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The Nation's Health

by Hugh Bayley

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1 **Introduction** 1

2 **Equity** 3

3 **Efficiency** 9

4 **Accountability** 13

5 **Priority setting** 15

6 **The market mirage** 17

7 **Paying for health** 21

8 **Making it happen** 24

9 **Conclusion** 27

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Introduction

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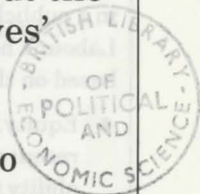
Ever since the introduction of the NHS internal market in 1990, the Labour Party has been obsessed with the *administration* of the NHS – with the management of Trusts and GP fundholding – instead of the *health* of the population. We may have won the argument against the Conservative health reforms, but the debate has been largely on the Conservatives' agenda. Labour's new health policy must decisively shift the agenda, and the public debate, away from administration and on to health.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This is not to say that administration is unimportant. We have made political capital out of challenging the Government on bed closures, surgery waiting times, spiralling administrative costs, managers' salaries and perks and the unrepresentative membership of health authorities and Trust boards, but beds, surgery and managers are all means to an end. The end is better health.

We need to put more emphasis on the wide and widening regional and social class inequalities in health; on the enormous variation in death rates (and life chances) between different health authorities; on the health benefits of primary care; on the link between social deprivation – unemployment, poverty, poor housing – and ill-health, and thus on the need to target improvements in welfare on those people in greatest need.

And we need to face some difficult choices: within a cash-limited budget more money for primary care, for example, means less for secondary care (i.e. more bed closures). Growth money provided to all health authorities, without regard to the health needs of the local population, simply perpetuates and reinforces health inequalities. The wasteful use of resources – hoarded as end of year surpluses by GP fundholders, or used to pay for surgery or drugs which do not work – delays and sometimes denies treatment for patients who desperately need it. These issues are politically hot to handle, but we have to recognise that Labour Ministers will be confronted by them on their first day in office. If we

are serious about reducing health inequalities we must face these problems and seek fair and equitable solutions.

What is the NHS for?

Before deciding how the NHS should be managed, we have to define what we want it to achieve – to answer the question, "What is the NHS for?"

The current statutory definition (in the 1977 NHS Act) says the Secretary of State has a duty to provide a comprehensive health service to secure improvements in health and in the prevention, diagnosis and treatment of illness. The Conservative *Health of the Nation* strategy talks more vaguely about adding years to life and adding life to years.

Neither definition addresses health inequality or the growth of a two-tier NHS; neither supports the basic egalitarian principle that health interventions in a publicly funded health care system should be provided on the basis of need. Labour's health policy should set out a clear 'mission statement' for the NHS, based on three fundamental principles:

- Equity. People should receive treatment (or other health interventions) and resources should be allocated on the basis of need – need being a person's ability to benefit from treatment. The benefit may be a cure, which removes the symptoms of disease; or palliative care, such as pain relief, which suppresses the symptoms and improves the patient's quality of life; or community care which helps the patient to live with the symptoms.
- Efficiency. NHS resources should be spent, in support of the equity principle, on effective treatments which maximise the collective health benefit to individuals. Every intervention has an opportunity cost – it is an intervention which is not provided to someone else – so resources should be targeted on treatments which have been shown by sound scientific research to be effective. Where two or more *equally effective* treatments exist, clinicians should use the one which is most cost-effective since this increases the resources available to treat other patients and thus to maximise the collective health benefit.
- Accountability. Within the constraints of equity and efficiency, patients should be free to choose what treatment they have and who provides it. Communities should be involved in determining the nature and priorities of their local health service. This principle depends on the NHS being reformed to make the NHS Executive, health authorities, Trusts, clinics and GP practices accountable to the people they serve, and the management culture being changed to make it more responsive to public opinion.

Equity

2

One of the last acts of the Callaghan government was to commission the Black report on inequalities in health, whose findings were quickly suppressed when it reported shortly after the Conservatives came to power. Penguin Books published the report, guaranteeing far wider readership than it would ever have achieved as a government document. Further research, since then, indicates that these inequalities have widened.

Labour's new health policy should pledge to pick up where we left off, by rewriting the government's *Health of the Nation* strategy to make the reduction of health inequality its over-riding goal. Last year Peter Phillimore and others (including Peter Townsend, one of the authors of the Black report) revealed that the death rate for people living in the most deprived electoral wards in the Northern RHA (St. Hilda's, Middlesbrough and West City, Newcastle) is now four times higher than in the region's most prosperous wards (*British Medical Journal*, 30 April 1994).

The Conservatives seek to 'excuse' the widening health gap by claiming that everyone's health is improving – it is, they say, just that the health of the better off is improving faster than the health of the poor. Even if this were true it would show that health policy is skewed in favour of achieving the biggest health gains for those people who need them least; but in some areas it is untrue – the health of the poor is getting worse in absolute terms.

As currently written, the *Health of the Nation* strategy fails to address the problems of inequality and poverty (other than in oblique references to "variations" under each section). One *Health of the Nation* target, for example, is "to reduce the death rate for stroke in people under 65 by at least 40% by the year 2000" (from 12.5 to 7.5 per 100,000 population). The Public Health Common Data Set 1993 lists the age-standardised death rate from stroke in each English district health authority. As a three-year average it is highest in West Birmingham (21.6 deaths per 100,000) and lowest in the Health Secretary's own authority, South West Surrey (6.0 per 100,000). Over the three-year period the

annual death rate in West Birmingham increased from 17.3 to 25.7, while in South West Surrey it fell from 8.5 to 5.3 per 100,000.

District by district figures are available for many of the *Health of the Nation* targets, but little is said about them by the Department of Health. There are dangers in reading too much into single year figures for individual health authorities, but taken as a whole they tell a consistent story of wide and often widening health inequalities, with people living in inner-city areas and in the north and Midlands suffering from a significantly higher burden of disease and death than those in shire counties and the south.

Draw a line from the Severn to the Wash and, according to the Public Health Common Data Set, the health regions with the highest death rates – among all age groups – are found north of the line, and with the lowest death rates south of the line (see table 1, below):

Deaths from all causes	Highest death rate	2nd highest death rate	2nd lowest death rate	Lowest death rate
age < 15	W Midlands	N Western	SW Thames	E Anglia
age 15-64	N Western	Northern	SW Thames Wessex & Oxford	E Anglia
age 65-74	Northern	N Western	SW Thames & Wessex	E Anglia

Table 1: Health Regions with highest and lowest death rates

The Common Data Set also reveals that the death rates from specific diseases in most of the *Health of the Nation*'s key areas reflect a similar north-south divide (see table 2, page 5).

Once every ten years the census provides comprehensive data on death rates by social class. The most recent figures are still based on the 1981 census. They tell us, for example, that the death rate among male steel erectors is two times, and among female clothing workers is one and a half times, greater than the national average. The death rate for teachers is 40%, and for local government officers 50% below the national average. Financial advisers and management consultants appear to live for ever.

Overall the death rate among professional workers is one third less than the average for men, and a quarter less for women. For unskilled male workers it is 65%, and for unskilled women 17%, more than the average (see table 3).

These figures were published in 1986, five years after the 1981 census, but the figures from the 1991 census, according to a recent Parliamentary answer, will not be released until "late 1997" which, conveniently for the Conservatives, is just after the latest possible date for the general election.

Cause of death	Highest mortality	2nd highest mortality	2nd lowest mortality	Lowest mortality
Heart disease:				
age under 65	Northern	N Western	Oxford	SW Thames
age 65-74	Northern	N Western	Oxford	SW Thames
Stroke:				
age under 65	Northern	N Western	SW Thames	E Anglia
age 65-74	Nothern	N Western	E Anglia	SW Thames
Cancer:				
Breast	SE Thames	W Midlands	Northern	Yorkshire
Lung: men	Northern	Mersey	S Western	E Anglia
women	Northern	Mersey	Wessex	E Anglia
Suicide	N Western	SE Thames	Mersey	W Midlands
Tuberculosis	NW Thames	W Midlands	S Western	Wessex

Table 2: Regions with highest and lowest death rates from selected cauese

	Standardised Mortality Ratio	
Social Class	Males	Females
All Social Classes	100	100
I - Professional	66	75
II - Intermediate	76	68
III - N - Skilled Non-manual	94	80
III - M - Skilled Manual	106	111
IV - Partly Skilled	116	107
V - Unskilled	165	117

Table 3: Death Rates (Standardised Mortality Ratios) by social class in 1979-83

More recent data about infant deaths by their father's social class are available from the government's Office of Population, Censuses and Surveys mortality statistics. Analysing these figures, the National Children's Bureau found the social class differential between class V and I had widened from 1.7 to 1.9 between 1987-88 and 1988-90 (Vinod Kumar, *Poverty and Inequality in the UK*, 1993). Put bluntly, the children of unskilled workers are now nearly twice as likely to die before their first birthday than professional workers' children. These figures underestimate the problem because they exclude births registered by single mothers and these babies are 80% more likely to die in their first year than babies born to married couples.

Childhood illness also is strongly related to social class as the figures in table 4, which are based on the government's General Household Survey and drawn from the National Children's Bureau report, illustrate:

Social Class	Boys (%)	Girls (%)
All Social Classes	7.4	5.2
I - Professional	5.5	3.4
II - Intermediate	6.3	5.0
IIIN - Skilled Non-manual	6.4	5.0
IIIM - Skilled Non-manual	7.4	5.8
IV - Partly Skilled	9.5	5.4
V - Unskilled	9.5	6.3

Table 4: Percentage of children, aged 0 to 15, reported by their parents to be suffering from a limiting long-term illness by social class in 1985-89

In the *British Medical Journal*, Chris Power reports that high unemployment and low benefits "are associated with a considerable increase in infant mortality" (30 April 1994). R. G. Wilkinson writes that mortality at all ages is "lower in countries with a more egalitarian distribution of income" (*British Medical Journal*, 18 January 1992). It is not just the very poor who suffer: Wilkinson found that "the health of the least well off 60-70% of the population may benefit from income redistribution" and he concludes that if Britain's income distribution was more like the most egalitarian European countries "about two years might be added to the population's life expectancy". Social inequality is killing people unnecessarily.

If the Conservatives were concerned about the health of the *whole* nation they would (i) make information on death rates, and on progress towards *Health of the Nation* targets, readily available both on a district by district basis and by social class, (ii) encourage public debate about the huge and unacceptable divide between different areas and social classes, and (iii) adopt a strategy to reduce health inequalities in relation to each of the *Health of the Nation* targets. A Labour government should intervene to improve the health of people in disadvantaged areas and social classes, to try to provide them with the same life chances as their more favoured fellow citizens.

The Conservatives are not doing that because they do not believe in equity. Their *Health of the Nation* strategy simply states: "the reasons for these variations are by no means fully understood. They are likely to be the result of a complex interplay of genetic, biological, social, environmental, cultural and behavioural factors".

Some diseases do have genetic or biological causes but this does not explain regional inequalities in health. People in the north are not genetically 'weaker' or 'inferior' to those in the south. The environment is badly polluted in some parts of the country but the problem is not confined to the north, although manual workers, both north and south, frequently face a more hazardous working environment. Cultural and behavioural factors – like smoking, drinking, poor diet and lack of exercise – have a big impact on health, adversely affecting health in the north more than in the south, although some diseases, like breast cancer, are more prevalent in the south. Economic factors such as poverty, unemployment and poor housing also have an enormous impact on health, although this is not acknowledged at all in the *Health of the Nation*. Regional and social class inequalities in health are mirror images of the same things. You cannot tackle one without the other.

Inequality

Labour's commitment to equity means that we must address the problem of health inequality head on. This is what is distinctively different about our approach to health. In Sweden all public agencies have specific goals to reduce socioeconomic inequalities and to assess the health impact of all national policies. The Finnish equivalent of *Health of the Nation* sets out to improve the environment at work and in residential areas. The Australian Government's national health strategy document, *Enough to make you sick: how income and environment affect health,* calls for action for equality in five key areas: the distribution of economic resources; education; living conditions; access to and conditions of work; and the provision of social support. A UK Labour government should draw on the Nordic and Australian approach and implement similar policies.

This will require co-ordinated action across government departments – by social security, environment, education, employment, transport and the Treas-

ury as well as health. Lifting poor pensioners out of poverty may do more to improve their health than by spending a similar amount of money on health care for the elderly. Tobacco advertising should be banned, and nutritional standards reintroduced for school meals. Public transport must be made more attractive to reduce diseases caused by vehicle pollution and injuries by road traffic accidents. One and a half million homes in Britain are unfit for human habitation, but are still occupied often by frail elderly people, so housing investment is essential too.

Reducing health inequalities also requires change at the Department of Health. Primary health services are poorer in inner cities, both south and north, than in shire counties. The reintroduction of free eye tests and dental checks would prevent disease in some patients and encourage early, and frequently more cost-effective, treatment for others. Early ante-natal care should be targeted on those women who run the greatest risk of losing their baby during pregnancy or shortly after birth. Ante-natal clinics should be held in deprived housing estates.

Efficiency

3

The Government's main measures of efficiency are 'throughput' (e.g. number of operations carried out, number of patients seen) and 'response times' (e.g. how long you wait for surgery, for an ambulance, etc.). Soon they will be measuring 'throughput per unit cost'. Both measures are inadequate – they do not reveal whether a health intervention made the patient better. In other words, did the operation work?

A great deal of information on health outcomes already exists. £213 million has been spent on medical audit since 1991 but the findings are not disseminated to the medical profession, still less to the public. Scattered across many hospitals there is a mine of unpublished information about which clinical procedures produce good outcomes and which do not, and on how successful individual doctors are at curing their patients. The confidential enquiry into peri-operative deaths is another greatly under used source of information. These data must be collected, analyzed and turned into clinical practice guidelines to promote safe and effective practice and discourage ineffective treatment. Until this happens, millions of pounds will continue to be poured down the drain each year on treatments which, while they boost the throughput figures, do not improve patients' health.

The Conservative Patient's Charter league tables say a little about a limited number of administrative measures, but nothing about health outcomes. By contrast, the U.S. Department of Health and Human Services publishes data on death rates from a wide range of conditions and treatments on a hospital-by-hospital basis, together with 'adjusted' figures that take account of casemix (the proportion of complex operations, the demography of the hospital's catchment area, etc.). They also collect information on patients' survival rates 90 days and 180 days after discharge from hospital. In England and Wales hospital mortality rates refer only to deaths in hospital. Patients who are discharged alive appear in government statistics to have been 'cured', or at least to have been treated successfully, even when they are subsequently re-admitted for repeat treatment for the same condition or when discharged to a nursing home, to a hospice or to die in their own home.

Patients' and consumer groups in the U.S. publish their own league tables of hospital outcomes based on the U.S. government's figures. The Washington Consumer Checkbook organisation supplements the government's league tables with survey data on which hospitals for which treatments, in Washington DC and neighbouring states, are used by doctors and other health professionals when they need treatment themselves.

This may seem an extreme form of consumerism – more suited to the United States, where health care is seen by many as a commodity to be bought and sold. In Britain we expect high quality health care to be available to all without charge, but if we had similar information on outcomes at each hospital for a range of common treatments, such as hip replacements, heart bypass surgery and cataract removal, it would highlight health inequity where it exists, and provide a powerful tool to root out inefficient, ineffective and dangerous practice (and practitioners).

Treatment rates

We also need information on treatment rates. A Parliamentary answer in December 1994 revealed that patients are twice as likely to be admitted to hospital to have their tonsils out in the North Western region as in Trent or Wessex. In January 1995 the Health Select Committee reported that some health authorities pay for four times as many patients to have haemorrhoid surgery, and twice as many to have hysterectomies or prostatectomies as others. In part these differences reflect health inequalities, but they also suggest that patients in some parts of the country are getting inappropriate treatment which does not help to make them better, while in other areas patients are being denied treatments they need.

Scotland is ahead of England and Wales on outcomes. The Scottish Office collects data on death rates 30 days after discharge and in December 1994 it published, for each NHS Trust in Scotland, outcome figures for a limited but nevertheless revealing range of conditions and treatments. The standardised mortality rate (30 days after admission) for patients with hip fractures varied from 1 patient in 9 in Dumfries and Galloway, to 1 in 24 in West Lothian. One in 3 emergency stroke patients died within 30 days in Falkirk but only 1 in 6 at the Western General Trust. One patient in 15 who had prostate surgery at the Perth and Kinross Trust was readmitted for the same operation within a year, compared with fewer than 1 in 200 at the Moray Trust. Poorer outcomes do not necessarily mean poorer treatment but surgeons and managers at Perth ought to be using clinical audit to find out why so many of their prostatectomies do not work.

It is possible to draw simplistic conclusions from outcome data, but it is more dangerous not to publish the information because it allows old-fashioned, ineffective and sometimes positively harmful treatment and clinical practice to go unchallenged. The Scottish figures were sensationalised by the media when

they came out, and the Scottish Office appears to be having cold feet about publishing them in future. English, Welsh and Northern Ireland health Ministers have told the Commons they have no plans to publish similar information.

A Labour government should grasp the nettle and agree with hospital doctors and other health professionals a meaningful range of outcome indicators which take account of casemix so as to avoid creating perverse incentives not to treat patients who have poorer chances of survival and recovery. This information should be made available to GPs, Community Health Councils and the public. The Conservatives simply miss the point when they publish league tables telling the public how long they have to wait for treatment at each hospital but not how effective the treatment is when you get it.

Ninety percent of NHS treatments are provided by primary care practitioners but there are virtually no outcome indicators in use in primary care. Hospital doctors are held accountable by health authorities and fundholding GPs, but GPs are accountable to no one but their patients. Although Conservatives argue that patients are free to 'shop around' for a new GP if they do not like the one they have, patients do not behave like that. Most people choose a GP for life, and in rural areas there is often only one practice in any case.

Every GP practice – and every general dental practice – should agree a clinical practice plan each year with its local health authority. Outcome indicators are needed for general practice, and GPs should be held accountable for their clinical performance against these indicators by their local health authority in the same way that fund-holding GPs currently have to account for the financial performance of their practice. As a term of their contract, GPs should provide the authority with regular clinical audit reports. Some audit data would come from the practice itself, while others could be provided by the hospitals to which the practice refers its patients.

Although league tables and clinical audit can provide useful data on outcomes, they reveal little about the relative clinical effectiveness of different treatments. This can only be established by rigorous research. These days reputable medical researchers use randomised controlled trials to test whether a specific clinical intervention helps or harms their patients, and with spectacular results. Some of the drugs used to suppress irregular heartbeat in people recovering from heart attack have been found to "increase, rather than decrease, the risk of death in such patients, and their routine use is now strongly discouraged", say Oxford University doctors David Sackett and William Rosenberg, in a forthcoming paper. They also report that half of the procedures used by doctors in pregnancy and childbirth have been subjected to randomised trials, and of these 40% have been found to be beneficial, but 60% are either of doubtful value or positively harmful.

Forward looking doctors are arguing strongly for 'evidence-based medicine', to ensure that the finite resources available for health care are spent on treatments that have been proved by rigorous research to be effective. Evidence

-based medicine relies on sound medical research and communication of the research results to doctors throughout the NHS. This cannot be left to market forces; the Royal Colleges and the Department of Health should disseminate best clinical practice guidelines – ideally on an on-line database to reassure doctors that the guidance they read is up to date. Doctors should be required to attend in-service training in order to retain their registration, and to pass competency-based post-graduate training before being licensed to use complex new technologies like keyhole surgery.

Accountability

4

As a publicly funded service the legitimacy of the NHS depends on it being responsive and accountable to the public. Patients, in principle, should have the right to choose what treatment they have – provided their doctor agrees the treatment is needed – and who provides it.

Despite the promise of 'money following patient', the internal market has restricted patients' choice to wherever their purchaser places its contracts. Labour should restore to GPs the right to refer patients to whichever consultant or hospital they prefer. While having the right to choose where they go, patients cannot have the right to determine the priority with which they are treated because the principles of equity and efficiency would be undermined if patients were selected for treatment on any basis other than clinical need.

As well as exercising individual choice as patients, the public, collectively (represented by Community Health Councils, politicians, health professionals, pressure groups, 'consumer' research, etc.), should be involved in setting priorities and deciding how resources are used in pursuit of equity and efficiency. If the public favour inequitable or inefficient health interventions, policy may have to be modified to retain legitimacy for the NHS. However, the Labour Party and health service managers and clinicians should provide leadership to keep the erosion of equity and efficiency to the minimum.

Over the past sixteen years district health authorities have become distant from the communities they serve. Regional Health Authorities, which at least had some local lay representatives, have been replaced by dirigiste 'outposts' of the NHS Executive, whose officials are accountable upwards to the NHS Chief Executive and the Secretary of State, instead of downwards to health care practitioners, patients and the public. Opinion polling and patients' surveys are no substitute for the loss of accountability of health authorities and they do not reassure the public that the NHS remains in touch with their views and needs. Trust Boards, meeting in private, are deeply mistrusted. Health authorities and hospital boards must be reconstituted to regain the public's trust, and they should meet in public. Some of their members should be retained for the sake of continuity but others need to be replaced to provide a wider range of experience and to ensure that the community is more fully represented. The

former, largely bi-partisan, approach to appointments has been undermined by Conservative Party patronage. Their recent attempt to counter criticism by advertising future vacancies is a step forward but appointments should be made by an independent public appointments commission which reports to a new Parliamentary Select Committee.

Few Community Health Councils have managed to provide an effective voice for patients and the public and thus to hold health authorities and Trusts to account for the services they buy or provide. Nor have they always been effective advocates for patients who are unable to gain the health services they need – such as registration with an NHS dentist or access to sub-fertility services. The CHCs are hampered by lack of resources, lack of independence from the very service which they are meant to hold to account, and lack of political legitimacy.

Most CHCs are serviced by a single officer, the CHC secretary, who has a relatively low status and salary in the NHS pecking order and is paid for by the NHS. To do an effective job in policy terms, CHCs need officers who possess, or are able to buy in, professional skills in public health medicine, nursing, health economics and accountancy to supplement their members' expertise as health service users. They need either statutory powers or political legitimacy conferred by the ballot box, or both, to enable them to seek and obtain data on the health of their community from their health authority, and on the clinical outcomes obtained by hospitals and primary care practices. They need a right to attend and ask questions at health authority and board meetings, and to be consulted on policy initiatives proposed by both bodies.

Appointing CHCs

A case can be made for local government to take over the responsibilities of health authorities but this would require yet another reorganisation because of the variation in the size of local authorities created by the Local Government Commission. It would tend to undermine the principles of equity and universality which are the hallmark of a *national* health service. Although it would provide better co-ordination between health and social services, the experience in Northern Ireland, which has joint health and social services boards, has been to marginalise social services in the same way that some NHS services, such as care for the elderly and mentally ill, have been seen as 'Cinderella' services.

Instead, local authorities could be given the right to appoint CHCs, and the duty to provide them with adequate staff and resources. The CHC would be made up of councillors, reflecting the political balance of the Council and co-opted members with voting rights, drawn from the range of patients' and community groups which make up CHCs at present. There is a precedent, of course, for co-opted members on local education authorities. The presence of elected councillors would give the CHC political legitimacy, and health authorities and boards would become more accountable if the CHC sent reports and minutes of its meetings to the full Council.

Priority setting

5

Labour cannot stand on the sidelines of the debate about health care rationing. Health authorities have always rationed care through waiting lists. Now they are also blocking treatment by cutting activity at the end of the financial year, blocking extra-contractual referrals and refusing to pay for certain treatments such as assisted conception. Labour will be no more able than the Tories to spend its way out of these difficult decisions. Even with a magic wand and more money for health care – as a result, perhaps, of cutting the spiralling administrative cost of the health reforms and rooting out ineffective treatment – decisions will still have to be made about what the state will pay for.

The U.S. state of Oregon's well documented approach of listing conditions and treatments in order of priority and excluding those treatments with relatively low health benefits may be appropriate in the United States, where 15% of population has no health cover at all. At least every Oregonian now receives a core service which is as comprehensive as that offered by most private U.S. health plans. But Britain's health problems are different; we spend less than half as much of our national wealth on health, compared to the U.S.; we still provide an almost complete list of acute treatments on the NHS. We do not need to exclude, or 'redline', any treatments which are currently provided.

Equity

Instead, we should apply the equity principle. When a choice has to be made about which categories of patients to treat first, or which new treatment, drug or technology to introduce into the NHS, we should expect clinicians to allocate

resources to the patients who have the greatest health needs (i.e. the greatest ability to benefit from treatment) on the basis of therapies which, as a result of randomised trials, are shown to have the best clinical outcomes. There is nothing unsocialist about setting priorities or allocating resources according to need. Quite the reverse: as Nye Bevan said, "The language of priorities is the religion of socialism."

Before allowing health authorities to redline treatments, we should require them to apply clinical practice guidelines derived from rigorous research and to use their local clinical audit findings, to identify which of their existing treatments are either wholly ineffective or bring only marginal health gains, and then compare those marginal health gains with the gains available from the treatments they want to ration out of the NHS. The Commons Health Select Committee's recent report on priority setting concluded that cost-cutting measures like rationing fertility treatment have only "marginal significance" on NHS resources, while at least 5% of hospital treatment, at a cost of £1,000 million a year, may not be effective in improving patients' health. Professor Michael Peckham, the NHS Director of Research, suggests the percentage of ineffective treatment may be as high as 20%.

There have also been proposals to exclude some categories of patients from NHS treatment – smokers, the obese, the elderly. A blanket approach of this kind is inconsistent with the principle of equity. Every patient should be treated according to need. If an effective treatment is available for that patient it should be provided. What matters is whether the patient is likely to benefit from the treatment, not whether he or she is a smoker. To do anything else would be to ration care on the basis of moral rather than clinical judgements, and that would be unethical.

Labour came a cropper with Jennifer's Ear at the last election but for the wrong reasons. Jennifer was waiting for grommets to relieve her glue ear. Glue ear impairs hearing and can be painful. Some children do need grommets but for many children 'watchful waiting' is the best treatment. In 50% of cases, the glue disappears of its own accord within three months; in 75% of cases it goes within six months. How many children have grommets inserted (and their ear drums scarred for life) for a condition which would resolve itself without treatment? At an average cost of £307 per operation it is often money wasted – used inefficiently, when it could have provided lasting health gain for some other patient.

34% of children admitted to hospital for surgery were found on the operating table to have no glue left in their ear (*British Medical Journal,* 1990). More unnecessary treatment. More frightened children. More days off school. More money wasted. Why were these children not tested again immediately prior to admission? Jennifer's counterpart, who had the operation privately, may have been the loser after all.

The market mirage

6

The apparent success of the free market in promoting economic growth in the late 1980s persuaded a gullible Conservative Party to apply market principles to the NHS, in the hope that it would promote efficiency and contain the escalating costs of caring for an ageing population and of introducing new health technologies. Neo-liberal economic theory takes as given that markets are efficient and that deregulation and consumer sovereignty drive up quality and drive down prices. Sadly for Conservatives and, in the case of the NHS, for patients, there is a yawning chasm between theory and practice.

The Thatcher government needed a quick fix to quell public protests about bed closures and health workers' pay in an underfunded NHS. The Downing Street think tank, which drew up the Conservative health reforms, met in secret without consulting the NHS or the public, and took no heed of the empirical evidence from other countries that market-driven health care is neither efficient nor cheap. Nor, for that matter, is it equitable, because markets tend to lead to a two-tier system in which people with private resources, or preferential access to public resources, are able to purchase preferential, and often better, treatment.

The United States, as the world's most determined adherent to free market medicine, spends 14% of its GNP on health, compared to 6% in the UK, but unlike the NHS the American mix of private insurance and publicly-funded Medicare and Medicaid still fails to provide universal access to care. Free market reforms in the Pacific rim in the early 1980s – in Chile, South Korea, the Philippines and Singapore – were unsuccessful. Health cost inflation accelerated, efficiency gains failed to materialise, and equity was undermined because high patient charges excluded the poor. Correcting market failures is both expensive and politically difficult – as President Clinton has discovered.

Ideology

Despite ample evidence that health markets do not conform to the laws of classical economics, the Conservative Party chose to listen to siren voices in the Adam Smith Institute and pressed ahead with their ideologically-driven reforms. They did not take the elementary precaution of piloting the NHS internal market in a few districts to see whether it would work. The result, as predicted, is that the overall cost of the NHS has escalated, largely as a result of the substantial increase in administrative costs, without showing any independently verifiable efficiency gains.

Classical economic theory assumes the existence of a state of near-perfect competition in which a large number of buyers and sellers conduct transactions over a clearly defined product of known quality at prices and on terms which are available to all the players. Health markets are more complicated than this and hardly any of the conditions for perfect competition apply. Trusts and GPs still have no idea of the cost of individual treatments. Patients gain access to the market through a single 'trader' – their GP. Theoretically they could shop around between different GP practices but in practice few do. In any case, at the point in time when a patient needs treatment he or she is registered with a single GP and can only gain access to health care through that GP's practice.

For most treatments patients have only one 'supplier' – their GP for primary care or a single Trust for secondary care. Only one person in three lives in a city which is large enough to have two or more acute hospitals. Even for this minority of patients the ability to exercise real choice about where a patient is treated is limited, and is exercised by the purchaser – the fundholding GP or health authority – rather than by the patient. When GPs need an acute admission, or patients need accident and emergency services, they go to the nearest hospital.

Playing the system

There is some evidence that GPs and health authorities have started playing one hospital off against another when purchasing non-emergency treatments, such as elective surgery or community health services; or at least that they are using the threat of competition to put pressure on their local hospital to improve services and clinical outcomes. But this affects only a small part of the NHS budget. It hardly justifies the additional £1,000 million a year out of the NHS budget which goes on the administrative cost of running the market.

The administrative costs of fundholding are particularly high because each practice has to employ a business manager to conduct its market transactions, and you lose the economies of scale which are available to health authorities arranging care for much larger numbers of patients. One of the striking features of the reforms is the government's refusal to allow any independent economic evaluation of the cost-effectiveness of the changes. If the internal

market was half as successful as they claim, they would be only too willing to open it to independent scrutiny.

By contrast, the split between commissioning and providing services has significantly increased the leverage which primary care practitioners exercise over the quality of hospital services. This is welcome and should be retained by a Labour government.

In practice the Government is backing away from the market, while maintaining the fiction of competition. In December 1994 the NHS Executive published elaborate guidelines to regulate competition in four areas: Trust mergers and joint ventures; providers in difficulty (i.e. insolvency); purchaser mergers; and collusion. The regulations mimic the traditional competition rules that apply to private firms, but place the Department of Health in a role akin to the Monopolies and Mergers Commission. It is an incestuous relationship because the Department is both line manager and regulator, and it would not be tolerated if a genuine market existed.

The new rules are rigging the market in secondary care to limit the damage from politically unpopular moves like hospital closures. The Conservatives also have insufficient confidence in their free market ideology to introduce competition into the NHS markets for capital or drugs, the prices of which, wisely, it still regulates with the Pharmaceutical Price Regulation Scheme. Their first steps towards replacing the stability of nationally negotiated salaries and conditions of employment with locally negotiated pay have triggered a wave of protests from NHS workers and further undermined staff morale.

Undermining

Although inconsistent and incomplete, the internal market undermines Labour's three cardinal principles of equity, efficiency and accountability. Fundholding GPs are not accountable for their purchasing decisions, which make up a large and growing proportion of the NHS budget. The National Audit Office has identified the fundholders' ability to secure preferential treatment for their patients, at the expense of other patients, and expresses concern about their ability to retain up to 5% of their budget at the end of the financial year if they underspend. The 5% rule is wrong because it leads to NHS resources being horded instead of being used to buy care for patients. The National Audit Office is pressing for enhanced accountability for fundholding practices through "the introduction of fund management plans as a basis for monitoring fundholders' performance" (National Audit Office, *GP Fundholding in England*, December 1994). Fundholding is out of control and creating a two-tier NHS. Worst of all, by switching contracts from one hospital to another, fundholders can drive up unit costs to the point where a service becomes unviable, thus denying access to it for other patients.

Competition between providers undermines their willingness to share information and to co-operate to prevent the unnecessary duplication and under-utilisation of expensive equipment such as scanners. Purchasing authorities, and GP fundholders, are unwilling to co-operate to pay for regional specialties, breast cancer screening or services for drug misusers. Doctors complain that medical research is being undermined because purchasers are refusing to indemnify doctors who are undertaking clinical trials to test new treatments.

The NHS internal market is incompatible in principle with Labour's objective of equity and incompatible in practice with the objectives of efficiency and accountability. The contracting process is costly to administer and has not brought comparable improvements in the quality of care or the cost of treatment. In most parts of the country there is little effective competition for treatments other than a limited amount of elective surgery. The internal market has been a costly flop, and should be scrapped.

Paying for health

7

The Conservatives say that they have increased health spending year on year since 1979. At first sight the figures bear out their claim. In the period up to the introduction of the internal market, hospital and community health service spending, adjusted for NHS inflation, rose from £13.7 billion in 1979-80 to £16.1 billion in 1990-91. But the figures ignore the growing demand for health services which comes from the increase in the number of elderly people (who need more care), the development of new health technologies and the introduction of community care.

The largest part of the growth in demand comes from the needs of the elderly. Before the creation of the internal market health authorities were funded on the basis of the volume of work undertaken in the previous year. The purchaser-provider split required a new population-based funding formula because health authorities became responsible for buying care for their resident population rather than for all patients treated within their catchment area. The new formula allocated specific sums of money for each resident, ranging from £110.37 for children between 5 and 14 to £1,908.24 for people aged over 84 (at 1989-90 prices).

What matters to patients, of course, is not how much money the NHS gets in total, but the amount that is available to treat them when they need it. The Government's Office of Population, Censuses and Surveys publishes estimates each year of the number of people in each age group, which can be used to calculate the amount of money available under the funding formula for each patient as a proportion of the overall allocation for hospital and community health services. These figures tell a different story. Under the last Labour government health spending grew in real terms by 2.2% per year, compared to 0.3% growth in real terms under the Conservatives between 1979 and 1991. The cost of the increase in demand due to technology and community care has

been estimated by the Government in evidence to the Commons Health Select Committee at 1% per year. When this amount is deducted from the population-based figures it indicates real growth in the resources for each individual patient of 1.2% per annum under Labour with a real terms cut of 0.7% a year under the Conservatives in the period before the internal market.

Thereafter health spending increased substantially in real terms to pay for the cost of creating the purchaser-provider split, running the internal market and providing cash incentives to purchasers and fundholding GPs in particular. The additional money has undoubtedly brought some benefits. If enough money is thrown at a problem it is hard not to achieve some progress, but the bureaucratic cost of the market has absorbed a large part of the increase which would otherwise have been available for improving patient care. It is not possible directly to compare the global figure for hospital and community health spending before and after the introduction of the internal market because the current figures include capital charges and a new "market forces factor".

Allocation

The abolition of Regional Health Authorities adds another twist to the story. Hitherto, funding was allocated to Regions, but in future the allocation will be made direct to district health authorities. In October the Department of Health published a revised formula, based on research into the health needs of local populations which it commissioned from economists at York University. The York research takes account of the impact of social factors – such as poor housing, unemployment, social class and the number of single parents and elderly people living alone – on the need for health care, and recommended a substantial shift of resources from suburban areas to the inner city and from southern England to the north. Although the Government modified the York proposal to reduce the impact on Tory constituencies in the south, the revised formula still implies a significant redistribution of NHS resources to those areas of the country with a greater burden of ill-health. The new formula compensates for the higher wages and capital costs in London and the home counties. If the Government had applied it this year (1995-96) it would have changed the hospital and community health service allocation for each region as shown in Table 5 (page 23).

The table shows a gross maldistribution of the NHS budget towards Anglia & Oxford and the South & West, and away from the Northern & Yorkshire and the North Thames regions. There is a similar maldistribution within each region. Health services in Tyneside, Teesside and inner-city West Yorkshire are grossly underfunded, as they are in East London and parts of inner-city West London, relative to other parts of their respective regions.

No one suggests that a redistribution should take place overnight. Services in Anglia & Oxford would be decimated if the region lost £286 million in a single year. The move towards funding equity will take time, but if the Conservatives

Region	Actual HCHS Allocation £ million	Target HCHS Allocation under revised formula £ million	Distance from Target (Over or under provision) £ million
Northern & Yorkshire	3,185	3,313	-128
Trent	2,182	2,237	-55
Anglia & Oxford	2,183	1,897	+ 286
North Thames	3,552	3,655	- 103
South Thames	3,331	3,319	+12
South & West	2,954	2,913	+41
West Midlands	2,439	2,447	-8
North West	3,200	3,220	-20

Hospital and Community Health Services Allocations to English Regions (1995-96)

cared about equity of treatment they would have made a start, however modest, in the current year. Instead, to 'maintain stability', they allocated exactly the same percentage increase to each region – 4.4% which, the Government says, equates to 0.85% in real terms. Growth of 0.85% on the £23 billion HCHS budget amounts to £196 million of additional funding, which could and should have been targeted on the areas of the country with the greatest unmet health needs. This would not have required any cut in real terms in the services provided in better funded areas.

A Labour government should apply the equity principle to health service funding and use whatever growth money is available to improve the standard of health provision in the areas of the country with the greatest burdens of unmet health needs. We should seek to raise standards in the worst-served areas until they equate with those in the best.

8 Making it happen

Labour has to reform the administrative structures of the NHS in order to abolish the internal market, but we should avoid reorganising for reorganisation's sake. The NHS is punch drunk with change and staff morale is at an all-time low. It is impossible to turn the clock back to a bygone age and it would be foolish to try. The NHS has always moved forwards and it should continue to do so under a Labour government – but guided by our policies and objectives rather than the Tories'.

Labour health ministers therefore should test each of the Conservatives' existing administrative structures, and each of our proposed reforms, against our three fundamental principles for the NHS and ask whether Labour's alternative will improve the equity, efficiency or accountability of the service. Some of the Tory reforms will survive because they are compatible with Labour's principles, even though this was not the Conservatives' intention.

Authorities

Using this test Labour would retain merged district and family health services authorities. The earlier decision to separate health authorities – charged with the task of deciding what health services are needed – from hospitals, and community health service providers, should also be seen as beneficial and therefore retained, although health authorities in future should plan and commission, rather than purchase, health services from providers. Health authorities need to retain control of the purse strings to enable them to hold providers to account if they fail to deliver the services commissioned, but health authorities should not be allowed to 'spot purchase' care, or to move provision from one provider to another without warning, because this is an inefficient way to use resources and it leaves the problems of inappropriate or unsatisfactory provision unresolved.

Fundholding

GP fundholding must be reformed because it cannot function if there is no internal market. The new arrangements should remove those aspects of fundholding which are incompatible with the principles of equity, efficiency and accountability. The two-tier referral system must be replaced by common waiting lists from which consultants prioritise patients according to clinical needs, irrespective of which GP practice has referred the patient.

All GPs, former fundholders and non-fundholders alike, should be required, under the terms of the GP's contract, to agree a clinical practice plan annually with their local health authority, and both their clinical practice and their use of NHS resources should be audited annually by the health authority. All GPs should have equal access to computers and other practice grants, although account should be taken in the short term of the need of non-fundholding practices if they can show they have received less than their fair share of resources, in recent years.

Labour should acknowledge that fundholding has brought some benefits. Hospital consultants are now more responsive to GPs and their patients' needs. This shift in the balance of power from secondary to primary care should be consolidated by establishing joint forums of GP practices and health authority managers to agree the local health commissioning plan and to monitor how it works in practice. The ability of fundholders to vire expenditure from drugs to other treatments such as counselling and physiotherapy needs to be extended to all practices, and should be regulated by the clinical practice plan agreed with the health authority. Practices would not be required to keep financial accounts of expenditure on treatments (although they should be free to do so if they wish) but instead could agree with their health authority, for example, to reduce the cost of tranquillisers prescribed by £10,000 a year in return for a part-time counsellor. As now, the health authority would keep track of prescribing costs and would be able to terminate the funding for the counsellor if the drug savings were not made. The health authority, as the commissioner of care from secondary providers, would process financial payments as it does now, thus achieving economies of scale in transaction costs.

Trusts

A pragmatic approach should be applied to NHS Trusts. Their status should be changed in as far as it undermines Labour's three fundamental principles. The Trust's assets should no longer be held independently but returned to the NHS. This would reflect Tony Blair's commitment to "renationalise the NHS". A public appointments commission reporting to a Parliamentary select committee should appoint non-executive board members from the community which the hospital serves. The board itself, perhaps renamed a Hospital Board, should have a status similar to that of a special health authority, although the

responsibility for appointing chief officers should be given to the regional outpost of the NHS Executive so that the chief officers could be held to account, and ultimately dismissed, if their hospital or community unit consistently failed to provide the services commissioned and paid for by the health authority. Board meetings, as for any other NHS authority, should be held in public.

The process of drafting, negotiating and agreeing contracts is wasteful of the NHS's valuable administrative resources especially when they cannot be enforced in a court of law. Large private companies use their internal management structure, rather than contracts, to ensure that each division of the company fulfils its objectives and meets its obligations to other parts of the company, and the NHS should act in a similar way.

The Conservatives have created a myth that no one can be trusted to deliver what is required of them unless they are held to account by a contract. Because the rules for the NHS internal market do not permit a health authority to take a Trust to court for failing to fulfil a contract, it begs the question, "Why have contracts at all?" Instead of wasting their time negotiating unnecessary and unenforceable contracts, NHS managers should spend it working with doctors and other health care professionals to develop meaningful clinical outcome indicators and to use them to improve the quality of care for patients.

Conclusion

9

Health is the policy area, above all others, in which the public implicitly trust us and mistrust the Conservatives. We must shift the political agenda from the administration of the NHS to the health of the people, and after the election we must boldly, decisively and quickly change the priorities of the NHS.

A new mission statement which defines the core objectives of the NHS as the pursuit of equity, efficiency and accountability should underpin Labour's prime policy goal of reducing health inequalities. The *Health of the Nation* strategy will need to be rewritten to reflect Labour's policy and approach. The new strategy should set objectives for all government departments, and require them to conduct a health impact assessment of their own activities.

The NHS should embrace evidence-based medicine as a means of encouraging doctors to use therapies which have been proved in rigorous clinical trials to be both effective and cost-effective. Patient choice and public accountability need to be enhanced.

Health service resources for primary and secondary care should be allocated to reflect the health care needs of local communities. Rationing decisions, which have always been made in the NHS, should give explicit priority to patients on the basis of equity and efficiency, and be brought out into the open to subject them to public scrutiny and debate.

The Conservative NHS internal market has been a costly flop and must be abolished. As ever the NHS will move forward, not back, and Labour should incorporate those elements of the Conservative reorganisation – such as the shift in the balance of power from hospitals to primary care – which are consistent with our three fundamental principles and capable of being used by a Labour government to reduce health inequality.

Above all, Labour must remember that the primary purpose of the NHS is to treat and where possible cure ill health. The promotion of good health depends on a much wider range of social policy, the most important of which, by far, is the reduction of social inequality.

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The Nation's Health

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Hugh Bayley (a former health economist at York University and, since 1992, Labour MP for York) writes that Labour should formally embrace three governing principles for the NHS:

- Equity: resources should be allocated on the basis of people's ability to benefit from treatment.
- Efficiency: resources should be spent on effective treatments which maximise the collective health benefit.
- Accountability: patients should be free to choose what treatment they have and who provides it.

Using new information obtained through Parliamentary Questions, he argues that the NHS internal market has been a "costly flop" and should be abolished. But where the reorganisation has been consistent with his three principles, such as the shift in the balance of power from hospitals to primary care, Labour should be ready to take advantage of these developments in its new strategy.

Bayley acknowledges that "we need to face some difficult choices: within a cash-limited budget more money for primary care, for instance, means less for secondary care (ie more bed closures". He argues that these tough decisions are an inevitable feature of an equitable system and that politicians should not be afraid to tackle them head-on.

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