

# Reforming the National Health Service

Reflections on four decades of NHS care

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# 1 Introduction

The current debacle over the Health and Social Care Bill mirrors the failure of past attempts by governments to get Britain's National Health Service (NHS) to match the performance of health care systems in comparable developed countries. The long waiting lists and poor standards of much NHS health care have caused tens, if not hundreds of thousands, of Britons to die much earlier than they should over the last fifty years, or suffer avoidable long term disability. This has been very costly for the UK economy in terms of reduced GDP, lack of international competitiveness and increased costs of welfare dependency.

Unfortunately, in trying to correct this state of affairs, Health Secretary Andrew Lansley produced a bill which proposed the creation of yet another set of complicated managerial tools and organizational structures designed to achieve aims which, by their nature, were quite incapable of being achieved. Not only were they fundamentally misconceived, springing as they did from political rhetoric rather than having any grounding in reality but, to the extent they introduced competition in the delivery of health care, they would inevitably be opposed by the powerful doctors' trade union, the British Medical Association (BMA).

What Mr Lansley seemingly failed to appreciate is that the principal obstacle to improving health care in the UK is not the structures or the financing, but the joint opposition of the Royal Colleges and the medical trade unions to any attempt to introduce genuine competition. Their baleful influence has ensured that, alone amongst all other professional services, health care remains a fifties-style nationalized industry – a cartel whose members are committed to maintaining, in all essentials, the basic reward structure they negotiated in 1948, and which has served them well for the last sixty years. The result has been that Britain, which prior to 1948 was recognized as having the best hospitals and doctors in the world, is now ranked 18th in survival to age 60 per thousand of

population by the World Health Organization – a ranking well below that of many nations which sixty years ago had only rudimentary health care systems.

It may be useful before getting to grips with this central problem underlying the NHS to say something about cartels for those with no direct experience of operating one. Prior to the Restrictive Trade Practices Act, 1956, industrial cartels operated quite legally in Britain. My first line management job was running a business which was part of a cartel of about 100 firms which controlled the imaging and manufacture of printing plates and cylinders. By agreements between ourselves and the trade union, we restricted entry to the trade to ensure a steady flow of work at prices which were fixed to maximize profits and thereby enable us to pay exceptionally high wages to the 16,000 trade union members employed in our closed shops.

When the RTPA made our cartel illegal we found ourselves having to face competition, for the first time ever, from both within our former cartel and from new entrants to our industry. This led to widespread changes to our working practices, the rapid introduction of new technology, and downward pressure on company profits and employee wages. But the advent of competition also produced immense benefits for our customers and the wider public. Work that under our ‘no compete’ agreements we would have taken several weeks to complete was now done in a matter of days at a fraction of what we could once charge. These changes made possible the low cost production of the wide range of colourful printed packaging of all kinds that meets the eye in today’s supermarkets, the numerous colour magazines seen in any newsagents, and the widespread use of colour photography and other illustrations in newspapers, mail order and advertising literature. None of this would have been possible had we not been forced by law to change from being a cartel operating for the sole benefit of ourselves and our employees to being a highly competitive modern industry.

The reforms introduced by Mr Lansley in his Health and Social Care bill sought, albeit in a limited and overly bureaucratic way, to use competition to improve the quality of medical services in Britain. Since the formation of the NHS, health care has been run as a state sponsored cartel for the benefit of doctors. They

not only controlled all access to our taxpayer funded public hospitals, but many were also able to augment their incomes further by ensuring that those hospitals offered a substandard service such that most patients who could afford to opted to be treated privately by the same doctors. This enabled these doctors to earn a substantial additional income over and above the generous salaries they already obtained from the taxpayer.

Before looking in more detail at how the medical profession has enriched itself to the detriment of both patients and taxpayers it is important to understand why politicians of all parties support the continuance of the NHS as a taxpayer funded service, free at the time of treatment, despite the evidence that it provides a lower standard of health care than exists in countries where health care is funded by social insurance schemes with compulsory patient co-payments at the time of treatment.

## **2 Why have a taxpayer funded National Health Service?**

From the politicians' point of view, the principal advantage of an entirely taxpayer funded health service is that by inducing a sense of dependency, it helps them to control peoples' lives to a much greater extent than they would be able to if people were able to choose for themselves how they funded their health care. By depriving the majority of the population of free choice in an area as critical to their lives as their personal wellbeing, politicians exercise a form of control over them in much the same way as an animal trainer is able to train an animal by the giving or withholding of its food. Another advantage from the politicians point of view is that while they strip the population of any real choice in one of the most fundamental aspects of their lives, they can at the same time posture as the peoples' champions by constantly declaiming the strength of their allegiance to the 'principles of the NHS'.

The constant flow of encomia on the NHS from all politicians and much of the media (in particular the BBC, a significant portion of whose drama output is devoted to showing NHS staff in the most favourable possible light) has disguised the growth, since the mid-sixties, of a system of two tier health care in the UK.

We are now a country where life expectancy depends on income to an extent that would have appalled Aneurin Bevan, had he ever suspected that it would be – at least in part – the result of him conceding that doctors would be able to combine work for the NHS with private practice. Today, those who can pay for private care live longer and suffer less morbidity than those who must rely on the NHS. This can be clearly demonstrated by comparing ward-based mortality tables, which differ widely between high income and low income electoral wards in all our cities – even though theoretically the same NHS hospital and the same consultants are responsible for the delivery of care in all of them.

Given that the NHS has been described as ‘the national religion’ it is as well to examine the so-called ‘founding principles of the NHS’ much more carefully than has hitherto been the case. These founding principles are set out in the Health White Paper and the Bill:

*‘The vision (for the NHS) builds on the core values and principles of the NHS – a comprehensive service, available to all, free at the point of use, based on need, not ability to pay’*

This appears on the face of it to be a wonderful set of principles on which to base a health service. Surely no one could disagree with it? Yet if we look at this vision more closely we find it is not a vision – it is a fantasy.

*Firstly*, the NHS doesn’t provide a ‘comprehensive service’ if this is intended to mean it provides a service which is available to everyone on equal terms. For many patients the NHS provides only a second rate vestigial service, as I will show later in some detail. Indeed, the White Paper itself accepts that there are variations in the standard of patient care the NHS offers. It says one of its key aims is to provide access to information which will give patients ‘the information they need about the best GPs and hospitals’. This implies that some GPs and hospitals are not as good as others and in itself belies the earlier claim that it provides a comprehensive service.

Tesco does not provide a list of which of its supermarkets are best – it does not need to. Competition in the market ensures all offer a more or less identical



standard of service. The employees at stores which cannot reach this required standard are rapidly replaced with others who can. By this means a culture is created where all staff know what is required of them and that no prisoners will be taken.

*Secondly*, the service is not ‘available to all’ – it is only available to the extent that the medical staff to whom the government delegates patients’ care choose to offer it to a patient, or offer it within a time frame and of a standard of quality that would be regarded as acceptable by the patients if they were paying for the service at the time, rather than paying for it in advance and then having to take what they got.

*Thirdly*, ‘free at the point of use’ is meaningless. A restaurant does not charge its customers until after they have eaten their meal, but few restaurateurs would claim their meals are ‘free at the time of eating’.

*Fourthly*, ‘based on need’ begs the question as to who decides what the need is. In the NHS treatment is decided by a clinician who is not directly responsible to the individual patient, but rather has a general responsibility to provide health care to that section of the population in his area or his field of expertise and within a budget determined by others. This by definition limits – and may preclude – his or her acting solely in the interests of any individual patient.

*Fifthly*, the words ‘not ability to pay’ create a charter for those who choose not to pay, but instead take a free ride on the backs of those who do. This is morally and economically unjustifiable. It has of course led to the widespread abuse of the service and waste of resources. It is moreover the principal engine of the ‘welfarism’ which removes the sense of personal responsibility essential in a free society, without which such a society cannot in the long term survive, and which is the essential driving force in securing economic growth.

### 3 The denial of competition and patient choice in Britain's health care system

Even if one dismisses the sentiments of the White Paper as mere rhetoric, there remains an even more fundamental objection to the Bill's adherence to these so called principles. This is that it continues to put decisions about patient care with clinicians, rather than with patients. The Health Secretary's slogan 'No decisions about me without me' is in fact a trite and meaningless sound bite. If the funding is not there, or is allocated in a way that limits the funds available for a particular patient or group of patients treatment, then a decision will be made about the patient's treatment whether the patient agrees with it or not.

To make matters worse for patients even the limited scope for competition amongst providers which was central to Lansley's bill has now been snuffed out by the NHS Future Forum. Panicked by adverse public reaction to the proposed reforms, the coalition government essentially decided to ditch them. To save as much face as possible, the prime minister set up a 'panel of experts' whose ostensible remit was to 'improve the Bill'. But in reality they were to be permitted to take out anything in the bill that the doctors didn't like. For that reason its membership of 44 comprised 21 doctors, 8 NHS bureaucrats, 14 other public or voluntary sector managers and just one patient representative. Removing even the limited competition Lansley tried to introduce means the medical establishment's taxpayer-funded gravy train will continue to roll for at least another decade.

Yet ironically the BMA's objection to the introduction of competition is not with competition per se. Indeed, its members by and large already compete with the NHS by providing private treatment for anyone who is willing to pay them a fee. What they really object to is that the substantial income they derive from this private practice will be significantly reduced if NHS patients are able to access better quality care from other providers than they would get on an NHS ward – and, crucially, without having to pay BMA members an additional fee for this care.

## 4 Does the NHS really meet the nation's needs?

Here we touch on another misconception about health care delivery in the UK. The NHS claims the overwhelming majority of NHS patients express satisfaction with the treatment they receive; yet as the NHS has no genuine competition, how accurate is this claim?

Considerable caution must be shown when viewing the NHS's patient satisfaction ratings. It is essential to break down the raw patient approval figures into different categories before any weight can be attached to them. No such analysis has ever been done by the Department of Health. Yet for the figures to have any relevance or validity it should exclude patients in the following categories:

1. Patients who normally enjoy good health, but then have a minor illness or suffer a minor accident. Such patients are easily and quickly treated by the NHS and then return to full health within a few days or weeks.
2. Patients who, for financial or ideological reasons, will suffer any amount of delay, discomfort, pain, or outright failure of treatment, rather than pay anything towards treatment – even if you could prove to them beyond doubt that their condition could be cured by paying for alternative treatment in the private sector.
3. Patients who are obliged to use the NHS as they cannot get private medical insurance due to a pre-existing condition, or who require treatment not generally available under private health insurance policies – like cosmetic surgery, in vitro fertilization, or HIV treatment – or who require long term treatment for, say, cancer or renal failure, which most private insurers cannot cover the cost of, as their narrow customer base and competitive premiums preclude the funding of such care packages.
4. Patients admitted as an emergency to NHS care who have never before been in a hospital, let alone in a hospital in a country with a more advanced health service than the UK's, and therefore cannot compare the care they received from the NHS with the care that they might have received in another country or in the private sector

5. Patients in public sector employment who qualify for paid time off for illness and who therefore suffer no loss of income due to delays in NHS treatment.

6. Immigrants from third world countries which either have only a rudimentary health service or one which requires the patient to pay for treatment. These people are not concerned with the standards or responsiveness of NHS care – they are grateful for any free care at all.

When all the above groups are excluded, I am certain the number of patients satisfied with the treatment they or their family have received from the NHS would at the very least be halved, making the NHS in terms of patient approval ratings probably the most unsatisfactory health care system in the developed world. This may seem a bold claim, but unfortunately my own experience bears it out.

## **5 The patient experience: a personal journey through the NHS**

As the medical profession claims it bases all decisions about patient care on evidence-based research, it is perhaps useful to carry out a reality check by looking at my experiences as an NHS patient. I do not suggest that my own experiences reflect those of a typical NHS patient, if only because most accounts of patient experience are based on a relatively short period during which the patient was under NHS care for one particular illness. My account is based on forty-five years' experience of NHS care in a variety of different settings and for a variety of different, serious conditions. Many of these conditions were themselves caused by incorrect or poor past NHS treatment protocols, in much the same way as the failure of a skilled mechanic to carry out a timely repair to a car engine will result in the need for more extensive future repairs to that engine, or even its complete breakdown.

By looking at a number of different NHS services it will be possible to demonstrate that sub-standard treatment is not an isolated incident confined to one category of care, but is present throughout all areas of the service.

## **NHS Renal Services**

Forty-five years ago my kidneys failed following a course of an antibiotic I had been prescribed for a chest infection. Unknown to my doctor, this particular antibiotic could have nephrotoxic effects if taken for more than a few days by patients who had some kidney damage. I apparently had some kidney damage as a result of childhood nephritis caused by a streptococcal infection – the result of drinking water taken from a well at a farmhouse in North Wales while on holiday with my family when I was ten.

This had cleared up after a few weeks and I had no reason to suspect I had suffered any long term effects. Indeed, I had passed both employment and life assurance medicals without any difficulty and was a keen sportsman. The failure of my kidneys meant I had the misfortune to have to go on dialysis, becoming in 1966 one of a handful of patients offered dialysis by the NHS. In fact, had my kidneys failed even three months earlier I would not have survived.

This was in stark contrast to the situation in most Western European countries, where the social insurance funding of health care had made dialysis quite widely available where it was required. Eight years after I had commenced dialysis treatment, I took a holiday in Spain and arranged to get dialysis there. I noticed an elderly patient was on dialysis in the clinic I attended. He was a bilateral amputee and had only one arm. He told me he was 86. A few days later I mentioned to the doctor who ran the clinic that I was surprised at the number of elderly patients on dialysis there as at that time there was still a cut off at age 50 for NHS dialysis. I still recall his response: 'Ah, yes, I understand you do operate such a policy in England. You complain about our killing bulls, but are happy to let people die. We think you are just barbarians.' His rebuke was delivered in a friendly enough fashion, but for the first time I began to question the so called principles on which the NHS was based.

How could it claim to offer a comprehensive health care system when it left so many people to die when a treatment was readily available? How could what was happening on the ground be reconciled with the stated aims of the NHS to provide a service that was comprehensive, available to all, and based on need,

not ability to pay? Why were the Spanish able to offer dialysis to everyone who needed it, but we who were living in a far richer country could not?

These were questions I returned to many times over the years. In total, I spent eighteen years on dialysis hoping to be offered a kidney transplant by the NHS, spending what should have been the best years of my life living like a man serving a lengthy prison sentence with no known release date. Despite making my wishes clear to the doctors in charge of my care, I was never offered a transplant. In the end, I managed to obtain a kidney transplant only because a nephrologist at a hospital I sometimes dialyzed at in Belgium was so angry at seeing me left on dialysis for so long that he bent the rules to put me on the Euro-Transplant list as a Belgian patient. The Belgians found me a kidney within a few months, and it is still functioning well today. The experience made me realize despite the boast that the UK has a joined up, unified and comprehensive health care system, we in fact have nothing of the sort. I was paying taxes to support an organization that couldn't achieve in eighteen years what the European social insurance model of health care achieved for me in five months.

It seemed that as I was dialyzing myself at home, I was to be left to continue on home dialysis indefinitely, even though the NHS consultants responsible for my care knew that the longer a patient was left on haemodialysis, the more likely it was that the excess calcium leached from their bones by high levels of parathyroid hormone and serum phosphorus would lead not only to progressive demineralization of bone, but also that the excess calcium deposited in their arterial system would bring in its wake the early onset of cardio-vascular and peripheral arterial disease.

To me, this exemplifies the dangers in allowing clinicians to make decisions about which patients will get treatment and when they will get it on so-called 'clinical grounds'. This is a right they safeguard jealously, but it disguises a great number of discriminatory and unethical practices. At any given point in time, and however many months or indeed years you may have been waiting for treatment, it will always be possible for a clinician to argue another patient is in 'in greater need of treatment'. Patients are therefore reduced to the status of unknowing competitors for treatment, instead of being free to choose a doctor who offers

the best combination of good quality treatment and a reasonable timeframe within which the treatment will be carried out, in the same way as a patient with private medical insurance does.

### **NHS Cardiology**

The low opinion I had by this time formed of the treatment offered by most NHS consultants was reinforced when, nine years later, I was listed for heart bypass surgery by the NHS cardiac consultant to whom I had been referred with persistent angina, caused by the deposition of calcified plaques in my coronary arteries. I once again found that my wishes and needs as a patient were irrelevant. I was fobbed off with the usual mix of lies, evasions and excuses about there being a long waiting list, limited resources, and so on. After four years on the hospital's waiting list for bypass surgery I was again left with no option but to go overseas for the treatment I needed. Of course I could have paid for the surgery as a private patient in the UK, but like most people I have an objection to being blackmailed into paying an NHS consultant a fee to do something he had already been paid for out of my taxes.

Typically, when I complained to the Department of Health about the delays that had led to my having to seek treatment overseas, an enquiry was set up into the management of waiting lists at the hospital concerned. As a result of the enquiry, the hospital's chief executive and her deputy were both dismissed. It was found the hospital had been removing patients from the list who had been on it for more than eighteen months and was then putting them on a new list so that it appeared they were still within the maximum eighteen-month waiting time that the government had promised NHS patients. In my case, my name had been removed twice as I had reached the 18 month maximum twice and still not been offered the surgery I was listed for.

This practice must have been known to the cardiologist and cardiac surgeon who were supposedly responsible for my care at that hospital. In fact I had written to them three times to draw attention to the length of time I had been waiting for surgery. I could not help suspecting that it was their intention to deny me the surgery I needed as, some years previously, while an elected member of the regional health authority, I had caused an enquiry to be made into the

high mortality rate at a new £5 million cardiac surgery facility in the region. This enquiry resulted in the closure of that unit, which had a post-operative patient survival rate of barely 70%, and the redundancy of the heart surgeons employed there. This meant referrals were directed to the two main regional centres, which had good results, but undoubtedly this reduced the time the consultants there could spend on their private work.

It would of course have been far easier at that time to simply replace the two cardiac surgeons at the new unit with more skilled and experienced surgeons. However, the health authority feared that their trade union representatives, supported as they would be by the Royal Colleges who had approved the qualifications and experience of the surgeons concerned, would be so opposed to this course of action that it would only be possible to dispense with their services by closing the unit down, and mothballing it for a number of years to allow the dust to settle. This demonstrated for me once again the power of the medical trade unions to intimidate any NHS managers who tried to discipline them. The recent press report about an NHS cardiologist remaining suspended on full pay for 5 years, at a total cost to the hospital in Ipswich that employed him of close to one million pounds in salary and legal fees, illustrates the difficulty the NHS has in getting rid of consultants they consider to be incompetent.

### **NHS Orthopaedics**

My next brush with the NHS was when I found I needed revision surgery for the hip replacements I had paid for as a private patient twenty-four years earlier. The NHS would not at that time offer me this treatment, even though it was the extended time I spent on dialysis that had eroded the femoral heads on both legs and left me in constant pain while walking. Twenty-four years on, the hip prostheses which had served me well and enabled me to work and pay substantial personal and corporate taxes were wearing out. Indeed, one hip joint had actually dislocated leaving me in constant pain on movement as the steel prosthesis constantly grated against the surrounding bone.

After spending over twenty months on crutches I realized that if I didn't take matters into my own hands once again I would be left to wait forever. Eventually I could hardly walk and could only work part time. I managed to get out of the



country on a wheelchair and was able once again to get the hip revision surgery I needed done overseas within the same month. I returned home with a pain free hip and within two weeks was walking normally and had resumed full time work.

### **NHS Ophthalmology**

Despite the sums spent on the NHS by the Labour government, the highly unsatisfactory situation UK taxpayers are in is readily demonstrated by my most recent experience of NHS care. Four years ago I suffered a detached retina when I fell off a stepladder. Now, retinal reattachment surgery is a speciality within ophthalmic surgery and for this reason the taxpayer funds consultant vitreo-retinal surgeons in all NHS tertiary referral centres for eye surgery. All cases of detached retinas are referred to these surgeons, as research by the Royal College of Ophthalmologists has found that even experienced ophthalmic surgeons achieve poor results in retinal reattachment work unless they specialize in it. In specialist hands there is a 95% chance of a successful reattachment. My operation unfortunately proved to be unsuccessful and as a result I was left completely blind in one eye. I obtained the theatre notes to see if I could find what had gone wrong, and discovered I had not been operated on by any of the three consultant retinal surgeons at the hospital. My surgery had been delegated by the consultant in charge of my care to a junior doctor from Pakistan who was on a training course at the hospital, and who had no UK qualifications in ophthalmic surgery whatsoever. I was for obvious reasons never informed let alone consulted about this, only becoming aware of it when at a later date I insisted on seeing the theatre notes. The consultant retinal surgeon in charge of my 'care' had apparently decided to leave the hospital that Friday lunchtime – leaving my eyesight in the hands of his inexperienced junior.

### **Community health care by Primary Care Trusts**

Substandard care and risk taking with patient's lives has long term implications both for the patient and the wider economy. As a result of my loss of any right-sided vision I subsequently failed to see an obstacle in my path and badly cut my shin. The wound did not heal. The modern procedure with a slow healing wound in such a critical area where blood supply might be limited in many older patients is, as I now know, to apply a vacuum system to obtain granulation of the wound as quickly as possible, and thus avoid the development of the ulcer

that will form if the cut fails to heal quickly. However, the primary care clinic treating my leg did not have access to this equipment (which can be leased for about three hundred pounds a month) and therefore applied various types of dressings, none of which proved effective. After eight months treatment the wound had not only failed to heal, but by then a large ulcer had formed in the affected area.

At this stage I paid for a private consultation with a vascular surgeon and learnt, for the first time, about the application of vacuum treatment to the wound. Unfortunately by then the ulcer had become so deep that despite the vacuum treatment being applied, it failed to granulate successfully. So what had been a superficial cut of about one millimetre depth in the skin directly above the shin bone was now a 2 centimetre deep ulcerating wound with my shin bone clearly exposed at its base as so much tissue had been lost in the eight months in which the primary care trust had failed to treat the wound effectively. This left me with no option but to have my right leg amputated below the knee and I now have the inconvenience of a prosthetic leg.

The examples of NHS care set out above are just those that have had the most serious consequences for me as a patient. In the course of preparing this paper, I have reviewed the records of each of the 32 surgical procedures I have undergone in the last 45 years. 25 of these operations were done in the UK, 7 were done overseas.

Of the UK operations 8 were done under the NHS, 17 were done in the private sector. These 25 operations were all either medium risk (e.g. primary hip replacement, femoral popliteal artery bypass graft) or low risk (e.g. carpal tunnel release). None were high risk either in terms of surgical/medical complexity or risk to patient survival. Only 3 of the 8 surgical procedures done under the NHS were successful, whereas 16 of the 17 operations done in the private sector, where the surgeon and hospital was selected by me, were successful. Over the 25 procedures there was no difference in the level of complexity or risk as between the operations done under the NHS and those done in the private sector.

Of the 7 operations done overseas all were major procedures in terms of both surgical/medical complexity and the risk to patient survival (e.g. triple coronary artery bypass, kidney transplantation). All were successful.

In Britain, a system where patients have no right to select the surgeon who will operate on them has led to semi-skilled surgical trainees (some of whom may be competent and capable, but all of whom have limited operating experience) being left to carry out procedures which are often beyond their competence, with disastrous consequences for their patients.

## **6 Difficulties in obtaining redress or compensation for patient injuries caused by poor NHS care; Comparison with the position under insurance-based systems**

In such circumstances NHS patients find themselves facing yet another raw deal in that few are able to obtain any compensation for personal injuries resulting from such substandard care. When a claim is made the medical profession is usually able to evade any serious sanctions because of the rule in 'Bolam' (a case which laid down rules which govern judges in clinical negligence cases). The Bolam rule means a patient has to show that his or her treatment fell so far below the accepted standard of medical treatment that the doctor must have been negligent. This means that in most cases, unless the patient can find two NHS consultants willing to testify that the treatment they received was significantly below the standard of care they should have received, the patient will lose their case and face a substantial counterclaim for costs. It is exceptionally difficult to find consultants willing to criticize a colleague in this way, making it almost impossible for most potential claims to proceed.

This is in stark contrast to the position of patients in an insurance-based system, where they are not just reliant on making a claim for personal injury on the basis of the breach of the doctor's or the hospital's duty of care. They also have the right to make a claim in contract law if they have paid, either directly or together with their insurer, for treatment that is not provided to a satisfactory standard for any reason that was in the control of the doctor or the hospital. Moreover, in the

event that further surgery is required to put right a procedure that was carried out badly, the insurer will also make enquiries as to why the fund should pay the doctor and the hospital twice for the same operation.

Because of the ease with which most NHS doctors can evade personal financial loss arising from negligent treatment of patients, or failure to properly supervise their care while in hospital, the quality of most NHS care is significantly worse than the care patients receive under insurance-based health care schemes.

## **7 The financial cost to patients and taxpayers**

Leaving aside the disastrous personal consequences for patients of much NHS care, the sheer financial loss caused to patients and to taxpayers is enormous. Over the last forty years I have spent more than £150,000 out of my after tax income in purchasing private health care both in the UK and overseas to make up for the deficiencies of the NHS . After voluminous correspondence, solicitors' letters and the threat of legal proceedings under EU law I eventually managed to get about 25% of this refunded from the Department of Health leaving me about £112,000 out of pocket. This sum is nevertheless dwarfed by the loss of income I have suffered in terms of loss of profits from my business. These are more difficult to quantify, of course, but I calculate that I have lost well over two million pounds of income during my working life as a result of the failure of an NHS care system that pays no attention to patients' needs or wishes, making it quite incompatible with running a business, or holding down any kind of demanding employment. I suspect that if an account was taken of the true cost of NHS care to Britain, it would amount to a significant constraint on GDP. Inflexibility, delays and poor diagnostic and treatment methodologies are built into a system which is designed more for ensuring that BMA members continue to operate a highly profitable cartel at the expense of the public, rather than for providing the responsive, high quality health service the country needs if it is to compete with our main overseas competitors.

## **8 Comparing the NHS with hospitals in countries with social insurance systems of health care – the patient’s perspective**

The difference in efficiency levels and the service offered to patients as routine in the largely privately-owned hospitals in countries like France, Germany, and Belgium and a typical NHS hospital is enormous. When I refer to these hospitals as privately-owned, this does not necessarily mean they are run at a profit that is distributed to shareholders, but rather that they are run to ensure there is an annual surplus of income over expenditure, as only in this way is it possible for them to have the funds to improve the facilities of the hospitals and thus the service they provide to patients. Many are owned by universities, or part-owned by local authorities or trade unions, charitable foundations or religious orders, or indeed insurance companies. The key difference is they are not owned by the state.

I have used overseas hospitals a lot over the years. In addition to having major surgery overseas on seven occasions, I would frequently dialyze at overseas hospitals when on business trips. This gave me many opportunities to compare the standards in those hospitals with standards of care in NHS hospitals.

Let me give an example of what I mean. Arranging a dialysis in an NHS hospital in London meant I had to get not only a letter from my consultant, which was fair enough, but had also to bring a copy of all my medical records, a disposable dialyzer, and an AA certificate (confirming I didn’t have hepatitis) dated no earlier than a week previously. When I arrived in the evening with all this I would generally have to wait around for up to two hours before they would have a room free, and invariably the room had not been properly cleaned after the last patient. This meant I had to start with a bucket and mop, and wash down all surfaces and the floor, then find where they kept the saline, hunt for a drip stand and a giving set and the rest of the disposables I needed.

Yet if I wanted a dialysis during a business trip to France, Belgium, Germany or the United States, a simple phone call or letter to the hospital with a note from my doctor in England was all that was needed. Everything was waiting for me

when I arrived so that I could dialyze myself right away and go. So while the NHS provided a dialysis that was technically 'free at the time of treatment', the time and money spent getting that NHS 'free' dialysis meant it was considerably more costly than the one I paid for.

## **9 Why have NHS managers failed to get better value for the taxpayer?**

The opinions in this paper are robust, but are based not only on decades of personal experience at the sharp end of the NHS, but also on the collective experiences of numerous NHS patients I have spoken to about their treatment, whether in hospitals or after they have been in hospital. I also served as a member of a regional health authority for four years, during which time I visited many hospitals to discuss performance, patient complaints, and budgetary and other compliance aspects. After thirty years in industrial line management I was shocked at the poor standard of NHS managers. Few would have been able to find employment in the private sector – and almost none at the level of remuneration they received from the NHS.

The NHS throws up endless examples of incompetent resource management, as well as poor doctoring and nursing. My abiding impression of the NHS is that unlike in private industry, where inefficient and time wasting practices were largely ended by management when the Thatcher governments' employment reforms limited the immunity of trade unions, these practices are still common amongst all grades of NHS staff from senior consultants to junior ward staff. This will continue while health care remains essentially a taxpayer-funded state monopoly, as this is the natural order of things in all monopolies not subject to the disciplines of the market and where the employees are protected by powerful trade unions.

Slipshod working practices will always arise in any organization where there is no prospect of immediate dismissal by management. In the NHS managers, whether at ward level or higher, have very limited disciplinary powers over other

NHS employees, and no great incentive to enter into confrontations with them or their trade union representatives. Indeed, there are virtually no sanctions that can be imposed on senior medical staff except in the most exceptional circumstances. When disciplinary action is finally embarked on the employee's trade union will normally support them through numerous appeal procedures. When chairing the staff appeals panel of my regional health authority, I would often be presented with a two inch thick file of minutes of previous discussions with the employee about their work, detailed records of verbal and written warnings, disciplinary meetings, and so on. In some cases these had gone on for as long as two or even three years prior to the employee's appearance before the panel during which time many employees, especially senior medical staff, would have remained on full pay.

The prevailing culture followed by all grades of NHS staff is to slavishly follow mechanistic, formulaic and bureaucratic patient care processes which at every stage of treatment seem deliberately designed to create additional work for themselves and delay and frustration for the patient. Many staff have a default setting that automatically rejects any suggestion as to how things could be done more efficiently or easily.

Whole industries have been built on offering time savings and convenience to people, but the NHS does not do either time saving or convenience. It does time wasting and inconvenience on a monumental scale. The net cost in lost output from the economy resulting from NHS time wasting and general inefficiency; the widespread practice of using unskilled doctors, surgeons and nurses to treat patients (who are then unable to resume work until further treatment is undertaken to put right what was done wrong); or patients suffering from unnecessary hospital acquired infections; or whose recovery is impaired by malnutrition from poor hospital food; all these impose a huge burden on the country.

Any experienced 'hands on' line manager from a successful high tech manufacturing company who spent a few months in a typical NHS hospital could come up with a list of a hundred and one ways to improve patient care and double the hospital's productivity at the same time. However, such an exercise

would be pointless unless there is a way to ensure both doctors and all other hospital medical staff co-operate to ensure the changes needed are introduced and fully implemented. Unfortunately this will never happen unless market disciplines are put into place, and this can only be done if hospitals are removed from government ownership.

## **10 What must be done to improve health care in the UK: the first steps**

The NHS only exists as it does today because Aneurin Bevan was compelled to allow doctors to continue to undertake private work as well as work for the NHS. Because of this they remain the only public servants who have a vested interest in ensuring the service they are handsomely remunerated by the taxpayer to provide remains a poor quality substitute for private treatment – whether in terms of lengthy delays for treatment as a result of their frequent absences from their place of work, the over delegation of treatment procedures to junior staff and trainees with insufficient experience, or the manipulation of waiting lists to encourage patients they believe might be induced to pay for private treatment to do so.

You cannot run a successful organization of any kind, if you allow your key salaried employees – which in the case of the NHS mean your medical and surgical consultants – to compete with you by providing an alternative and better service than the one you provide. No company would survive for long if it allowed its key employees to operate as freelance competitors, while continuing to enjoy all the benefits of secure salaried and pensionable employment. Whatever justification there may have been for this in the 1940s, when doctors had been trained at their own or their family's expense, it hasn't applied for the last forty-odd years, during which the cost of doctors' training has been borne largely by the taxpayer.

Of course, while the government remains the owner of the NHS hospital estate, and the de facto employer of all NHS staff, it will not be possible for it



to change the terms and conditions of doctors' employment. Andrew Lansley's bill contained no proposals to do this, yet it is only by selling off the NHS's acute hospital estate into multiple private ownerships that it will be possible to introduce real competition, which is the pre-requisite to improved standards of patient care. So long as the government is obliged to negotiate directly with the medical trade unions it will invariably be held to ransom, as it has been for the last fifty years, since the doctors alone provide the work force whose labour the government cannot do without if it is to keep the NHS's hospitals open.

Until doctors are forced to negotiate with individual hospital owners, or separate groups of hospitals, and hospitals and doctors receive their income from patients, patients will never get a better deal, since most doctors have a vested interest in ensuring their income from private practice is maintained and increased.

## **11 Starting a social health insurance fund**

There are only two ways to remove the UK's current two tier health care system; either private health care is abolished – which hardly seems appropriate in a free society – or the NHS is replaced with an insurance-based social health care fund which gives all patients direct access to the fund to purchase their own health care, subject to the co-payment of a proportion of their health care costs up to a fixed annual limit. This would essentially put all patients on the same footing as privately insured patients.

If the NHS hospital estate was sold off the sale receipts could be used to establish such a health insurance fund. Its future annual income could subsequently be obtained from earnings-related contributions paid in by employers and employees. It is unlikely the proceeds of the sale of the NHS estate will be less than £100 billion and may be considerably more if the auctions were spread over a number of years so as not to overload the financial markets. The aim should be for the fund eventually to be entirely self-financing with two main sources of income: the employer and employee contributions and the co-payments from patients. As the treasury would no longer need to fund the NHS it could then

reduce direct and indirect taxation by such sum as would offset the additional contributions made by both employers and employees to the health insurance fund.

It should be noted that co-payments are essential for any health care system to be viable in the long term. Without them, costs have a tendency to spiral endlessly upwards. These co-payments should be set at around 20% of treatment costs from a basic GP consultation to hospital in-patient costs, but limited to a maximum of £6,000 per patient in any one year. Private insurers should be encouraged to enter this secondary market on a needs-blind basis. As they would be required to cover a maximum insured risk of only £6,000 in any year, with the average annual claim being significantly less than that, insurance cover should be available for around £250 per annum. Consideration should be given to making this form of insurance compulsory, in much the same way as third party car insurance is, so that when people were unemployed their co-payments towards their health care costs are covered up to the £6,000 per annum maximum.

## **12 Conclusion**

Without the kind of radical approach to future health care delivery outlined here, which would make hospitals compete for patients, and make doctors' income dependent not on the taxpayer, but on what their patients pay in fees for consultations, we will continue to provide sub-standard health care compared to that in competitor countries. As I have demonstrated in this paper, the economic, human, and social cost of Britain's anachronistic, two-tier health service is enormous. Genuine reform, which goes far beyond anything yet contemplated by the British government, must therefore be considered an urgent priority.

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## About the author

Chris Davies comes from what he describes as a strictly working class background: 'Apart from my father most of my wider family were either miners or railwaymen so I always had a pretty strong work ethic.' He supported himself through university by working part time as a coal heaver breaking up coal at the pit head, then bagging and delivering it. He spent his second year rising each day at four a.m. to take out a milk cart for Express Dairies.

He gravitated naturally into industrial management, working in line management roles with two Dow Jones multi-nationals. Finding his career shortened in his mid-twenties when his kidneys failed unexpectedly, he found himself having to find some kind of work he could combine with his need to spend three days a week in hospital for what were then ten hour dialysis sessions. After a short period practising law and 'trying to be in court and hospital at the same time' he decided he had no option but to find the capital to start his own business, giving him the freedom to fit his weekly timetable round his dialysis sessions.

'In those days the NHS had not grown into the over-managed bureaucratic leviathan it is now,' says Chris. 'I was able to persuade my then consultant to let me have a dialysis machine at home. This meant I could dialyse overnight and work during the day.' He then persuaded his bank manager to lend him £10,000 and used this to acquire a small light engineering company that had a good product, but been negligently managed by a large group who, after years of losses, had lost the will to struggle with its heavily unionised workforce.

After a series of battles with the trade unions, whose insistence on over-manning and restrictive practices were the root cause of the company's on-going losses, he was able to force through productivity measures, enabling the company to move rapidly into profit. He eventually employed nearly four hundred workers in three factories in the North West, manufacturing a range of specialist products for the packaging industry and building a substantial export business to Germany.

Now in his early seventies, Chris is retired but still contributes occasional articles to business journals.