The BOW GROUP

POLICY IN THE MAKING

A Radical Alternative to Wanless: Lessons from the Lion City

by Lee Craven

About The Bow Group

The Bow Group has three aims:

- To create new and thought-provoking research for the Conservative party
- To provide a forum for its members to meet each other socially
- To provide opportunities for its members to meet senior Conservative party figures to discuss the issues of the day.

The Group has no corporate view, which allows it to approach each issue on its merits and with an open mind. Accordingly, the views expressed in Bow Group publications are those of the authors, and do not represent a statement of Conservative party policy, or the views of other members of the Group.

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CONTENTS

PREFACE

The Bow Group is delighted to be able to publish this paper by Lee Craven, which positions the Group once again at the cutting edge of policy formulation in the area of healthcare. The paper rigorously analyses the flaws of the National Health Service in light of the merits of the French and Singaporean healthcare systems, and advocates a radical reform of the way in which the funds allocated by the Treasury to the Department of Health are spent. In particular, the author recommends that the Government should give each citizen a Healthgrant to purchase his or her healthcare needs from insurers based on a standard package. An executive summary of the paper follows on the next page.

The Group has already published some weighty material in this critical area of public concern. An earlier paper, 'Making the NHS Better: Disclosing and Enforcing Health Service Standards' by Chris Philp, made front page headlines in *The Daily Mail* (December 27, 1999) with its observation that 230 lives a day would be saved if Britain matched European best practice in healthcare. Its recommendation for a new body, Ofhealth, to enforce standards anticipated Professor Ian Kennedy's recommendations for an independent Council for the Quality of Health Care, while it was one of the first publications to call for individual surgeons' death rates to be published.

This was followed in November 2000 by a policy brief by Mark Nicholson, 'New Labour Unspun…on Waiting Lists', which analysed in a cold light many of the claims made by the Government in relation to its record on the NHS. In a different vein, 'Eighteen Plus: The Politics of a New Generation' by James Robertson (2001), based on extensive primary research amongst sixth-formers, measured the importance which tomorrow's voters attach to healthcare. *The Ideas Book 2000*, published by the Group in advance of the general election, set out a stall of healthcare ideas for the main political parties to borrow from. *The Ideas Book for London*, to be published later this year, will build on those ideas as they relate to the Capital.

Lee Craven's paper will add kindling to the debate raging about the role of government in healthcare provision. In line with the Group's policy of having no corporate view, however, this paper will not represent the last word on this subject from members of the Group. If in the meantime you want more details about healthcare research in the Group, please contact us.

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March, 2002

EXECUTIVE SUMMARY

The NHS has for some time been struggling to meet the needs and demands of its users, and is now starting to lose their trust. In the meantime, the Government is failing to turn the institution around.

This paper[1] looks at the healthcare systems in France and Singapore, two countries with excellent records in this area. Drawing on the lessons to be learnt from these systems, we propose that the Government should, out of the funds in the Budget earmarked for healthcare spending:

- give each citizen a 'Healthgrant', a personal healthcare fund out of which the citizen would have to pay for an insurance policy to cover his (or her) own needs for specialist and hospital care, and from the balance of which he would pay for visits to the GP;

- negotiate with the insurers a standard package of healthcare which citizens' health insurance would cover;

- free NHS hospitals from government control while making them compete with non-NHS hospitals for business from the insurers; and

- increase the incentives for GPs and patients to get more patients screened for health problems.

The essential moral principle of healthcare in this country, universal healthcare free at the point of delivery, would be preserved. Yet the Healthgrant would also ensure that certain other aims would be met: healthcare would become less bureaucratic; proper incentives would be given to those in our healthcare system; political meddling would become a thing of the past; the focus of healthcare would become broader; and the costs of healthcare would be contained (but not cut).

The Need for Root and Branch Reform

The problems of the NHS are profound, and will not be solved without a fundamental rethink. Health economists have long understood the unique difficulties which plague the provision of healthcare, and which apply equally to all healthcare systems in the world, including the NHS. Effectively ignoring these difficulties, the Government continues to cling stubbornly to the belief that the NHS lacks only resources, and that bringing British healthcare spending up to an EU average – even if it could be done – will somehow heal all the service's wounds.[2] What the

[1] The scope of this paper is broad, in the sense that it covers most aspects of healthcare, including dental, optical and mental services, as well as the provision of care through nursing homes. Geographically speaking, on the other hand, the paper's scope is narrow, since (in view of devolution) it concentrates on the reform of healthcare in England. This does not mean, of course, that the reforms proposed would somehow be inappropriate for Scotland, Wales and Northern Ireland. In many cases, however, healthcare statistics are available only for the UK as a whole, and so we have had no choice but to quote these.

[2] Admittedly, the Government is starting to appreciate that new ideas, and private sector help, are increasingly needed (Alan Milburn's speech, January 15, 2002), but, as the paper examines later, the new proposals are flawed in themselves and the thinking behind them is nowhere near comprehensive enough.

NHS needs most desperately, however, is clear thinking from first principles, and the courage of people to argue from such principles. Extra money will buy some time, but will not solve the underlying failings: the motto should be 'reform, then resources'.

The NHS suffers from several major weaknesses: a bureaucratic, unbalanced structure; a widespread lack of appropriate incentives to improve performance; political interference; the effects of the Government's confused attitude to the private sector; and too narrow a focus on cure rather than prevention.

The rationale for a national system of healthcare remains, however, unchallenged: the NHS was created by political and social forces that remain largely intact; and inspired by principles that, rightly, are still held deeply by the majority of the population. By far the most important of these is equity; the belief that everyone, regardless of income or wealth or geographical location, should have access to good quality healthcare. That essential principle lies at the core of the reforms advocated here, even if it is a principle that the NHS itself is increasingly failing to honour.

Learning from Other Countries

Indeed, for an institution that is supposedly 'the envy of the world', it is surprising that no other major country has chosen to copy the NHS model. This paper will look at the experience of France; a country similar to England in terms of wealth and demographics, but one which has chosen to organise its healthcare very differently. Acknowledging certain weaknesses in the French system, we look at Singapore, whose government has studied healthcare systems in France and many other nations, and produced its own unique answers to the problems of healthcare provision. Although Singapore is in many respects a very different country from our own, there are crucial aspects of its comprehensive review and its healthcare reforms from which other countries, and England in particular, can learn.

A Sound Basis for Reform

On the basis of this analysis of healthcare in France and in particular Singapore, certain broad aims for any reform of the NHS in England can be identified. Specifically, any reform would need to go some significant way to:

- dismantling the NHS's centralised bureaucracy, and ensuring a certain 'balance of power' between the main elements of a reformed system;
- providing proper incentives to all participants in healthcare provision;
- thwarting political meddling;
- broadening the system's focus to the entire spectrum of healthcare services; and
- controlling the costs of healthcare.

Transforming the NHS through Healthgrants

The paper concludes by proposing a series of radical reforms, based on funding healthcare through a Healthgrant. These reforms would transform healthcare here if implemented by the Government, and, if adopted by the Opposition as its policy, would offer the Conservative party an opportunity to seize the initiative in this vital area of public services.

Specifically, the paper recommends that:

● Transforming Healthcare Funding

- Although the NHS would continue to be funded ultimately from general taxation, each citizen should receive an annual Healthgrant from the Government, and, using this, should pay for his (or her) health needs over a twelve month period.[3] A Healthgrant would not be dependent on a person's income or wealth, but would vary with the recipient's age and/or the number of his children.

- From the annual Healthgrant, each citizen should be obliged to buy a Government-approved health insurance policy to cover specialist and hospital treatment. These insurance policies would be provided by competing, private sector insurers, such as Bupa, PPP, Standard Life, Norwich Union and so on.[4] All policies would be vetted by the Government, and each would guarantee a certain 'standard package' of medical care, as defined by annual negotiations between the Government and insurers.[5] Insurers would be legally obliged to meet the agreed standards.[6] Any citizen needing specialist and/or hospital treatment would, on referral from his GP, approach his respective insurer, who would arrange the treatment on his behalf. Any citizen unhappy with the service of the insurer would be free to change to another one the following year.

- The Healthgrant should be set at such a level as to leave a balance, once the annual compulsory insurance premium had been paid. From this balance, the Healthgrant holder should pay for his visits to the GP.[7]

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[3] In other words, the Treasury would collect revenues in the normal way, and, as at present, an agreed amount would be transferred to the Department of Health (DOH). The DOH would then decide the level of the Healthgrant for the following year, and distribute the Healthgrants accordingly. On receipt of a Healthgrant, the ownership of the monies within it would pass to the patient.

[4] Private sector healthcare insurers would include non-profit organisations, such as Bupa, and profit seeking firms, such as Norwich Union, Standard Life and so on.

[5] This 'standard package' would specifically define aspects of care, such as waiting times between a specialist appointment and hospital treatment, no mixed sex wards, a maximum number of beds on a ward, availability of non-generic drugs of proven effectiveness, access to post-operative care and so on. All insurers would have to provide a service equal, at least, to the standard package.

[6] Many people remain suspicious of private health insurers, believing that they try and 'skim off' younger and healthier people while 'discouraging', through higher premiums, those who are older or who are known to have a history of illness. There is much truth to these fears in an unregulated private health insurance market, but, under the Healthgrant scheme, these weaknesses would be tackled head-on: no insurer would be allowed to refuse to take on a citizen, if he or she wished to join a particular insurer. Put another way, all insurers would have to accept the Healthgrant as 'legal tender'. This subject is tackled in greater detail in section 3.2.

[7] Initially, Healthgrant balances would be used solely to pay for visits to GPs. In time, however, once the Healthgrant system was established, the Government could decide to allow balances to be spent on other items, such as dental check-ups, eye-tests and medicine prescriptions.

- Any Healthgrant balance left at the end of the year would have to be withdrawn in cash by the holder, and could be spent or saved in any way he chose.[8] Healthgrant balances could not be carried forward into the following year.

● Transforming the Hospital Sector

- The Healthgrant scheme would not differentiate between public and private hospitals. The majority of both public and private hospitals' income would come from the insurance funds. The insurers would pay the hospitals for work done. The value of this work would be calculated by further developing the existing Health Related Group (HRG) system of classifying medical treatment.[9] Private insurers would be free to build and run their own hospitals, if they chose.[10] Other organisations, such as charities, would also be free to enter the hospital sector.

- No NHS hospitals would be privatised. NHS hospital trusts should, however, be given complete operational and financial independence from the Government and would eventually rely on one main source of income: work done on behalf of the insurers. There would, however, be a subsidiary source of income for those hospitals (more specifically, hospital departments) which carry out pioneering work: they would eventually be funded solely by the interest income of endowment funds.[11] The capital within such funds would be provided by the Government over a number of years, but, after the capital fund had reached a certain predetermined level, further Government involvement and financing would cease.

● Transforming Primary Healthcare

- Healthgrant holders would pay for GP visits using the monies remaining in their Healthgrant after their compulsory insurance, as described above, had been paid. The amount charged for a 'standard' visit would be agreed annually between the Government and GPs.

- GPs would be free to organise themselves in any way they chose. They would be free, within limits, to charge Healthgrant holders for extra services (e.g. a higher price for an appointment in the evening or at the weekend).

- The infrastructure of Primary Care Groups (PCGs) and Primary Care Trusts (PCTs) would therefore be dismantled, as the job of 'buying' specialist and hospital services from the hospital sector would now be in the hands of the insurers. If a GP felt that a patient's ailment needed specialist attention, he would write down his assessment of

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[8] That is, the balance, once withdrawn, would no longer represent money 'reserved' for healthcare: it could be saved, or spent on any consumer goods and services.

[9] The HRG is the English-developed version of a Diagnosis Related Group system of 'pricing' healthcare treatment. There are many DRG systems in the world, and all are attempts to measure the 'cost' of similar types of health treatment, using international observation and experience, and allowing for certain variations. Singapore has introduced (and Germany will soon introduce) a DRG system based on the one presently used in Australia. Please refer to section 2.3 and Appendix 2.

[10] Some insurers, such as Bupa, already do.

[11] 'Pioneering' treatment includes such operations as heart and lung transplants, or the use of new experimental drugs.

the problem, and hand the form to the patient. The patient would then contact his insurer, who would arrange the necessary specialist attention.

● Transforming Preventative Healthcare

- The Government would organise targeted health screening programmes for selected groups of the population, such as those above 55, say, or those whose family had a history of a certain disease. The soon-to-be-created Strategic Health Authorities (SHAs) would regulate and supervise this system.

- GPs would be responsible for organising the health screening of their patients, and would be reimbursed for their work directly. GPs would be paid an amount by their respective SHA to cover the cost of each person they screened, as well as a bonus if the total number of people screened met or exceeded a certain percentage of those who were eligible for screening.[12]

- If, as a result of the screening programme, a particular patient was deemed to need specialist attention, the GP would contact that patient, as well as that patient's insurer, to request the relevant follow-on treatment.

- Insurers would be allowed (and indeed encouraged) to offer 'discounts' to the price of their insurance policies to those citizens who could prove (by a GP's declaration) that they had received the relevant health screenings. A lower premium would mean a higher balance left at the end of the year for the Healthgrant holder and, by catching disease and other medical problems earlier than would otherwise have been the case, the screenings would also be in the best interests of the insurers.[13]

Conclusion

The reform programme outlined briefly here is radical but workable. Recent 'reforms' of the NHS suffer from their proponents' inability to see the wood for the trees, and thus lead, at best, to only marginal improvements. If the NHS were fundamentally sound, that might be enough. Unfortunately, however, English healthcare suffers from profound weaknesses that no amount of tinkering can solve. A fundamental rethink is required.

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12 This mirrors, to a large degree, the current practice regarding GPs and the Government's vaccination policy: in the case of the MMR vaccine, for example, if a GP vaccinates 70% of eligible children, he receives a bonus of £910, rising to £2,730 if 90% are vaccinated (*The Independent*, February 7, 2002).

13 In fact, the health insurers would be free to create and run their own supplementary health screening programmes.

CHAPTER ONE AN NHS IN CRISIS

1.1 Time to Admit Malaise

In January 2000, Lord Winston, a medical specialist and Labour peer, caused a furore by castigating the NHS, saying that there was a lot wrong with the health service '…and nobody is prepared to say so'; that healthcare provision was getting worse; and that what was needed was fundamental reform, which was unlikely from a government that includes '...very few original thinkers'.[14]

Lord Winston's comments acted as a catalyst. Whereas in the past, it has been almost blasphemous to question, let alone criticise, the NHS, the press this time responded with informed and wide-ranging reports on its many failings and the advantages and weaknesses of healthcare systems in other countries. A taboo had been broken, and intelligent observers began to look around for something better.

Sadly, the official response was predictable. The Government has announced huge extra spending: their aim is to increase NHS spending by one half in cash terms and one third in real terms by 2005. The aim is to bring healthcare spending up to an 'EU average', although the Government fails to explain why this moving target is relevant, given the huge differences between the healthcare system here and the healthcare systems in other EU countries. Most recently, Mr Milburn has announced changes to the way hospitals would be funded, and vaguely suggested that tentative private sector involvement might be extended in certain circumstances. Yet such policy announcements tumble forth without, it seems, an overall strategic vision as to what the desired end should be. Vague soundbites such as 'increasing consumer choice' and 'freedom to innovate' are not enough. Indeed, some policies, as we shall see, are likely to have the opposite effect to the ones intended.

1.2 The Evidence of Malaise

● Statistical Evidence

The difficulty for the researcher is that, despite the comments of Lord Winston, the failings of the NHS are not clearly discernible in much of the broad data. Appendix 1 shows data for the UK, France and Singapore. From these data, and bearing in mind Singapore's younger population, it seems that the UK's performance, although not particularly good, is not particularly bad either. The statistics, in short, do not adequately reflect the acute problems and failings that do afflict the NHS. More specific statistics are therefore needed. For example:

- Deaths from lung disease, at 105 per 100,000 people, are twice the European Union average.

[14] *The Sunday Times*, January 16, 2000.

- Survival rates for major killers such as cancer are way behind other European countries, with English sufferers of lung cancer having a better chance of recovery in Poland.[15]

- Waiting list figures are also worrying. Over 50,000 people have now been waiting more than a year for hospital admission, on a waiting list that includes a further 1 million, much of it for routine treatments such as hip replacements. These figures discount, however, the time people have to wait to see a specialist: the notorious 'waiting list for the waiting list'.[16]

● Anecdotal Evidence

Anecdotal evidence, by people who work in the system or from patients who have experienced it, is similarly depressing, particularly in the case of hospital treatment. Lord Winston's comments, for example, were prompted by the thirteen hour wait in casualty his diabetic mother endured; Mr Blair was famously ambushed during the 2001 general election by the partner of a cancer patient, who had also been left stranded in casualty; and, most recently, a seventy-one year old lady, who needed both knees replacing, was told not to expect treatment until late 2005.[17] An unpublished survey by the British Orthopaedic Association shows that two-thirds of surgeons believe their waiting lists are increasing.[18] Certain drugs are available from some Health Authorities but not from others, leading to serious inequities. The latest spat involved an old lady, Rose Addis, who was left blood-spattered and confused in an Accident & Emergency ward at Whipps Cross hospital in London for many hours.[19]

There are fewer major problems in the primary healthcare sector, but working people know they have to put aside half a day to see a GP, and few are able to make an appointment outside working hours. Furthermore, many GPs are unhappy with the average time of seven and a half minutes that they can spare for each consultation,[20] and frustrated at the time wasted on bureaucracy.

Overall, throughout the NHS, signs of strain, in resources, the morale of staff and the confidence of patients, are everywhere.

1.3 The Anatomy of Malaise

The reasons for failure are numerous, but can be divided into several broad, underlying themes. The NHS's problems stem from:

- a bureaucratic and unbalanced structure;

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[15] Chris Philp, 'Making the NHS Better: Disclosing and Enforcing Health Service Standards', The Bow Group, 2000.

[16] *The Daily Telegraph*, January 19, 2000.

[17] *The Sunday Times*, October 28, 2001.

[18] *The Sunday Times*, October 28, 2001.

[19] *The London Evening Standard*, January 24, 2002.

[20] *The Daily Telegraph*, January 20, 2000.

- a failure to give the people within the system the correct incentives;
- political interference;
- the Government's confused attitude to the private healthcare sector; and
- an excessively narrow focus on only certain aspects of healthcare.

● A Bureaucratic and Unbalanced Structure

The NHS is a massive, highly-centralised organisation. In September 1999, for example, there were an astonishing 897,567 non-medical staff in England, and total healthcare expenditure in 1998-9 was over £45 billion pounds. Late last year, Mr Milburn boasted that he would shortly be spending a billion pounds *a week* on the NHS. Unfortunately, these vast sums are poured into a structure which is bureaucratic, subject to constant structural change, and unbalanced.

A Bureaucratic Structure

The NHS consists of a myriad of bodies:

- the NHS headquarters in Leeds;
- under that, the NHS Executive Regional Offices, of which there are eight in England;
- under the Regional Offices, 100 Health Authorities (HAs), which are responsible for health and health services in their respective regions;
- Community Health Councils (CHCs), whose role is to represent the interests of the public to Health Authorities;
- Primary Care Groups (PCGs), of which there are 481, and which take money from the local Health Authority and commission services from other providers, such as hospital trusts and community nursing;
- Primary Care Trusts (PCTs), which are able to provide services directly, as well as commission them; and
- NHS Trusts, which operate as self-governing healthcare providers independent of Health Authority control and are responsible to the Secretary of State. Most public hospitals belong to such trusts.

It is clear that the above system is organised from the top down. Money is distributed from the NHS Executive to the HAs, who then distribute it to the PCGs, PCTs and the hospital trusts. In other words, the flow of money is from the top downwards, and the administrative structure reflects that.[21] A consequence of this is the allocation of healthcare resources through

[21] This structure is due to change: PCTs will be given funding from the Executive, and will 'buy' services from the Trusts using these monies. In other words, money will flow to the Trusts via the PCTs. HAs will merge to become 'Strategic Health Authorities'.

administrative rules, rather than by a reliance on market signals; hence, it is extremely difficult to measure whether resources are used efficiently. Implicit *bureaucratic* admission that this structure fails to serve the public well comes in a variety of forms: for example, the introduction of CHCs, created to ensure that the system acts in the interests of the public, is an acceptance, surely, that often it does not. Likewise, the recent creation of the National Institute for Clinical Excellence (NICE), conceived to guarantee 'consistency' in the public's access to health services, is an admission that the present system often fails to do that.[22]

Structural Change

The failure of such a bureaucratic system persuades governments to try to 'improve' things through further structural changes. All of the organisations listed above are merely the latest attempt to try to improve performance. Health Authorities, for example, are due to be largely disbanded in their present form, to be replaced by PCGs and PCTs. Yet the responsibilities and tasks of the PCTs are virtually indistinguishable from those of the HAs (there are simply more of them). A GP we have discussed this point with believes that, as economies of size prevail, PCTs will merge, diminishing their number. Thus, over time, they will come to replicate the recently dissolved HAs. Yet the HAs themselves were only created in 1996. Constant organisational upheaval is a symptom of a failing NHS, as politicians try desperately to look as if they are 'doing something'. It leads to exhaustion and demoralisation amongst the NHS's staff, as they are forced to cope with yet another 'reorganisation'.

An Unbalanced Structure

A further problem concerns the relative 'balance of power' within the present system. Hospital trusts, because they enjoy a monopoly supply position, have a disproportionate amount of influence.[23] If a particular trust is underperforming, that will drag down the overall quality of healthcare in a particular area, no matter how efficient the primary health sector in that region may be. GPs have virtually no leverage to make the local trust more responsive to the GPs' patients' needs.

This 'lack of balance' problem is likely to be exacerbated by the Government's recent structural changes. Currently, trusts negotiate their budgets with their respective HA; despite the system's faults, there is, at least, a crude balance of power between these two negotiating partners. Shortly, however, PCTs will take over this bargaining function from the HAs. One director of a London hospital trust has told the author that he believes that, through inexperience and a diminution of their 'buying power' (there are over four times as many PCTs as there are HAs), PCTs will be vulnerable to the increased relative negotiating power of the trusts. The Government created PCTs to try to make the system more responsive to patients' needs: instead, the NHS structure risks becoming even more unbalanced.

● Inadequate Incentives

The problems inherent in the structure outlined above are compounded by a lack of appropriate incentives.

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[22] For a detailed analysis of the flawed administrative structure set up to monitor the NHS, see Chris Philp, 'Making the NHS Better', op. cit.

[23] This is a point picked up in a recent editorial in *The Financial Times*, January 16, 2002.

Primary Healthcare

In the primary care sector, most GP income is derived from the General Medical Services (GMS) that doctors provide for NHS patients. GMS income is defined by the 'Red Book', which is antiquated, bureaucratic and, most importantly, does not reward GPs for the quality of their medical work, or the time taken to diagnose a patient. Instead, GPs are funded largely by the number of patients registered with them. If a GP take thirty minutes to diagnose a patient properly, instead of the average seven minutes, he is not, under the present system, rewarded for his thoroughness.

The Hospital Sector

In the hospital sector, HAs negotiate with Trusts on an annual basis, and a lump sum is given by the relevant HA to each trust at the beginning of the financial year. This sum is based roughly on predictions made about the likely number of heart bypass operations, births, hip replacements and so on over the following year. In other words, funding is based on *predicted* work, not *actual* work. The estimated 'value' of each particular type of treatment is worked out using Health Related Group (HRG) analysis. Based on a similar system used in the USA, HRG is a way of working out what a particular operation should cost, after allowing for certain variations such as the social circumstances of the patient base.

In the case of the NHS Trusts, however, the incentive to strive constantly for better services and better value for money is largely absent. For a start, the 'quality' of work is not defined, or even properly measured: the emphasis, as ever, is on quantities. Furthermore, if a particular Trust is run efficiently, and manages to perform more than its 'quota' of work, the HA increases its workload the following year. If a Trust is inefficient, and does not meet its 'quota,' then the HA can threaten to withdraw some funding the following year, but this, unfortunately, is not a credible threat, given the present shortage of capacity in the hospital sector as a whole. That leads to the other part of the problem: the fact that HAs are (as shortly PCTs will be) obliged to buy healthcare services *only* from the Trusts. The threat of losing customers is the greatest incentive for any institution, whether public or private, to deliver good service. Deprived of this vital lever, the PCTs will struggle to exert any kind of meaningful and sustained pressure for improvement on the Trusts.

The Government is finally beginning to understand the importance of having the correct incentives in place. On January 15, 2002, Mr Milburn announced that the best performing NHS Trusts would be give special 'foundation' status. They will have more freedom from the tight financial and operational controls of the NHS Executive. At present, details of the powers of such 'foundations' are hazy, although they will, apparently, have the right to sell 'surplus' assets to the private sector. The worst performing Trusts, on the other hand, are threatened with the removal of their management, and the imposition of new management from other Trusts, charities, or even the private sector. Again, the details are still vague, but it is already clear that the Government is failing, once again, to think through its policies properly. The country as a whole is short of good hospital managers: there is no ready pool in the private sector waiting to be quickly drafted in. Likewise, although many charities, in the days before the NHS was created, *were* heavily involved in the provision of hospital care, the sweeping nationalisation of the entire healthcare sector put an end to such charity-run hospitals.[24] Charities today consequently have little or no relevant experience.

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[24] In countries such as France and Germany, charities are still involved in hospital care provision.

● Political Interference

Closely linked to the above problems is another: the fact that the present system allows regular and repeated political interference in the day-to-day running of hospitals. Politicians have discovered that they can dictate priorities to particular hospitals on a weekly or even daily basis. One senior manager at a well-known hospital has cited one (by no means unique) example to the author. Infuriated by bad press reports about patients kept waiting on trolleys for operations, a Government minister called her and demanded that no one was to be kept waiting. This demand led, however, to cancelled operations and people being told to go home. Shortly afterwards, therefore, the same minister called again and demanded that there be no more cancelled operations. This, in turn, meant people again waiting on trolleys in the hope that their operation could be slotted into a very tight schedule. The two aims, dictated by a politician, were mutually incompatible.

This feature – day-to-day political interference in the operational management of hospitals – seems unique to England. In Singapore, all the public hospitals have now been 'restructured', allowing them autonomy from government. In both France and Singapore, the government sets *basic* legal and medical standards, but leaves the operational running of hospitals to the hospital managers themselves, *even if the state is often the ultimate owner of the hospitals*. Political interference, driven by short-term media management, is one of the most pernicious features of healthcare provision in England.

● The Government's Attitude to the Private Sector

The Government's attitude to the private sector is erratic, and shot through with contradictions. On the one hand, it considers the private sector a competitive threat to public healthcare provision; one that 'steals' resources from the State. In this light, the Government wants to force surgeons to work for minimum lengths of time in the NHS before they are allowed to do private work. The Wanless report, commissioned by the Chancellor, Gordon Brown, seems to support this viewpoint, arguing that the future of the NHS depends simply on an expansion of public provision and public funding. Mr Brown, leaning heavily on the report for his pre-Budget statement in November,[25] quickly dismissed other forms of funding, such as private or social insurance, and promptly received public congratulations from the public sector unions.

Yet, over at the Department of Health, the Government is making tentative contact with the private sector. Earlier this year, it bought a heart hospital in London from a private Singaporean healthcare group. More recently, it has announced a deal with a Bupa-owned annex to an NHS hospital in Surrey. This unit will carry out around 5,000 routine operations a year for the NHS.[26] There is a chance that more of this cooperation with the private sector will take place, but it should be noted, first, that no-one in Government is asking why the State should be commissioning surgery directly in the first place; and, secondly, that the Treasury states that the use of private hospitals is merely 'temporary'.[27]

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[25] *The Financial Times*, November 28, 2001.

[26] *The Daily Telegraph*, December 5, 2001.

[27] *The Sunday Times*, December 2, 2001.

What seems to be happening is that the NHS is being sucked into the much-reported power struggle between Mr Blair, on the one hand, and Mr Brown and 'his' Treasury on the other.[28] This leads to confusion and contradictions. Neither side, unfortunately, has even tried to rethink the basic principles underlying the NHS.

● An Excessively Narrow Focus

The Government has adopted an excessively narrow focus on certain areas of healthcare.

On Diseases in their Advanced State

Healthcare resources in England are not used efficiently, leading to shortages and queues. In such circumstances, money gets sucked into those areas that require immediate attention, and away from fields that would reap the best rewards in the longer term. A good example is cancer treatment. Most cancers, if detected early enough, can be treated relatively cheaply, and with less pain and suffering for the patient. Far more resources should therefore be spent on the systematic screening of patients for such ailments. In England, early detection of diseases such as cancer is poor. In Germany, for example, women go for regular ovarian scans from an early age. The problem in England is that, because resources are inefficiently used, they go to meet immediate needs, not to try and forestall future ones. Too much attention is devoted to large-scale fire-fighting, and not enough to minimising fires.

On Acute Hospitalised Care

For the reasons outlined above, too much time and resources are devoted to care in hospitals, which covers only one end of the healthcare spectrum. Take care for the elderly, for example. This ranges from, at one end of the spectrum, visits by nurses to a person's home; to day care in a centre; to full time care in a nursing home; to non-acute care in a 'community' hospital; and, finally, to acute care in an acute hospital.

This 'continuum' of care is not reflected in the NHS, which tends to be heavily biased towards acute treatment. The Government claims it is becoming more aware of this problem and recently promised extra funds to try to prevent hospital 'bed-blocking' by elderly patients who have no appropriate place (e.g. a non-acute community hospital or nursing home) to go to after discharge.[29] However, a recent report commissioned by the Liberal Democrats undermines this claim, revealing that 'top-ups' paid by charities to elderly care homes have increased alarmingly for several years.[30] These contributions are usually paid by the Government, but it is now withdrawing funding and forcing the charities to meet the shortfall. This is merely one aspect of a wider crisis that currently afflicts many elderly care homes, which are struggling to survive as Local Authorities and central Government withdraw funds, while, at the same time, demanding higher safety standards.[31] The end result of this crisis is the 'blocking' of scarce hospital beds by elderly patients who ought to be in care homes.

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[28] It is unknown what the Treasury thinks about Alan Milburn's latest proposals.

[29] Barry Hassell, Chief Executive of the Independent Health Association, believes that around 6,000 NHS beds are blocked at any one time by patients unable to go home because arrangements have not been made for follow-on care (*The Daily Telegraph*, January 19, 2000).

[30] As reported in *The Daily Telegraph*, January 7, 2002.

[31] Between 1999 and 2000, 15,000 beds were lost due to the closure of residential homes.

Overall, a focus on the full spectrum of healthcare services is needed, since no single part works in isolation. Yet in England, non-hospitalised healthcare is usually administered by the Local Authorities, although it is 'overseen' by the Department of Health, whereas day care is the responsibility of a separate Government department completely (the Department of Work and Pensions). The Local Authorities have no incentive to take pressure off the local NHS Trust by ensuring an adequate supply of nursing home beds. Indeed, the incentives flow in the other direction: if an elderly patient is being looked after in the local hospital, he is not a burden on the budget of the Local Authority. The critical need to step back and look at healthcare services as a whole is not being met, and healthcare provision in England is consequently badly fragmented.

On Only Part of the Total Costs

The Government often opts for measures that save money in the short term, but involve longer term costs. Up until very recently, for example, beta-interferon, an expensive drug that relieves the symptoms of multiple sclerosis, was not available on the NHS (or, rather, it was available only in a minority of 'postcodes').[32] The NHS argued that the drug was too expensive, but, by delaying in many cases the onset of the disease, it spares the State the cost of special care for the patient, at least for a while. Alzheimer's sufferers are another example: a drug such as Aricept, by giving an Alzheimer's patient an extra year of autonomy, can translate into a saving of around £50,000 a year on 24-hour care.

● Inadequate Control over Costs

One of the often-stated advantages of the NHS is the Government's apparent ability to keep an overall lid on cost increases. Yet such a claim is misleading. The Government does not control, for example, the drug market, and costs of even generic drugs have risen rapidly in the last two years,[33] putting a strain on Health Authorities' drug budgets. Likewise, the Government has little control over the private health sector; cost increases here do affect the NHS, since some doctors, nurses and healthcare managers in the public sector always have the option of moving to the better-paid private sector. The Government must therefore 'shadow', to a certain degree, pay rises in private medicine.

The Government may, in the short term, be able to put a lid on *overall* spending, but has far less influence over what *comprises* such spending. If drug prices rise, for example, resources are sucked from other sectors, and the Government is faced with a dilemma: either to release more funds overall, to avoid cuts in these other sectors; or to resist more overall spending, and risk under-funding these sectors. In time, given the political sensitivity of the NHS, it is likely that the Government would wobble and release extra funds. This has indeed been the pattern ever since the NHS was created.

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[32] NICE recently stated that beta-interferon would be available from all HAs, but the manufacturer would be refunded only if the patient was shown to respond positively to the drug. This seems to be a recipe for confusion and argument.

[33] *The Daily Telegraph*, January 19, 2001.

1.4 Conclusion

Taking all these failings together, it is clear that the Government lacks an overall vision of what the NHS should be trying to do, and where it should be going. Two things are needed: an ability to think clearly from first principles; and the humility to acknowledge that other countries tackle healthcare problems far more successfully than England. In the next chapter, the paper looks at the experience of France and Singapore and distils from their experience first principles for healthcare reform. In the final chapter, we propose a series of reforms based on these first principles and bolstered by the experience of these two countries.

CHAPTER TWO LESSONS FROM THE LION STATE

2.1 Learning from France and Singapore

When discussing the NHS, it is necessary to look abroad to see how other countries tackle the profound problems of healthcare provision. This Government seems, unfortunately, determined to ignore lessons from abroad, and is convinced that the present status quo, with perhaps a little tinkering, is the only way forward. Such thinking is blinkered. The truth is that most other countries have discovered far superior ways of organising their healthcare systems, and are more than willing to share their experience and knowledge with others.

France and Singapore seem to offer the most appropriate studies. France is an obvious candidate: in terms of wealth and demographics, it is very similar to England. In addition, because it is often caricatured as a country with monopolistic central control, and a *dirigiste* approach to industry, the fact that French healthcare is *not* run in such a way is therefore especially surprising and informative.[34]

Yet the French system has its weaknesses, which is why Singapore's approach is studied in detail. At first glance, it may seem odd to study a small island state with a population of less than 4 million. Singapore's government has, however, been particularly adept at studying, adopting and adapting the features of many different healthcare systems in the world, and producing a unique hybrid that combines the quality of the French system, but at a lower, and contained, cost. It has also articulated, in an admirably clear 1993 white paper that should be required reading for our Government, the problems that afflict all healthcare systems in the world.

2.2 Healthcare in France

The French healthcare system is expensive but highly regarded by its users. A survey done in 1996 revealed that less than 15% of the French population is 'very and fairly dissatisfied' with the system, compared with the 41% who claim to be dissatisfied with the NHS.[35] Patients' health spending is reimbursed generously; there is a large measure of freedom of choice; there are virtually no waiting lists; and the quality of medical treatment, as measured by international standards, is high.[36] Compared with the NHS, the French system seems to offer everything that is lacking in English healthcare: the structure is diffuse rather than centralised; provides the correct incentives to most of those who work within it; and frustrates direct political interference in its day-to-day running. France also has a non-ideological view of the private sector, which consequently plays a large role in the provision of health services.

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[34] The German system of healthcare is also touched on occasionally in this paper, but since it is, with the major exception of its principle of competing state insurers, similar in important ways to the French system (i.e. based largely on compulsory contributions from employees and their employers to social insurance funds), to discuss it in detail would make this paper unnecessarily unwieldy.

[35] Mossialos, E. (1997), 'Citizens' view on health systems in the 15 member States of the European Union,' Health Economics, Vol.6, 109-116. If the same survey were done again today, the percentage of the English dissatisfied with the NHS would probably be much higher.

[36] Imai, Y., Jacobzone, S., and Lenain, P., (2000) 'The Changing Health System in France', OECD Economics Department Working Paper, no 269.

The system has its faults, however, the main one being its high cost, combined with an ongoing failure to contain costs: French healthcare consumed 9.4% of GDP in 1998 against 6.8% in the UK, and the government is struggling to keep a lid on price increases. But these problems should not detract from its relative success. Having identified the broad failings of English healthcare in the preceding chapter, it is worth examining whether the same criticisms can be made of French healthcare.

● How French Healthcare Works

The French healthcare system is large and complicated, but more diffuse (and therefore less bureaucratic) than the English. The government plays a central 'overseeing' and regulating role, but does not attempt to run a monolithic, top-down structure of the kind exemplified by the NHS. Healthcare is not provided, or even funded, directly by the state, but patients rely instead on insurance cover provided by a number of different insurers. These refund patients' costs, whether those originate from doctors, specialists or hospitals. Most French citizens rely on two different types of insurance. Broadly speaking, *all* of the costs of healthcare are now covered by such insurance, although patients usually have to pay some costs up front, which their insurers then reimburse.[37] The insurers themselves receive their funds from mandatory contributions from employees and employers, with the latter contributing the greater portion.

French Healthcare Funding

Money for health spending ultimately derives from payments made by employees and employers to various insurance funds, combined with revenue raised directly by the government through general taxation.

Every employed French citizen has to contribute to one of eighteen social insurance funds, each of which is specific to certain professions. The largest of these funds, covering some 80% of the population, is the Caisse Nationale d'Assurance Maladie des Travailleurs Salariés (CNAMTS), which covers salaried workers in the commercial and industrial sectors. These funds are non-governmental and non-profit making bodies. The premiums for these funds average around 20% of the cost of the employee's gross pay, with the employer paying around two-thirds and the employee, until recently, the remainder.[38]

Ten per cent of healthcare spending is funded by two more contribution-based sources of funds: mutuelles, which are voluntary mutual organisations whose members comprise 80% of the population; and private sector health insurance. Private sector insurance comprises both profit-making and non profit-making institutions.

The rest is funded by universal health insurance, couverture medicale universelle (CMU), which was introduced in January 2000 for the neediest members of society. The most important

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[37] This contradicts Gordon Brown's comments on the Wanless report. In his Commons statement on November 27, 2001, Brown stated that employees in France still 'pay charges for every GP and hospital visit even after their social insurance premiums'. Even a slight knowledge of French healthcare reveals that, in over 80% of cases, *all* charges can be reclaimed by patients from their relevant insurers.

[38] The rate of employee contributions has now been reduced significantly, and the shortfall made up by money raised from an earmarked social security tax. In other words, France has moved recently to a system in which more reliance is placed on finance from general tax revenues. Such a base is seen as being broader and more equitable, since the burden is carried by all taxpayers, not just those in employment. For an excellent and recent study of French healthcare, see Green and Irvine, 'Healthcare in France and Germany: lessons for the UK', published by Civitas, 2001.

element of this scheme is its free provision to the needy of the supplementary cover offered by mutuelles and private insurers.

Together, mutuelles, private insurers and the CMU, combined with the public insurance funds outlined above, ensure that, for the majority of the population, any healthcare spending is fully refunded. The job of paying out claims made by members of the public, whether for doctor visits or hospital treatment, rests with the various insurers.

Healthcare Provision

The bulk of healthcare is not provided directly by the French government. For example, although the government ultimately owns three-quarters of hospital beds in France, hospital services are not financed directly by the state; instead, hospitals rely for their income on payments made by the various insurance schemes, acting on behalf of patients. Broad budgets are set annually by the government, which is anxious to try and contain the overall cost of healthcare in France. These budgets are, however, not binding, and the health insurance funds' reimbursements can, and often do, exceed the targets set by the government. In the hospital sector, these reimbursement rates tend to be based on the hospitals' past levels of expenditure, and so the incentive for hospitals to control costs is blunted.

With regard to primary care, most is provided by doctors (both general and specialist) in private practice on a fee-for-service basis. Around three-quarters of doctors are classed as 'sector 1' and the charges they can make are based on a nationally negotiated fee schedule (NGAP). Almost all of the remainder of doctors are in 'sector 2'. Doctors in this sector can charge more than the NGAP doctors, and this feature has proved so attractive that access to sector 2 is now heavily restricted.[39] In either the case of sector 1 or 2, the patient recoups all or most of the cost of treatment from his insurer(s).

Patients have a great deal of choice over the doctor and specialist they consult and the type of hospital they ultimately choose. Their respective insurance fund does not 'direct' them to certain hospitals or specialists, and is ideologically indifferent as to whether the hospital chosen is public or private.

● A Diffuse System

This brief overview of the structure of French healthcare begins to reveal why it is more successful than its English equivalent. It is not a bureaucratic top-down structure: the government does not try to do everything. Instead, the system is broken down into distinct, manageable parts, each with its own responsibilities. This is a practical outcome, not an ideological one: it is simply not possible, even for the finest administrators on earth, to manage, centrally, healthcare systems of this size. The French government, wisely, does not even try.

● Better Incentives

Most participants in the English system lack appropriate incentives. This is less of a problem in France, although weaknesses remain. The primary care sector largely comprises private sector doctors, whose incomes tend to be closely related to the services they provide, and are

[39] See Green and Irvine, op. cit., pp 41-42.

not, as in England, based largely and crudely on the number of patients registered with GPs. Because the profession promises a good income, and a large degree of autonomy, it has successfully attracted a large number of recruits. There is thus a large supply of doctors and specialists in France.

As in England, however, there is in France little incentive for public hospitals to restrain costs and generally use their resources thriftily. At present, the reimbursement of hospitals is based on past levels of expenditure. There is, therefore, a growing interest in France in paying for hospital treatment on the basis of Diagnosis Related Groups (DRGs).[40] In essence, for a certain medical procedure, there is a certain agreed standard (a DRG), based on international observation and calculation, of what such an operation should cost, allowing for certain variations. If a particular hospital is inefficient, and, for example, keeps patients in bed longer than necessary, or uses an unnecessarily expensive drug, then it will not be refunded for those extra costs. Singapore is already implementing such a system and Germany hopes to have their version in place by the end of 2003.[41] The author expects France to adopt a version of this system in the very near future.

● No Political Interference

There is some scope for political interference, particularly in the hospital sector, but this does not involve, as in England, meddling in daily clinical priorities. Because the staff in the public hospitals are classed as civil servants, they are subject to the general rules set for the entire civil service, including those that apply to recruitment, redundancy, promotion and wage setting. In addition, hospital boards are chaired by the local mayor, who has an incentive to preserve the jobs created by the hospital, rather than take a dispassionate view of the best use of hospital resources. These things should be viewed more properly as government-imposed rigidities: they are very unlike the kind of interference already studied in England. The diffuse structure of French healthcare, broken down into various legally distinguishable parts, prevents this. [42]

● A Positive Attitude to the Private Sector

France has a much more positive attitude to the private sector. Indeed, the funding of healthcare through insurance income has encouraged the foundation and growth of private clinics to specialise in routine operations. In the field of eye surgery, digestive diseases and endoscopies, for example, private hospitals handle around 80% of the work.[43]

Even the new CMU, a universal state insurance scheme for the needy, displays this healthy attitude to the private sector: members can, for their choice of supplementary insurance cover, choose between a public health insurance fund, a mutuelle, or a *private* insurer.

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[40] See Appendix 2 for a more detailed description of how such systems are designed to work, and also how the English equivalent, Health Related Groups (HRGs), affects the current financing of hospital care in England.

[41] Green and Irvine, op. cit., pp 69-70.

[42] For example, in 1997, the Government's 'Juppé Plan', instituted to try and regulate costs in the ambulatory (GPs and specialists) sector, was successfully challenged in Court, (Imai et al, op. cit., p. 20).

[43] Imai et al, op. cit.

France, in short, does not indulge the ideological nonsense that causes the British Government to view the private healthcare sector in England with, at best, suspicion and, at worst, public hostility.

● A Broader Focus

One of the weaknesses of English healthcare is its concentration on hospitalised care and neglect of preventative health screening programmes.

In the field of preventative health programmes, France is probably *inferior*: public health policies are still not properly developed, although they are improving.[44] Yet the French are much likelier to survive major diseases such as lung cancer. The main reason for this apparent discrepancy is the fact that, because doctors and specialists are readily available, and because, likewise, patients are not kept waiting for the necessary hospital treatment, the chances of catching diseases in their earlier phases are much increased. French survival rates are good, *despite* the relatively undeveloped public health system. The NHS is good at providing acute care but, if the system worked better, there would be fewer patients needing such care in the first place: their diseases would have been caught earlier, at much less cost to the state, and much less pain to themselves.

A further weakness of the system in England is its inability to focus on the broader requirements of care, such as nursing homes, non-acute hospitals and so on. Here again, the French are ahead: subsidiary funds of the public health insurers cover care for long term disabling illness, invalidity and so on.

● Relatively High Costs

The greatest weakness of the French system is its relatively high cost. Doctors and specialists are able to charge largely on a fee-for-service basis, and this has led to problems of supply-generated demand[45] in this sector. Hospitals, as we have seen, charge on the basis of past costs and so have little incentive to restrain such costs. More fundamentally, because the various supplementary insurance schemes now usually refund 100% of patients' spending, there is little incentive for patients to moderate their consumption.[46] The recently introduced CMU is likely to exacerbate this problem.[47]

The Singapore government is acutely conscious of this cost inflation problem, and, by studying the experience of countries like France, has found ingenious ways of trying to moderate it. Even Singapore, however, has not met with total success. Yet the specifics of Singapore's approach are less important than the underlying reasoning, and it is that which, after briefly

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[44] Imai et al, op. cit., p 15.

[45] This is what economists call supply-induced demand. Because doctors know far more about medicine than their patients ('information asymmetry'), they have a temptation to over-prescribe, safe in the knowledge that the patients are unlikely to argue, thus boosting their own income.

[46] Economists call this phenomenon 'moral hazard'. Because a patient bears only a part, or perhaps none, of the costs, he has no incentive to moderate his consumption. This phenomenon plagues insurance markets generally, and health insurance in particular.

[47] A further weakness is the burden on employers, who pay the bulk of the contributions to the insurance funds. This adds to the non-wage costs of employing people in France.

discussing healthcare in Singapore, forms the basis of the policy proposals outlined in the final chapter.

2.3 Healthcare in Singapore

Singapore is a small country with a strong, firmly entrenched, government. It can therefore take risks. Although it is run on strictly technocratic and meritocratic principles, grafted to those principles is the belief that all citizens should be properly protected, be able to buy their own homes and have access to good quality affordable healthcare. It is Singapore's success at combining the best features of the competitive private sector with the social and moral requirements of a modern democracy that offers such interesting insights for England.

● How Singaporean Healthcare Works

Singapore's healthcare system is a success: it was recently ranked sixth in the world by the World Health Organisation (WHO). It provides good quality care at a cost that is affordable for almost all Singaporeans. For those who cannot afford the necessary care, an effective safety net is in place. It is, in short, equitable. Healthcare costs are under control, so it is unlikely that a disproportionate amount of the nation's resources will be sucked into the sector. Hospitals are well run, most are modern, and all are forced to deliver value for money. There are no waiting lists.

Healthcare Funding

Every working Singaporean contributes to a Central Provident Fund (CPF). These contributions are compulsory, tax-free and comprise 20% of the employee's salary. The same amount is paid in by the employer. A person's CPF is his own property, and any monies remaining at the person's death can thus be passed to relatives. The monies in the CPF earn a competitive rate of interest.

Originally set up to finance peoples' retirement, the CPF was expanded in 1984 to cover healthcare in the form of Medisave. Out of the total amount, equal to 40% of the employee's salary, paid into the CPF by the employee and employer, 6-8% (depending on the relevant age group) is now directed into a portion of a person's CPF known as a Medisave account. From this Medisave account, a working Singaporean can withdraw funds to finance medical expenses incurred at approved hospitals. In short, therefore, *Medisave is a compulsory savings' scheme to finance healthcare.*

Medisave is bolstered by two government-devised *optional* insurance schemes: MediShield and MediShield Plus. The first was introduced in 1990, and is a low-cost catastrophic illness insurance scheme '…designed to help members meet the medical expenses from major or prolonged illnesses which Medisave balances would not be sufficient to cover'.[48] Premiums are kept low, and can be paid out of a person's Medisave account. MediShield Plus is simply a more generous version of MediShield, offering more perks but at the cost of higher premiums. MediShield Plus also covers treatment at approved private hospitals.

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[48] Singapore Ministry of Health website, 2001, 'Health Care Financing in Singapore.'

The government regulates the CPF, MediShield and MediShield Plus closely. It defines, first, the exact 'package' of healthcare that each scheme has to provide. Then, when a patient makes a claim under one of these schemes, he is obliged to pay up to a certain amount (the deductible). Above this, the insurance policy pays 80% of the cost, with the remaining 20%, the co-payment, to be paid by the patient. Deductibles and co-payments are designed to minimise the 'moral hazard' aspect of other insurance schemes.[49]

Medifund is the final main element of healthcare financing in Singapore. It is an endowment fund set up to act as a safety net for poor and indigent Singaporeans. It was established in 1993 and finances healthcare for those who, despite Medisave and MediShield, cannot afford their medical expenses. Applications for Medifund are considered by Medifund committees, which are based in each of the major public hospitals, and include individuals who are involved in community or social work, and who are thus usually aware of the applicants' predicaments. In the 1998 financial year, 69,300 Medifund applications were considered, and 66,900 approved. Successful applicants receive the same quality of healthcare as other patients.

Complex as this system is, it is important to remember that 'no patient in Singapore is turned away by a doctor or hospital because of inability to pay: the necessary treatment is always given first.'[50]

Healthcare Provision

The Hospital Sector

The public hospitals are ultimately owned by the government, but it does not try to run them directly. Indeed, all public hospitals have now been 'restructured', freeing them from civil service rules and giving them operational autonomy. They are expected to compete for income in the same way as a private hospital, and the government has even hinted that it would be prepared to allow any failing *public* hospital to close. In fact, the government now acts as the largest single buyer of healthcare from such hospitals[51]. Consequently, it demands value for money, paying hospitals only for specific work done, and not, as in France, on the basis of hospitals' general historical operating costs. In other words, hospitals currently charge for each operation, or other medical procedure. This system has its weaknesses, however. If a hospital keeps a patient for three nights when, medically, only two nights' stay is required, it would be reimbursed for this 'unnecessary' additional cost, and thus be 'rewarded' for inefficiency. Because of this problem, the Singaporean government has begun to introduce a DRG-type system known as 'casemix', which has been adapted from Australia.[52]

The Government deliberately subsidises treatment in the public hospitals to ensure it remains affordable. The subsidy system is subtle. Wards are divided into four types, and each type receives a different level of government subsidy. For example, 'b2' class wards, with six beds,

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[49] Please refer to footnote 46.

[50] Mr Yeo Cheow Tong, Singapore Minister of State for Health, answering a Parliamentary question, October 12, 1998.

[51] Because the government heavily subsidises hospital treatment, it is often paying the major share of hospital bills, although this share is dependent on the level of subsidy a particular patient has chosen.

[52] DRG analysis (of which Casemix is a variation) is complicated and a DRG system must be implemented carefully, and over time. For a better feel for the principles involved, and how it affects hospital financing, please refer to Appendix 2.

receive a subsidy of 65%. Class 'c' wards, which have more beds, receive an 80% subsidy. Class 'a' wards, in which a patient usually has a room to himself, receive no subsidy.[53] Across all wards, the quality of medical care remains the same: the only significant difference between the ward classes is the level of privacy. The author can attest that standards of cleanliness and orderliness are exceptionally high in *every* ward class.

An interesting feature of the subsidy system is that it is not means-tested. Thus, a Singaporean multimillionaire, if he wanted to take advantage of the 80% government subsidy, could choose to stay in a class 'c' ward.[54]

Primary Healthcare

Around 80% of primary care is provided by the private sector, which charges on a fee-for-service basis. For those who might struggle to meet the costs, the government owns and runs polyclinics, which are heavily subsidised, but given a large degree of operational independence. As everyone has to pay something, however small, there is some moderating effect on consumption.

- **A Diffuse System**

Singapore, like France, has chosen to organise its healthcare system flexibly. Its unique strength is its CPF saving system, which has proved easily adaptable to healthcare needs. Therefore, unlike in England, where perennial problems provoke constant structural upheaval, health provision in Singapore is settled. Progress and improvements are made on an ongoing basis, without upsetting the underlying structure.

- **Better Incentives**

Primary care in Singapore is largely left to private sector doctors, who charge on a fee-for-service basis. They thus obtain a market rate for their services, and are largely responsible for their own affairs. The profession has therefore proved an attractive one, and there is a ready supply of doctors.

Because both public and private hospitals are to be paid a casemix price for the work they do, they have an incentive to restrain costs and use resources thriftily.

- **No Political Interference**

There is no political interference in the day-to-day running of hospitals. The government instead agrees the basic health package that every Singaporean is entitled to, and then oversees the actual delivery, *by others,* of such a package.[55] It does not supply hospital

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[53] It should be noted that the government subsidy applies to all medical costs incurred in the hospital, not just 'bed' or accommodation costs.

[54] This is not true, of course, of Medifund, which is means-tested. A successful applicant for Medifund assistance has all his health costs paid by the government. Given the broad-based prosperity of Singapore, however, this means-tested portion forms a very small part of overall health expenditure.

[55] 'The basic package will reflect up-to-date good medical practice. It will contain essential and cost effective medical treatment of proven value. The treatment will be delivered without frills by trained personnel using appropriate facilities. It will exclude non-essential or cosmetic services, experimental drugs and techniques whose effectiveness is not yet proven, and extravagant efforts to keep gravely ill patients alive using high technology equipment, regardless of their quality of life and prospects of recovery' (Singapore Government White Paper, 1993, pp 3-4).

services directly, but is, rather, the nation's biggest single buyer of such services, and therefore adopts a commercial approach to the 'sellers'. In fact, the nearest the Singaporean government gets to direct delivery of healthcare to its citizens is via the primary sector polyclinics. Because these are heavily subsidised by the government, they do display some of the problems of NHS primary care; namely, over-use, and doctor frustration at the brevity of time he or she can spare to diagnose a patient.

● A Positive Attitude to the Private Sector

The Singaporean government has a non-ideological view of the private sector. So long as a private hospital abides by the conditions set by the government regarding the pricing, through casemix, of hospital care, Medisave holders can choose to go for treatment at a private hospital. Medishield Plus insurance policyholders can also be treated at private hospitals, provided, again, that the hospital adheres to the casemix pricing system.

● A Broader Focus

The Singapore government is taking a long term view of the country's health needs. In July 2000, it created a Community Health Screening programme that, over a period of three years, aims to screen 374,000 people over the age of fifty-five for illnesses such as diabetes, hypertension and high blood cholesterol. The elderly are encouraged to take part so that these ailments '…can be detected early and treated to reduce severe disabilities. In the longer term, this will result in lower social and medical costs.'[56]

At present, the scheme is voluntary, but the participation rate, despite heavy subsidy, has been somewhat disappointing. People are apparently afraid of what the tests might reveal so, in future, the Singapore government may move to some form of compulsion. The main point, though, is the fact that the state is trying to manage and contain future healthcare policies by adopting sensible screening policies now. Too many resources in England are instead spent expensively treating the *symptoms* of diabetes, high blood cholesterol and so on.

Singapore also views the whole spectrum of healthcare as a continuum, with, at one end, day care for those who are old and/or disabled but generally capable, with a little help, of living independently; through day care centres, nursing home care and community hospitals; to, finally, acute care in one of the major hospitals. It understands that no one part of the healthcare system works in isolation. For the 3% of elderly people who are expected to need full time care in a nursing home, for example, the government is creating an 'Eldercare' endowment fund, the interest income of which will go to finance those people needing such care.[57] Such a broad approach is better for the patients, who receive the level of care they need and desire, and better for the state's limited resources, since patients who could be treated in a nursing home relatively cheaply are not held, expensively, in an acute hospital bed for lack of anywhere else to go.

In a similar vein, the government recently reorganised public healthcare into two broad 'clusters', each comprising both polyclinics and hospitals. This is to improve patient care

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[56] Singapore Ministry of Health press release, August 23, 2000.

[57] Second reading in Parliament of the 'Endowment Schemes Bill', February 22, 2000.

across the whole continuum, allowing more seamless movement between family doctors and hospital-based specialists, for example.[58] Again, there is a focus on the broader picture.

- **Contained Costs**

Like France, Singapore delivers good quality healthcare. Crucially, unlike France, it has been able to keep health costs stable. It achieves this in many different ways. It stresses, first, individual responsibility for health: a person has to save for his Medisave account, but the monies accumulated belong to him, not to the state. When buying healthcare, he is therefore spending his own money, and is expected to think carefully before spending it. Secondly, even when a patient makes a claim under the MediShield and MediShield Plus insurance schemes, he is still obliged to pay the deductible and the co-payment.[59] He thus has a vested interest in ensuring that his medical bills are not 'inflated'.

To restrain hospital costs, the government, being the biggest single buyer of hospital services, has insisted that all hospitals begin charging for their services on a DRG basis. Costs were already well controlled before this, since the government paid hospitals only for work done, not, as in France, on the basis of historical operating costs. The casemix system will refine this, and ensure even better value for money.

2.4 Introducing Singaporean Reforms to England

Could the Singaporean system be adopted in England? The short answer is 'probably not'. Some of the specific features of Singapore's system, particularly the role played by the CPF, are unique to the country. While, in theory, the English tax and saving systems could be drastically reformed in this way, there would be enormous practical difficulties in doing so. The reform programme advocated in this paper already involves major changes; as all change provokes criticism and resentment, fundamentally changing the English tax system *as well* would be a step too far. A further problem is that, because the CPF saving scheme, the core of the Singaporean healthcare system, is based on contributions paid out of gross income, a potential equity question would be raised if the same principle were to be adopted in England: different people would have different levels of savings to finance healthcare. While, in principle, this equity problem could be mitigated, for practical *political* reasons this paper rejects the idea of a compulsory savings scheme to finance healthcare in England. Such a scheme would expose the reformer to too much political flak.

That said, many of the specific ideas in Singapore *can* be adopted: health screening programmes; a broader focus on non-acute aspects of healthcare; and the use of insurance policies, to list just some of these ideas. Far more important, however, is the *underlying reasoning* behind the Singaporean healthcare system; particularly its emphasis on individual choice and responsibility. France, as we have seen, also ensures that patient choice is a paramount consideration. Indeed, it is these two principles – choice and responsibility – which infuse the proposals outlined in the following chapter.

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[58] Speech by Mr Lim Hng Kiang, Minister for Health, on November 20, 2000.

[59] See Appendix 2.

2.5 First Principles of Healthcare Reform in England

● Introduction

To reform the NHS successfully, several fundamental principles must be observed. We have identified, in an earlier chapter, the profound weaknesses that afflict healthcare in England; so the solutions proposed must target precisely such weaknesses. Furthermore, the French and particularly the Singaporean healthcare systems give us clues as to precisely how such weaknesses can be tackled.

● A Less Bureaucratic, More Diffuse Structure

The problem is not that the NHS is large, but that it is too rigid, too centralised, too bureaucratic and too unaccountable. Neither France nor Singapore attempts to run its health system from the top down using government diktat. Instead, different institutions, with separate legal and financial identities, are responsible for different facets of the system. In England, the 'command economy' approach to healthcare provision must be ended, once and for all. A new structure must break down responsibilities, so that each element in the new system understands where its own duties lie, and, equally importantly, is given the authority to carry out those duties. A new structure must also have a certain balance, so that no one type of institution is able to exert a disproportionate amount of influence over the others.

● Better Incentives

The NHS regularly fails to give the people who work within it decent incentives. GPs, nurses, surgeons and managers can be superb or indifferent performers: the present system makes little distinction for quality. It has already been shown, in private sector industries, that if people are responsible for their own affairs, if they can be held accountable for their actions, if they have the authority to do what is necessary and, finally, if they are suitably rewarded for their efforts, then remarkable changes can be wrought. The author knows several examples of firms in eastern Europe which have been able to transform themselves from lumbering state-owned manufacturers into profitable firms able to compete with western competitors. Healthcare is admittedly more complicated than these cases, but the same transformation of incentives must, one way or another, be achieved.

The present absence of the right incentives means that the NHS is stagnating and its morale is falling. The Government's response has always been to create another institution to enforce standards in the existing NHS structures. Put another way, the Government's response has always been yet more structural change. This approach is inadequate. Equally, although incentives could be improved by a better regulatory regime,[60] that, *in itself*, is in our view insufficient to secure a fundamental improvement. Employees of the NHS need more than just the stick of regulatory sanction and enforcement; they also need the carrot of greater reward for better quality work.

● Less Political Interference

The structure of the NHS is dangerously vulnerable to political interference in the day-to-day running of hospitals. Only in England, it seems, can the political demands of media-sensitive

[60] Chris Philp, The Bow Group, op. cit.

politicians override clinical objectives set by hospital managers and doctors. The President of The Royal College of Surgeons recently stated outright that politicians should get out of the way and leave the running of hospitals to professional managers.[61] Even the French government, the supposed paragon of state interference in industry, has not been foolish enough to try and interfere in the running of hospitals. A successful reform programme must therefore *guarantee* the NHS protection from political meddling.

- **A More Positive Attitude to the Private Sector**

We have seen how the Government's attitude to the private sector is often absurd and always confusing. Private insurers have unique skills in pooling risk, and healthcare is all about the risk of falling ill. These skills must, therefore, be harnessed. Private hospitals, too, could play a far larger role in the provision of much routine hospital treatment. In the words of Barry Hassell, chief executive of the Independent Healthcare Association (IHA), '…we could make quite a difference to the waiting lists if we could have an open, non-threatening dialogue with the government… there is spare capacity'.[62] The private sector must be an integral part of a reformed NHS.

- **A Broader Approach**

Successful reform must target all health needs, not just certain parts of these needs. A day care centre for the elderly is as worthy of consideration as an acute hospital. There also has to be a fundamental shift of resources, over time, towards targeted health prevention and screening programmes. Only in this way, in the longer term, can costs be better controlled and the survivability of major diseases improved.

- **Control of Costs**

A reformed system would be a largely self-regulating one, in that each element of the structure would have an incentive to use resources thriftily. If a system based on the same principles as the Singaporean were introduced into England, making use (for instance) of private insurance, the private insurer would be keen to ensure that it was being charged a fair price for a particular operation. NHS hospitals, knowing that they would invoice only for specific work done, and knowing that the Government would not step in to meet any budget shortfall, would also have a strong incentive to restrain costs. Finally, the patient, spending what would be in effect his own money, would be expected to think carefully before spending on healthcare services. All of these factors, and others, would combine to create a system in which costs are controlled.

2.6 Conclusion

Any successful reform of the NHS must adhere to all of the principles identified in the last section by making use of the experience of France and, particularly, Singapore. Policy proposals for England must be workable in practice and viable politically. It is no good proposing changes that leave the would-be reformer easily vulnerable to the caricatures of political opponents and the vested interests that benefit from the status quo.

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[61] *The Daily Mirror*, December 7, 2001.

[62] *The Daily Telegraph*, January 19, 2000.