COHSE THE HEALTH CARE UNION

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The Rt. Hon. Margaret Thatcher MP,
Prime Minister
10 Downing Street
London W1

Dear Prime Minister

We welcome your decision to review the financing of the National Health Service, and I take this opportunity to submit our proposals for improving and enhancing the service provided by the NHS.

We look forward to the results of your review and trust that the proposals will build upon the existing structure, and use the dedication and skills of all NHS workers to the full.

Yours sincerely

Hector MacKenzie
General Secretary

enc.

CONFEDERATION OF HEALTH SERVICE EMPLOYEES

COHSE'S EVIDENCE TO THE GOVERNMENT REVIEW ON RESOURCING THE NATIONAL HEALTH SERVICE

Glen House,
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General Secretary:
H. U. MACKENZIE.

FUTURE FUNDING FOR THE NHS

PREAMBLE

1. The Confederation of Health Service Employees is Britain's major Health Service Union. It represents 220,000 Health Service staff. COHSE's members work in all jobs and occupations within the NHS, local authority social services, and voluntary and private sector health care provision.

2. At the same time as Health Authorities are facing acute shortages of funds and there are a barrage of complaints about inadequate hospital services, the Government claims it is spending more than ever before on Health.

3. How is this possible? It is true that between 1978/79 and 1986/87 Government funding to the NHS increased 25.7% above the general level of inflation. However, set against NHS inflation (taking into account the actual rise in prices faced by the NHS) this meant a real increase in resources of 10.4% over eight years.

4. At the same time the number of people waiting for treatment by the NHS has risen for the last three years, and now stands at 799,760. Of that number 207,938 have waited over a year. Health Authorities are in such a bad financial position that by the end of last year 3,100 acute beds had been closed purely because of lack of funds (BMA Consultants Survey).

5. How is it that the 10.4% real increase in resources has not brought down waiting lists and left health authorities in a healthy financial position? There are two reasons for this. First, the major part of the increase in resources for the NHS occurred between 1979 and 1981, mainly due to the Clegg awards. In the six financial years from 1980/81 to 1986/87 the cumulative growth was only 3.2%. Indeed, in the most recent four financial years (1982/83 to 1986/76) the cumulative growth was a mere 0.4%. To begin with, waiting lists fell from the all time high of 752,000 in 1979, but they have now risen for the last three years in a row.

6. Secondly, as the Minister of State at the DHSS confirmed to the Social Services Committee (on Public Expenditure on the Social Services) in 1986 "Health Authority Services need at present to grow by about 2% a year in order to meet the pressures they face. 1% is needed to keep pace with the increasing number of very elderly people (although this pressure is now at a peak and will decline into the 1990s); medical advance takes an additional 0.5%, and a further 0.5% is needed to make progress towards meeting the Government's policy objectives

for example to improve renal services and develop community care)".

7. By applying the 2% growth target to the period 1980/81 to 1987/88 the Social Services Committee reported that even after taking account of cash releasing cost improvements, the cumulative underfunding of the Hospital and Community Health Services (HCHS) amounted to £1.9 billion at 1987/88 prices. Health Authorities estimate that for the financial year 1988/89 the Government have underfunded them by £235 million.

8. It is clear that despite increases in money terms the NHS is badly underfunded and the situation is getting worse. The Government have in effect conceded this point by releasing a further £101 million for the last financial year to try to cut waiting lists.

INTERNATIONAL COMPARISONS

9. The real scale of the problem can be seen by comparing UK spending on health with other countries. The UK spends 5.9% of Gross Domestic Product (GDP) on health. The US spends 10.7% of GDP, Sweden 9.4%, France 9.1% and West Germany 8.1%. The only country in the EEC that spends less than the UK is Greece, who are currently setting up a national health service and increasing their spending on health. In 1982 France spent $996 per person on health care, the Netherlands spent $851, Germany spent $883, but the UK only spent $539. The UK is also increasing spending at a much slower rate than the rest of the EEC. From 1960 to 1983 the UK increased its share of GDP spent on health by 2.3%, compared to 5.0% in France, 3.4% in West Germany and 4.9% in the Netherlands.

10. The result of this underfunding is that the UK scores poorly on international rankings for everything from tooth decay to heart disease. In fact, mortality rates, an often-used measure of a nation's health, are higher only in Portugal, Greece and Italy of all EEC countries (source: Social Trends). Indeed, standard mortality ratios of death by all causes (source: OPCS), which has been falling for years, actually rose for both men and women in the UK in 1985 (the most recent year for which data is available).

11. It is a credit to the NHS, and the people who work for it, that given the persistent underfunding over many years, such that spending on health in Britain as a share of GDP is now 50% less than the European average, the health of people in Britain is no worse than it is.

COHSE'S PROPOSALS

12. It is now widely accepted that the NHS needs more funds in order to cope properly with the demands put on it. However COHSE do not believe that the problems of the NHS will be solved simply by throwing money at it. What is needed is a carefully drawn up strategy to provide a stable planning environment for Health Authorities to the end of the century.

13. We propose that:

i. There should be an immediate cash injection of £2.5 billion into the NHS. £2 billion should be used to make up for the shortfall in funding since 1979, and be devoted to improving patient-care. £500 million should be used as a matter of urgency to improve the conditions of the thousands of dedicated workers in the NHS, such as extending paid maternity leave, providing child care facilities on a 24 hour basis and enabling people to choose more flexible work patterns.

ii. Funding to the NHS should increase in line with the growth in Gross Domestic Product (GDP) in real terms (taking into account higher NHS inflation for goods and services).

iii. In addition to this, funding should be increased by 2.5% per annum so that UK spending on health as a share of GDP will rise to the current EEC average (9%) by the year 2000.

iv. All pay awards to NHS staff should be fully funded by Central Government.

v. The NHS should continue to be funded via general taxation.

vi. Health care should be provided free at the point of delivery.

14. If the economy is booming as the Government claims, and certainly tax revenues are pouring into the treasury, then there is extra money that can be devoted to the NHS. All evidence suggests that there is majority support for this throughout the population.

15. Why move towards the EEC average spending on health? Certainly the UK is above average in terms of wealth, and there is no reason to believe that Britons have different preferences over health from their counterparts in Europe. Therefore to bring healthcare in the UK just up to the European average is a modest demand.

16. Why all pay awards fully funded? Any award which is not fully funded means arbitrary cuts in patient care forced on health authorities, which makes it impossible to plan a proper service.

17. Why funded through general taxation? As with other services funded by the state, such as defence, the health service should be funded through a progressive tax system so that those in a position to pay more contribute to the general health of society. Proposals to set up lotteries or give tax relief to those opting out undermine the NHS. No-one proposes funding Trident through a lottery and pacifists have never been given tax relief on taxes going to arms expenditure.

18. Why free at the point of delivery? First, we hold to the principle that in an advanced industrialised country, everyone, regardless of their ability to pay, should have equal access to the very best healthcare that can be provided. The only way to ensure this is by providing healthcare free at the point of delivery. Indeed many countries have grafted a public health service on to their inadequate (but expensive) insurance-based systems. Some countries, notably Italy, Greece and Portugal are moving towards a national health service with equal access, free at the point of delivery.

19. Secondly, it is much more cost-effective than a system where every patient has to be individually billed for treatment. A recent OECD study showed that far less of the NHS annual budget is used for administration costs (less than 5%) compared to insurance-based systems such as in the USA (more than 20%). A steady stream of right-wing US economists have come to examine the NHS to discover the flaw in tax-based public health systems, to which they are ideologically opposed. These would-be critics have left after studying the NHS, singing its praises.

20. Why should the NHS be funded and run on a national basis? First, as a bulk buyer of drugs and medical equipment the NHS has been able to keep much better control of medical costs than in many other countries. Secondly, through central planning the NHS is able to direct funds into priority areas such as services for mentally ill people, people with learning difficulties and elderly people. Thirdly, because of being a national service the NHS is in a position to even out regional differences through the RAWP and SHARE procedures.

ALTERNATIVE SYSTEMS

21. Some people, because of their ideological position, have tried to use the current crisis in the NHS to put forward a host of alternative ways of financing and delivering healthcare in this country. An idea that is currently fashionable is that with a system that delivers free healthcare, demand for that care is infinite and therefore the Government can never hope to fund it adequately and private health care should be expanded. COHSE do believe that the National Health Service is having to deal with the results of disastrous policies in other areas such as unemployment, poverty and homelessness. But demand for healthcare free at the point of delivery is not infinite. Health is fundamentally different from services such as sports centres or under fives' nurseries. To claim that demand is infinite is to suggest people will deliberately injure themselves in order to take advantage of free health care. It is true that people will feel more able to seek medical attention if it is free at the point of delivery. This is the purpose of primary health care, since it means that in many cases illness will be detected early and expensive treatment can be avoided.

22. Most of the proposed changes to the structure of the NHS are based on the view that it is desirable to separate provision of care from the financing of it. COHSE would dispute this. Once such an artificial separation is made, money is linked to treatment rather than treatment to medical need. We believe that the result would inevitably be higher administrative costs and more unmet need. This would lead the NHS to be less effective and efficient. Equality of access to treatment would also be compromised.

HMOs/MHUs

23. The proposal to introduce American style HMOs into the NHS is likely to lead to less effective health care at higher cost. In an American context where health care costs are spiraling out of control because of the inefficiencies of private markets, HMOs make some sense. In a British context where costs are controlled and administrative costs are less than 5% they have little or no relevance.

24. Four main types of HMOs have emerged in America:

i) **Public Sector HMOs** - These are like mini NHSs. They pay doctors a salary, own their own hospitals and allocate funds centrally.

ii) **Capitated HMOs** - They pay doctors a capitation fee of $X per patient in return for which doctors undertake to treat them for a specified period. This introduces strong incentives for doctors not to treat bad risks and suffers from many of the problems that an insurance based system would encounter. This system tends to produce over-treatment of well people and under-treatment of ill people.

iii) **Independent Practice Association HMOs** - They pay doctors a fee for service. This creates the incentives to overtreat patients which are such a widespread and inefficient feature of the American system. Administration costs are also high because HMOs that pay a fee for service have to monitor the behaviour of their doctors if they are to have any chance of keeping costs down. Only the public sector HMO could be transplanted into the British system in any form.

iv) **Social HMOs** - Much has been made of the ability of the HMO system to care for the poor and the elderly. These claims just do not stand up to close scrutiny.

25. In the USA currently only 3% of Medicare beneficiaries are enrolled in HMOs and even this low figure is declining. This is because it is not in the interests of HMOs to enroll people who are likely to have above average health care needs. HMOs who enrolled large numbers of the elderly or poor would face unpredictable costs which would adversely affect profitability. In Minnesota, United Healthcare have just dropped 15,000 over 65s from their organisation leaving them without any medical cover at all. At best HMOs offer the elderly and the poor and indeed other "bad risks" such as AIDS victims unstable health care provision with little or no security. They are no substitute for a publicly funded system which spreads risks and treats according to need.

WHY HMOS?

26. A claim is made that HMOs can cut costs. Again in an American context, where the system is outrageously expensive, this is true. HMOs have achieved cost savings by cutting the link between provision of service and doctors fees. However, this link does not exist in Britain's NHS, although it could conceivably be developing in the burgeoning private sector in this country. The disturbing thing about HMOs is that they work by reducing care. If they are reducing excess care then they can have a positive role but overtreatment is a much more significant feature of private system than it is in the NHS.

CONCLUSION

27. HMOs have nothing to offer in the British context. Their introduction would be likely to cause currently low administration costs to soar, taking scarce resources away from patient care. At the same time, HMOs can not offer coverage to "bad risks" without being heavily state subsidised. If medical treatment is to be subsidised, the most efficient and equitable way to do it is by using the current system.

INTERNAL MARKETS

28. COHSE has no objection at all to developing centres of excellence in particular specialisms. It would be inefficient and less effective to insist that every hospital must do its own open heart surgery. In so far as this could be said to be an internal market, then COHSE would approve. However, if the phrase 'internal markets' is defined as the introduction of general market functions across hospitals, then COHSE would strongly disapprove.

ADMINISTRATIVE COSTS WOULD SOAR

30. In order to introduce internal market functions, a bureaucracy would have to be established to administer the transfer of cash from the Government to the providers and across health authority boundaries. Each expense incurred in the NHS would have to be attributed to individual patients, an excessively costly administrative exercise which the NHS currently avoids. Often entire floors of American hospitals are devoted to billing patients and chasing unpaid debts. The American system spends 22% of all health care dollars on administration according to a recent study by Himmelstein and Woolhandler (Cambridge Hospital/Boston University - New England Journal of Medicine 1986). They went on to calculate that $38.4 billion could be saved by instituting a NHS in America.

29. If an internal market is instituted one of two things is likely to happen:

i) Hospitals will compete for less ill patients where profits are easier and simpler to make. They will specialise in lesser treatments;

or

ii) Hospitals will compete for lucrative sick patients offering to do kidney dialysis for example.

This type of system will introduce incentives to neglect chronically ill people, the mentally ill, the elderly, the mentally handicapped and AIDS victims.

31. The introduction of internal markets creates incentives for hospitals to treat patients in response to their own institutions' financial needs, rather than the medical needs of patients. The logical outcome of internal markets is that patients will be willing to travel the length and breadth of the country to get treatment, and that hospitals who do not treat people for profit will somehow close. This is patently absurd.

WHY ASSUME THAT COMPETITION IS GOOD?

32. In much of the current discussion on the future of the NHS, it is taken as axiomatic that competition is a good thing. In fact the evidence points to the fact that competition in a health care context is downright harmful. A recent study by S M Shortell and E F Hughes, published in the New English Journal of Medicare, April 1988, on the effects of regulation competition and ownership on mortality rates amongst hospitals found that there are:

> "Significant associations between higher mortality rates, the stringency of state programmes to review hospital rates and the intensity of competition in the market place".
>
> Mortality rates were between 6% to 10% higher in areas of higher competition. Amongst the conclusions, Shortell and Hughes said:
>
> "These findings raise serious concerns about the welfare of patients who are admitted to hospitals in relatively competitive markets. Regardless of the nature of their ownership, hospitals that face severe regulatory constraints, strong competitive pressures in the local markets or both, may respond to these forces in ways associated with poorer outcomes for patients".
>
> In other words, competition kills patients.

NEW PROPOSALS

33. COHSE believes that the founding principles of the National Health Service, as stated in the Royal Commission Report into the NHS 1979, viz:

a. Encourage and assist individuals to remain healthy;

b. Provide equality of entitlement to health services;

c. Provide a broad range of services of a high standard;

d. Provide equality of access to these services;

e. Provide a service free at the time of use;

f. Satisfy the reasonable expectations of its work;

g. Remain a national service responsive to local needs;

remain as true today as they were 40 years ago.

34. We therefore believe that any new proposals for change to the NHS structure should be measured against these principles. Only if proposals measure up to and enhance these principles should they be introduced, or it must be demonstrated that the principles no longer apply.

CONCLUSIONS

35. It is clear that the NHS is underfunded both in the Government's own terms and compared to the rest of the industrialised world. COHSE therefore propose making up the underfunding since 1979 and, by moving steadily towards the average level of funding in the EEC, provide a stable planning environment for Health Authorities from now to the end of the century. A service which is free at the point of delivery and financed through the tax system is both equitable and cost-efficient. No alternative method of providing healthcare measures up to a properly financed public health system and many countries are moving towards the UK model of health provision.

36. The alternative systems for the provision of health care currently being discussed are more bureaucratic, less cost efficient and would not provide comprehensive healthcare for the people of Britain.

37. The National Health Service is the best way to provide healthcare so long as it is given a stable planning environment by guaranteeing adequate resources now and in the future.

38. As one leading economist in the field stated "All systems of healthcare are bad, but the NHS is the least bad".

June 1988.