



What's good about the NHS

*and why it matters who
provides the service*

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1. NHS success.....	3
Universal, comprehensive, equitable and free at the point of delivery.....	3
2. Principles: fair shares for all	4
Risk pooling and risk sharing.....	4
3 Funding the NHS through risk pooling.....	4
Progressive central taxation is the best way.....	4
Box 1. How markets fragment risk pools	
How private voluntary insurance works	5
Box 2. The US health care market	
Why user charges or out of pocket payments are unfair	5
Box 3. How private health insurance works: the example of the US	6
4. What other options are there for raising NHS funds?	7
a. Local taxation: creating risk pools which are too small	7
b. Social insurance	7
5. Delivering the NHS: building integration into the delivery system.....	7
Box 4. NHS services which suffer because they have not been integrated	8
NHS employees.....	9
6. Threats to the NHS	9
‘Eternal vigilance is the price of liberty’	9
a. The concordat with the private sector	9
b. Long term care	10
Box 5. Long term care	
c. How care trusts could open the door to charging and greater privatisation of NHS services.....	11
7. Why it matters who provides the services.....	12
Further reading	12

What's Good About the NHS and Why it Matters Who Provides the Service

The NHS Act 1946 provides a complete and medical service free of charge at the time it is required for every citizen.

Introduction to the NHS Act 1946

It will provide you with all your medical dental and nursing care. Everyone rich or poor, man, woman or child can use it or any part of it. There are no charges, except for a few special items; there are no insurance qualifications. But it is not a charity. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness'.

Charles Webster *The National Health Service: a political history* 1998

The NHS will be devoted 'not to this or that sectional interest'.

Aneurin Bevan *In place of fear* 1952

1. NHS success

Universal, comprehensive, equitable and free at the point of delivery

Ushered in on 5 July 1948 the UK NHS was established to provide to the entire population of the UK health care free at the point of delivery. Its aim was to treat all alike on the basis of need and not the ability to pay. Charity, market-based provision and National Insurance schemes had failed to deliver the universal health care that the nation required. In the 1930s only 43% of the population were covered by the National Insurance scheme, and these mainly men and only for general practitioner services. More than 21 million people, mainly women and children, were not covered by the scheme, and the sick carried the burden of paying for their care. It was not until the Second World War that the population had a taste of universal health care when the government created the emergency bed services which brought all hospitals under government control.

The UK NHS was created by national consensus in order to ensure that every citizen was guaranteed health care, and so for the first time the population as a whole would have 'freedom from fear' and above all freedom from the costs of ill health.

But the NHS was only one of the pillars of the new welfare state. As Beveridge scathingly noted 'want is a needless scandal due to not taking the trouble to prevent it - it is well within the economic resources of the country to prevent it'. During the war years he had been asked by the government to work on a plan for eradicating what he termed the five giants: ignorance, idleness, want, disease, and squalor. His report, *The Plan for Social Security and Allied Social Services* was published in 1944 and sold out within 24 hours. It bequeathed to a nation, worn out from war, a huge programme of reform, which would bring public services to the forefront of redistribution, equity, and a more just society. Thus it and the NHS became a model for public services across much of the western world.

2. *Principles: fair shares for all*

Risk pooling and risk sharing

The architects of the NHS recognised that equity in health care could only be achieved by sharing the risks and costs of care across the whole of society from rich to poor and from healthy to sick. It is well established that poverty and ill health are closely associated. The poor have higher rates of sickness and illness than the wealthy. Risk sharing means that those with the highest needs must not be penalised for being both sick and poor. It was for this reason the architects of the NHS embedded solidarity and collective provision into the structures for the funding and delivery of care.

3 *Funding the NHS through risk pooling*

Progressive central taxation is the best way

In the April 2002 budget, the current Chancellor Gordon Brown reaffirmed the UK commitment to central taxation as being the most progressive and efficient way of risk pooling in the NHS. It allows those with the greatest health and wealth to share the benefits of their good fortune with those who are not so fortunate. Importantly, it removes the stigma of charity by making health care an entitlement to which we all contribute.

But there is a growing lobby in support of funding alternatives. The Adam Smith Institute and the Conservative Party have proposed a switch to insurance funding and along with the private sector are lobbying for private insurance. The argument is that alternatives would leave more resources for those with greatest need within the NHS or would increase efficiency. But the consequence of the alternatives is market-oriented health care – decreased access, reduced quality and increased cost(see Box 1)

Box 1. How markets fragment risk pools

In contrast to universal public services, which consolidate and strengthen the risk pool through integration, markets work by dividing the population into winners and losers.

Profit is maximised where providers can pick the winners and reject the losers. In health this means selecting the profitable patients and the profitable services. The profitable patients are the healthy and wealthy while the losers are those with chronic disease or disability and the poor. In health care the market seeks to minimise its risk by risk selection, eg, by asking questions about the risks and presence of disease, disability, and family history in order to exclude entry.

The market also seeks to pass the risks back to the individual by minimising or capping care by placing time limits or a ceiling on the benefits available. Finally the market responds to market forces by selecting services and treatments on the basis of profitability, not need. This is why the pharmaceutical industry focusses on lifestyle drugs rather than the less profitable area of developing treatments for unusual diseases and conditions.

How private voluntary insurance works

Private voluntary insurance is a market-based system of funding. Access to it is only on the basis of ability to pay. The cost of private health insurance premiums increases sharply for older people and people with chronic diseases because of their risk. Private insurers segment the risk pool by selecting those they wish to cover (low risk, ie, young and healthy) and excluding the high risk elderly and sick) much in the same way as life insurance is currently sold. The greater the number of private insurers the more the risk pool is segmented and fragmented. Around 10% of the UK population have private health insurance cover. But where individuals can opt out of the risk pool to buy their care privately they are in fact choosing to exit the NHS risk pool and their voices are lost to the defence of the pooled health system, even though they are still covered by it. Allowing these individuals to opt out introduces market elements and fragments the risk pool decreasing the ability to distribute health care on the basis of need, and decreases the efficiency leaving the NHS with the most frail and sick to look after.

Box 2. The US health care market

Nowhere is the impact of the for-profit private health care sector more apparent than in the US, where the wealthiest country in the world denies health care to around 45 million of its population - mainly the working poor. The US health care system is designed around private voluntary insurance with government support targetted at only certain groups - the elderly and the very poor. Forty percent of all personal bankruptcies are due to health care bills. People are afraid to change employment lest they lose their health care benefits. Unlike in the UK, in the US people do not have freedom from fear of health care bills and the burden of health care debts. So despite having the most advanced economy in the world, and despite having the highest GDP spend on health care in the world, the US government is unable to guarantee its citizens health care as a right.

Why user charges or out of pocket payments are unfair

In July 2000, the UK government wrote in *The NHS Plan*:

“Charges are inequitable in two important respects. First, new charges increase the proportion of funding from the unhealthy, old and poor compared with the healthy, young and wealthy. In particular, high charges risk diminishing access to healthcare by the poor. As the World Health Organisation report - which assessed the United Kingdom as having one of the fairest systems in the world for funding healthcare - concludes: ‘Fairness of financial risk protection requires the highest possible degrees of separation between contributions and utilisation. “

Department of Health. *The NHS plan: a plan for investment, a plan for reform*. London: The Stationery Office 2000.

User charges of any kind are regressive since they cannot discriminate between rich and the poor, for example between people earning £5,000 or £50 a week. It is possible to try to get round this by having exemption categories for charges and means testing. But means testing

does not help people who fall outside the threshold. Charges also adds considerably to the administrative costs since there is a cost associated with their collection. User charges transfer the risks and costs of care from the wealthy and well to the poor and sick and the elderly. Transferring the risks and responsibility to the individual creates barriers to access.

Some NHS services *are*, however, funded by user charges. These services are usually paid for by the individual until too poor to pay as out of pocket payments. This is increasingly the case for dentistry and orthodontic services, long-term care. Long waiting lists for hip replacement and coronary artery bypass operations means that those who are willing and able to pay go into the private sector - at the expense of those who remain behind in the NHS.

Box 3. How private health insurance works: the example of the US

All private health insurers seek to maximise profits by risk reduction strategies. These include screening tools designed to exclude high cost, high risk patients. For example, you may have to climb three flights of stairs to enrol for insurance, and adverts are placed on the bottom of swimming pools to attract only the fit and healthy. Community rating, which prevented insurance companies from setting different premiums at different levels of risk, has now been abandoned, because of the high costs to the state and employers. Many people are denied care because they are too old, too poor, or too sick, or because their risk of ill health is too high.

Private health insurers seek to cap their liabilities by capping payments and benefits. Superman actor Christopher Reeves, when he was rendered quadriplegic following a riding accident, found that his private health insurance ran out and he was liable for costs.

Private health insurers also try to cap insurer liabilities by passing the risks to providers, which in turn passed the risks to the clinician and patients. In the US private managers in private hospitals control the ability of doctors to refer, prescribe, and treat to such an extent that this has fuelled major discontent even among the truly conservative medical establishment. In some cases financial remuneration of doctors is now linked to incentives to cut or limit the costs of providing care. The less care they provide the more they can keep. Public outrage has forced states to intervene passing laws, for example to prevent 'drive-by mastectomies' and same-day deliveries, enabling patients to stay longer in hospitals if they or their doctors deem it to be necessary. But these regulations have to be paid for either by the state or by the individual.

4. *What other options are there for raising NHS funds?*

a. Local taxation: creating risk pools which are too small

Bevan recognised that a National Health Service required central taxation. Prior to the inception of the NHS local authorities had established and run health services, but they could not create a national health service since they were largely reliant on the wealth of their local communities and local areas and could not compensate for the huge variation wealth across the country. Only in prosperous areas could local authorities raise enough taxes to provide the range of services required.

One of the consequences of dividing the responsibility for health and personal care between the NHS and local authorities was that it opened the way to charging for personal care. Local authorities did not use the powers given to them in 1948 until the late 1970s when government cut their revenue budgets and imposed rate capping. Increasingly local authorities charge for personal care. The effect is to make personal care a local responsibility, increasingly dependent on the wealth of the local community and the individual (see box 5), and to erode the risk pool by creating a mechanism which would allow the blurring of the boundaries between NHS funded health care and means tested personal care.

b. Social insurance

Some European countries such as Germany fund their health service through social insurance. These funds rely on employer and employee contributions. However, where countries have several competing or complementary funds in a universal health care system, governments have to take special measures to prevent ‘cream skimming’ or selection. This results in complex, highly bureaucratic mechanisms being required to ensure fairness, adding greatly to the cost of administering the funds. This is the case in Germany.

5. *Delivering the NHS: building integration into the delivery system*

Just as the funding system has to be designed to prevent patients being excluded from care, so too must services be organised so that they cannot deny patients care or pass patients from one service to another in an attempt to pass the risks and costs of care.

The NHS has been criticised for being a monopolistic employer and provider but this is its strength. For integration is the key to risk sharing. All public services have elements using cross-subsidisation and integration to share the risks and costs of care across populations, communities, and services and between patients. For example, the higher costs of delivering services to rural communities must be shared with urban communities because access to services and costs of supplying services is greater. This is as true of health as it is of transport, education, the utilities, or postal services.

Expensive treatments or rare conditions such as bone marrow transplant and blood transfusion services require service integration and risk sharing so that the less expensive parts of the service or investigations subsidise the more expensive. When a patient is admitted for a routine operation and requires ventilation and intensive care, the cost of this treatment is subsidised by treatments which are less expensive. Research, training, and even administration

deliver cross subsidisation through the sharing of overheads, pay roll, human resources, and capital costs. Integration is the essence of risk sharing.

Bringing services under public ownership reduces transaction and administration costs as it does not necessitate complex market and pricing mechanisms. It allows greater control over service planning and workforce deployment and prevents needless duplication. When elements of services are contracted out or privatised, the ability to pool risks efficiently is diminished and market elements are introduced. This in turn escalates transaction and administration costs, competition, duplication, and inequitable supply. The result is disintegration. In the UK before the internal market, transaction costs were around 6% - they are now 12%. In the US they are in excess of 25%. In other words, for every dollar spent, 25 cents goes on marketing and administration.

Separating out service elements or 'unbundling' reduces the ability to integrate services. But now the World Bank and international financial institutions are promoting policies which target public services precisely designed to unbundle services, eliminate cross subsidisation and allow these services to be commodified and floated on the market. This unbundling attacks the very essence of public services - which is risk sharing and risk pooling.

Box 4. NHS services which suffer because they have not been integrated

Hospices

The hospice movement was identified by local communities as a need that the NHS did not fill. However, despite the resounding success of the hospice movement no government has sought to incorporate the hospice movement into the NHS, instead leaving hospices dependent on local charity and fundraising for more than half their annual revenues. The result is that the hospice movement has to operate like a small business in order to generate income. It is also dependent on the vagaries of charity and government funding, its provision is variable across the country, and it is increasingly inefficient because it cannot benefit from the cross subsidisation of its overheads by other parts of the NHS. As John Stuart Mill wrote, 'charity almost always does too much or too little: it lavishes its bounty in one place and leaves people to starve in another.' (JS Mill, Principles of Political Economy, 1848)

Dentists

In contrast to the rest of the workforce, dentists, opticians, and GPs owned their own premises, leased or owned equipment, and employed their own staff, including nurses and secretarial and support staff. The NHS contracted with these providers for services. Thus the individuals were self-employed businesspeople, much of whose work was taken up with the transaction costs of administration rather than with caring. They also carried the risk for any business failure. Because NHS dentists found they were not being adequately remunerated NHS dentistry has virtually disappeared in some parts of the country and the service is usually available only in the private sector and on the basis of ability to pay and not need.

NHS employees

It is not always realised that redistribution and equity were built into the employment and working conditions of staff. Although the NHS has been criticised for being a monopolist provider, able to keep wages low, this also gave added advantage to employees when bargaining for national terms and conditions and tenure. The national terms and conditions of services were critical in levelling out pay differentials and in ensuring that the massive major gradients and differentials, which exist in the private sector, did not occur.

In return, staff freed from fee for service and income generation were able to think of patients on the basis of their needs and not their ability to pay. As Bevan has described, the time taken in the running of a business could be put to much better intellectual use. Professionalism grew as staff engaged in creating better resources for their patients and improving services and training. As a result many of the advances in mental health and older peoples services, such as geriatric day care and social services, were widely admired and copied through out the western world. There was no incentive to select patents on the basis of ability to pay but rather to treat on the basis of need.

National terms and conditions of staff are a barrier to market entry. Just as the market segments risk for patients, it likes to segment the workforce into winners and losers – high earners and low paid. Three factors contribute to the erosion of national pay bargaining. The first is the existence of a private sector which allows individuals to supplement their NHS income. The second is the increasing trend to the contracting out of staff to the private sector by the NHS. The third and most recent is the shift to local flexible paybargaining as trusts are freed to set terms and conditions of service. All this is contributing to a growing differential in wages and terms and conditions of service. Most recently the Health Select Committee has described how the differentials between staff grow into social apartheid.

6. Threats to the NHS

‘Eternal vigilance is the price of liberty’

The NHS is one our most prized and valuable institutions. However, decades of underfunding have seen the volume, range, and quality of services it once provided decline and staff and patients come under growing pressure. Increasingly in the NHS some services are charged for, and some services including long term care, fertility treatments and therapy services are so scarce that they are available only on the basis of ability to pay either by out-of-pocket payments or private health insurance. Most seriously, the principle of risk pooling underpinning a universal health service has been breached both through the erosion of entitlements and benefits and the increasing privatisation of the delivery system and loss of services which were once integral to it. These services include long term care, NHS dentistry, catering, ancillary services, pathology, and now elective care. The NHS faces new threats.

a. The concordat with the private sector

The NHS Concordat sees a greater role for the private sector. Already companies such as Norwich Union finance, own, and operate GP premises while others such as BUPA and PPP provide NHS hospital care to NHS patients paid for by the NHS. These companies currently promote and sell private health insurance as well as privately funded health care. There are no provisions in the Act prohibiting the sale and promotion of private health insurance or privately funded health care to NHS patients from NHS purchasers and providers, such as care

trusts. Public Private Partnerships and care trusts blur the boundaries for funding and responsibility for provision making backdoor privatisation much easier, perhaps inevitable.

b. Long term care

The Royal Commission on Long-Term Care, established by the Labour government in 1997, concluded that no system of private funding, whether private insurance, pensions, or charges could meet the unpredictable and catastrophic costs of personal care. Its core recommendation was that the state should provide personal care through a universal element in state provision met from general taxation. By doing so it would give ‘the best thing society can offer – freedom from fear and a new security in old age’ (Royal Commission on Long Term Care. *With respect to old age: long term care - rights and responsibilities*. London: The Stationery Office 1999)

Box 5. Long term care

Personal care concerns those most intimate of daily tasks: washing, feeding, toileting, and dressing. Since 1979, NHS service provision for older people, convalescence, rehabilitation, and mental illness has decreased to around a quarter of all care beds in the UK. The remaining three quarters are in the independent sector, with NHS service closures continuing at the rate of 4,000 beds a year in 1999-2000.¹ Formerly provided as universal care, free at the point of delivery, this care is increasingly provided by an under regulated for-profit private sector and paid for by the individual until too poor to pay.

Increasingly people who are old or disabled have had cause for concern over charging for personal and social care. In 1975 of all the people going into long term care of one sort or another – whether in nursing homes, residential homes, or long stay hospitals – 25% would receive this care free under the NHS. By 1995 only a tenth of people would be entitled to free long term care.² In 1995 only 9% of places for the elderly in long term care were in NHS institutions compared with 28% in 1970.³

Charges for personal social services have increased from £502 million in 1992-93 to £2,039 million in 2000-01, and the proportion of total spending recouped by local authorities in fees and charges has risen from 9.1% in 1992-93 to 16.1% in 2000-01.⁴ Similarly for domiciliary care, whereas in the 1970s charging was largely unheard of, in 1992-93 72% of councils charged and now it is 94%. [Audit Commission, *Charging with Care 2000*] and charges account for a growing proportion of their expenditure, funding 12% of costs in 2000-01 compared with 8% in 1993-94. The effect of these charges has been to reduce many users to a level of income below the income support levels deemed appropriate to their age.

NHS Executive. *Bed availability and occupancy. England 1999-00*. London: Department of Health 2000. But some NHS services are charged for.

William Laing, evidence to the Health Select Committee.

Laing's Review of Private Health Care 1996

Memorandum by the Department of Health to the Health Select Committee. Public Expenditure Questionnaire 2001. London: The Stationery Office 2001.

It is unfortunate that having made the case for abolishing charges on redistributive and economic grounds *The NHS Plan* of 2000 undergoes an extraordinary volte face. 'The Government does not believe that making personal care universally free is the best use of these resources.' Instead of moving forward with plans to abolish charges as Scotland is doing, the government has published a consultation document on charging for home care and social services confirming that local authorities and primary care trusts under delegated authority can charge. Thus the risks and costs of care now pass first to local communities and then to the most vulnerable and least able to bear them.

c. How care trusts could open the door to charging and greater privatisation of NHS services

Primary care trusts are intended to evolve into care trusts (a new kind of NHS body) which will bring health care and social services under a single umbrella. They will be purchasers and providers rolled into one. Health care will continue to be free at the point of use. But social care will be charged for. The government anticipates that care trusts will control about 75% of the NHS budget by 2004. But care trusts, like NHS hospital trusts, will have to break even.

One way of doing so will be through intermediate care, that is, care provided in order to ease the transition from hospital to home. The government wants to create an extra 5,000 intermediate care beds by the middle of 2004. Some will be in community hospitals, others in special wards in acute hospitals, and some in purpose-built new facilities or redesigned private nursing homes. The plan also aims to introduce 1,700 extra non-residential care places. Much of this care will be provided in the for-profit independent sector of nursing and residential care homes and domiciliary care. These homes will also be competing for the same scarce resources.

The government has introduced guidance time-limiting NHS care. 'Based on current practice an intermediate care episode should typically last no more than six weeks. Many episodes will be much shorter than this, for example, 1-2 weeks following acute treatment for pneumonia or 2-3 weeks following treatment for hip fracture'. Thereafter, NHS care — meaning nursing and medical care — will be provided free of charge but means-tests and user charges will apply to housing and living costs and to the costs of 'personal care'. It has also introduced into the Act mechanisms for 'topping up' services for those prepared to pay for extras out of pocket. Care will in this case be provided on the ability to pay and not on need.

Care trusts and foundation hospitals, laden with PFI debts and health authority deficits, will have a strong interest in redefining NHS care and defining personal care as broadly as possible and encouraging patients to top up care. All these steps will help them maximise revenue from user charges. Issues are bound to arise over the status of many ordinary tasks of daily living (mostly centring on washing, feeding, and bathing). When is giving a patient a bath, for example, medical care and when is it personal care? It will be up to care trusts to say.

All these changes could greatly favour the development of an expanded market in private medical insurance. It may be that insurers will offer policies that take effect at the point where the care provided by care trusts ceases to be free. Holders of such policies could, for example, be entitled to longer stays in hospital with the insurer meeting the cost no longer covered by the state. The effect however of doing so will be to break up the risk pool and introduce new inequities.

7. *Why it matters who provides the services*

Politicians say it doesn't matter who provides the services so long as they are publicly funded. But redistribution is built into the design of the funding and delivery system through risk pooling and integration. The two tier system, where some people can gain access to private care outside the NHS, is being accompanied by the break up of the NHS by competition, contracting out, trust status, and user charges. The greater use of the private sector will have the same effect. Unless there is a reversal of the privatisation policies, the NHS could become a rump service where the high costs of using the private sector will inevitably mean a deterioration in access to quality and coverage by the NHS and an end to freedom from fear.

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Further reading

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