



Wasting Lives 2011

A statistical analysis of NHS performance since 1981

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The TaxPayers'
Alliance

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Foreword

The last few months have seen regression in the public debate about health options in the UK with a disregard of key evidence. The TaxPayers' Alliance is to be congratulated on its restatement of what should be one of these key pieces of evidence—how far is the NHS delivering an adequate performance in terms of preventing mortality.

There is now an accepted methodology developed by McKee and Nolte at the London School of Hygiene for estimating numbers of premature deaths and a number of studies have shown that the NHS is performing poorly on this indicator. In this latest review the UK rate of mortality amenable to healthcare in 2008 was 33 per cent higher than the average rate of the Netherlands, France and Spain leading to 11,749 more deaths. Such evidence does not affect deep emotional loyalty but it should surely prevent the kind of uncritical endorsement of the current system which we have heard so much of from the BMA, Baroness Williams with greatest eloquence. They are uncritically endorsing a system which is not delivering rather than showing any sense of urgency in seeking explanations.

But why? It used to be quite possible to argue that the main problem was underfunding that England was spending less than the Euro average. The last ten years have seen an actual test of this hypothesis with a growth of spending that has brought the NHS close to the Euro average and above low spenders such as Scandinavia and Spain. Yet there has been no change in the rate of improvement in mortality. The "UK has caught up with its European peers at a nearly constant rate between 1981 and 2008." There has not been a surge of improvement related to the surge of spending. Of course the argument is already being made that the NHS needs more spending as a result of demand factors: but even if this were feasible there is little reason to expect any better results than in the previous period.

The Report reviews other health systems and presents a strong case that the real problem with the NHS is responsibility. People at the local level are deprived of capability for key decisions on performance. Where not frozen by politicisation, decisions are parked by bureaucracy. Any attempt at local initiative such as the recent strategy for London tends to be blocked for political reasons. Most key decisions such as on pay and service are dictated from the centre. The TaxPayers' Alliance has made a worthy contribution which challenges the health establishment to act on evidence.

It is clear that triple nationalization – funding, resource allocation and provision delivers results which are deeply damaging to many patients. A single payer system linked to pluralism in supply – in effect the model in comparator countries – will produce better results for patients. Research by Cooper has shown that competition saves lives for



patients with cardiac problems. Hospital competition lowered death rates from heart attacks 2002-8 by approximately 7 per cent. But will we ever shake the Groupthink of the health establishment and persuade them to put patients first?

Nick Bosanquet, Professor of Health Policy at Imperial College London

Executive summary

This paper updates the TaxPayers' Alliance's 2008 publication *Wasting Lives: A statistical analysis of NHS performance in a European context since 1981*. It details the poor performance of the NHS when compared with European peers, despite huge increases in funding over the last decade.

The report examines mortality amenable to healthcare – the number of deaths from certain conditions, and at certain ages, that healthcare can reasonably be expected to avert – to compare NHS performance with that of three other European countries: the Netherlands, France and Spain.

The World Health Organisation produce an international mortality database, which was filtered for deaths from those conditions considered amenable to healthcare, at certain ages. A substantial analysis of the raw data from 1981-2008 was carried out, providing a thorough examination of the progress of British healthcare over the last thirty years.

The key findings are:

- In 2008, the latest year for which data is available, **11,749 more deaths occurred in the UK** than would have if the UK had matched the average mortality amenable to healthcare rates of European peers.
- This is more than **four times the total number of deaths from road accidents** in 2008. It is equivalent to over **2,000 more deaths than those related to alcohol** in 2008.
- The UK has caught up with its European peers at a nearly constant rate between 1981 and 2008. In that time there has been a **huge increase in spending on healthcare** since 1999. This suggests that **money alone has no discernable effect on mortality rates**.
- In the last two years studied (2007-2008) the UK's amenable mortality convergence relative to European peers was slower than the trend over the entire period. This suggests that **relative improvements in mortality amenable to healthcare could be slowing**.

This study confirms that the situation since our 2008 report has not improved. Over the last thirty years, there have been some incremental reforms to the NHS, and a period of huge increases in spending. Both have achieved largely the same results: the NHS still lags behind our European neighbours' systems. The NHS needs to be fundamentally reformed. The problems we highlighted in our previous study persist today:



- **The system is too centralised.** Local NHS organisations have very little room for independent decision making. In other European countries it is more decentralised.
- **The NHS is heavily managed by politicians.** It is uncommon for health ministers to have had healthcare or management experience. European healthcare systems, in Germany, France, Switzerland and the Netherlands, have genuinely independent providers of hospital care and social health insurance that are not managed by politicians.
- **The NHS is a monopoly.** It has access to a huge amount of taxpayers' money, but it does not give patients enough choice over how they receive their healthcare. Recent research by the Centre for Economic Performance at the London School of Economics found that the introduction of fixed-price competition in the NHS drastically improved performance.

The proposed reforms in the Health and Social Care Bill only go part of the way to solve these problems. Moves to give commissioning powers to GPs and abolish Primary Care Trusts have been watered down somewhat, as have initial proposals to increase competition.

The solution is not more spending. NHS Expenditure in 2011-12 is set to reach £122.5 billion, an increase of £34 billion – or 39 per cent – compared to five years previous in 2006-07.¹ Reforms are needed to ensure that money is spent efficiently.

Healthcare in Britain fails to match up to the standards of its European neighbours not because it is underfunded. The NHS is too centralised, overly-managed by politicians and is too insulated from competition. That wastes lives.

¹ HMT Public Expenditure Statistical Analyses 2011, Table 1.3

1. Introduction

NHS reform is a difficult issue. It is an institution the British public is very attached to and any suggested changes in structure or funding provoke an emotive response from NHS staff, unions, media outlets and others. This has the unfortunate consequence of skewing any real debate on how we can improve healthcare outcomes and treatment for patients.

As a result, politicians can be popular when they announce record levels of “investment” in the NHS. It pays for them to advocate spending increases, regardless of the actual result. Improvements in healthcare are too often directly attributed to this new money, and credit claimed. So does more money mean better healthcare?

There are many other factors at play. New technology means that healthcare can improve with little or no policy change, for example. So a more important and helpful question is: have huge increases in healthcare spending over the last decade led to British healthcare improving at a higher rate relative to other comparable countries?

This report maps that progress out over the last thirty years. It sets out where we are now before going back to 1981 and tracking that progress in detail. It then discusses the systems of our European peers, before analysing what the UK is getting wrong. The results suggest that taxpayers should be demanding much more from our healthcare system, especially given the decision to ring-fence the NHS budget.

2. Methodology

It is notoriously difficult to quantify the relative performance of healthcare systems in different countries. Many different approaches have been tried but they have significant drawbacks. These were assessed briefly in our 2008 paper, and are repeated here:²

- Life expectancy and variants such as disability adjusted life expectancy are, perhaps, the most common measure used to assess a nation's health. Disability Adjusted Life Expectancy was used by the World Health Report 2000.³ However, as a measure of healthcare system performance, this will be distorted by mortality rates linked to conditions that healthcare systems cannot have a significant effect upon.⁴
- Surveys of public opinion provide subjective evidence of a healthcare system's effectiveness. However, there is no reason to think that public opinion is an effective gauge of a healthcare system's aggregate performance. The Picker Institute highlights the three variables that a patient will reflect in satisfaction surveys:⁵
 1. The personal preferences of the patient
 2. The patient's expectations
 3. The realities of the care received
- Disentangling the reality of care received cannot be done reliably. The public have limited evidence with which to assess the system beyond their own interactions with it and will only occasionally experience the healthcare systems of other countries that should provide a benchmark.
- Studying individual conditions can allow for a more detailed examination of how a healthcare system performs.⁶ However, if certain conditions are studied in detail and then taken as samples with which to build an aggregate picture of a healthcare system the result can be highly distorted. A common criticism of the National Health Service is that targets lead to high profile conditions being prioritised and others neglected. There is a huge risk of having either disproportionately prioritised or neglected conditions in your sample and coming to erroneous conclusions. While this can be controlled for such controls can only pick up the most acute anomalies.

² Matthew Sinclair (2008) Wasting Lives: A statistical analysis of NHS performance in a European context since 1981. Available at www.taxpayersalliance.com

³ World Health Organization, 'The world health report 2000. Health systems: improving performance', June 2000, <http://www.who.int/whr/2000/en/index.html>

⁴ Nolte, E. & McKee, M. (2003) 'Measuring the health of nations: analysis of mortality amenable to health care', British Medical Journal, volume 327, Figure 2

⁵ Picker Institute, 'Survey Information', <http://www.pickereurope.org/page.php?id=21>

⁶ Gubb, J. (2007) 'Just How Well Are We?' A glance at trends in avoidable mortality from cancer and circulatory disease in England & Wales', Civitas

Mortality amenable to healthcare

This paper uses aggregate mortality amenable to healthcare to compare performance. Mortality amenable to healthcare is a measure of deaths that could have been averted by the healthcare system for a given range of ages. This measure excludes subjectivity and gives an accurate picture of the conditions and ages where healthcare can expect to make a significant difference.

It is a comparative method that is robust and well respected:

- An international comparison using mortality amenable to healthcare was performed by Nolte & McKee.⁷ They found that when nineteen developed countries were ranked on healthcare performance the UK placed nineteenth. An update of this study showed some progress but still found the UK ranked among the worst performing developed countries.⁸ This can be compared to when they were judged on disability adjusted life expectancy where the UK placed tenth. They argue that the World Health Organisation ranking of healthcare systems would be improved by replacing Disability Adjusted Life Expectancy with mortality amenable to healthcare.⁹
- Public bodies are increasingly moving to report mortality amenable to healthcare. The Office for National Statistics has consulted on plans to create a series¹⁰ and the Scottish Public Health Observatory has created estimates for Scotland.¹¹

Mortality amenable to healthcare is not without criticisms though, and it is worth addressing these:

- It has been criticised for showing insufficient correlation with healthcare inputs.¹² However, this would seem to be a more telling comment upon the complexity surrounding healthcare productivity – we should only expect that greater quantities of healthcare inputs will reliably feed into better healthcare if we assume static and uniform productivity.
- Another criticism could be that by focusing exclusively on the mortality record our study neglects some other priority. This is a risk with any measure but mortality

⁷ Nolte, E. & McKee, M. (2003) 'Measuring the health of nations: analysis of mortality amenable to health care', British Medical Journal, volume 327

⁸ Nolte, E. & McKee, M. (2008) 'Measuring the health of nations: Updating An Earlier Analysis', Health Affairs, January

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

¹⁰ Office for National Statistics, 'Measuring premature and avoidable mortality: ONS proposals for national indicators; Response to the Consultation', September 2006,

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

¹¹ Grant, I. et. al. 'Mortality amenable to Health Care in Scotland 1981-2004', June 2006,

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

¹² Nolte, E. & McKee, M. (2004) 'Does health care save lives? Avoidable mortality revisited', Nuffield Trust, page 43



amenable to healthcare includes a wide range of conditions so should be taken as relatively robust with respect to this criticism.

How the mortality amenable to healthcare figures were calculated

The methodology used in our 2008 report was repeated using new data up to and including 2008. Detailed mortality data from the World Health Organisation Mortality Database was extracted.¹³ This gave the number of deaths in each age group, in each gender, in each year within the set of causes identified as amenable to healthcare by Nolte & McKee.¹⁴

We included Ischemic Heart Disease in our analysis, but evidence shows that only half of the deaths from these conditions are amenable to healthcare. We have adjusted the data accordingly and halved these rates.

We have followed the methodology of Nolte and McKee with regard to the ages of certain conditions which are amenable to healthcare at certain ages, for example deaths from the measles are considered amenable to healthcare is only between 0-14 years. Again, the data has been analysed accordingly.

For each gender, for each country and for each year age-standardised mortality amenable to healthcare rates were calculated: the number of deaths for the amenable conditions, within the amenable age groups, were added up and divided by the relevant population (figures also from the World Health Organisation Mortality Database) to produce age-specific mortality rates. These were weighted by the European Standard Population to produce an age-standardised rate for that year.¹⁵

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

Countries and years studied

The countries chosen for comparison – the Netherlands, France and Spain – are the largest nations in the EU-15 for whom sufficient mortality data is available up to 2008. Germany only had data up until 2006, which is why they are excluded from this study. Italy did not have data in 2008. The countries analysed are large and wealthy, and can be considered comparable to the UK.

¹³ World Health Organisation, Mortality Database, updated 25th March 2011

<http://www.who.int/whosis/mort/download/en/index.html>

¹⁴ Nolte, E. & McKee, M.(2003) 'Measuring the health of nations: analysis of mortality amenable to health care', British Medical Journal, volume 327, Table 1

¹⁵ NHS Executive 'Quality and Performance in the NHS: High Level Performance Indicators and Clinical Indicators', May 2001, Annex D1: Age-standardisation and calculating confidence intervals,

<http://www.performance.doh.gov.uk/indicat/d.pdf>



This paper analyses data from 1981-2008, the latest year for which data is available. Starting in 1981 provides a twenty year time series. It is long enough to demonstrate significant trends and is a reasonable time-span in which to consider the implications of a number of policy decisions and funding changes.

Britain's data is missing for 2000 so that year has been left out.

3. The NHS in 2008

The rates of mortality amenable to healthcare in the UK compare poorly to European peers. The latest WHO data runs up to 2008, and taking that year in isolation is revealing:

- In 2008, there were 11,749 deaths in the UK that could potentially have been avoided if we matched the average rate of mortality amenable to healthcare of our European peers.
- The UK rate of mortality amenable to healthcare in 2008 was 33 per cent higher than the average rate of the Netherlands, France and Spain.
- The UK rate is 45 per cent higher than the best performing country in 2008 – France.

Boosting the UK's performance could plausibly save nearly 12,000 lives a year. This is more than four times the total number of deaths from road accidents in 2008.¹⁶ It is equivalent to over 2,000 more deaths than those related to alcohol in 2008.¹⁷

Table 3.1: Mortality amenable to healthcare in the UK and selected European countries, 2008

2008	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	30,151,337	85.8	
Female	31,231,820	69.6	77.6
Netherlands			
Male	8,134,243	62.6	
Female	8,311,366	61.8	62.2
France			
Male	30,000,450	57.9	
Female	31,962,834	49.0	53.3
Spain			
Male	22,512,354	70.8	
Female	23,081,031	48.9	59.7
	Euro-average (excluding UK)		58.4
	<i>Difference between UK and Euro-average</i>		19.1
	Deaths per year in UK implied by difference from Euro-average		11,749

¹⁶ Department for Transport statistics: <http://webarchive.nationalarchives.gov.uk/+http://www.dft.gov.uk/pgr/statistics/datatablespublications/accidents/caualtiesmr/rcgbmainresults2008>

¹⁷ Office for National Statistics: <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=14496>

Our results fit in with a broader pattern of poor performance measured by other metrics. They do not relate to our methodology – analysing mortality amenable to healthcare – but they reveal an illustrative pattern of how the UK's healthcare performance compares with other countries':

- Research commissioned by the Department of Health and published in respected health journal *The Lancet* found that for four different types of cancers, overall survival rates were lower than the relative rate in England, Wales and Northern Ireland. Survival from 1995-2007 was higher in Australia, Canada, and Sweden, while Norway scored at around the relative rate. For example, the study found that England recorded a 53.7 per cent five year survival rate for colorectal cancer in 2005-07, while Australia recorded a 65.9 per cent survival rate.¹⁸
- In England, premature mortality from all circulatory diseases in 2007 for males under 65 was 55.4 per 100,000 compared to the 51.5 per 100,000 EU-15 average.¹⁹ For women, England is again above average: the numbers are 20.7 and 17.9 per 100,000, respectively.²⁰

Increased spending has not improved the rates of mortality amenable to healthcare, and the UK is still behind in other metrics. That isn't to say that focused and directed spending by a Government will never yield positive results. It is easy to argue that such activity from command economies has actually reduced mortality rates, for example child mortality in Chile, Costa Rica and Cuba has decreased by over 80 per cent since 1970.²¹

Systematic studies have produced nuanced results too. A paper examining the implementation of Medicare in America – universal health insurance for the elderly – found that the welfare gains from the reductions in risk exposure may be substantial relative to the costs of Medicare itself.²²

Studies like these imply two things: that the huge increase in expenditure on the NHS over the last decade has been a dismal failure; or, it has been a dismal failure because increasing spending on healthcare is so much less important than societal improvements in lifestyle or technology, for example.

¹⁸ Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995—2007: an analysis of population-based cancer registry data, *The Lancet*, Volume 377, Issue 9760, Pages 127 - 138, 8 January 2011

¹⁹ Department of Health *'Health Profile of England 2009'*, March 2010, Chart 3.10: Male premature mortality from all circulatory diseases

²⁰ Department of Health *'Health Profile of England 2009'*, March 2010, Chart 3.12: Female premature mortality from all circulatory diseases

²¹ The World Health Report 2003, World Health Organisation:
<http://www.who.int/whr/2003/chapter1/en/index2.html>

²² Finkelstein and Robin McKnight (2005), *What Did Medicare Do (And Was It Worth It)?*, National Bureau of Economic Research Working Paper No. 11609

Either way, it is important to understand that reform is crucial, as there is a limit on the effect of greater resources in healthcare.

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

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

As discussed, the first two of these points will affect any study conducted on the healthcare performance of a country. They do not affect the conclusions of this study, however, so that means that the third point – the system itself – must be examined separately. In the meantime, it is worth briefly addressing points 1 and 2 in turn.

Lifestyle

Changing lifestyles will affect any assessment of healthcare outcomes. It is important to note three reasons why this is not crucial to this study:

- There is a large body of research – the EURO CARE study on cancer survival is one example – which shows significant differences in survival rates.²³
- Governments attempt to change people's behavior through taxation. For example, the decisions made in the 2011 Budget will bring in an additional £350 million in tax revenues on tobacco over the course of this Parliament.²⁴
- The healthcare system itself can affect lifestyle. People face a greater incentive to stay healthy if they bear all or part of the cost of treating unhealthy lifestyles. Debates about procedures like stomach stapling becoming more commonly used to tackle obesity are an example of this.²⁵

²³ Berrino, F. et. al. 'Survival for eight major cancers and all cancers combined for European adults diagnosed in 1995-99: results of the EURO CARE-4 study', *Lancet Oncology*, Volume 8, Issue 9, September 2007, pp. 773-783

²⁴ Budget 2011, Table 2.1 Budget Policy Decisions

²⁵ David Batty, *The Guardian*, Friday 27 August 2010 <http://www.guardian.co.uk/society/2010/aug/27/nhs-obesity-operation-ninefold-increase>



Differences in health due to changing lifestyles should be seen as a crucial part of assessing healthcare performance, along with a number of other factors including housing, sanitation and safer working conditions.

Technology

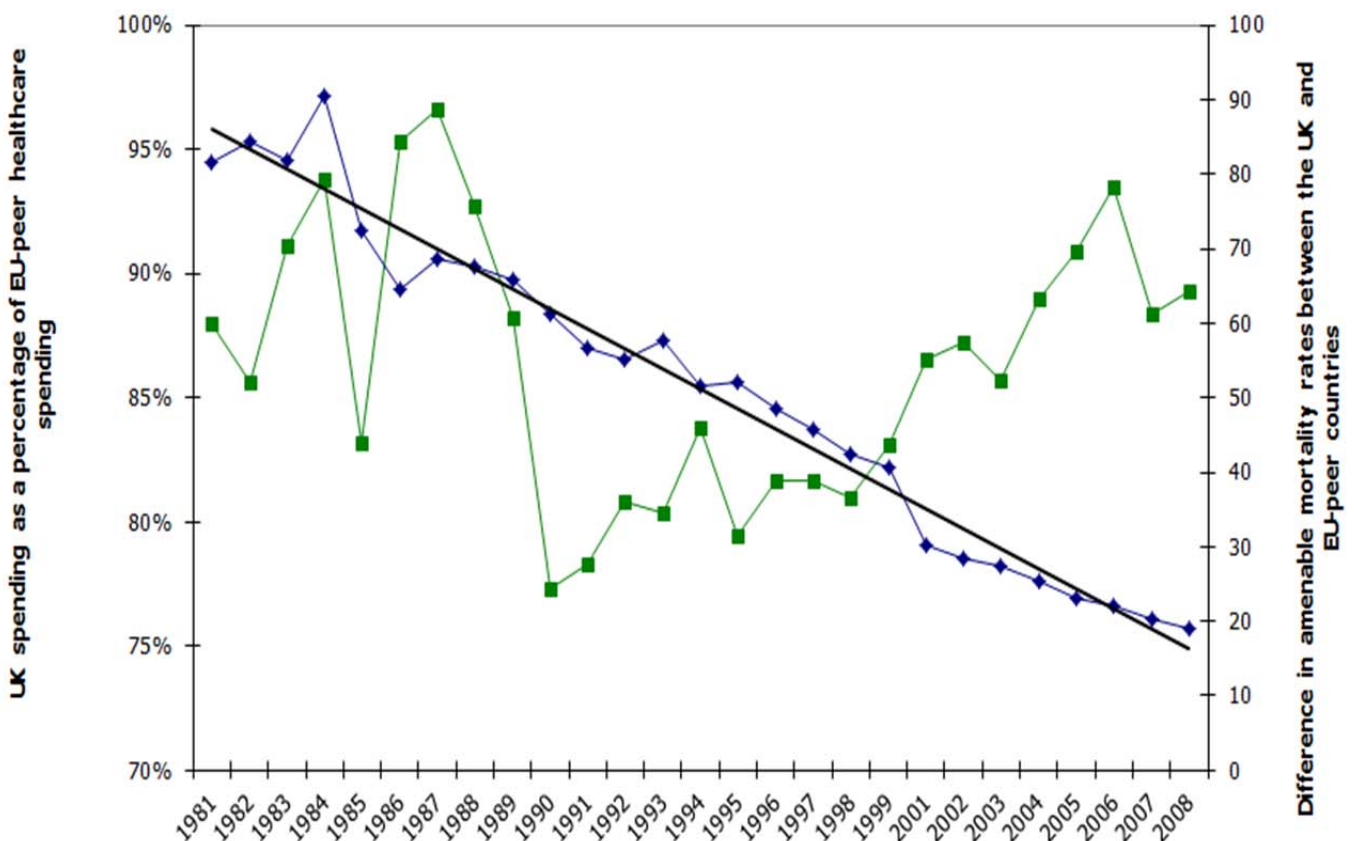
Technological improvements are an important factor in healthcare performance. As outlined in our 2008 study, this is unlikely to reflect differences in health policy between countries:

- Technologies, whether developed by pharmaceutical companies, universities or governments, tend to be available globally to anyone who can afford them.
- Technological improvement is likely to lead to falling amenable mortality rates over time. It should also lead to convergence between better and worse performing healthcare systems. A historical advantage is effectively wiped out when old investments, in scanners of a certain precision – for example – are made obsolete. Technological progress will only create differences in healthcare performance between countries if the health service is slow to adopt new technologies.

4. How has the NHS improved over the last twenty years?

To find out how the NHS compared with European peers over the last three decades, we compared the average age-standardised mortality amenable to healthcare rates of the Netherlands, France and Spain with the UK's. The rate of deaths that could have reasonably been expected to be averted has improved in the UK, relative to peers. The question then is: to what extent is this to do with big increases in spending?

Figure 4.1: UK health spending as a percentage of average spending in selected European countries compared to differences in mortality amenable to healthcare between the UK and selected European countries, 1981-2008



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

- Between 2000-01 and 2010-11, NHS expenditure will have increased by 70 per cent to £102 billion from £60 billion.²⁶ Despite this, since 2000 total UK NHS productivity decreased by an average of 0.2 per cent per year. Productivity in hospitals fell by around 1.4 per cent per year during the same period.²⁷
- Increases in staffing have been faster among administrative, rather than clinical, functions. Between 2000 and 2010 the number of managers in the NHS increased by 65.3 per cent. In the same period, the number of qualified nurse increased by 22.2 per cent.²⁸

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

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

The Thatcher government decided that the basic structure of the NHS, funded by general taxation and organised as a nationalised industry, could not be tampered with. Instead, it implemented significant incremental reforms.

The 1983 Griffith's report led to the bringing in of professional managers and efficiency measures such as the outsourcing of catering and cleaning were brought in.²⁹

In 1989 'Working for Patients' introduced competition for resources between hospitals; the internal market. This reduced the amount of intervention necessary from central government and introduced a rudimentary price system – although it certainly did not create the incentives of a true market.³⁰

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

²⁶ National Audit Office (2010), *Management of NHS hospital productivity*, page 6

²⁷ House of Commons Committee of Public Accounts (2010), *Management of NHS hospital productivity*
<http://www.publications.parliament.uk/pa/cm201011/cmselect/cmpublicacc/741/741.pdf>

²⁸ http://www.ic.nhs.uk/webfiles/publications/010_Workforce/nhsstaff0010/Census_Bulletin_March_2011_Final.pdf

²⁹ Seddon, N. "Quite Like Heaven? Options for the NHS in a consumer age", *Civitas*, November 2007 pp. 22-23

³⁰ *Ibid*, pp. 24-25

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

- The service has £1,000 of new funding to spend and two options for spending it, satisfying demand for Drug A or Drug B, with Drug A offering better value for money.
- That health service, if it is at all well managed, will choose to spend on Drug A.
- If another thousand pounds of funding is secured the remaining option will be to spend on Drug B. This will produce weaker results.

This abstract example illustrates how the returns from new increases in funding can be expected to diminish as the most pressing demands for new funding are satisfied. New funds will be spent on increasingly marginal investments and higher costs will swallow up ever more money.

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

5. Healthcare delivery in other European countries

There are clearly major institutional differences between how Britain and other European countries organise their healthcare systems. The relative dominance of government healthcare spending in the UK means that the NHS is particularly dependent upon Government. However, a more detailed examination of the institutional arrangements in a few of the peer countries will provide us with more lessons as to how healthcare can be more effectively delivered.

This rest of this chapter is largely taken from our 2008 report *Wasting Lives: A statistical analysis of NHS performance in a European context since 1981*. The different systems analysed in that report have not been significantly reformed since its publication. Mortality amenable to healthcare in Germany was analysed in our original paper, but as outlined in Chapter 2 data for Germany only exists up until 2006. However, it is included in this section along with a brief analysis of Switzerland's healthcare system, as both may provide useful lessons for reform in the UK.

The Netherlands

Dutch health care has been the object of some significant reform in recent years, and while this has not constituted a wholesale reinvention of the system – as with Spain's 1986 changes – it has seen the transformation of one of Europe's more complicated and unwieldy regimes into what is today a more streamlined and equitable system. The health care services are provided almost entirely by private suppliers, often non-profit establishments.³¹ These are a legacy of a historical voluntary healthcare system.

The Dutch government – Ministry of Health, Welfare and Sport – is responsible for the accessibility and quality of health care across the country's regions. It also defines policies to ensure the general health of the population. Before January 2006 it oversaw a complex tripartite SHI system but now it monitors the delivery of the obligatory national insurance scheme that is in place. This scheme guarantees each resident of the Netherlands access to basic care. Health insurance companies operating in the country are legally obliged to offer at least this basic package, and insurers cannot refuse coverage to any citizen, on any grounds. Insurers instead compete on price and quality, with some offering additional services bundled into the basic package.³² People can of course top up their basic package with supplemental benefits too, for an increased premium, but the basic package on its own costs on average \$1200 (£601) to \$1300 (£651).³³

³¹ European Observatory on Health Systems and Policies, 2005, *Health Systems in Transition: Netherlands*, Summary, p.2

³² Richard Grol, 2006, 'Quality Development in Health Care in the Netherlands', *The Commonwealth Fund*, p.2

³³ Ibid. p.2

Primary care is very well developed in the Netherlands, with roughly 9,000 GPs, each in receipt of at least two years of specialist training.³⁴ The Dutch GP is the gate-keeper into the health care system, which explains the low rates of referral. What distinguishes them from British GPs is the emphasis given to communication, which is an integral part of their special training; prescription rates are given in just 66 per cent of cases, compared to a European average of 75-95 per cent.³⁵

Primary care professionals mostly work in private practices, with a majority working alone or in small two- or three-person practices. However, due to political and patient pressure, large primary care centres are being established in which four or more GPs work, assisted by nurses and specialists. New payment procedures were introduced in 2006, which included capitation per patient and a fee per consultation.³⁶

France

In 2000 the WHO ranked the French health care system the best in the world, due in large part to 'generally high levels of health, the degree of freedom for physicians and patients, ease of access to health care, the near absence of waiting lists and genuine existence of universal coverage'.³⁷

The present system is genuinely Bismarkian, however it is far more concentrated and uniform than other Bismarkian systems, with a far greater role played by the state in the management of the system. It remains though, significantly more decentralised and privatised than the National Health Service, with considerable regional involvement. It is built on the idea of 'statutory health insurance': every French wage-earner contributes a proportion of their wage to one of the funds available. 95 per cent of the population are covered by one of the three main schemes; the general health insurance scheme (*'regime general'*) which covers employees in commerce and industry and their families; the agricultural scheme; and the national insurance fund for self-employed non-agricultural workers.³⁸ The remaining 5 per cent of the population enjoy the superior health insurance schemes tied to their specific professions. One cannot shop around between the statutory health insurance funds, as they are strictly occupation linked (giving weight to some claims that the system is less than equitable). However private health insurance funds are numerous and popular: about 85 per cent of the population

³⁴ Ibid. p.2

³⁵ European Observatory on Health Systems and Policies, 2005, *Health Systems in Transition: Netherlands*, Summary, p.5

³⁶ Richard Grol, 2006, 'Quality Development in Health Care in the Netherlands', *The Commonwealth Fund*, p. 3

³⁷ European Observatory on Health Systems and Policies (2004), 'Summary' of *Health Care Systems in Transition: France*, p.1

³⁸ Sandier, Paris, Polton (2004), *Health Care Systems in Transitions: France*; European Observatory on Health Systems and Policies, p.8

own such policies.³⁹ Indeed the public health insurance system covers only about 75 per cent of total health expenditure. Half of the outstanding amount is covered by patients' out-of-pocket payments and the other half is paid by private health insurance companies.⁴⁰

Access to care is unlimited: patients can see as many physicians, as often as they like. Patients do not need referrals to see specialists, and in general, there is no gate-keeping system of any kind. Since 2000, residency is enough to give you the right to be seen by a doctor, but unlike the UK, treatment, whether private or public, is not free at the point of delivery. On seeing a doctor or specialist (*specialiste*) you first pay the full bill (*tarif*) and are then reimbursed at a later date (about 10 days). Generally speaking, *Sécurité sociale* refunds 70 per cent of the cost of a visit to a *médecin traitant* (a GP or family doctor) and most *specialistes*. Prices once varied depending on the fund, but disparate reimbursement rates have now been replaced by uniform rates.

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

The French Ministry of Health houses a General Directorate of Health, which is responsible for broad health policy. This is aided by three, more specifically tasked Directorates: one for hospital and health care, responsible for the management of resources; one for social security, responsible for financial matters; and finally a general directorate for social policy, which is responsible for the specifically social aspects of health care (such as care for disabled, elderly or vulnerable people).⁴¹

The State and the National Health Insurance Funds are the main government bodies involved in the French healthcare system, although regional authorities also have a role. The regions are responsible for implementing national policies, regulating the numbers of doctors (as a cost containment measure) and their specialisations. Prices and budgets are determined through negotiations between professionals and the health insurance funds. Budgets are subject to the national ceiling for health insurance expenditure which (since 1996) is decided annually by the National Assembly. Total health care expenditure has remained stable at around 10 per cent of GDP since 1995. However the relative value of spending has actually decreased, as increasing amounts

³⁹ Medical News Today 'The French Healthcare System', June 2004, <http://www.medicalnewstoday.com/articles/9994.php>

⁴⁰ Ibid.

⁴¹ Sandier, Paris, Polton (2004), 'Health Care Systems in Transitions: France', European Observatory on Health Systems and Policies, p.20



are absorbed by pharmaceutical costs. The ONDAM (the annual health care budget) is divided between private practices, public hospitals, private for profit hospitals and social care. Public hospitals are paid in advance on a monthly basis by the health funds. For profit hospitals are paid a fixed rate covering all costs but doctors, who are paid on a fee-for-service basis. As fees are specified in the contract between doctor and hospital there is significant variation in fees.

Spain

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

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

It is the autonomy of Spain's regions that has determined the development of a significantly decentralised organisational structure for the country's NHS. Central government – the Ministry of Health and Consumer Affairs – has responsibility for the coordination of the system (not letting one region fall far behind another), defining the minimum benefits package guaranteed by the NHS, pharmaceutical policy and medical education. The 17 autonomous regions hold health planning powers as well as the capacity to organize their own health services.⁴² Health care policy is made principally by the regions.

Within the regions, health competencies are separated between health authorities and health zones. All regions have a health map which stipulates territorial sub-divisions – each health 'area' covers no less than 200,000 people, no more than 250,000, providing them with primary and specialist care. The zone is the smallest administrative unit, organised around a single primary care team. GPs are – as in the UK – the gate-keepers to the system, and like in the UK, dissatisfaction is aimed primarily at this point in the health care process. The numbers of patients who choose to avoid GP consultation and

⁴² European Observatory on Health Systems and Policies, 2004, *Health Care Systems in Transitions Summary: Spain*, p.2

referral by going straight to hospital emergency rooms is ever increasing.⁴³ As in the UK too, Spain has moved towards greater levels of hospital independence over the past decade, with the establishment of 'foundation' hospitals. However unlike the UK, on top of the pre-existing devolution of health care power to the regions, these foundation hospitals are genuine self-governing units, with less bureaucratic control and less emphasis on outcomes (targets).

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

Germany

Perhaps the most complicated to understand of all Europe's health care systems, the German is the original Bismarkian (insurance-based) model. It exhibits a high degree of decentralisation and privatisation, with 453 sickness funds in operation during 2001, down to 292 in 2004, mainly as the result of mergers. The system is further decentralised by the strong federalism of the country (the Länder play a major part in health care). The European Health Observatory describes how 'it is characterised by a predominance of mandatory statutory health insurance (SHI) with multiple sickness funds and private/public mix of providers'.⁴⁴ In 2003, roughly 88 per cent of the country was covered by comprehensive SHI (78 per cent mandatory and 10 per cent voluntary).⁴⁵ The remainder is covered by private funds or free government schemes – police, soldiers and civil servants.

Membership of SHI's is compulsory for workers whose income does not exceed a certain level – €40,000 in the West, €32,000 in the East.⁴⁶ Contributions to the sickness funds are based on wage income, and are shared between employer and employee. Average contributions in 2001 were around 6.5 per cent of pre-tax income; for those whose income is too low, only the employer pays.⁴⁷

Structurally, at the top level the important players are the Federal Assembly, the Federal Council and the Federal Ministry of Health and Social Security. These control the statutory insurance market, and set higher policy for healthcare. The Länder are

⁴³ European Observatory on Health Systems and Policies, 2004, *Health Care Systems in Transitions Summary: Spain*, p.4

⁴⁴ European Observatory on Health Systems and Policies, 2004, 'Summary' of *Health Care Systems in Transition*, p.2

⁴⁵ Ibid. p.2

⁴⁶ Scottish Parliament, 2001, *European Health Care Financing and Expenditure*, Information Centre, p.5

⁴⁷ Ibid. p5

then responsible for implementing those policies and managing the healthcare system on a day-to-day basis; capacity, capital investment, pay. Since 1996, every person has been able to choose which fund they wish to belong too – some offer limited services and cheaper rates, others more options (spa treatments for example) for a higher price. Everyone is entitled to change annually, and there is a lot of mobility between funds.

The system has the potential for serious inequity, both in terms of contributions (people who earn more are paying much more) and in terms of expenditure (healthy, young professionals are contributing a lot and taking out very little). To reduce that, the federal government imposes a complex formula on the sickness funds. As the Scottish Information Department explain it: 'All funds must provide or receive compensation for the differences in contributions and expenditures... The formula determines the relative need to pay or receive compensation.... This is intended to reduce the differences between funds' contribution rates'.⁴⁸

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

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

Switzerland

Of all the Bismarckian systems, Switzerland's is the least complex at the national level. Under the Federal Health Insurance Act, which underpins the entire system, health insurance is compulsory for all persons who are resident in the country – each person is required to obtain a basic health insurance package within three months of gaining residency.⁴⁹ The Swiss central government decides and legislates as to what the basic health package must include at a minimum, in terms of services and benefits.

⁴⁸ Scottish Parliament Information Centre 'European Health Care Financing and Expenditure', 2001, p.5

⁴⁹ OECD and WHO survey of Switzerland's health system, 2006;

www.oecd.org/document/47/0,2340,en_2649_201185_37562223_1_1_1_1,00.html

Only those insurance companies which accept the strictures of the Health Insurance Law, and are registered with the Federal Office of Social Insurance, may provide these compulsory health insurance schemes (CHIs). Insurance companies are not supposed to make a profit out of the CHIs. They also cannot set any conditions, be they age, sex or state of health, to the provision of coverage. If a person applies, the company must accept them.⁵⁰ Premiums do vary between funds (called 'Krankenkassen', 'Caisses-Maladie', 'Casse Malati' depending on whether one speaks German, French or Italian) due to differences in place of residence, the degree of supplementary benefit coverage chosen and the excess level chosen. However the cost of the premium must be identical for all insured persons of the same age group within that company's scheme, regardless of sex or state of health.⁵¹

The insured person tends to pay part of the cost of any treatment themselves, either because they have chosen to have an excess in their policy – gaining a lower premium price in return – or because they face a 10 per cent charge on all the costs over and above the excess. Around 40 per cent of the population chose to supplement their CHI with complementary coverage, e.g. dental care.⁵²

The insured person can choose from a combination of public, subsidized private and totally private providers of care (in their particular region), in the knowledge that the insurance company will pay up to the level agreed to in their policy.

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

The Swiss healthcare system is expensive. However, it is also widely approved of by its users and ranked highly in international comparisons.⁵³ This is perhaps because, as in most Bismarckian systems, patients are the people paying, and as such, they expect to see any GP, whenever they wish, and to visit a specialist without referral.

⁵⁰ European Observatory on Health Care Systems, 2000, *Health Care Systems in Transition: Switzerland*, pp. 9-17

⁵¹ OECD and WHO survey of Switzerland's health system, 2006;
www.oecd.org/document/47/0,2340,en_2649_201185_37562223_1_1_1_1.00.html

⁵² Civitas, 2002, 'The Swiss Health Care System', p.4

⁵³ OECD and WHO survey of Switzerland's health system, 2006;
www.oecd.org/document/47/0,2340,en_2649_201185_37562223_1_1_1_1.00.html

6. Why is the UK getting it wrong?

The NHS is a large and complex organisation. Reform will necessarily be a big task. The proposals set out by the Coalition Government have had to be drastically reined in, and key proposals have been changed or watered down. There are three big problems with the NHS as it currently exists and each is reviewed in turn.

Centralisation

The NHS has a large number of local bodies: the Primary Care Trusts, Acute Trusts and regional Strategic Health Authorities. The original White Paper on NHS reform proposed abolishing Strategic Health Authorities and Primary Care Trusts, and all hospitals were to become Foundation Trusts – where they notionally have more freedom from central control – to grant them more autonomy. Local GPs were to take over commissioning.

These reforms are now not so straightforward. GP Consortia – groups of local GPs that would work together on commissioning – will now be called Clinical Commissioning Groups and involve other professional groups. The deadline for when GP Consortia were originally intended to take over from Primary Care Trusts – 2013 – has also been relaxed.

Whatever the final design of local structures, they will be overseen by a central NHS Commissioning Board.

Perhaps the single biggest obstacle to genuinely decentralising healthcare is centralised pay bargaining. Staff pay is the largest item of spending in most public sector organisations and the NHS is no different.⁵⁴ Pay rates are determined nationally by the NHS Pay Review Body,⁵⁵ and apply across the country.

John Appleby, Chief Economist at the King's Fund, highlighted how big an issue pay is when he appeared before the Health Select Committee. He said that there has been a 90 per cent real terms increase in the NHS budget since 1997. But crucially, he also said that 80 per cent to 90 per cent of that had been 'siphoned off for pay rises for some particular people'. He went on to say:⁵⁶

"GPs and consultants in this country are some of the best-paid doctors in the world...I think the NHS itself would admit that they have not got

⁵⁴ King's Fund *"An Independent Audit of the NHS under Labour (1997-2005)"*, March 2005, Figure 2.4: Breakdown of NHS Expenditure, 2003-04

⁵⁵ Office of Manpower Economics *"NHS Pay Review Body"*, <http://www.ome.uk.com/review.cfm?body=6>

⁵⁶ David Williams, NHS pay clashes likely in two years, MPs told, Public Finance, November 2010 <http://www.publicfinance.co.uk/news/2010/11/nhs-pay-clashes-likely-in-two-years-mps-told/>



as much out of these contracts with GPs and consultants – and possibly the workforce in general – in terms of productivity improvements that they should have."

If local NHS Trusts cannot have any autonomy at all at setting pay rates then they have no real control over their budgets. If they have no control over their budgets then they have no real control of providing the best healthcare possible for local patients.

The original White Paper had this to say on centralised pay bargaining:⁵⁷

"Pay decisions should be led by healthcare employers rather than imposed by the Government. In future, all individual employers will have the right, as foundation trusts have now, to determine pay for their own staff. However, it is likely that many providers will want to continue to use national contracts as a basis for their local terms and conditions."

This is vague, and implies that centralised pay bargaining is likely to continue as it is across most of the NHS. There is a notional control of the one crucial budget line that would guarantee more decentralisation. However this is likely to be neutered in the face of significant pressure from public sector unions.

Further, a London School of Economics study in 2008 found that centralised pay bargaining directly contributes to poor healthcare performance, and higher death rates from certain conditions in certain areas. The abstract explains:⁵⁸

"We present evidence that stronger local labor markets significantly worsen hospital outcomes in terms of quality and productivity. A 10% increase in the outside wage is associated with a 4% to 8% increase in AMI death rates. We find that an important part of this effect operates through hospitals in high outside wage areas having to rely more on temporary "agency staff" as they are unable to increase (regulated) wages in order to attract permanent employees. By contrast, we find no systematic role for an effect of outside wages of performance when we run placebo experiments in 42 other service sectors (including nursing homes) where pay is unregulated."

⁵⁷ Department of Health, Equity and excellence: Liberating the NHS, 2010
http://www.dh.gov.uk/prod_consum_dh/groups/dh.digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117352.pdf

⁵⁸ Hall, Propper and Van Reenen (2008), Can Pay Regulation Kill? Panel Data Evidence on the Effect of Labor Markets on Hospital Performance, Centre for Economic Performance at the London School of Economics
<http://cep.lse.ac.uk/pubs/download/dp0843.pdf>

Local healthcare providers must be able to set pay themselves, to manage their budgets more efficiently and in turn provide better healthcare.

Here it is worth repeating our 2008 study's summary of other how other European countries decentralise healthcare:⁵⁹

- Research into the Swiss healthcare system suggests that its success is due, in large part, to decentralisation.⁶⁰ It effectively runs 26 healthcare systems within a common framework of regulations which makes the systems comparable and, therefore, allows for cantons whose systems are struggling to learn from the more successful. Some responsibilities are even devolved further to the local authorities.
- The German system decentralises to a multitude of insurance funds who buy services from a range of providers. The Länder have significant leeway to vary health policy.
- The Spanish system, while quite similar to the NHS in many other ways, is highly decentralised with most healthcare policy set in the regions.
- The French system decentralises healthcare to a number of insurance funds which are then able to buy freely from independent and state-run providers. This provides significant, though limited thanks to a large measure of central government intervention, decentralisation.

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

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

Political Management

Politicians are responsible for the technical details of healthcare delivery that they are unlikely to fully grasp. They are often poorly qualified for this role and even if they do have expertise Secretaries of State do not spend long in their roles. There have been fourteen Secretaries of State responsible for health during the period we have analysed, an average tenure of just over two years.

⁵⁹ Matthew Sinclair (2008) *Wasting Lives: A statistical analysis of NHS performance in a European context since 1981*. Available at www.taxpayersalliance.com

⁶⁰ Civitas *"The Swiss Healthcare System"*, 2002

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

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

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

Monopolistic

The NHS has no fear of bankruptcy and can rely on a significant amount of taxpayers' money every year. Monopolies have no competition and have no risk of losing customers as they have no choice but to use the monopoly provider. Customers have no choice and no redress. Monopolies naturally dull the need to innovate, improve and reduce costs. While record levels of money were spent on the NHS over the last decade productivity fell. The Office for National Statistics found that despite an average annual increase of input (money) of 4.6 per cent productivity fell 0.2 per cent on average every year.⁶¹

When the NHS does encourage competition healthcare results improve. A recent study by the Centre for Economic Performance at the London School of Economics found that when fixed-price competition was introduced under the last Government death rates dropped by 7 per cent, and fell quicker in more competitive markets. The research found that there were 300 less deaths from heart attacks a year after the reforms were introduced in 2006. They added the rates would be significantly higher if other ailments were taken into consideration.⁶²

⁶¹ Public Service Output, Inputs and Productivity: Healthcare (March 2011), Office for National Statistics

⁶² Cooper et (2011) *Does hospital competition save lives? Evidence from the English NHS patient choice reforms*, The Economic Journal, 121 (August)



This evidence – and that presented in this paper – means that the most important priority for reform of British healthcare is to increase the amount of competition within the NHS. Insurance based models are used across Europe, for example in France and Germany where insurance-based systems providers compete to offer quality service at low cost to insurers. The Dutch and Swiss systems detach their insurance models from employment.

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

The simple truth is that these systems out-perform ours. Unless we are willing to properly analyse why this is and what works elsewhere, our monopolistic system will continue to underperform and deny many patients adequate healthcare.

7. Conclusions

This study's results suggest that significant increases in NHS funding have not provided better mortality amenable to healthcare rates relative to our European peers; the improvement in mortality amenable to healthcare remains constant.

- In 2008, the latest year for which data is available, **11,749 more deaths occurred in the UK** than would have if the UK had matched the average mortality amenable to healthcare rates of European peers.
- This is more than **four times the total number of deaths from road accidents** in 2008. It is equivalent to over **2,000 more deaths than those related to alcohol** in 2008.
- The UK has caught up with its European peers at a nearly constant rate between 1981 and 2008. In that time there has been a **huge increase in spending on healthcare** since 1999. This suggests that **money alone has no discernable effect on mortality rates**.
- In the last two years studied (2007-2008) the UK's amenable mortality convergence relative to European peers was slower than the trend over the entire period. This suggests that **relative improvements in mortality amenable to healthcare could be slowing**.

Both incremental reforms and huge increases in spending have been demonstrated to be ineffective. The returns from additional spending are likely to diminish rapidly and incremental reforms are strictly limited if the fundamental structure of the NHS cannot be altered.

In its final design, the Health and Social Care Bill must properly and robustly address the three key problems of decentralisation, professional management and competition. Failing to do so will mean it is little more than another piecemeal reform that will prolong poor performance relative to other European countries. Sticking plasters and more money will not fix the system.

Appendix A: Amenable mortality data 1981-2008

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

1981	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	27,372,160	247.9	
Female	28,943,840	172.5	209.2
Netherlands			
Male	7,065,000	160.4	
Female	7,182,200	113.8	136.9
France			
Male	26,435,400	134.3	
Female	27,530,500	91.4	112.4
Spain			
Male	18,526,200	158.6	
Female	19,224,600	109.3	133.5
	Euro-average (excluding UK)		127.6
	<i>Difference between UK and Euro-average</i>		81.6
	Deaths per year in UK implied by difference from Euro-average		45,936

1982	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	27,389,435	242.9	
Female	28,926,405	170.7	205.8
Netherlands			
Male	7,092,100	156.9	
Female	7,220,600	110.6	133.5
France			
Male	26,596,200	127.6	
Female	27,884,200	88.5	107.6
Spain			
Male	18,634,200	145.5	
Female	19,327,100	101.7	123.2
	Euro-average (excluding UK)		121.4
	<i>Difference between UK and Euro-average</i>		84.4
	Deaths per year in UK implied by difference from Euro-average		47,520

1983	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	27,413,975	237.6	
Female	28,938,345	167.3	201.5
Netherlands			
Male	7,113,400	152.3	
Female	7,253,700	108.7	130.3
France			
Male	26,706,500	125.6	
Female	28,021,800	87.2	105.9
Spain			
Male	18,741,000	144.0	
Female	19,431,100	102.1	122.7
	Euro-average (excluding UK)		119.6
	<i>Difference between UK and Euro-average</i>		81.8
	Deaths per year in UK implied by difference from Euro-average		46,123

1984	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	27,480,123	222.0	
Female	28,979,657	157.1	188.7
Netherlands			
Male	7,136,900	150.8	
Female	7,287,300	106.6	128.5
France			
Male	26,801,600	120.8	
Female	28,145,100	83.3	101.6
Spain			
Male	18,827,700	140.2	
Female	19,514,100	97.8	118.6
	Euro-average (excluding UK)		116.2
	<i>Difference between UK and Euro-average</i>		72.5
	Deaths per year in UK implied by difference from Euro-average		40,915

1985	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	27,564,414	217.8	
Female	29,052,276	157.1	186.7
Netherlands			
Male	7,167,100	148.6	
Female	7,324,600	107.2	127.7
France			
Male	26,900,200	120.9	
Female	28,270,200	81.5	100.7
Spain			
Male	18,911,300	135.2	
Female	19,593,500	94.1	114.3
	Euro-average (excluding UK)		114.2
	<i>Difference between UK and Euro-average</i>		72.4
	Deaths per year in UK implied by difference from Euro-average		41,015

1986	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	27,634,211	200.8	
Female	29,126,449	152.5	176.0
Netherlands			
Male	7,204,400	144.9	
Female	7,367,800	104.1	124.3
France			
Male	27,002,200	119.2	
Female	28,392,000	80.8	99.5
Spain			
Male	18,968,200	129.6	
Female	19,635,800	92.0	110.4
	Euro-average (excluding UK)		111.4
	<i>Difference between UK and Euro-average</i>		64.6
	Deaths per year in UK implied by difference from Euro-average		36,648

1987	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	27,721,103	202.3	
Female	29,202,817	148.2	174.5
Netherlands			
Male	7,249,000	134.7	
Female	7,416,100	99.1	116.7
France			
Male	27,107,600	111.7	
Female	28,522,600	75.6	93.2
Spain			
Male	18,998,200	125.6	
Female	19,718,200	90.5	107.7
	Euro-average (excluding UK)		105.9
	<i>Difference between UK and Euro-average</i>		68.6
	Deaths per year in UK implied by difference from Euro-average		39,074

1988	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	27,794,119	196.7	
Female	29,262,121	144.9	170.2
Netherlands			
Male	7,295,100	130.0	
Female	7,465,000	95.1	112.3
France			
Male	27,225,800	106.7	
Female	28,657,900	74.9	90.4
Spain			
Male	19,044,700	122.2	
Female	19,764,300	88.9	105.3
	Euro-average (excluding UK)		102.7
	<i>Difference between UK and Euro-average</i>		67.5
	Deaths per year in UK implied by difference from Euro-average		38,514

1989	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	27,888,165	189.9	
Female	29,342,925	142.7	165.7
Netherlands			
Male	7,337,400	127.6	
Female	7,511,400	95.3	111.2
France			
Male	27,363,800	102.5	
Female	28,796,300	73.0	87.4
Spain			
Male	19,085,000	117.2	
Female	19,803,200	86.2	101.4
	Euro-average (excluding UK)		100.0
	<i>Difference between UK and Euro-average</i>		65.7
	Deaths per year in UK implied by difference from Euro-average		37,606

1990	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	27,987,365	182.3	
Female	29,408,305	136.0	158.6
Netherlands			
Male	7,389,000	122.3	
Female	7,562,500	94.8	108.4
France			
Male	27,623,300	97.7	
Female	29,111,800	70.5	83.7
Spain			
Male	19,122,100	116.1	
Female	19,837,100	84.3	99.9
	Euro-average (excluding UK)		97.3
	<i>Difference between UK and Euro-average</i>		61.2
	Deaths per year in UK implied by difference from Euro-average		35,137

1991	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	28,949,622	172.4	
Female	29,567,315	132.1	152.0
Netherlands			
Male	7,449,800	118.0	
Female	7,619,800	93.7	105.7
France			
Male	27,783,500	96.4	
Female	29,271,900	69.9	82.8
Spain			
Male	19,156,200	113.6	
Female	19,868,700	81.9	97.5
	Euro-average (excluding UK)		95.3
	<i>Difference between UK and Euro-average</i>		56.7
	Deaths per year in UK implied by difference from Euro-average		33,192

1992	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	28,337,172	168.5	
Female	29,649,848	126.9	147.2
Netherlands			
Male	7,507,800	113.0	
Female	7,676,300	92.6	102.7
France			
Male	27,941,900	91.7	
Female	29,431,700	67.3	79.2
Spain			
Male	19,099,300	110.6	
Female	19,906,400	79.2	94.6
	Euro-average (excluding UK)		92.2
	<i>Difference between UK and Euro-average</i>		55.1
	Deaths per year in UK implied by difference from Euro-average		31,928

1993	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	28,447,319	173.4	
Female	29,722,541	128.0	150.2
Netherlands			
Male	7,560,600	117.3	
Female	7,729,800	93.7	105.4
France			
Male	28,079,000	91.7	
Female	29,575,400	67.1	79.1
Spain			
Male	19,137,800	107.5	
Female	19,948,300	78.8	92.9
	Euro-average (excluding UK)		92.5
	<i>Difference between UK and Euro-average</i>		57.8
	Deaths per year in UK implied by difference from Euro-average		33,614

1994	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	28,562,442	160.4	
Female	29,807,568	121.0	140.3
Netherlands			
Male	7,606,700	111.2	
Female	7,776,100	90.4	100.7
France			
Male	28,195,200	87.5	
Female	29,704,300	65.9	76.4
Spain			
Male	19,165,400	103.6	
Female	19,984,100	74.7	88.8
	Euro-average (excluding UK)		88.6
	<i>Difference between UK and Euro-average</i>		51.6
	Deaths per year in UK implied by difference from Euro-average		30,144

1995	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	28,695,253	160.1	
Female	29,883,537	120.0	139.7
Netherlands			
Male	7,644,900	109.5	
Female	7,814,100	89.9	99.6
France			
Male	28,308,700	87.1	
Female	29,830,400	64.6	75.5
Spain			
Male	19,190,500	102.2	
Female	20,019,200	73.0	87.3
	Euro-average (excluding UK)		87.5
	<i>Difference between UK and Euro-average</i>		52.2
	Deaths per year in UK implied by difference from Euro-average		30,555

1996	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	28,820,820	155.2	
Female	29,950,670	114.6	134.5
Netherlands			
Male	7,679,500	109.0	
Female	7,851,000	88.9	98.8
France			
Male	28,422,900	85.8	
Female	29,951,900	63.2	74.2
Spain			
Male	19,215,000	100.5	
Female	20,055,300	69.6	84.7
	Euro-average (excluding UK)		85.9
	<i>Difference between UK and Euro-average</i>		48.6
	Deaths per year in UK implied by difference from Euro-average		28,562

1997	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	28,949,622	147.2	
Female	30,025,118	111.0	128.7
Netherlands			
Male	7,718,400	103.4	
Female	7,892,200	84.8	94.0
France			
Male	28,538,200	83.3	
Female	30,071,700	62.9	72.8
Spain			
Male	19,235,300	96.3	
Female	19,235,300	68.4	82.3
	Euro-average (excluding UK)		83.1
	<i>Difference between UK and Euro-average</i>		45.7
	Deaths per year in UK implied by difference from Euro-average		26,933

1998	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	29,082,991	142.8	
Female	30,110,579	107.5	124.9
Netherlands			
Male	7,766,700	101.8	
Female	7,940,500	84.5	93.1
France			
Male	28,657,800	83.6	
Female	30,194,800	64.0	73.6
Spain			
Male	19,253,000	95.7	
Female	20,118,200	66.7	80.9
	Euro-average (excluding UK)		82.5
	<i>Difference between UK and Euro-average</i>		42.4
	Deaths per year in UK implied by difference from Euro-average		25,069

1999	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	29,249,735	139.1	
Female	30,203,915	104.8	121.6
Netherlands			
Male	7,819,800	96.5	
Female	7,992,300	84.6	90.5
France			
Male	28,469,781	82.8	
Female	30,152,897	63.2	72.7
Spain			
Male	19,384,064	95.7	
Female	20,242,089	64.9	80.0
	Euro-average (excluding UK)		81.1
	<i>Difference between UK and Euro-average</i>		40.6
	Deaths per year in UK implied by difference from Euro-average		24,130

2001	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	28,809,603	118.3	
Female	30,241,244	91.3	104.5
Netherlands			
Male	7,940,911	89.7	
Female	8,105,269	78.0	83.8
France			
Male	28,755,212	73.2	
Female	30,437,385	57.3	65.1
Spain			
Male	19,901,194	86.4	
Female	20,713,159	61.5	73.7
	Euro-average (excluding UK)		74.2
	<i>Difference between UK and Euro-average</i>		30.3
	Deaths per year in UK implied by difference from Euro-average		17,898

2002	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	28,911,254	115.1	
Female	30,317,731	87.6	101.0
Netherlands			
Male	7,993,719	87.8	
Female	8,155,209	77.2	82.5
France			
Male	28,989,574	71.6	
Female	30,688,679	55.9	63.5
Spain			
Male	20,266,005	85.2	
Female	21,048,014	59.0	71.8
	Euro-average (excluding UK)		72.6
	<i>Difference between UK and Euro-average</i>		28.4
	Deaths per year in UK implied by difference from Euro-average		16,846

2003	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	29,108,024	110.7	
Female	30,445,759	85.4	97.7
Netherlands			
Male	8,030,692	84.6	
Female	8,194,609	72.8	78.6
France			
Male	21,378,383	70.0	
Female	30,929,006	55.3	61.4
Spain			
Male	20,626,192	84.4	
Female	21,378,383	58.1	71.0
	Euro-average (excluding UK)		70.3
	<i>Difference between UK and Euro-average</i>		27.4
	Deaths per year in UK implied by difference from Euro-average		16,332

2004	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	29,270,975	103.2	
Female	30,563,339	80.3	91.5
Netherlands			
Male	8,055,946	77.9	
Female	8,225,832	68.9	73.4
France			
Male	29,466,782	64.0	
Female	31,176,524	52.9	58.3
Spain			
Male	20,987,670	79.1	
Female	21,704,081	54.8	66.7
	Euro-average (excluding UK)		66.1
	<i>Difference between UK and Euro-average</i>		25.4
	Deaths per year in UK implied by difference from Euro-average		15,196

2005	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	29,497,036	98.5	
Female	30,741,347	77.8	88.0
Netherlands			
Male	8,071,765	73.7	
Female	8,248,245	68.6	71.1
France			
Male	29,638,708	64.1	
Female	31,357,203	51.6	57.7
Spain			
Male	21,367,297	79.4	
Female	22,030,893	53.2	66.1
	Euro-average (excluding UK)		65.0
	<i>Difference between UK and Euro-average</i>		23.0
	Deaths per year in UK implied by difference from Euro-average		13,857

2006	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	29,693,967	93.2	
Female	30,893,382	74.4	83.6
Netherlands			
Male	8,083,032	70.3	
Female	8,263,210	64.2	67.2
France			
Male	29,816,076	60.8	
Female	31,781,576	49.8	55.1
Spain			
Male	21,725,232	75.0	
Female	22,343,012	50.5	62.6
	Euro-average (excluding UK)		61.6
	<i>Difference between UK and Euro-average</i>		21.9
	Deaths per year in UK implied by difference from Euro-average		13,295

2007	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	29,916,107	89.1	
Female	31,059,248	71.9	80.3
Netherlands			
Male	8,100,302	65.3	
Female	8,281,408	62.7	64.0
France			
Male	30,000,450	59.8	
Female	31,962,834	48.0	53.7
Spain			
Male	22,155,286	73.8	
Female	22,718,281	50.8	62.1
	Euro-average (excluding UK)		59.9
	<i>Difference between UK and Euro-average</i>		20.4
	Deaths per year in UK implied by difference from Euro-average		12,444

2008	Population	Amenable mortality rate	Combined amenable mortality rate
UK			
Male	30,151,337	85.8	
Female	31,231,820	69.6	77.6
Netherlands			
Male	8,134,243	62.6	
Female	8,311,366	61.8	62.2
France			
Male	30,000,450	57.9	
Female	31,962,834	49.0	53.3
Spain			
Male	22,512,354	70.8	
Female	23,081,031	48.9	59.7
	Euro-average (excluding UK)		58.4
	<i>Difference between UK and Euro-average</i>		19.1
	Deaths per year in UK implied by difference from Euro-average		11,749

Appendix B: Spending data

Year	Spending per person per capita, \$ Purchasing power parity					UK as a percentage of EU-peer average
	Netherlands	France	Spain	EU-peer average	United Kingdom	
1981	799	-	404	601	529	88%
1982	866	-	442	654	560	86%
1983	899	-	473	686	625	91%
1984	921	-	481	701	657	94%
1985	960	1,031	494	828	689	83%
1986	1,021	-	515	768	732	95%
1987	1,085	-	567	826	798	97%
1988	1,161	-	682	922	854	93%
1989	1,299	-	763	1,031	910	88%
1990	1,412	1,445	870	1,242	960	77%
1991	1,514	1,553	950	1,339	1,049	78%
1992	1,602	1,650	1,028	1,426	1,153	81%
1993	1,669	1,750	1,083	1,501	1,206	80%
1994	1,714	1,810	1,111	1,545	1,295	84%
1995	1,795	2,100	1,190	1,695	1,346	79%
1996	1,859	2,161	1,247	1,755	1,433	82%
1997	1,915	2,228	1,298	1,814	1,481	82%
1998	2,054	2,313	1,383	1,916	1,551	81%
1999	2,178	2,404	1,450	2,011	1,671	83%
2000	2,340	2,553	1,537	2,143	1,828	85%
2001	2,555	2,726	1,635	2,305	1,996	87%
2002	2,833	2,931	1,745	2,503	2,184	87%
2003	3,097	2,991	2,023	2,704	2,318	86%
2004	3,309	3,122	2,131	2,854	2,540	89%
2005	3,450	3,306	2,269	3,008	2,735	91%
2006	3,613	3,493	2,536	3,214	3,006	94%
2007	3,944	3,679	2,735	3,452	3,051	88%
2008	4,241	3,809	2,971	3,674	3,281	89%

Source: OECD Health Expenditure and Financing Data:
http://stats.oecd.org/Index.aspx?DatasetCode=HEALTH_STAT