of additional spending in the NHS in 2004-2005, for example, was consumed by cost pressures.³⁰
- Increases in staffing have been faster among administrative, rather than clinical, functions. Between 1999 and 2004 the number of managers and senior managers increased more than twice as quickly as the number of clinical staff.³¹

²⁸ Total health spending amounts taken from Yuen, P. 'Compendium of Health Statistics, 2005-06, 17th Edition', Office of Health Economics, September 2005, pp. 70

²⁹ King's Fund 'An Independent Audit of the NHS under Labour (1997-2005)', March 2005, Figure 2.4: Breakdown of NHS Expenditure, 2003-04

³⁰ King's Fund 'An Independent Audit of the NHS under Labour (1997-2005)', March 2005, Figure 2.6: Allocation of Hospital and Community Health Services Growth Funding, 2004-05

³¹ Office for National Statistics 'Public Sector Employment Trends 2005', October 2005, Table 6.4: NHS workforce by location and occupation group, Headcount

- While reform has always been limited the process over the last ten years of reversing, reinstating³² and then reversing again³³ reforms aimed at introducing more competition within the NHS has been enormously disruptive.

What will it take for the NHS to catch up with its European peers?

The evidence above suggests that the NHS has caught up, relative to its European peers, at an almost exactly constant rate over the last 25 years. However, it would be a big mistake to conclude – from that – that it is likely to continue catching up over the next few years regardless of what policies are in place. Pre-1999 health policy was not standing still.

- The Thatcher government, after deciding that the basic structure of the NHS, funded by general taxation and organised as a nationalised industry could not be tampered with, implemented significant incremental reforms.
 - The 1983 Griffith's report led to the bringing in of professional managers and efficiency measures such as the outsourcing of catering and cleaning were brought in.³⁴
 - In 1989 'Working for Patients' introduced competition for resources between hospitals; the internal market. This reduced the amount of intervention necessary from central government and introduced a rudimentary price system – although it certainly did not create the incentives of a true market.³⁵

These reforms clearly had something of a positive effect on the NHS and moved it closer to the more flexible and effective systems seen in continental Europe. Despite that strategy appearing to have had some success it seems unlikely that improvements in NHS performance from incremental reforms could have continued. There are only so many effective reforms that can be made if the underlying structure of the NHS as a nationalised industry cannot be changed.

Equally, increases in funding are likely to decrease in effectiveness over time. To understand why consider a hypothetical health service:

- The service has £1,000 of new funding to spend and two options for spending it, satisfying demand for Drug A or Drug B, with Drug A offering better value for money.
- That health service, if it is at all well managed, will choose to spend on Drug A.

³² Jenkins, S. 'A painful lesson on healthcare in the NHS Bermuda triangle', *Sunday Times*, April 2006

³³ Timmins, N. 'Private sector health scheme role to be cut', *Financial Times*, November 2007

³⁴ Seddon, N. "Quite Like Heaven? Options for the NHS in a consumer age", *Civitas*, November 2007 pp. 22-23

³⁵ *Ibid*, pp. 24-25



- If another thousand pounds of funding is secured the remaining option will be to spend on Drug B. This will produce weaker results.

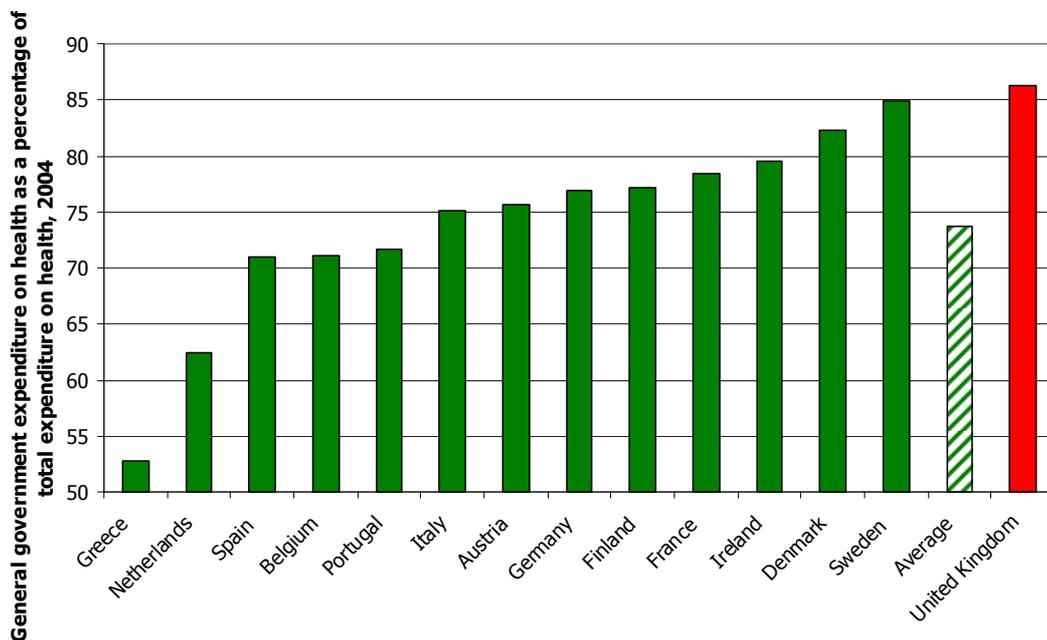
This abstract example illustrates how the returns from new increases in funding or changes in policy can be expected to diminish as the most pressing demands for new funding are satisfied. New funds will be spent on increasingly marginal investments and higher costs will swallow up ever more money. This may be presaged by the slowing of improvements that can be seen in figure 4.3; the last three years studied have all seen slower convergence than the average in earlier years.

In order to get the results seen in other European countries we need to look at how their healthcare systems are organised.

5. How is healthcare delivered in other European healthcare systems?

There are clearly major institutional differences between how Britain and other European countries organise their healthcare systems. The relative dominance of government healthcare spending in the UK can be seen in the following graph:

Figure 5.1: Government spending on health as a percentage of total spending on health, EU-15, 2004



This suggests that Britain's healthcare is particularly dependent upon Government. However, a more detailed examination of the institutional arrangements in a few of the peer countries will provide us with more lessons as to how healthcare can be more effectively delivered. Switzerland is included despite not being part of our European Union peer panel as it is widely cited as a successful system from which we might learn useful lessons.

Germany

Perhaps the most complicated to understand of all Europe's health care systems, the German is the original Bismarkian (insurance-based) model. It exhibits a high degree of decentralisation and privatisation, with 453 sickness funds in operation during 2001, down to 292 in 2004, mainly as the result of mergers. The system is further decentralised by the strong federalism of the country (the Länder play a major part in health care). The European Health Observatory describes how 'it is characterised by a predominance of

mandatory statutory health insurance (SHI) with multiple sickness funds and private/ public mix of providers'.³⁶ In 2003, roughly 88 per cent of the country was covered by comprehensive SHI (78 per cent mandatory and 10 per cent voluntary).³⁷ The remainder are covered by private funds or free government schemes – police, soldiers and civil servants.

Membership of SHI's is compulsory for workers whose income does not exceed a certain level – €40,000 in the West, €32,000 in the East.³⁸ Contributions to the sickness funds are based on wage income, and are shared between employer and employee. Average contributions in 2001 were around 6.5 per cent of pre-tax income; for those whose income is too low, only the employer pays.³⁹

Structurally, at the top level the important players are the Federal Assembly, the Federal Council and the Federal Ministry of Health and Social Security. These control the statutory insurance market, and set higher policy for healthcare. The Länder are then responsible for implementing those policies and managing the healthcare system on a day-to-day basis; capacity, capital investment, pay. Since 1996, every person has been able to choose which fund they wish to belong too – some offer limited services and cheaper rates, others more options (spa treatments for example) for a higher price. Everyone is entitled to change annually, and there is a lot of mobility between funds.

The system has the potential for serious inequity, both in terms of contributions (people who earn more are paying much more) and in terms of expenditure (healthy, young professionals are contributing a lot and taking out very little). To reduce that, the federal government imposes a complex formula on the sickness funds. As the Scottish Information Department explain it: 'All funds must provide or receive compensation for the differences in contributions and expenditures... The formula determines the relative need to pay or receive compensation.... This is intended to reduce the differences between funds' contribution rates'.⁴⁰

German health care is increasingly dependent upon out-of-pocket co-payments. Special arrangements are made for the poor and disabled, but generally people are expected to pay more themselves. 10 per cent of Germany's health care spending goes on pharmaceuticals bought outside any of the insurance funds. Hospital services are provided by a complex tripartite co-operation between the Länder, insurance funds and the hospitals

³⁶ European Observatory on Health Systems and Policies, 2004, 'Summary' of *Health Care Systems in Transition*, p.2

³⁷ Ibid. p.2

³⁸ Scottish Parliament, 2001, *European Health Care Financing and Expenditure*, Information Centre, p.5

³⁹ Ibid. p5

⁴⁰ Scottish Parliament Information Centre 'European Health Care Financing and Expenditure', 2001, p.5

themselves. The latter two determine the costs and so forth, the Länder determine the capital flow.

SHIs only financed about 57 per cent of total health expenditure in 2002, however they dominate the public debate on health. Their organisation and management is complex but manages to ensure 99.5 per cent of the population is covered by adequate health insurance, and access to primary and specialist attention, even for those in the most basic funds, is easily and quickly obtained.

France

In 2000 the WHO ranked the French health care system the best in the world, due in large part to 'generally high levels of health, the degree of freedom for physicians and patients, ease of access to health care, the near absence of waiting lists and genuine existence of universal coverage'.⁴¹

The present system is genuinely Bismarkian, however it is far more concentrated and uniform than other Bismarkian systems, with a far greater role played by the state in the management of the system. It remains though, significantly more decentralised and privatised than the National Health Service, with considerable regional involvement. It is built on the idea of 'statutory health insurance': every French wage-earner contributes a proportion of their wage to one of the funds available. 95 per cent of the population are covered by one of the three main schemes; the general health insurance scheme (*'regime general'*) which covers employees in commerce and industry and their families; the agricultural scheme; and the national insurance fund for self-employed non-agricultural workers.⁴² The remaining 5 per cent of the population enjoy the superior health insurance schemes tied to their specific professions. One cannot shop around between the statutory health insurance funds, as they are strictly occupation linked (giving weight to some claims that the system is less than equitable). However private health insurance funds are numerous and popular: about 85 per cent of the population own such policies.⁴³ Indeed the public health insurance system covers only about 75 per cent of total health expenditure. Half of the outstanding amount is covered by patients' out-of-pocket payments and the other half is paid by private health insurance companies.⁴⁴

Access to care is unlimited: patients can see as many physicians, as often as they like. Patients do not need referrals to see specialists, and in general, there is no gate-keeping system of any kind. Since 2000, residency is enough

⁴¹ European Observatory on Health Systems and Policies (2004), 'Summary' of *Health Care Systems in Transition: France*, p.1

⁴² Sandier, Paris, Polton (2004), *'Health Care Systems in Transitions: France'*, European Observatory on Health Systems and Policies, p.8

⁴³ Medical News Today *'The French Healthcare System'*, June 2004, <http://www.medicalnewstoday.com/articles/9994.php>

⁴⁴ Ibid.

to give you the right to be seen by a doctor, but unlike the UK, treatment, whether private or public, is not free at the point of delivery. On seeing a doctor or specialist (*specialiste*) you first pay the full bill (*tarif*) and are then reimbursed at a later date (about 10 days). Generally speaking, *Sécurité sociale* refunds 70 per cent of the cost of a visit to a *médecin traitant* (a GP or family doctor) and most *specialistes*. Prices once varied depending on the fund, but disparate reimbursement rates have now been replaced by uniform rates.

The responsibilities of the various actors in the system are not always defined in the most coherent manner. The parliament's budget provisions determine how much public money will go to health expenditure, the cabinet decides reimbursement rates and sets the amount of contributions earmarked for the funds, while the funds themselves negotiate with health care professions to set tariffs designed to ensure the system operates at the breakeven point.

The French Ministry of Health houses a General Directorate of Health, which is responsible for broad health policy. This is aided by three, more specifically tasked Directorates: one for hospital and health care, responsible for the management of resources; one for social security, responsible for financial matters; and finally a general directorate for social policy, which is responsible for the specifically social aspects of health care (such as care for disabled, elderly or vulnerable people).⁴⁵

The State and the National Health Insurance Funds are the main government bodies involved in the French healthcare system, although regional authorities also have a role. The regions are responsible for implementing national policies, regulating the numbers of doctors (as a cost containment measure) and their specialisations. Prices and budgets are determined through negotiations between professionals and the health insurance funds. Budgets are subject to the national ceiling for health insurance expenditure which (since 1996) is decided annually by the National Assembly. Total health care expenditure has remained stable at around 10 per cent of GDP since 1995. However the relative value of spending has actually decreased, as increasing amounts are absorbed by pharmaceutical costs. The ONDAM (the annual health care budget) is divided between private practices, public hospitals, private for profit hospitals and social care. Public hospitals are paid in advance on a monthly basis by the health funds. For profit hospitals are paid a fixed rate covering all costs but doctors, who are paid on a fee-for-service basis. As fees are specified in the contract between doctor and hospital there is significant variation in fees.

⁴⁵ Sandier, Paris, Polton (2004), 'Health Care Systems in Transitions: France', European Observatory on Health Systems and Policies, p.20

Spain

Spanish health care is something of an anomaly when viewed in the context of health care development across Europe as a whole. Moving away from statutory health insurance schemes towards a publicly funded NHS in the 1980's, it was a reform direction that broke from the general European trend.

However, to pose Spain's NHS as analogous to Britain's would be misleading. Both are Beveridge systems, funded through general proportionate taxation, in which each citizen contributes a fixed proportion of their income. Both, as in every European system, make provision for those in society who cannot afford to contribute, guaranteeing health care as a universal right. But even at this level of generalisation, the two NHS systems are not entirely comparable; Spanish coverage for instance, is still linked to employment rather than citizenship, and the provision made for the poor differs between the autonomous regions.

It is the autonomy of Spain's regions that has determined the development of a significantly decentralised organisational structure for the country's NHS. Central government – the Ministry of Health and Consumer Affairs – has responsibility for the coordination of the system (not letting one region fall far behind another), defining the minimum benefits package guaranteed by the NHS, pharmaceutical policy and medical education. The 17 autonomous regions hold health planning powers as well as the capacity to organize their own health services.⁴⁶ Health care policy is made principally by the regions.

Within the regions, health competencies are separated between health authorities and health zones. All regions have a health map which stipulates territorial sub-divisions – each health 'area' covers no less than 200,000 people, no more than 250,000, providing them with primary and specialist care. The zone is the smallest administrative unit, organised around a single primary care team. GPs are – as in the UK – the gate-keepers to the system, and like in the UK, dissatisfaction is aimed primarily at this point in the health care process. The numbers of patients who choose to avoid GP consultation and referral by going straight to hospital emergency rooms is ever increasing.⁴⁷ As in the UK too, Spain has moved towards greater levels of hospital independence over the past decade, with the establishment of 'foundation' hospitals. However unlike the UK, on top of the pre-existing devolution of health care power to the regions, these foundation hospitals are genuine self-governing units, with less bureaucratic control and less emphasis on outcomes (targets).

⁴⁶ European Observatory on Health Systems and Policies, 2004, *Health Care Systems in Transitions Summary: Spain*, p.2

⁴⁷ European Observatory on Health Systems and Policies, 2004, *Health Care Systems in Transitions Summary: Spain*, p.4

It is the decentralised nature of Spain's NHS that really distinguishes it from Britain's. Central government's role is restricted to coordination and financing, but the detail of how that money is spent is left to regional politicians, and more often than not, to hospitals. The in-built competition between the regions that is a reality of Spanish politics probably has had some impact on health care policy too, as the regions have worked to build and maintain superior health systems to their neighbours.

The Netherlands

Dutch health care has been the object of some significant reform in recent years, and while this has not constituted a wholesale reinvention of the system – as with Spain's 1986 changes – it has seen the transformation of one of Europe's more complicated and unwieldy regimes into what is today a more streamlined and equitable system. The health care services are provided almost entirely by private suppliers, often non-profit establishments.⁴⁸ These are a legacy of a historical voluntary healthcare system.

The Dutch government – Ministry of Health, Welfare and Sport – is responsible for the accessibility and quality of health care across the country's regions. It also defines policies to ensure the general health of the population. Before January 2006 it oversaw a complex tripartite SHI system but now it monitors the delivery of the obligatory national insurance scheme that is in place. This scheme guarantees each resident of the Netherlands access to basic care. Health insurance companies operating in the country are legally obliged to offer at least this basic package, and insurers cannot refuse coverage to any citizen, on any grounds. Insurers instead compete on price and quality, with some offering additional services bundled into the basic package.⁴⁹ People can of course top up their basic package with supplemental benefits too, for an increased premium, but the basic package on its own costs on average \$1200 (£601) to \$1300 (£651).⁵⁰

Primary care is very well developed in the Netherlands, with roughly 9,000 GPs, each in receipt of at least two years of specialist training.⁵¹ The Dutch GP is the gate-keeper into the health care system, which explains the low rates of referral. What distinguishes them from British GPs is the emphasis given to communication, which is an integral part of their special training; prescription rates are given in just 66 per cent of cases, compared to a European average of 75-95 per cent.⁵²

⁴⁸ European Observatory on Health Systems and Policies, 2005, *Health Systems in Transition: Netherlands*, Summary, p.2

⁴⁹ Richard Grol, 2006, 'Quality Development in Health Care in the Netherlands', *The Commonwealth Fund*, p.2

⁵⁰ Ibid. p.2

⁵¹ Ibid. p.2

⁵² European Observatory on Health Systems and Policies, 2005, *Health Systems in Transition: Netherlands*, Summary, p.5

Primary care professionals mostly work in private practices, with a majority working alone or in small two- or three-person practices. However, due to political and patient pressure, large primary care centres are being established in which four or more GPs work, assisted by nurses and specialists. New payment procedures were introduced in 2006, which included capitation per patient and a fee per consultation.⁵³

Switzerland

Of all the Bismarkian systems, Switzerland's is the least complex at the national level. Under the Federal Health Insurance Act, which underpins the entire system, health insurance is compulsory for all persons who are resident in the country – each person is required to obtain a basic health insurance package within three months of gaining residency.⁵⁴ The Swiss central government decides and legislates as to what the basic health package must include at a minimum, in terms of services and benefits.

Only those insurance companies which accept the strictures of the Health Insurance Law, and are registered with the Federal Office of Social Insurance, may provide these compulsory health insurance schemes (CHIs). Insurance companies are not supposed to make a profit out of the CHIs. They also cannot set any conditions, be they age, sex or state of health, to the provision of coverage. If a person applies, the company must accept them.⁵⁵ Premiums do vary between funds (called 'Krankenkassen', 'Caisses-Maladie', 'Casse Malati' depending on whether one speaks German, French or Italian) due to differences in place of residence, the degree of supplementary benefit coverage chosen and the excess level chosen. However the cost of the premium must be identical for all insured persons of the same age group within that company's scheme, regardless of sex or state of health.⁵⁶

The insured person tends to pay part of the cost of any treatment themselves, either because they have chosen to have an excess in their policy – gaining a lower premium price in return – or because they face a 10 per cent charge on all the costs over and above the excess. Around 40 per cent of the population chose to supplement their CHI with complementary coverage, e.g. dental care.⁵⁷

The insured person can choose from a combination of public, subsidized private and totally private providers of care (in their particular region), in the

⁵³ Richard Grol, 2006, 'Quality Development in Health Care in the Netherlands', *The Commonwealth Fund*, p. 3

⁵⁴ OECD and WHO survey of Switzerland's health system, 2006; www.oecd.org/document/47/0,2340,en_2649_201185_37562223_1_1_1_1,00.html

⁵⁵ European Observatory on Health Care Systems, 2000, *Health Care Systems in Transition: Switzerland*, pp. 9-17

⁵⁶ OECD and WHO survey of Switzerland's health system, 2006; www.oecd.org/document/47/0,2340,en_2649_201185_37562223_1_1_1_1,00.html

⁵⁷ Civitas, 2002, 'The Swiss Health Care System', p.4



knowledge that the insurance company will pay up to the level agreed to in their policy.

Despite its size, the Swiss healthcare system is divided up by twenty six semi-autonomous zones, there is no truly national health policy, and there are cross-canton differences in provision.

The Swiss healthcare system is expensive. However, it also widely approved of by its users and ranked highly in international comparisons.⁵⁸ This is perhaps because, as in most Bismarkian systems, patients are the people paying, and as such, they expect to see any GP, whenever they wish, and to visit a specialist without referral.

⁵⁸ OECD and WHO survey of Switzerland's health system, 2006;
www.oecd.org/document/47/0,2340,en_2649_201185_37562223_1_1_1_1,00.html

6. What is British healthcare getting wrong?

The structure of the NHS is so Byzantine that any reform to it will require considerable work. However, there are a number of key problems with the way the NHS functions.

Centralisation

The NHS has a large number of local bodies, the Primary Care Trusts, NHS Trusts and Regional Strategic Health Authorities. However, these are all both legally non-departmental bodies answering to the Department of Health and effectively part of one organisation. Most have only a very limited ability to act independently:

- Their decisions over which drugs to buy are expected to conform to guidance from the National Institute for Health and Clinical Excellence.⁵⁹
- IT expenditure is mostly handled by Connecting for Health which runs the National Programme for IT⁶⁰, the largest single information technology project in the world.⁶¹
- Staff pay, the largest item of expenditure,⁶² is determined nationally by the NHS Pay Review Body.⁶³
- Amounts of funding are also set nationally according to a weighted capitation formula.⁶⁴ This became very controversial in 2006 when the Government were accused of manipulating the funding decision for political advantage.⁶⁵

Other countries decentralise healthcare:

- Research into the Swiss healthcare system⁶⁶ suggests that its success is due, in large part, to decentralisation. It effectively runs 26 healthcare systems within a common framework of regulations which makes the systems comparable and, therefore, allows for cantons whose systems

⁵⁹ National Institute for Health and Clinical Excellence "About NICE guidance: what does it mean for me?", <http://www.nice.org.uk/nicemedia/pdf/AboutGuidance.pdf>

⁶⁰ NHS Connecting for Health, "Background and introduction", <http://www.connectingforhealth.nhs.uk/about/background/index.html>

⁶¹ ComputerWeekly.Com "Warning signs surround world's largest IT project", April 2006, <http://www.computerweekly.com/Articles/2006/04/11/215270/warning-signs-surround-worlds-largest-it-project.htm>

⁶² King's Fund "An Independent Audit of the NHS under Labour (1997-2005)", March 2005, Figure 2.4: Breakdown of NHS Expenditure, 2003-04

⁶³ Office of Manpower Economics "NHS Pay Review Body", <http://www.ome.uk.com/review.cfm?body=6>

⁶⁴ Department of Health "About NHS allocations", July 2007, http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Financeandplanning/Allocations/DH_076547

⁶⁵ Helm, T. "Hewitt defends NHS cash for Labour areas", *Daily Telegraph*, November 2006, <http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/11/22/nhealth122.xml>

⁶⁶ Civitas "The Swiss Healthcare System", 2002

are struggling to learn from the more successful. Some responsibilities are even devolved further to the local authorities.

- The German system decentralises to a multitude of insurance funds who buy services from a range of providers. The Länder have significant leeway to vary health policy.
- The Spanish system, while quite similar to the NHS in many other ways, is highly decentralised with most healthcare policy set in the regions.
- The French system decentralises healthcare to a number of insurance funds which are then able to buy freely from independent and state-run providers. This provides significant, though limited thanks to a large measure of central government intervention, decentralisation.

Making decisions at a local level has a number of advantages:

- It is easier to vary decisions according to local circumstances.
- It is easier to feed local information and the views of individual professionals and patients into the decision.
- People will feel greater ownership of institutions that they are more closely connected to.

Political Management

When politicians manage a public service the means as well as the ends are determined politically. That makes politicians ultimately responsible for technical details of healthcare delivery that they cannot possibly understand. Even if they have the very best advisers they will need to choose which, often conflicting, advice to trust. They are poorly qualified for this role.⁶⁷

- Since 1981 not a single one of the Secretaries of State responsible for the health service has been a professional with in-depth knowledge of the health service.
- Few have had experience of management before becoming an MP.
- Given that it is the fourth or fifth – depending on whether you count the US Department of Defense as a single organisation – largest organisation in the world after the People’s Liberation Army in China, the Indian railways and Walmart,⁶⁸ there are few positions that really provide someone with experience running an organisation on the scale of NHS.
- Even with this proviso in mind what management experience incoming Secretaries of State have had has been on a very small scale.

⁶⁷ Biographical information from Dods Online Political Biographies

⁶⁸ Trefgarne, G. "NHS reaches 1.4m employees", *Daily Telegraph*, March 2005, <http://www.telegraph.co.uk/money/main.jhtml?xml=/money/2005/03/23/cnnhs23.xml>

- There have been twelve Secretaries of State responsible for health during that time, an average tenure of less than two years.

Despite all these problems it is important that democratic control be maintained over any service that is going to be run by the government and, hence, not subject to market discipline. An independent NHS might have experienced leadership but would be unaccountable. The challenge is to end political control while keeping the service accountable to ordinary people.

In Switzerland, France, Germany and the Netherlands the healthcare system is based upon insurance providers – sometimes private companies, sometimes state organisations – that commission healthcare, often from private providers:

- This means that politicians and civil servants are responsible for less of the management of healthcare than in the UK.
- In the Netherlands and Switzerland, in particular, insurance companies are often not monopolies so do not need to be democratically accountable in the way the NHS has to be. Decentralisation is politically feasible because central Government is less likely to be held responsible for the failure of a private company than a state monopoly whether or not that state organisation is run by local government or a quango.

Monopolistic

Organisations with a monopoly defended by unique access to taxpayers' money have no competition and no threat of customer loss or bankruptcy. Customers have no choice and no redress. These monopolies therefore remove the basic tools of management and kill the need to innovate, improve and reduce costs.

Not only does the NHS have unique access to taxpayers' money but it offers its services as a single package. Patients are not allowed to pay for private care for only part of their treatment for a particular condition. The former nurse Colette Mills, who wanted to pay for a particular cancer drug not available on the NHS, was threatened with having NHS support for her other care removed.⁶⁹ This restriction prevents people suffering thanks to a weakness of the NHS in a particular area mitigating some portion of the harm.

Perhaps the most important priority for reform of British healthcare is to increase the amount of competition within the health service.

- In France, Germany and other countries with insurance-based systems providers compete to offer quality service at low cost to insurers.

⁶⁹ Templeton, S-K. 'NHS threat to halt care for cancer patient', Sunday Times, December 2007

- Competition is being advanced in its most complete form, at least within the EU-15, in the Netherlands where consumers may choose between a number of nationwide healthcare insurance plans. Those plans can compete on premiums, types of plan and service levels. The insurers will then have to negotiate with providers to keep their own costs low.

Preventing healthcare expenditure becoming a burden on employment

A common criticism of the German and French healthcare systems is that the burden for funding them falls particularly on employment. This means that they increase unemployment and become particularly difficult to sustain with an ageing population. The World Bank has described how the German system faced a severe crisis when Social Health Insurance Revenues fell as unemployment rose and the population aged.⁷⁰

This is not a necessary flaw of insurance-based healthcare though. Both the Swiss healthcare system and that in the Netherlands run an insurance-based system that is detached from employment.⁷¹

⁷⁰ Wagstaff, A "Social Health Insurance Reexamined", *World Bank Policy Research Working Paper 4111*, January 2007

⁷¹ Seddon, N. "Quite Like Heaven? Options for the NHS in a consumer age", *Civitas*, November 2007 pp. 164

7. Conclusions

This report has shown that significant increases in NHS funding have not provided corresponding increases in performance. Extra NHS spending since 1999 has made no difference to the downward trajectory of mortality amenable to healthcare:

- In 2004, the latest year for which data is available, higher rates of mortality amenable to healthcare in the United Kingdom relative to the average of European peers led to 17,157 deaths in that year. This is equivalent to over five times the total number of deaths in road accidents and over two and a half times the number of deaths related to alcohol.
- The United Kingdom caught up with its European peers at a nearly constant rate between 1981 and 2004. This implies that the massive additional spending since 1999 has had no discernable effect on mortality rates.
- If NHS spending had continued to increase relative to European peers at its pre-1999 rate £34.3 billion – £1,350 per household – less would have been spent between 1999 and 2004. In 2004 alone, £9.8 billion less would have been spent, 9.7 per cent of total spending in that year. This extra money has largely been wasted.
- In the last three years studied (2002-2004) amenable mortality convergence was slower than the trend over the entire period. This suggests that, if anything, relative improvements in mortality amenable to healthcare are currently slowing.

The pattern appears to be that incremental reforms in the 1980s and early 1990s achieved roughly the same results as massive increases in spending in the later years. Neither strategy is likely to be able to sustain improvements, however, as the returns from additional spending are likely to diminish rapidly and incremental reforms are strictly limited if the fundamental structure of the NHS cannot be altered.

Failing to reform the NHS comprehensively leaves British healthcare without the decentralisation, competition and professional management that it so urgently needs. Confused and unstable policy has managed to combine the worst of both worlds through constant transitions but little lasting reform.

The poor performance of British healthcare is not preordained. It is not a price we pay for ensuring that everyone gets the treatment they need, given that the other European countries this study has examined all look after the unfortunate. Equally, our healthcare system has proved unable to make effective use of large amounts of additional resources so this is not a problem that will go away with more money. Gordon Brown has proved that.



Politicians should stop trying to do the impossible and focus on their proper role of setting high-level policy. Professionals working in the health service can enjoy greater autonomy which will make for more satisfying and possibly even less stressful careers.⁷² Patients can live longer and healthier lives. All it requires is that we learn important lessons from how other countries organise the provision of healthcare.

⁷² Business Link, "*Tackle the causes of workplace stress*",
<http://www.businesslink.gov.uk/bdotg/action/detail?type=RESOURCES&itemId=1074428207>

Appendix A: Amenable mortality data

NB: UK data for 2000 is not available and so 2000 is not included in this series of tables

1981

	Population, 1981	Amenable mortality rate, 1981	Combined amenable mortality rate, 1981
United Kingdom			
Male	27,372,160	347.0	
Female	28,943,840	257.2	300.8
Netherlands			
Male	7,065,000	221.8	
Female	7,182,200	179.1	200.3
Germany			
Male	29,501,300	275.6	
Female	32,180,700	191.3	231.6
France			
Male	26,435,400	189.2	
Female	27,530,500	137.8	163.0
Spain			
Male	18,526,200	221.9	
Female	19,224,600	160.0	190.3
	Euro-average excluding UK		196.3
	<i>Difference between UK and Euro-average</i>		104.5
	Deaths per year in UK implied by difference from EU average		58,853.6

1982

	Population, 1982	Amenable mortality rate, 1982	Combined amenable mortality rate, 1982
United Kingdom			
Male	27,389,435	337.1	
Female	28,926,405	250.6	292.7
Netherlands			
Male	7,092,100	213.8	
Female	7,220,600	165.7	189.5
Germany			
Male	29,481,900	263.0	
Female	32,155,700	184.0	221.8
France			
Male	26,596,200	180.4	
Female	27,884,200	134.5	156.9
Spain			
Male	18,634,200	206.3	
Female	19,327,100	150.3	177.8
	Euro-average excluding UK		186.5
	<i>Difference between UK and Euro-average</i>		106.1
	Deaths per year in UK implied by difference from EU average		59,777.6

1983

	Population, 1983	Amenable mortality rate, 1983	Combined amenable mortality rate, 1983
United Kingdom			
Male	27,413,975	331.3	
Female	28,938,345	245.9	287.4
Netherlands			
Male	7,113,400	206.9	
Female	7,253,700	165.3	185.9
Germany			
Male	29,364,700	255.6	
Female	32,058,400	183.3	217.9
France			
Male	26,706,500	177.5	
Female	28,021,800	134.5	155.5
Spain			
Male	18,741,000	200.5	
Female	19,431,100	149.3	174.5
	Euro-average excluding UK		183.4
	<i>Difference between UK and Euro-average</i>		104.0
	Deaths per year in UK implied by difference from EU average		58,605.0

1984

	Population, 1984	Amenable mortality rate, 1984	Combined amenable mortality rate, 1984
United Kingdom			
Male	27,480,123	307.5	
Female	28,979,657	229.6	267.6
Netherlands			
Male	7,136,900	204.0	
Female	7,287,300	160.2	181.9
Germany			
Male	29,240,700	243.6	
Female	31,934,400	172.5	206.5
France			
Male	26,801,600	169.5	
Female	28,145,100	128.6	148.5
Spain			
Male	18,827,700	198.9	
Female	19,514,100	145.1	171.5
	Euro-average excluding UK		177.1
	<i>Difference between UK and Euro-average</i>		90.5
	Deaths per year in UK implied by difference from EU average		51,068.9

1985

	Population, 1985	Amenable mortality rate, 1985	Combined amenable mortality rate, 1985
United Kingdom			
Male	27,564,414	299.2	
Female	29,052,276	230.2	263.8
Netherlands			
Male	7,167,100	200.2	
Female	7,324,600	164.1	181.9
Germany			
Male	29,181,100	235.0	
Female	31,842,900	169.8	201.0
France			
Male	26,900,200	169.2	
Female	28,270,200	123.2	145.6
Spain			
Male	18,911,300	192.9	
Female	19,593,500	138.4	165.2
	Euro-average excluding UK		173.4
	<i>Difference between UK and Euro-average</i>		90.4
	Deaths per year in UK implied by difference from EU average		51,178.6

1986

	Population, 1986	Amenable mortality rate, 1986	Combined amenable mortality rate, 1986
United Kingdom			
Male	27,634,211	271.7	
Female	29,126,449	226.5	248.5
Netherlands			
Male	7,204,400	199.7	
Female	7,367,800	157.4	178.3
Germany			
Male	29,232,800	221.0	
Female	31,833,200	165.9	192.3
France			
Male	27,002,200	166.5	
Female	28,392,000	123.1	144.2
Spain			
Male	18,968,200	181.8	
Female	19,635,800	136.8	158.9
	Euro-average excluding UK		168.4
	<i>Difference between UK and Euro-average</i>		80.0
	Deaths per year in UK implied by difference from EU average		45,425.6

1987

	Population, 1987	Amenable mortality rate, 1987	Combined amenable mortality rate, 1987
United Kingdom			
Male	27,721,103	276.1	
Female	29,202,817	219.7	247.2
Netherlands			
Male	7,249,000	182.4	
Female	7,416,100	153.9	168.0
Germany			
Male	29,322,900	211.2	
Female	31,754,100	160.5	184.8
France			
Male	27,107,600	156.9	
Female	28,522,600	116.6	136.2
Spain			
Male	18,998,200	175.1	
Female	19,718,200	134.0	154.2
	Euro-average excluding UK		160.8
	<i>Difference between UK and Euro-average</i>		86.4
	Deaths per year in UK implied by difference from EU average		49,161.0

1988

	Population, 1988	Amenable mortality rate, 1988	Combined amenable mortality rate, 1988
United Kingdom			
Male	27,794,119	270.5	
Female	29,262,121	213.5	241.3
Netherlands			
Male	7,295,100	178.7	
Female	7,465,000	149.7	164.0
Germany			
Male	29,544,300	202.8	
Female	31,905,200	159.3	180.2
France			
Male	27,225,800	148.3	
Female	28,657,900	115.7	131.6
Spain			
Male	19,044,700	172.5	
Female	19,764,300	133.7	152.7
	Euro-average excluding UK		157.1
	<i>Difference between UK and Euro-average</i>		84.1
	Deaths per year in UK implied by difference from EU average		48,006.4

1989

	Population, 1989	Amenable mortality rate, 1989	Combined amenable mortality rate, 1989
United Kingdom			
Male	27,888,165	258.0	
Female	29,342,925	208.3	232.6
Netherlands			
Male	7,337,400	171.5	
Female	7,511,400	147.6	159.4
Germany			
Male	29,891,000	196.8	
Female	32,171,500	153.7	174.4
France			
Male	27,363,800	143.8	
Female	28,796,300	111.2	127.1
Spain			
Male	19,085,000	165.6	
Female	19,803,200	132.5	148.7
	Euro-average excluding UK		152.4
	<i>Difference between UK and Euro-average</i>		80.1
	Deaths per year in UK implied by difference from EU average		45,860.5

1990

	Population, 1990	Amenable mortality rate, 1990	Combined amenable mortality rate, 1990
United Kingdom			
Male	27,987,365	246.6	
Female	29,408,305	199.3	222.4
Netherlands			
Male	7,389,000	165.6	
Female	7,562,500	144.2	154.8
Germany			
Male	38,276,300	209.7	
Female	41,088,200	159.8	183.9
France			
Male	27,623,300	138.9	
Female	29,111,800	108.8	123.5
Spain			
Male	19,122,100	165.3	
Female	19,837,100	127.1	145.9
	Euro-average excluding UK		152.0
	<i>Difference between UK and Euro-average</i>		70.4
	Deaths per year in UK implied by difference from EU average		40,405.8

1991

	Population, 1991	Amenable mortality rate, 1991	Combined amenable mortality rate, 1991
United Kingdom			
Male	28,949,622	229.0	
Female	29,567,315	194.5	211.5
Netherlands			
Male	7,449,800	161.7	
Female	7,619,800	145.6	153.6
Germany			
Male	38,657,700	202.4	
Female	41,326,600	157.9	179.4
France			
Male	27,783,500	137.8	
Female	29,271,900	109.7	123.4
Spain			
Male	19,156,200	160.6	
Female	19,868,700	128.6	144.3
	Euro-average excluding UK		150.2
	<i>Difference between UK and Euro-average</i>		61.3
	Deaths per year in UK implied by difference from EU average		35,898.3

1992

	Population, 1992	Amenable mortality rate, 1992	Combined amenable mortality rate, 1992
United Kingdom			
Male	28,337,172	227.0	
Female	29,649,848	186.0	206.0
Netherlands			
Male	7,507,800	152.9	
Female	7,676,300	150.3	151.6
Germany			
Male	39,060,200	195.9	
Female	41,534,300	152.7	173.6
France			
Male	27,941,900	131.9	
Female	29,431,700	105.7	118.5
Spain			
Male	19,099,300	156.5	
Female	19,906,400	121.2	138.5
	Euro-average excluding UK		145.5
	<i>Difference between UK and Euro-average</i>		60.5
	Deaths per year in UK implied by difference from EU average		35,069.6

1993

	Population, 1993	Amenable mortality rate, 1993	Combined amenable mortality rate, 1993
United Kingdom			
Male	28,447,319	232.5	
Female	29,722,541	186.4	208.9
Netherlands			
Male	7,560,600	159.3	
Female	7,729,800	144.4	151.8
Germany			
Male	39,433,300	195.9	
Female	41,745,900	151.7	173.2
France			
Male	28,079,000	131.1	
Female	29,575,400	106.2	118.3
Spain			
Male	19,137,800	152.8	
Female	19,948,300	122.1	137.1
	Euro-average excluding UK		145.1
	<i>Difference between UK and Euro-average</i>		63.8
	Deaths per year in UK implied by difference from EU average		37,137.5

1994

	Population, 1994	Amenable mortality rate, 1994	Combined amenable mortality rate, 1994
United Kingdom			
Male	28,562,442	213.5	
Female	29,807,568	178.7	195.7
Netherlands			
Male	7,606,700	151.8	
Female	7,776,100	141.6	146.6
Germany			
Male	39,433,300	195.9	
Female	41,745,900	151.7	173.2
France			
Male	28,195,200	124.4	
Female	29,704,300	105.8	114.9
Spain			
Male	19,165,400	152.3	
Female	19,984,100	117.5	134.5
	Euro-average excluding UK		142.3
	<i>Difference between UK and Euro-average</i>		53.4
	Deaths per year in UK implied by difference from EU average		31,183.5

1995

	Population, 1995	Amenable mortality rate, 1995	Combined amenable mortality rate, 1995
United Kingdom			
Male	28,695,253	217.1	
Female	29,883,537	177.5	196.9
Netherlands			
Male	7,644,900	148.3	
Female	7,814,100	143.6	145.9
Germany			
Male	39,731,000	184.6	
Female	41,930,000	145.9	164.7
France			
Male	28,308,700	125.8	
Female	29,830,400	103.1	114.2
Spain			
Male	19,190,500	147.0	
Female	20,019,200	114.2	130.3
	Euro-average excluding UK		138.8
	<i>Difference between UK and Euro-average</i>		58.1
	Deaths per year in UK implied by difference from EU average		34,043.1

1996

	Population, 1996	Amenable mortality rate, 1996	Combined amenable mortality rate, 1996
United Kingdom			
Male	28,820,820	211.5	
Female	29,950,670	168.9	189.8
Netherlands			
Male	7,679,500	151.3	
Female	7,851,000	138.2	144.7
Germany			
Male	39,887,700	178.9	
Female	42,008,000	143.9	161.0
France			
Male	28,422,900	121.9	
Female	29,951,900	99.8	110.5
Spain			
Male	19,215,000	145.2	
Female	20,055,300	107.5	125.9
	Euro-average excluding UK		135.5
	<i>Difference between UK and Euro-average</i>		54.3
	Deaths per year in UK implied by difference from EU average		31,896.7

1997

	Population, 1997	Amenable mortality rate, 1997	Combined amenable mortality rate, 1997
United Kingdom			
Male	28,949,622	200.8	
Female	30,025,118	163.9	182.0
Netherlands			
Male	7,718,400	138.5	
Female	7,892,200	137.3	137.9
Germany			
Male	39,989,100	171.9	
Female	42,062,600	135.7	153.3
France			
Male	28,538,200	119.9	
Female	30,071,700	100.4	109.9
Spain			
Male	19,235,300	138.2	
Female	19,235,300	106.7	122.5
	Euro-average excluding UK		130.9
	<i>Difference between UK and Euro-average</i>		51.1
	Deaths per year in UK implied by difference from EU average		30,160.8

1998

	Population, 1998	Amenable mortality rate, 1998	Combined amenable mortality rate, 1998
United Kingdom			
Male	29,082,991	196.1	
Female	30,110,579	159.6	177.5
Netherlands			
Male	7,766,700	140.1	
Female	7,940,500	134.8	137.4
Germany			
Male	39,992,300	166.3	
Female	42,036,700	130.7	148.0
France			
Male	28,657,800	121.9	
Female	30,194,800	101.9	111.6
Spain			
Male	19,253,000	137.1	
Female	20,118,200	105.3	120.8
	Euro-average excluding UK		129.5
	<i>Difference between UK and Euro-average</i>		48.1
	Deaths per year in UK implied by difference from EU average		28,446.4

1999

	Population, 1999	Amenable mortality rate, 1999	Combined amenable mortality rate, 1999
United Kingdom			
Male	29249735	189.768699	
Female	30203915	155.3643831	172.2904612
Netherlands			
Male	7819800	131.6894771	
Female	7992300	138.2331118	134.9969879
Germany			
Male	40048000	160.2133577	
Female	42038600	126.6171474	143.0078986
France			
Male	28469781	121.6795144	
Female	30152897	102.2833228	111.7029765
Spain			
Male	19384064	137.6928601	
Female	20242089	100.9175195	118.9070416
	Euro-average excluding UK		127.1537261
	<i>Difference between UK and Euro-average</i>		45.13673505
	Deaths per year in UK implied by difference from EU average		26835.43648

2001

	Population, 2001	Amenable mortality rate, 2001	Combined amenable mortality rate, 2001
United Kingdom			
Male	28,809,603	167.6	
Female	30,241,244	137.1	152.0
Netherlands			
Male	7,940,911	126.3	
Female	8,105,269	130.9	128.6
Germany			
Male	40,214,370	151.3	
Female	42,151,183	116.0	133.2
France			
Male	28,755,212	110.8	
Female	30,437,385	93.6	101.9
Spain			
Male	19,901,194	124.7	
Female	20,713,159	97.6	110.9
	Euro-average excluding UK		118.7
	<i>Difference between UK and Euro-average</i>		33.3
	Deaths per year in UK implied by difference from EU average		19,670.7

2002

	Population, 2002	Amenable mortality rate, 2002	Combined amenable mortality rate, 2002
United Kingdom			
Male	28,911,254	165.0	
Female	30,317,731	136.1	150.2
Netherlands	t		
Male	7,993,719	123.5	
Female	8,155,209	127.5	125.5
Germany	t		
Male	40,310,430	147.4	
Female	42,171,879	116.8	131.7
France			
Male	28,989,574	106.8	
Female	30,688,679	92.3	99.3
Spain			
Male	20,266,005	124.2	
Female	21,048,014	95.3	109.5
	Euro-average excluding UK		116.5
	<i>Difference between UK and Euro-average</i>		33.7
	Deaths per year in UK implied by difference from EU average		19,969.2

2003

	Population, 2003	Amenable mortality rate, 2003	Combined amenable mortality rate, 2003
United Kingdom			
Male	29,108,024	156.2	
Female	30,445,759	131.0	143.3
Netherlands	t		
Male	8,030,692	116.9	
Female	8,194,609	120.5	118.7
Germany	t		
Male	40,349,200	142.7	
Female	42,170,976	111.1	126.5
France			
Male	21,378,383	105.6	
Female	30,929,006	91.3	97.2
Spain			
Male	20,626,192	122.4	
Female	21,378,383	94.7	108.3
	Euro-average excluding UK		112.7
	<i>Difference between UK and Euro-average</i>		30.6
	Deaths per year in UK implied by difference from EU average		18,232.6

2004

	Population, 2004	Amenable mortality rate, 2004	Combined amenable mortality rate, 2004
United Kingdom			
Male	29,270,975	148.5	
Female	30,563,339	122.7	135.3
Netherlands			
Male	8,055,946	109.6	
Female	8,225,832	118.9	114.3
Germany			
Male	40,350,091	134.8	
Female	42,151,183	107.1	120.6
France			
Male	29,466,782	94.0	
Female	31,176,524	88.3	91.1
Spain			
Male	20,987,670	115.3	
Female	21,704,081	86.1	100.5
	Euro-average (excluding UK)		106.6
	<i>Difference between UK and Euro-average</i>		28.7
	Deaths per year in UK implied by difference from Euro-average		17,157

Appendix B: Spending data

Year	Spending, per person, per capita, US\$ PPP						UK as a percentage of EU-peer average
	Netherlands	France	Spain	Germany	EU-peer average	United Kingdom	
1981	\$831.00		\$406.00	\$1,077.00	\$771.33	\$547.00	71%
1982	\$895.00		\$444.00	\$1,123.00	\$820.67	\$578.00	70%
1983	\$922.00		\$476.00	\$1,186.00	\$861.33	\$645.00	75%
1984	\$953.00		\$483.00	\$1,282.00	\$906.00	\$678.00	75%
1985	\$984.00	\$1,059.00	\$496.00	\$1,378.00	\$979.25	\$712.00	73%
1986	\$1,048.00		\$518.00	\$1,423.00	\$996.33	\$756.00	76%
1987	\$1,108.00		\$569.00	\$1,500.00	\$1,059.00	\$823.00	78%
1988	\$1,184.00		\$684.00	\$1,630.00	\$1,166.00	\$881.00	76%
1989	\$1,327.00		\$765.00	\$1,623.00	\$1,238.33	\$937.00	76%
1990	\$1,434.00	\$1,499.00	\$872.00	\$1,730.00	\$1,383.75	\$989.00	71%
1991	\$1,541.00	\$1,612.00	\$952.00		\$1,368.33	\$1,078.00	79%
1992	\$1,631.00	\$1,712.00	\$1,029.00	\$1,933.00	\$1,576.25	\$1,182.00	75%
1993	\$1,697.00	\$1,812.00	\$1,086.00	\$1,949.00	\$1,636.00	\$1,240.00	76%
1994	\$1,739.00	\$1,872.00	\$1,114.00	\$2,082.00	\$1,701.75	\$1,331.00	78%
1995	\$1,821.00	\$2,065.00	\$1,193.00	\$2,225.00	\$1,826.00	\$1,384.00	76%
1996	\$1,878.00	\$2,130.00	\$1,246.00	\$2,355.00	\$1,902.25	\$1,464.00	77%
1997	\$1,932.00	\$2,202.00	\$1,279.00	\$2,373.00	\$1,946.50	\$1,525.00	78%
1998	\$2,047.00	\$2,285.00	\$1,356.00	\$2,443.00	\$2,032.75	\$1,600.00	79%
1999	\$2,134.00	\$2,358.00	\$1,450.00	\$2,518.00	\$2,115.00	\$1,713.00	81%
2000	\$2,258.00	\$2,487.00	\$1,520.00	\$2,634.00	\$2,224.75	\$1,859.00	84%
2001	\$2,525.00	\$2,649.00	\$1,617.00	\$2,754.00	\$2,386.25	\$2,034.00	85%
2002	\$2,775.00	\$2,795.00	\$1,723.00	\$2,886.00	\$2,544.75	\$2,228.00	88%
2003	\$2,910.00	\$3,011.00	\$1,951.00	\$3,129.00	\$2,750.25	\$2,328.00	85%
2004	\$3,094.00	\$3,191.00	\$2,101.00	\$3,169.00	\$2,888.75	\$2,560.00	89%

Source: OECD Health Division "OECD Health Data 2007", Expenditure on health (total, public, private), October 2007