



Derek Wanless
Health Trends Team
Room 82/G
HM Treasury
Parliament Street
London
SW1P 3AG

24 January 2002

Dear Mr Wanless

I enclose a response to your Interim Report: *Securing Our Future Health: Taking a Long-Term View*.

Reform is an independent campaign to promote new directions for public policy – in particular the need for modern, high quality public services – based on the principles of free enterprise, limited government, and individual liberty. Our advisory council of medical practitioners and experts includes Professor Karol Sikora, Professor Nick Bosanquet and Professor John Spiers.

Your report sets out in striking detail how the NHS achieves markedly inferior outcomes to other developed countries. Yet these countries have different systems of health financing. It therefore seems perverse to conclude that “the current UK system for financing healthcare shapes up well against the alternatives”. As you know the Government’s use of this aspect of your report to rule out any consideration of alternative financing was widely criticised.

We respectfully suggest that your conclusion was peremptory and that the final version should address the question of financing more thoroughly. We implore the Group to consider more carefully the potential benefits of alternative systems, in particular their ability to empower patients and promote choice.

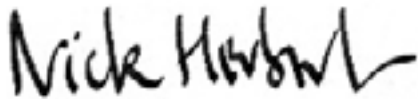
Under a predominantly tax-funded system, the NHS has suffered persistent under-funding and now delivers unacceptably low standards for the world’s fourth largest economy. All the evidence suggests that simply increasing public funds

for the NHS in its current form will not produce an adequate improvement in outcomes.

Ultimately it is doubtful that the Government's objective of greater patient choice can be realised without giving patients more control over the funding of their healthcare. Other healthcare systems combine higher standards with equity and choice, consistent with the Government's stated principles of health reform.

We believe that a genuine national debate on the future financing of healthcare is long overdue. We would value the opportunity of meeting you and your team in order to discuss these points before your final report.

Yours sincerely

A handwritten signature in black ink that reads "Nick Herbert". The signature is written in a cursive, slightly slanted style.

NICK HERBERT
Director

Reform
42 Brook Street
London
W1K 5DB

Tel 020 7958 9066
Fax 020 7958 9090

REFORM

NEW DIRECTIONS FOR PUBLIC POLICY

Reform is an independent campaign to promote new directions for public policy – in particular the need for modern, high quality public services – based on the principles of free enterprise, limited government, and individual liberty

Response to the Wanless Interim Report

- With the Wanless Interim Report, the Government launched a **national “debate” on the funding of healthcare** – and immediately ruled out any alternatives to tax funding.
- But in its current form **the NHS has become one of the most under-funded health services in the developed world**. The NHS suffers from very low capacity and delivers some of the poorest standards in the developed world. A new international study undermines the standard defence of the NHS, that it is efficient.
- The Prime Minister has repeated his pledge to increase health spending to the EU average – but the King’s Fund now estimate this will cost **£45 billion a year**. It has been estimated that tax rises of only £10 billion would reduce GDP by £13.3 billion.
- Spending more on the NHS in its current form is unlikely to deliver sufficient improvements to the service. **The Government has already increased spending by nearly a third but achieved only a small increase in the amount of patients treated**. The President of the Royal College of Surgeons has said that the NHS is in a “desperate” state. Alternative methods of funding and more profound structural reform are needed.
- There has been strong and near unanimous criticism of the Government’s unwillingness to consider more radical reform of the NHS, with the notable exception of the unions. **The latest polls show that the public believes that services are not improving** – and support for tax rises to fund more spending has fallen dramatically.
- The Government has proclaimed welcome new reforms, including limited use of the private sector. But **the vast majority of NHS patients will have no further choice** under the plans, not least because the NHS has no spare capacity. England and Wales have fewer doctors per head of the population than most of the developed world.
- Alternative financing systems are consistent with equity and choice, the Government’s principles for NHS reform. In fact the principle of choice is only likely to be achieved by giving patients control over elements of the financing of healthcare. **A genuine national debate on the future financing of healthcare is long overdue**.

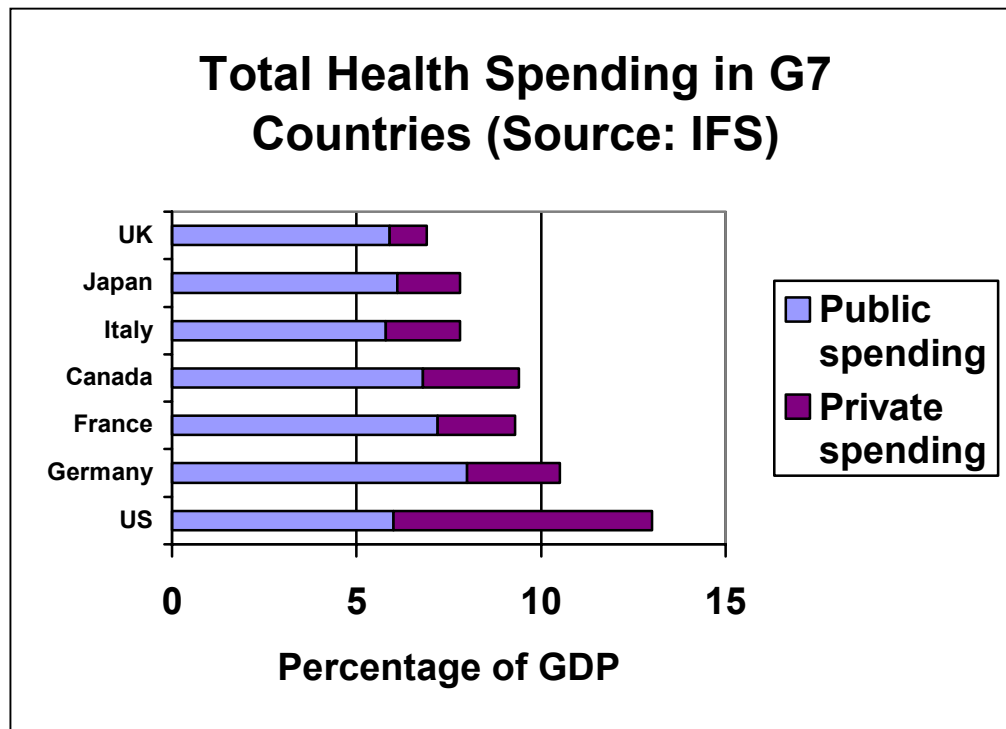
Response to the Wanless Interim Report

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1. Countries with mixed funding systems are better funded and achieve better outcomes

“Things are in such a mess, much worse than I would have imagined possible The NHS is in a desperate state”. (Professor Sir Peter Morris, President of the Royal College of Surgeons, *New Statesman*, 7 December 2001).

- 1.1 The Wanless Interim Report made clear that the NHS performs very poorly compared to other countries with more mixed systems of health financing. Other evidence, particularly on waiting times, might have been included and further demonstrates the poor quality of care available in Britain.
- 1.2 The important difference between the British healthcare system and those in other developed countries is that Britain raises comparatively little from private sources.
- 1.3 British underspending is not a recent phenomenon. Cumulative under-investment in the NHS compared with the EU average between 1972 and 1998 is **£267 billion** (Wanless Interim Report, page 37).
- 1.4 The result, as the Wanless Interim Report makes clear, is that the NHS is heavily under-resourced. **England and Wales has fewer doctors per head of the population than most of the developed world.** Britain has half the number of doctors in France. In fact in Europe only Turkey and Albania have fewer (Source: Adam Smith Institute). Professor Sir Peter Morris, President of the Royal College of Surgeons, has said that the NHS faces a shortfall of 1,500 surgeons by the end of the decade and that surgical services were "second rate". The NHS Executive says England will need 1,920 extra consultant surgeons by 2009. But a shortfall of 1,454 is predicted. (*Daily Telegraph*, 12 December 2001).



- 1.5 In the first annual report of the **NHS Modernisation Board**, the Government has announced that it is succeeding in increasing the capacity of the NHS, for example by employing 10,000 more nurses over the last year. But the report glossed over the far higher standards achieved on the Continent. Experts at the King's Fund have estimated that **the NHS would need an extra 100,000 doctors and 300,000 nurses to meet German levels** (*Health Service Journal*, 1 November 2001).
- 1.6 As a result of this lack of capacity, Britons wait far longer for treatment than people in other countries. **Over 1 million people remain on the NHS inpatient waiting list alone.** In a 2000 survey, a third of Britons reported that they had waited for longer than four months for a non-emergency operation. Only 1 in 8 Canadians and only 1 in 100 Americans had waited as long. **In France, there are no waiting lists except for transplant operations** (*Health Affairs*, 18, 2000).
- 1.7 A survey of GPs for the **Adam Smith Institute** (13 January 2002) found that 86 per cent had patients who had chosen to pay for operations privately due to the length of waiting lists. If this trend was repeated across the country, as many as 100,000 patients may have paid for surgery last year.
- 1.8 Due to the EURO CARE and EURO CARE II studies, the best data for comparable outcomes is for cancer patients. **These show that, for nearly every cancer, Britons have a lower chance of survival than continental Europeans and Americans.** For example, two thirds of women suffering from breast cancer here are alive five years after diagnosis, compared to four-fifths in France and America (Source: EURO CARE 2). If Britain achieved the European average performance in

cancer care, 10,000 lives a year would be saved. If we met the best European performance, that would rise to 25,000 lives a year.

2. Tax funding is not efficient

“The NHS was introduced in 1948 at roughly the same time that the Communists were taking over in China. Today the Chinese are introducing social insurance and consumer care. We are still waiting.”
(Dr David Green, director of Civitas, *Sunday Times*, 2 December 2001).

2.1 Supporters of the current system of healthcare have argued that the NHS provides cost-effective healthcare and that its fundamental problem is public underfunding. In reality huge recent increases in public health spending have been lost within the structure of the NHS.

- Since 1997, the NHS budget has risen by 30 per cent in real terms. But the number of routine patients treated has been stuck at between 1.2 million and 1.4 million a quarter (*Independent*, 5 November 2001).
- Since the NHS still employs over one million people, the impact of any increases in funding are diluted since much is devoted to increases in salaries. The NHS received an increase in funding of £4 billion last year, of which nearly **£2 billion was spent on salary increases**. (*Times*, 26 November 2001). **The Adam Smith Institute** has estimated that only 17 per cent of any new resources for the NHS ends up in front-line services.
- On 22 January 2002, the BBC obtained a letter from the chief executive of the **NHS in the South East** which revealed that, despite the Government's large increase in funding of around 9 per cent this year, the region is forced to cut costs by £60 million to meet its budget this year. John Appleby, chief economist of the King's Fund commented: "Pay has gone up quite a lot, non-pay things like drugs costs have increased. This has eroded that 9 per cent, turning it into more like a 3 per cent increase in real terms. Then on top of that, junior doctors' hours have been reduced."
- **The Department of Health** has estimated that 16 to 20 per cent of the NHS budget – between £7 billion and £10 billion – is lost through waste, fraud and inefficiency. (*Sunday Times*, 2 December 2001).
- **The International Monetary Fund (IMF)** has warned that spending rises "may be difficult to implement without incurring significant waste". It said: "we would call for caution. Additional spending increases should be undertaken only if clear-cut economic justification can be found and in the context of reforms to raise spending efficiency." (IMF, 11 December 2001).

2.2 Commentators have argued that the NHS is constructed in such a way that it limits access to treatment and prevents innovation:

- **The OECD** blamed Britain's unusual emphasis on public provision: "Services are provided on a much larger scale privately in many OECD countries and greater ambition in this respect would raise competition and performance". (*Times*, 27 November 2001).
- **Martin Taylor**, former chief executive of Barclays Bank, said: "You can't run an organisation with one million employees. You can administer something in the way the British civil servants administered India but that's a different job. But the NHS, I'm sure, must be cut up into small pieces. People must be made more responsible for things. There is almost more interest in preventing political problems arising from the NHS than in providing patient care." (*Daily Telegraph*, 16 November 2001).
- **Ruth Lea**, Head of the Policy Unit at the **IoD**, has described the structure of the NHS as "triple nationalisation": "a public sector quasi-monopoly of funding, decision-making about resource allocation, and healthcare provision" (*Healthcare in the UK, the need for reform*, June 2000).

2.3 New evidence, published after the Wanless Interim Report, has greatly strengthened the argument against the efficiency of the NHS. The first ever study of the efficiency of the NHS against a similar provider shows that **the NHS in fact delivers far lower standards than an American health provider does with the same cost per patient.**

2.4 The authors of the study, published in the British Medical Journal on 19 January 2001, have compared the NHS with the American health provider Kaiser Permanente, largely based in California. **Kaiser Permanente has many similarities with the NHS.** It provides for a large group of patients (8 million); employs its own medical staff; it draws its patients are from the whole of society, including employed people, poor people and the elderly; and it was founded in 1945 based on health provision for organised labour. Kaiser's patients pay for care either largely through employer-based insurance, Government insurance for the elderly (Medicare) and Government insurance for poor people (Medicaid).

2.5 The authors estimate that the costs per patient are similar in each system: \$1,764 in the NHS and \$1,951 in Kaiser. However, **Kaiser delivers a significantly higher level of service.** Patients have access to between twice and three times the number of specialists and spend far less time waiting for treatment. Because Kaiser devotes more resources to catching diseases early, for example by a higher use of screening and outpatient clinics, it is better than the NHS in keeping patients out of hospitals, which are the most expensive part of healthcare.

Comparisons: Numbers of Consultants, Hospital Bed Use, Waiting Times		
	NHS	Kaiser
Cardiologists per 100,000 population	4.1	8.3
Oncologists per 100,000 population	0.9	1.7
Time spent with primary care doctor	9 minutes	10-20 minutes
Bed days per 1,000 population per year	1,000	270

Waiting time to see consultant	36% less than 4 weeks 80% less than 13 weeks 4% over 6 months	80% less than 2 weeks
Waiting time for inpatient treatment	41% less than 13 weeks 33% more than 5 months 7% more than 12 months	90% less than 13 weeks 0% more than 5 months

- 2.6 The authors also provide tentative suggestions as to why Kaiser achieves so much higher standards. They note that Kaiser is a fully integrated organisation, all of which is devoted to providing patient care, whereas the NHS is divided into many different parts with their own agendas. Kaiser treats patients at the most effective level of care rather than sending large numbers to hospital. **Kaiser operates in a competitive market with other providers, and responds more directly to its customers.** Kaiser has a far higher level of information technology.
- 2.7 This study is timely given the current debate on the financing and organisation of healthcare. It suggests that the simple allocation of more money to the NHS is not the answer to raising standards. Contrary to the Government's claims, it shows that insurance-based systems can deliver high *and* cost-effective standards of care. It offers the possibility that empowering patients and encouraging competition between providers may be a route to raising standards.

3. Increases in taxes damage the economy

“Households will have to pay twice for a tax financed increase in health spending – they will have to pay the tax itself and then pay the economic cost in lower incomes or reduced job opportunities.” (Professor Doug McWilliams, Centre for Economic and Business Research, December 2001).

- 3.1 The **Prime Minister** has repeatedly reaffirmed his pledge to meet the European average spend on health care from public funds. On 28 November 2001, the day following the publication of the Wanless Interim Report, he was asked by Charles Kennedy: “The Prime Minister committed himself to raising health expenditure in our country to the European Union average by 2005. Is that still the policy of his Government?” Mr Blair replied: “Of course it is. That is precisely the point of the Chancellor's announcement yesterday”.
- 3.2 The **Institute for Fiscal Studies** initially costed this commitment at **£10 billion**. Mr Blair immediately tried to back away from the pledge, saying: “I am not deciding spending levels now. I am saying in broad terms what I have said previously. We have in broad terms to match other European countries.” (*Independent on Sunday*, 2 December 2001). He has also tried to claim that “The EU average ... has been round about 8 per cent for the last decade, and that is the commitment that we are giving ...” (Prime Minister's Questions, 5 December 2001).
- 3.3 However, using a more accurate methodology, the **King's Fund** – which supports the Government's policy to fund healthcare through taxation – has estimated that average EU health spending will be much higher – at 10.7 per cent – by 2005-06. To meet that target, Britain would have to be spending an extra **£45 billion** a year

by then, the equivalent of 15p on the basic rate of income tax (*Independent*, 10 December 2001).

- 3.4 The Government's suggestion that taxes could rise substantially to increase spending on the NHS has continued to attract criticism. In December 2001, the independent **Centre for Economic and Business Research** estimated that an increase in taxes of only £10 billion would reduce Britain's GDP by **£13.3 billion**. The cost is equivalent to £500 for every British household.

4. Tax and spend rejected

“An allegedly independent study of the future pressures on healthcare funding has been turned into a political tool to try to forestall a debate about the way that the NHS is funded By clumsily trying to close down the debate on NHS funding mechanisms, the Government has weakened its case for a tax-funded NHS rather than strengthened it.” (**Nick Timmins**, Social Affairs Editor of the *Financial Times*, 28 November 2001).

- 4.1 In his **Pre-Budget Report** on 27 November the Chancellor of the Exchequer called for a national “debate” on the future of the NHS. But he then used the Wanless Interim Report immediately to rule out any alternative to taxpayer funding. Mr Brown said: “I believe that out of this debate an enduring national consensus can be built around the two central conclusions at the heart of this report: that a publicly funded national health service is best for Britain and that a modernised national health service will need significantly greater capacity and significantly more long-term investment.”
- 4.2 Commentators from across the political spectrum have criticised the Government's peremptory rejection of any alternative methods of funding:
- **Peter Mandelson**, the former Cabinet Minister, said: “The variants of social insurance that are under discussion in progressive countries such as the Netherlands do introduce elements of patient choice that the NHS system does not presently permit. Is it sensible simply to dismiss the concept, when people can see the standards it has delivered and look enviously at countries such as France and Germany where the problem seems to be one of over-spending and an excess of healthcare?” (*Guardian*, 6 December 2001).
 - **Stephen Pollard**, senior fellow at the Centre for the New Europe, said: “We are entitled to be sceptical about a review which promises consultation with doctors, nurses and NHS staff but makes no mention of consultation with the users of the service, the patients, who should have been the first port of call Yesterday's [Pre-Budget] statement may be recalled as a missed opportunity for health care in Britain” (*Independent*, Leader, 28 November 2001).
 - **Anatole Kaletsky**, Associate Editor of *The Times*, said: “The ... question is whether an NHS that is free at the point of use is really compatible with the sort of choice and service that people have come to expect in modern Britain

.... People want more control over treatments, doctors and hospitals. It is questionable whether the Wanless approach can ever offer this freedom of choice" (*The Times*, 29 November 2001).

- **Michael Prowse** said: "The history of the past fifty years shows that general taxation has been a poor revenue source for healthcare. Economic pressures and ideological convictions have conspired to keep the NHS starved of resources. Why should Brown expect the next half century to be any different? ... If Britain continues to rely on general taxation as a funding source, there is next to no chance that the NHS' budget will rise sufficiently to provide the kind of healthcare that British citizens both want and can afford (*Financial Times*, 9 December 2001).
- **Professor Sir John Morris**, President of the Royal College of Surgeons, said: "All we are doing at the moment is trying to catch up. Things have gone downhill so much over the past ten years that we'll spend two or three years just trying to get back to where we were then As to whether there will be enough money: again, I suspect not We need to be thinking about other possible means of funding." (*New Statesman*, 7 December 2001).

4.3 The Government has attempted to claim that the public is committed to the tax funding of the NHS. In fact polls suggest that the public wants new thinking:

- An **ICM** poll for the *News of the World* (2 December 2001) found that only 54 per cent of people support higher taxes to pay for an improved NHS, compared to 79 per cent two years ago.
- The latest **British Social Attitudes** survey has found that the number willing to pay higher taxes for more spending on public services and benefits has fallen from 60 per cent in 1997 to 50 per cent now.
- **MORI** polls for the *Times* found that after the election a large majority of people agreed that the Government's policies would improve public services. But by October, the public were evenly split, with 45 per cent in agreement and 42 against (MORI, 26 October 2001).
- A **MORI** poll for GMB revealed that only 20 per cent of voters think schools and hospitals have improved since Labour won power in 1997. 53 per cent of Labour voters said they would consider voting for another party or not voting at all if they believed public services had not improved. (*The Mirror*, 4 December 2001).

4.4 The Government has attempted to deflect this criticism by attacking the cost of other systems of financing. At a press conference on 7 December 2001, **the Prime Minister** claimed that private insurance would cost a British family between £130 and £240 a month to insure themselves.

4.5 But as **Civitas** has pointed out, the NHS costs £207 a month for every household in Britain. As David Green, director of Civitas said: "It would be well worth an extra £33 [a month] to get rid of waiting lists, to have complete freedom of choice of hospital or doctor and have access to the latest medical technologies currently

denied us. It would also be a small price to pay for ending ‘third world wards’, not to mention mixed-sex wards. And it would be well worth it if – like the French – the largest wards had four patients in them instead of about 40.” (Sunday Times, 9 December 2001).

- 4.6 **The cost of the NHS per household has more than doubled in ten years: it was £95 in 1990. If the cost of bringing health spending up to the EU average is £13 billion – and it could well be more (see above) – households will pay an extra £45 a month, making the NHS (£252 a month) more expensive than an insurance-based system. As the *Sunday Times* said: “The new figures blow a hole through Mr Blair’s decision to go along with Gordon Brown’s resistance to different methods of financing health” (Leader, 9 December 2001).**

5. Limits of the Government’s reform programme

“[The NHS is] the last great nationalised industry ... I can’t run a million strong organisation from Whitehall.” (Alan Milburn, Interview with *the Times*, 14 January 2002).

- 5.1 Following the negative reaction to the publication of the Wanless Interim Report, the Government has proposed new strategic reforms to the NHS designed to increase choice for patients and diversity of provision. **The Government’s change of rhetoric is welcome.** But while the reforms may be significant if fully implemented in the long term, at present they seem likely to cause only marginal change.
- 5.2 In the aftermath of the publication of the Wanless Interim Report, Alan Milburn announced that he was negotiating with the private insurer BUPA so that, by the end of next year, the **BUPA** Redwood hospital in Surrey would provide operations exclusively for NHS patients. Up to 5,000 operations a year would be carried out by a mixture of BUPA and NHS staff.
- 5.3 It is clear that the Government brought forward the announcement of its deal with BUPA in an attempt to challenge the perception, following the Autumn statement, that it is hostile to private provision of healthcare. The *Sunday Times* commented that the story was “**overblown**”: the 36 bed hospital is “tiny and surplus to Bupa’s needs”, and Bupa is not negotiating with the Government over other schemes (9 December 2001). As Stephen Pollard pointed out, “It makes no difference to the big questions: how do we fund healthcare, and then structure its delivery?” (*Sunday Telegraph*, 9 December 2001).
- 5.4 **The vast majority of NHS patients will have no further choice under the Government’s plans.** Only 1,100 heart surgery patients are waiting for longer than 12 months, out of a total NHS waiting list of over 1 million. Mike Stone, Director of the **Patients’ Association**, warned that all patients would assume that they could now exercise choice, and would be disappointed.
- 5.5 Interviewed in *The Times* on 14 January 2002, the Secretary of State for Health **Alan Milburn** announced his intention to decentralise decision-making within the NHS, give new freedoms to the best hospitals and allow voluntary organisations and not-

for-profit private companies to run the worst. He described the NHS as “**the last great nationalised industry**” and said: “I can’t run a million strong organisation from Whitehall.”

- 5.7 Until the details have been filled in, it is difficult to judge the long-term importance of the announcement. **Nick Timmins**, Social Affairs Editor of the *Financial Times*, said: “Wait and see. Over time, it could lead to much more diverse provision of NHS services by the private, public and not-for-profit sectors. But huge amounts of detailed thinking remain to be done and it could prove only a small change at the margins.” (*Financial Times*, 16 January 2002).

6. Equity and choice

“Decentralised management of hospitals – and genuine improvements in the choices available to individual patients – are impossible if all funding remains under Treasury control.” (Anatole Kaletsky, *the Times*, 24 January 2002).

- 6.1 In his speech on 15 January 2001, the Secretary of State for Health, **Alan Milburn**, set out his vision for a new NHS built on the values of equity and choice. On choice, he said: “The balance of power has to shift decisively in favour of the patient. So now most fundamentally of all, our reforms will give patients greater choices over services.” On equity, he emphasised that although the NHS in the future could be composed of a variety of providers, it would be based on the fundamental principle of equity, that care would be free at the point of use and based on need not ability to pay.
- 6.2 **We agree that British healthcare should be built on the principles of equity and choice. But alternative funding arrangements can still be consistent with these principles.** For example, an insurance-based system could still be free at the point of use. The IMF has pointed out that systems involving more private contributions can still be equitable, through the state paying for the contributions of less well-off people (11 December 2001).
- 6.3 Most importantly, as the Wanless Interim Report recognises, **the great disadvantage of tax-funded systems is that they tend not to empower the patient.** To quote from the report: “The degree of individual choice available to patients tends, however, to be relatively limited under tax financing. The overall level of resources available for health care is constrained by what the government judges the economy can afford and choices between what services are and are not provided are made centrally. (Wanless Interim Report, 4.28). Other forms of finance do allow greater choice. For example, the French social insurance system allows patients to choose their insurers.
- 6.4 **Under a predominantly tax-funded system, the NHS has suffered persistent under-funding and now delivers unacceptably low standards for the world’s fourth largest economy. All the evidence suggests that simply increasing public funds for the NHS in its current form will not produce an adequate improvement in outcomes. Ultimately it is doubtful that the Government’s objective of greater patient choice can be realised without giving patients**

more control over the funding of their healthcare. Other healthcare systems combine higher standards with equity and choice, consistent with the Government's stated principles of health reform. A genuine national debate on the future financing of healthcare is long overdue.

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For further information please contact Nick Herbert or Andrew Haldenby

Reform
42 Brook Street
LONDON
W1K 5DB

Tel: 020 7958 9066
Fax: 020 7958 9090

info@reformbritain.com