

Why the NHS is the sick man of Europe

James Gubb

'...things are starting to get better, and they will be dramatically improved. I am so confident of that, let me say this: if the NHS is not basically fixed by the next election, then I am quite happy to suffer the consequences. I am quite willing to be held to account by the voters if we fail.'

Tony Blair, 2002

In January 2002, Tony Blair stated his government should stand or fall on reform of the NHS. It didn't fall, but the NHS remains pretty sick and none of the major parties are prepared to face up to the problem. As medical advances and an aging population fuel demand, the NHS is struggling to cope: efficiency, quality and – most damagingly so far as its ideals are concerned – equality are all suffering, and in some cases irreparably.

until we swallow our pride and look across to Europe at better ways to provide universal health care, the NHS will continue to groan with pain rather than roar with vitality

The root of the problem is not the world-class doctors, nurses or even managers who work in the NHS, but the system they are working in; the system that prevents patients from taking control of their health care and prevents frontline professionals from revolutionising services for their patients' benefit.

While provision is slowly becoming more autonomous, the government still clings resolutely to the mantra that the centre knows best; to its 'right' to direct resources, dictate service provision and, ultimately, to its 'right' to control the purse strings. Until this changes, until we swallow our pride and look across to Europe at better ways to provide *universal* health care, the NHS will continue to groan with pain rather than roar with vitality.

Symptoms

INEQUITY

The NHS prides itself on being the most equitable health system in the world, but the reality is much more sombre. Health inequalities have widened under the Labour government. Sir Ara Darzi's interim report documents how the gap in life expectancy between the most and least deprived areas in England is nearly 10 years (for men) and has increased in recent times.¹ To take a snap-shot, premature death rates for coronary heart disease vary from 2.1 deaths per 10,000 of the population in Kensington & Chelsea to 8.5 in Hartlepool.²

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The opportunity to access health-care is actually worse in areas of greater need.³

Then there is the deeper issue of ‘he who shouts loudest’; the quality of care a patient receives in the NHS depends far too much on education, intelligence and connections. ‘While the aristocracy of pull receive their cancer treatment in the Royal Marsden, the inarticulate and less-well-connected may never see an oncologist’, writes Willem Buiters of the LSE.⁴

And where you are treated really matters; to take just one example, there is a fourfold variation in mortality rates between NHS organisations for coronary artery bypass graft (CABG) operations⁵ – assuming, of course, that you ever get to this stage. Studies have shown clearly that patients in deprived areas, despite having a greater clinical need for CABG, are much less likely to get them than those in higher socio-economic groups.⁶ The same applies for hip replacements.⁷ The NHS plays to the middle-classes who are able to use their sharp elbows.⁸ In the words of the new Liberal Democrat leader, Nick Clegg MP, ‘the centralised system has failed for the people who need it the most’.⁹

just 33 per cent of elective patients received treatment within 18 weeks in Hastings & Rother PCT compared with 82 per cent in Blackpool PCT

allocate resources accordingly. Expenditure on cancer treatment per cancer patient varies fantastically

‘the centralised system has failed for the people who need it the most’

The crux of the problem is that the NHS has never found a satisfactory mechanism to assess clinical need, or the demand for health care, and

between £17,028 in Nottingham City Primary Care Trust (PCT)¹⁰ to just £5,182 in Oxfordshire PCT and even more so per premature heart disease death, where spending ranges from £166,151 in Wakefield PCT to just £17,241 in Calderdale PCT.¹¹ Postcode lotteries also preside over how long people can expect to wait for treatment. As of October 2007, just 33 per cent of elective (non-emergency) patients received treatment within 18 weeks in Hastings & Rother PCT compared with 82 per cent in Blackpool PCT.¹² Where you live, and how much you shout, accounts for much in the standard of treatment you can expect.

Table 1: 18 weeks referral-to-treatment

Bottom and top PCTs	Treated within 18 weeks of referral
Hastings & Rother PCT	33%
Barking & Dagenham PCT	34%
Havering PCT	35%
Westminster PCT	36%
Brighton & Hove City PCT	36%
England average	60%
Torbay Care PCT	79%
Somerset PCT	81%
Heart of Birmingham Teaching PCT	81%
Telford & Wrekin PCT	82%
Blackpool PCT	82%

Source: DH, 18 weeks referral to treatment¹³

Of course, this is just focusing on inequity *within* the NHS. A wider point is that many who can afford to opt out of the system completely do so and buy

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private health insurance. This applies to around 11 per cent of the population, but is significantly higher amongst doctors and trade union members.¹⁴ Read what you will into this statistic, but the NHS entrenches a two-tier system.

FUNDING GAPS

In 2000/01 total public spending on the NHS stood at £46.0bn; it is now £90.7bn – a massive increase of nearly 100 per cent in cash terms and around 70 per cent in real terms.¹⁵ Health spending in England is now approaching the EU average,¹⁶ yet the NHS still struggles to afford everything, as the variations in spending between PCTs shows only too clearly.

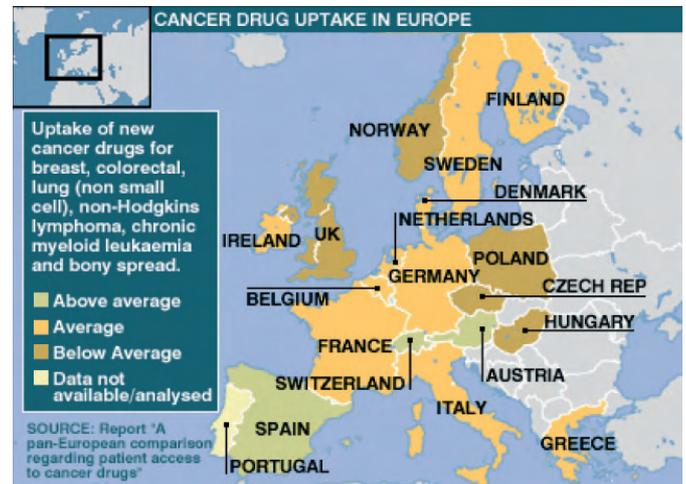
With a finite budget, the NHS typically ‘solves’ this problem by rationing treatment. Historically, this has been done in a somewhat under-hand way, either through unrecorded transactions between doctors, patients and their families, priority-setting, or very lengthy waiting lists.¹⁷ But with the introduction of payment-by-results, and such political capital invested in cutting waiting times, the whole process has come out in the open.

In a survey of chief executives carried out by the *Health Service Journal* in 2007, 70 per cent of PCT leaders reported restricting access to treatment.¹⁸ The populist way to do this, couched in terms of ‘rights and responsibilities’, is to deny treatment to people who lead unhealthy lifestyles¹⁹ – a practice that many PCTs are apparently carrying out for smokers and the obese.²⁰ Another way is simply closing wards, as Worcestershire Acute Hospitals Trust did in January 2008 due to ‘unrelenting pressure on resources’.²¹

But where rationing is most acute is in access to new medicines and procedures. Cancer care is the best example. In the UK there are just 4.1 units of radiotherapy equipment per million of the population, compared with an OECD average of 6.2,²² which – as a report by the Department of Health’s cancer tsar, Prof. Mike Richards, acknowledges – provides some 63 per cent fractions per million fewer than what is required.²³ Much of

Fig. 1. The UK has one of the lowest rates for the uptake of new cancer drugs in Europe.

Source: Karolinska Institute



this radiotherapy kit is not equipped with the latest technology; only 28 of the 61 radiotherapy centres in the UK can provide Intensity Modulated Radiotherapy (IMRT), with just three providing it as standard – a procedure that is the norm in most of Western Europe.²⁴

Unsurprisingly, the same story is evident for the latest cancer drugs; the respected Karolinska Institute in Sweden has shown beyond doubt that the UK is well below average in the rate at which it has adopted some of the most revolutionary new drugs, such as trastuzumab, gemcitabine and vinorelbine.²⁵ Contentious cases such as that of Colette Mills – denied access to the drug Avastin on the NHS, offering to pay for it privately, and being told she cannot without also paying for her entire course of cancer treatment²⁶ – show this only too clearly.

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It is startling that both the British Medical Association (BMA)²⁷ and a rising proportion of doctors²⁸ now

believe ‘the NHS will not be able to provide all services’, yet those in Westminster resolutely refuse to admit that the NHS, with current funding streams, cannot afford everything. This is perverse, because this dishonesty will only cause inequity outside as well as inside the service; in both worlds the least well-off are the most disadvantaged.²⁹

INEFFICIENCY

The most ironic thing about the funding gaps is that they wouldn't be half as acute if only the NHS were more efficient. The most shocking thing about the case of cancer is that per capita spend in the NHS is almost certainly amongst the highest in Europe.³⁰ As the level of funding has rocketed, it is clear the quality and level of service has not increased at anything like the same rate. The NHS has been a victim of silo planning by its political masters. Nearly half the extra funding went on higher input costs, particularly higher pay for staff, which has not brought the intended productivity benefits.³¹ Much of the rest paid for the shopping list of investment in extra staff, hospital and GP premises, hospital beds, equipment and IT systems required by the NHS Plan.³²

The results have been unimpressive. Spending on outpatients increased by 66 per cent between 1999/00 and 2005/06, yet activity only increased by 30 per cent. Spending on elective (planned) and emergency services rose by 47 per cent, yet activity only increased by 18 per cent.³³ And much of this growth is accounted for by increased admissions from A&E departments – a sign of supply-side inefficiency in itself. Sir Derek Wanless provides a startling account of what this means: had the NHS registered the efficiency he thought would be reasonable in his 2002 review, it could have treated an extra one million emergency and elective patients in 2005/06 alone.³⁴

But then perhaps this is hardly surprising given the Audit Commission's assessment last year, which concluded that 31 per cent of NHS bodies failed to meet even minimum requirements on use of resources. In fact, 27 failed every single test of good management,³⁵ despite up to 15 per cent of a trust's income now, apparently, going on management costs.³⁶ NHS productivity, according to the latest estimates by the Office of National Statistics, has fallen by an average of one per cent per annum over the past 10 years.³⁷

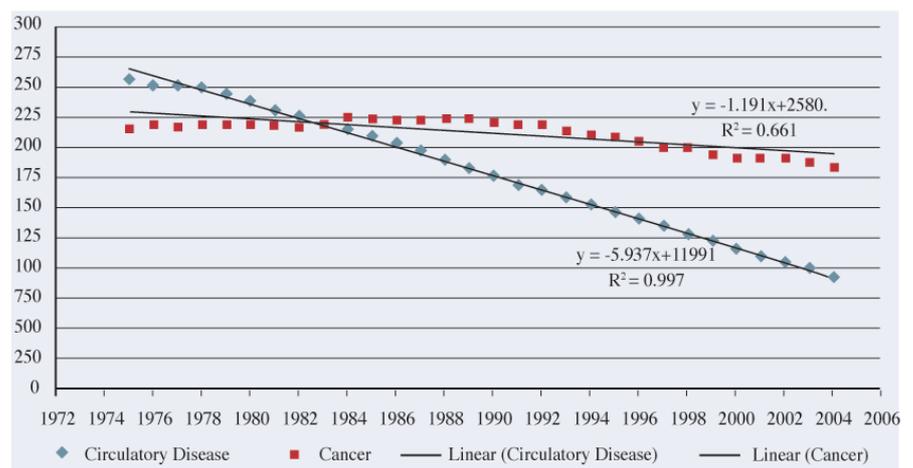
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Neither has the quality of care increased commensurably. The biggest achievement has undoubtedly been the fairly dramatic fall in waiting times over the past five years, but at the latest count 387,152 people still waiting for treatment had been waiting over a year from initial referral – a wait that would be unheard of in most developed countries.³⁸

Another positive is that the average length of stay has decreased and that more patients are being treated as day cases, but then emergency re-admissions within 28 days of discharge actually increased from 5.4 per cent in 2002/03 to 6.6 per cent in 2005/06,³⁹ which suggests pressure on resources has been more of a driver than real efficiency gains. The Healthcare Commission still only sees fit to rate 46 per cent of trusts as either 'excellent' or 'good' on quality, indicating that a majority are not even meeting basic standards of care – in fact, the number of PCTs making the grade actually decreased last year.⁴⁰

The latter statistic also reflects wider concerns over the contribution of primary care. Access has improved with the advent of NHS Walk-In Centres and NHS Direct, and much is made of the increase by a fifth in the number of prescriptions dispensed between 2002 and 2006 (18.3 per cent of which were lipid-busting statins),⁴¹ but out-of-hours care has become woefully inadequate⁴² and in half of PCTs GPs do not follow up on people with long-term conditions properly.⁴³

Fig. 2. Mortality rates from circulatory disease and cancer (age-standardised, per 100,000 of the population)



UNHEALTHY OUTCOMES

The same picture is evident so far as health outcomes go. There remains, as ever, an absence of routine data on changes in health status as a result of NHS interventions,⁴⁴ but what evidence we do have is not universally encouraging.

To start with the good news, hospital-standardised mortality rates (HSMR) have accelerated downwards. Improvement in HSMR has been registered in 95 per cent of trusts in England and the national ‘crude’ rate has fallen from 6.2 per cent in 2000/01 to 5.5 per cent in 2005/06. This is also reflected at the aggregate level for the ‘biggest killers’. Age-standardised death rates per 100,000 of the population fell by 25 per cent in the case of circulatory disease, and six per cent in the case of cancer, between 1999 and 2004.⁴⁵

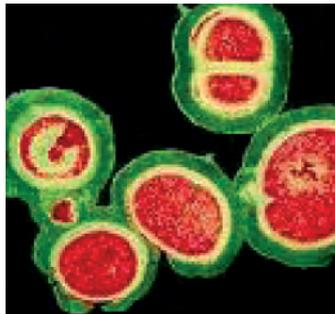
However, there is little evidence, at least at the aggregate level, that this represents any improvement on performance prior to the dramatic increases in funding; trends over time are approximately linear.⁴⁶

In fact, when deaths that could realistically have been averted by good health care are isolated, the picture is even less impressive. Not only has there been little, if any, improvement on the long-term trend here,⁴⁷ but for cancer progress appears to be slowing. Improvements in avoidable mortality fell year-on-year from 3.6 per cent between 2000 and 2001 to just 1.7 per cent between 2004 and 2005.⁴⁸ Unsurprisingly, the NHS still languishes at the bottom of European league tables on cancer survival rates, much closer to the performance of Poland and the Czech Republic than Sweden, Finland and Switzerland – the best performers.⁴⁹

The same applies for stroke care⁵¹ and, more generally, for deaths from all medical conditions that are a priori preventable.⁵² If all NHS trusts were to reduce mortality rates just to the ‘expected rate’ 7,400 deaths would have been avoided in 2005/06.⁵³

Yet, all this is not to mention the risk patients bear by simply going into hospital – akin to doing a bungee jump according to Prof. Trevor Sheldon, an

between 8.7 and 10 per cent of hospital stays in the NHS involved mistakes – half of which Prof. Sheldon considered preventable – resulting in the death of around 90,000 patients



The NHS still has one of the worst rates of MRSA in Europe

expert in the field. He recently used medical records to show that between 8.7 and 10 per cent of hospital stays in the NHS involved mistakes – half of which he considered preventable – resulting in the death of around 90,000 patients.⁵⁴ Then we must add hospital-acquired infection to the mix. Rates of MRSA are still the worst in Europe, with the exception only of Ireland, Malta and Portugal,⁵⁵ and rates of *C-difficile* remain stubbornly high; there

were 13,660 cases reported in under-65s in the first quarter of 2007/08 alone in NHS hospitals.⁵⁶

Table 2: Five-year cancer survival rates (2000-02 base years)

	All cancers (men)	All cancers (women)
England	44.8%	52.7%
France	-	-
Germany	50.0%	58.8%
Netherlands	47.1%	58.3%
Sweden	60.3%	61.7%
Switzerland	54.6%	61.1%

Source: EURO CARE-4⁵⁰

Neither are patients feeling more satisfied with their care. Satisfaction ratings for general practice, inpatients and outpatients have all fallen since the 1990s, with only A&E registering an improvement; and those who have had a lot of recent contact with the NHS tend to be the most dissatisfied with it.⁵⁷ The most significant problem, according to the Picker Institute, is the continuing failure of clinical staff to engage with patients in their care.⁵⁸ The NHS is far from the patient-led, patient-centred, service that the government keeps promising.⁵⁹

Chief executives, senior doctors and senior nurses are forced to spend so much time trying to second-guess where the politicians will turn next that they are inevitably prevented from focusing where they want to: on the patient

Diagnosis

The NHS's problems are systemic. The source of its problems are certainly not the world-class doctors, consultants, nurses and, yes, even managers, that work in the service; rather the perverse incentives created by the system they work in.

Since 2000 the government has introduced some noteworthy reforms: the increased autonomy afforded to Foundation Trusts; a more open attitude to the independent sector and competition; payment by results; and, most recently, a hefty emphasis on PCTs to take the lead as 'world class commissioners'. But the benefits that these initiatives should have brought have not been realised, because the government refuses to countenance the other side of reform – the demand side, that is necessary truly to revolutionise the service and put control in the hands of health professionals and patients. As Norman Lamb MP, the Liberal Democrat health spokesperson, has said: 'Ninety-five per cent of taxes are raised centrally compared with the EU average of 60 per cent. Power resides where money is raised. The strangle-hold has to be broken.'⁶⁰ Too true.

The true source of inefficiency, the funding gaps, the inequity and the poor health outcomes is the determination of central government to cling to the purse strings. It thus has the means – and the constant urge – to direct the health system from the centre.

What this means is all too obvious to anyone associated with the NHS. Chief executives, senior

doctors and senior nurses are forced to spend so much time trying to second-guess where the politicians will turn next, what their budgets will be next year, what the rules allow them to do – not to mention the inevitable targets, 'top-down pressures, diktat and bullying'⁶¹ that comes from the government and its enforcers in the DH – that they are inevitably prevented from focusing where they want to: on the patient.

Is it any accident that the NHS is now heading for an embarrassing £1.8 billion *surplus* for 2007/08 – despite such obvious funding gaps – when Patricia Hewitt, then Secretary of State for Health, staked her political life on turning around the deficit of 2005/06;⁶² when PCTs have been reconfigured by the DH just three years after they were established; when Strategic Health Authorities (SHAs) have top-sliced some £729 million from PCT budgets in this financial year alone; and when PCTs have been left in limbo over the funding they will receive post-2008/09 because the DH is waiting on an 'independent' advisory committee to report on how the resource allocation formula is to be re-jigged?⁶³

And is it any accident that the NHS is one of the most investment and innovation-shy health systems in the developed world⁶⁴ when at any moment another 60 or so 'instructions' could come tumbling down from the top *à la* the NHS operating framework for 2008/09;⁶⁵ when the government has an unnerving habit of coming up with new initiatives, such as the national screening programme for cardiovascular disease, diabetes and kidney disease, without even consulting doctors;⁶⁶ and when the DH employs sinister tactics such as adjusting tariff top-ups to strip hospitals of specialist services it deems are no longer necessary?⁶⁷

Needless to say, with money completely divorced from the patients that use the service, resources certainly don't end up where they should – where they would be productive. As two surgeons from Eastern Europe,



The NHS' focus is on Whitehall, not the patient as it should be

who have worked in the NHS, recently asked: ‘why does your government insist on managing the NHS in the same way the Soviets used to run our industries?’ With the government able to exercise such control, it does not matter if the system nominally provides for an element of competition or that hospitals are in theory more ‘autonomous’; a fact that is only too clear to Foundation Trusts, who are sitting on some £995 million in cash balances in the absence of ‘greater certainty about the long-term requirements of commissioners’.⁶⁸ Only the biggest and boldest trusts, such as Heart of England in Birmingham and UCLH, have dared to venture out of the cage and begin to revolutionise health care. For the average patient treated in too many of the rest, standards are far from world-class. Health outcomes are intrinsically linked to inefficiency.

Many will respond by saying that we can put up with some of this because a centralised health system at least promotes equity in health care. This is simply not true; universal health care is not synonymous with centralised health care. The deluge of central direction the NHS is subject to in its day-to-day working serves, more often than not, to prevent hospitals and PCTs from developing their own initiatives more relevant to local populations, which actually exacerbates inequality.

The fundamental point is that centralised, national policy will inevitably be more appropriate for some areas than others. The national screening programme to be introduced for cardiovascular disease will be much more cost-effective in Blackpool or Sandwell, where years of life lost to the disease are very high, than in Kensington & Chelsea or Westminster where they are much lower.⁶⁹ In some cases the effect can be much more severe. Staff pay is set at the national

The same universal and comprehensive ideals are held almost without exception across Western Europe, but the difference is that many European countries... have succeeded in achieving higher standards of health care for all



UCLH Foundation Trust: one that's dared to venture forth

level by the NHS Pay Review Body, which fails resolutely to account for regional differences in average pay. As a result, hospitals in the south – particularly in inner London – rely too heavily on temporary agency nurses, who can be paid more but tend to be less experienced, and death rates within 30 days of a heart attack are at least four to five per cent higher.⁷⁰

To make matters worse, when patients fall foul of the system there is little they can do about it. By denying patients meaningful choice in all areas apart from electives, the NHS ensures that those who happen to live in an underperforming area are stuck with inadequate health care. Unless they have the money to go private, there is no means by which patients can complain and ultimately take their business elsewhere if they are dissatisfied with the care being bought for them by their PCT or provided for them by their local hospital. This is tragic enough in itself, but also begets serious inefficiency; without any test of value for money, resources do not end up where patients – and staff – would want them. We have gone full circle.

Treatment

It is often said that the NHS *could* work well if the politicians would just take their hands off, if management was just left to medical people, if its funding could just be allocated according to need rather than political imperatives. But the fact is that if this is going to happen, it will require more than just tinkering around the edges; it will require *genuinely* putting money in the hands of patients and *genuinely* empowering those who deliver health care to do so.

This does not mean embracing the US health system, leaving some 47 million people uninsured⁷¹ and putting power in the hands of big insurance

Table 3: Equity in health care

	Physician	GP	Hospital care	Specialist care
France	0.017	-0.005	0.035	0.063
Germany	0.010	-0.021	-0.029	0.045
Netherlands	-0.017	-0.038	-0.040	0.019
Sweden	0.042	-	-0.006	-
Switzerland	-0.008	-0.024	-0.063	0.074
UK	(0.003)	-0.042	0.013	0.017

Source: Van Doorslaer, E, et al., Income-related Inequality in the use of Medical Care in 21 OECD Countries, *OECD: Paris, 2004(5), Tables A7-A11*

Horizontal equity index for utilisation, needs adjusted. A score of zero approximates to equitable access; positive a pro-rich bias and negative a pro-poor bias.

companies often no better than the government; it means universal, patient-centred, health care and it means looking to Europe.

The NHS attracts support because of its ideals: to provide universal and comprehensive health care that is free at the point of need. In this sense, support is well-founded, but in the way the NHS actually delivers health care it is not. The same universal and comprehensive ideals are held almost without exception across Western Europe, but the difference is that many European countries, by contemplating economic viability much more closely than the NHS, have succeeded in achieving higher standards of health care *for all*. Those who can afford to pay for their health care do so and those who cannot get comprehensive top-ups from the government so they can get the same access. Not only are health outcomes better, but health care is more comprehensive – the latest drugs and treatments are much more widely available – and just as, if not more, universal. You don't have to go private to get the best care. Unsurprisingly, doctors also have real autonomy and consumer satisfaction is typically much higher.

Table 4: Consumer satisfaction

	Points	Ranking (29 countries)
France	786	3
Germany	767	5
Netherlands	794	2
Sweden	740	6
Switzerland	770	4
UK	581	17

Source: Euro Health Consumer Index⁷²

The major difference between the NHS and the health systems in countries like France, Germany, Switzerland and the Netherlands is that the state is not cast as either the main funder or provider of health care, but effective regulator.

In these countries, health care is not paid for through general taxation, but through social insurance. Certain principles apply almost universally. All individuals are obliged to pay into a health insurance plan from a menu of insurers; insurers are obliged to accept all the applicants that choose them; and the government both defines the mandatory minimum package, and pays for/tops up for those on low incomes or with excessive health risks. In Germany and France this is done through the wage packet (in effect a health tax that goes direct to an insurer); in Switzerland and the Netherlands this is done largely through income-sensitive health premiums (similar to paying for private health insurance in the UK but heavily subsidised for those who cannot afford it), which has the advantage of detaching health care from employment and the fluctuations of the labour market. Either way, the consumer – the patient – controls the purse strings, not the government.

Immediately, therefore, the government is both much less able and much less inclined towards interfering in the day-to-day running of the health system, with all the problems this brings. But the benefits are much more widespread than this. The fact that a person is keenly aware of the transaction made between him/herself and the insurer, compared with the £1,700 sum that is simply taken out of the average person's tax to pay for the NHS, means there is a direct accountability that is virtually absent in the NHS. The insurers (akin to PCTs) and the providers work for the patient, rather than the government, because the people who pay the bills are price-conscious enough to seek value for money; a mechanism which is also supported in many countries by a degree of up-front payment for treatment *for those who can afford it*. In France, Germany, the Netherlands and Switzerland, small charges are applicable for seeing a GP; patients in the Netherlands, for example, pay €9, which they can claim back from their insurer.⁷³ In Switzerland there are also small 'hotel' charges of CHF10 per day for a stay in hospital.⁷⁴

This system both helps to ensure that demand and supply are more closely in balance *and* that health care is allocated more closely according to need; an individual's money covers both the costs of their own expectations and – unlike in the US – also pays for the more vulnerable to have access to a whole range of new treatments and services that in the UK only the rich can access privately.⁷⁵

Of course, all this assumes that choices are available, whereas in the NHS there are pitifully few. Without multiple providers – which may be for-profit, non-profit or state – and, ideally, multiple insurers (the commissioners of care, akin to PCTs in the NHS) competing for custom, there is no meaningful mechanism by which value for money can be sought; there is no mechanism by which patients *and* staff, if they are dissatisfied, can ultimately go elsewhere. This is crucial. Through money following patients' choices, competition creates incentives for service providers to be responsive to the needs of users and efficient in the use of resources. This is the engine that constantly drives quality improvement in other health systems.⁷⁶

In France and Germany, for example, *all* patients enjoy a choice of doctor, whether GP or specialist, whether working in a public or private hospital. Similar choices are also open to the Swiss – so long as the insurer is not a managed care organisation – and the Dutch, who both, along with the Germans, also have choice over their insurer and health insurance plan.⁷⁷ No such mechanisms exist in the NHS – save the largely unknown option for choice in electives – which is particularly strange seeing that such choice has a further benefit too; the postcode lotteries that so plague the UK health system are laughed about in most European countries because they simply don't exist. Patients, *all* patients, if dissatisfied with their local hospital or GP practice, just up and go elsewhere. Doctors, nurses and managers, on the other hand, have the ability to ensure that this doesn't happen by inducing change and tailoring services to patients' needs.

It is time for the NHS to be progressive; to embrace real reform; to put money in the hands of the patients; and, above all, to empower health professionals. It is time to swallow our pride and learn from Europe. The NHS's ideals of universal

and comprehensive health care are right, but the method of delivery is not. Compared with many of our European neighbours, the NHS is providing an inferior service to those who need it the most; and the reasons are largely systemic. Where the NHS frantically tries to provide universal health care through a centralised, monopolistic and heavily politicised system, the best European systems achieve this very same ideal through a decentralised, competitive and patient-led one, that produces much better outcomes and is more equitable to boot.

In 2006 the Netherlands faced up to a whole host of problems so familiar to the NHS – lengthy waiting lists, an inefficient and complicated bureaucracy, strong central control over hospitals, underpowered patients and a rigid two-tier system of private health insurance for the rich / mainly tax-funded social insurance for the rest⁷⁸ – with a suitably progressive solution. Funding has been pulled from the state to the individual, with mandatory health insurance, plentiful choice and extensive top-ups for the very sick and those who cannot afford it. In essence, it harnesses the incentives and efficiency mechanisms of competition in a way that acts for the public good.⁷⁹ Now the Dutch healthcare system is being hailed as possibly the most streamlined, equitable and competitive system in the world;⁸⁰ it is time for the NHS to follow.

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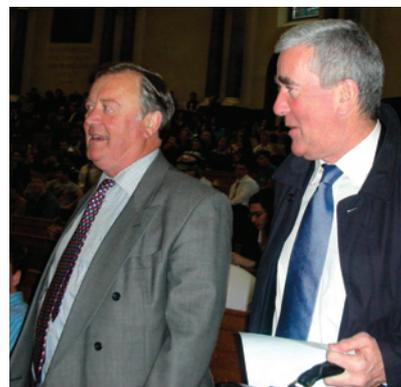
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EU: Trick or Treaty?

Over six hundred students and teachers attended this year's conference on the EU, held at the Emmanuel Centre in Marsham Street on 31 January. Entitled *'The EU: Reform or Bust?'* the conference was dedicated to furthering students' knowledge of the European Union, but also encouraging them to take a more inquiring approach to their understanding of the UK's relationship with the EU. The day began with lectures on institutions and economic policy, provided by Gisela Stuart MP and John Peet,



Rt Hon Kenneth Clarke MP and Derek Scott, former economic adviser to Tony Blair, debated the case for and against the EU Treaty at the Civitas conference in January.

Europe Editor at *The Economist*. The morning also included a discussion panel on 'youth issues', featuring three young researchers involved in European affairs, which proved to be a lively session. In the afternoon Tony Benn gave an engaging address to the conference on the impact of EU membership on parliamentary sovereignty, before Derek Scott (former economic adviser to Tony Blair) and Ken Clarke QC MP concluded proceedings with a robust debate on *'Constitutional Reform: Trick or Treaty?'*.

The Butterfly Book

The outstanding progress made by children in the joint Civitas/ New Model School supplementary schools project is largely due to Irina Tyk's phonics reading and writing course *The Butterfly Book*. Mrs Tyk, head of Holland House School and a governor of the New Model School, first produced the book in 1991 when she realised that the methods currently in use were confusing children. It was privately published until Civitas brought out the first commercial edition in September 2007. On 11 December the *Daily Mail* ran an article by its education correspondent Sarah Harris headed 'Reading? It's simple with the Butterfly', ending with our phone number. For the next two weeks the phones in the office didn't stop ringing, and we sold nearly 1,000 copies of the book, almost all to concerned parents and grandparents from all parts of the country. This was in addition to the copies sold through bookshops and Amazon.

Eleanor Rogerson, manager of the supplementary schools project, describes why Irina Tyk's message is so important:

I was recently contacted by the parents of a 12-year-old boy, Vincent, who were very concerned about his poor reading ability and the problems it was causing for him at school.

When I first met Vincent I asked him to read a passage about Roman Britain so I could get some idea of his reading ability. He read fairly well and only struggled over the longer words and the unfamiliar names of Roman rulers like 'Caractacus', and 'Caligula'. On face value, it seemed like his reading wasn't too bad. However, when I asked him to read out the sounds which make up simple words, he found it very difficult. He struggled over sounding out 'c-a-t' and 's-l-a-m'. Although he could read these words as a whole, he could not easily identify the individual sounds as relating to the whole word.

His parents told me he was taught to read by looking at pictures and pairing them up with words.



**Irina Tyk, author of
The Butterfly Book, with one of the
pupils at Holland House School**

Photo: Nick Skinner

He learnt to recognise 'cat', 'dog' and 'cow' but what if Vincent saw a word he didn't recognise – 'crocodile'? He would know what a crocodile was but if he'd never seen it written down before he wouldn't have a clue how to read it. It might as well say 'zebra'. A child taught by phonics could decode the word by sounding it out.

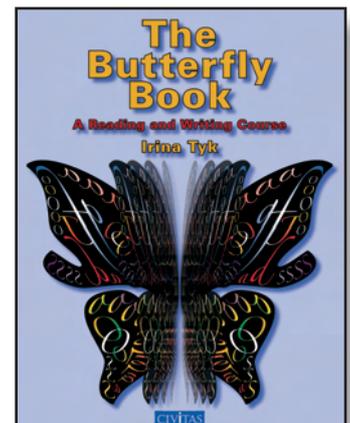
This is why Vincent could not recognise the names of the Roman rulers – even though they are simple to decode when you take them sound by sound, they look daunting if you're expected to know the whole word by sight. For words he didn't recognise, Vincent would look at the first few letters and then guess at what it might be based on

words that look similar (but mean something entirely different) like 'scarily' for 'scarcely' or 'queen' for 'quench'.

Without phonics, children like Vincent will have to learn and remember every new word as a unique sound. This is much more difficult than learning the 44 sounds of the English language and applying them to unfamiliar words. Vincent told me that he is beginning to struggle in comprehension exercises and often doesn't recognise words in maths and science questions.

I've now started working through the Butterfly Book lesson-by-lesson with Vincent. I can see that he's making good progress, but was initially concerned that he might find repeating the sounds a little dull. Quite to the contrary, he seems delighted to have a new way of working out how to read almost any word.

The Butterfly Book is available from Civitas for £12.25 including p&p.



'Our Island Story' Essay Competition



In September 2005 Civitas, in conjunction with Galore Park Publishing, brought out the centenary edition of H.E. Marshall's classic one-volume history of Britain for children Our Island Story. Thanks to the generosity of Civitas supporters and readers of the Daily Telegraph

we were able to offer free copies to schools to promote the study of chronological, narrative history that would help children to understand the emergence of those institutions that made Britain a free and prosperous country. To further that aim we launched an essay competition for children in years six and seven, asking them to write about a major change or momentous episode the country has undergone during the century since the book was published, with particular reference to their own family. There were cash prizes for first,

second and third categories in both year groups, and each school received one hundred pounds in book tokens. On 17 July 2007 Frank Field MP presented the prizes and spoke to the children about their work at a ceremony in the Palace of Westminster. We print the two first prize-winners in both year groups.



Frank Field MP with prize-winners of the Civitas History Essay Competition. Elinor Bushell (first prize, year seven) is on the left, Narjiss Seffar (first prize, year six) is on the right.

Changes in Rural Suffolk Over One Hundred Years

Narjiss Seffar

Year Six, Bedfield VCP School

The Victorian period (1837-1901) was a time of extraordinary change. The Victorians' energy and great inventions made them world leaders. But in 1901 Britain was no longer the world's leading power.

Since the 1870s, the United States and Germany were industrialised, and were rapidly overtaking Britain.

Poverty was still widespread, Britain was at war, and there were problems in the British Empire.

The Victorians had transformed Britain from an agricultural to an industrial economy. At the beginning of the 19th century nearly half the working population were employed in farming; by the end of the century the figure

had dropped to 6%. The 20th century saw many other changes in Suffolk due to advanced engineering, new transport systems, importation and exportation of all kinds of goods, improved medicine and better education.

Over the last hundred years, Britain has fought in two world wars and there have been big changes in the laws and legislation affecting people's lives. During 1860-1940 mechanisation came to the farms in Suffolk and less people were needed to work on the land. Steam machinery was used but was too heavy to do most of the everyday jobs about the farm, so the horses were kept on.

Two companies in Suffolk produced traction engines and steam lorries. They were Ransomes (which became Ransomes, Simms and Jefferies) and Garretts of Leiston. The wealthier farmers could afford the latest machines, such as horse-drawn drills, hoes, reapers and binders and this meant less work-force and reduced running costs.

Ransomes produced the first ever ride-on mower but it was the Americans who developed the first tractors. These took over all the jobs which teams of horses and men had done before.

The thresher was the most revolutionary machine. In a few days it could do the work that would have previously kept the farm workers busy all winter. This was later replaced by the combine harvester.

Agricultural contractors would hire the large machines and operators to the farmers who could not afford to buy for themselves. Grain came in from the new American prairie farms on new steamships and was sold on the English market for less than home-produced corn. Farmers grew less and less cereal crops and began rearing stock, some specialised in poultry, pigs and dairy cows.

But there was competition from refrigerator ships bringing cheap lamb and beef from New Zealand and Argentina. The middle class and the town settlers benefited from cheap, imported foodstuffs.

To help the farmers continue to earn a living from the land, subsidy rates reliefs, import tariffs and guaranteed prices were set up. In 1942 the Agricultural Wages Act fixed minimum wages to protect the farm labourers.

During the war, farmers were encouraged to grow sugar beet so that Britain would not have to import its

sugar. This grew into a successful industry and many women worked as land girls while the men were at war. At this time hundreds of windmills were replaced with steam, and later diesel-driven mills. Much of the agricultural land in Suffolk was concreted to create airfields for fighter squadrons during the war. Martelsham, Woodbridge, Wattisham, Mildenhall and Horham all had air-bases.

During the First World War (1914-1918) and the Second World War (1939-1945) many farmers and labourers lost their lives. Many heirs to great estates also lost their lives. Many landowners sold their farms to sitting tenants or newcomers. Soldiers coming back to their villages were changed men and had to look for other work, often going from village to village or moving to the town to find jobs.

The number of farms grew less and more people moved away from the countryside. This saw the decline of other jobs such as the blacksmiths and the wheelwrights, millers and local butchers and grocers.

Suffolk suffered under-employment, rural depopulation, low land and property values. In 1960, however, Suffolk boomed again. Old properties, especially thatched cottages and timber-framed farmhouses, were in demand. Ipswich grew as a thriving port town as more trade came to the area and more roads and lorries too.

Agriculture came back to life. Farmers bought new equipment and farmed more intensively than ever before. Every farmer tried to get more from their land. Hedges, copses and ditches were got rid of to make the fields as large as possible for tractors and combines to work easier. Chemical fertilisers were used extensively. More people moved into the area. Farm cottages were bought and restored as homes for the new arrivals.

Over the last decade, there has been more concern about the environment and farmers have been encouraged to re-plant hedgerows and trees to encourage back the birds and other wildlife. Some farmers have stopped spraying their crops and grow organic crops and rear organic livestock. Now there are 46 licensed organic farms in Suffolk.

My House

Elinor Bushell

Year Seven, St Leonards, Mayfield

Peeling the old, musty and plain wallpaper off my bedroom wall, my parents discovered a pencil-marking. Scribbled on the plaster were the words 'kitchen door was here', and a date, 1987. My room would have led out into the alley, and to the view of the garden under a rounded archway. Now my bedroom bears little resemblance to our modern kitchen and breakfast room, designed for more casual living. It is rather small and cold especially in the winter, perhaps not surprisingly, because the maid would have worked there, and there would have been no modern white goods to accommodate, for washing probably was sent to the laundrette and freezers and fridges would not have existed.

The kitchen is but one reminder of the past history of my house. Opposite my room are some servants' bells, which are for the main rooms like the master bedroom, the dining and drawing room. My little sister's room used to be a storeroom so she has large cupboards, and a dumb waiter once passed from the downstairs up to a grand master bedroom that opened out to a garden balcony and views over the valley below, which was then probably green and unspoiled by building.

In the 1920s, the house stood on a large plot of land and was designed for wealthy owners for whom the house was obviously a status symbol. In order to qualify for permission to build in Culverden Down, the deeds made clear that the house had to cost at least £2,000, a sizeable sum for those days.

The original owner was of Anglo-Indian background, and named the house Kufri Lodge, probably after the ski resort and alpine village in the Indian Himalayas. It is very close to Simla, (about 18 kilometres), and was well-known, particularly by the British who had served in India. Kufri was the 'playground' of the British Raj and every summer the Indian government moved there from New Delhi to escape the heat.

In the 1920s, British rule over India could be expected to end before too long, so a rich man, Ernest Douglas Mabbett, who made his wealth from being in the Indian civil service, sought a property in England close to family and friends. He bought my house from Culverden Chase Limited, a building company. The land on which the house was built had been sold to the building company by



Elinor Bushell with her family outside their house

Dame Maud Julia Blunt, daughter of Sir David Salomons who, with her mother, Dame Laura Julia Salomons, had just unexpectedly inherited the land. Her brother, who had been the heir, had unfortunately died in the First World War.

The Salomons ladies needed to sell some land in order to meet death duties from their substantial inheritance. Like many families with estates, there was probably little spare income (after paying for household comforts like servants) to afford the inheritance tax. The latter was begun by Lloyd-George and the Liberal government of 1909 to fund unemployment and health insurance schemes for the poor and was the first attempt to redistribute wealth more evenly. Today, the Estate of David Salomons survives in name only. By the time the Second World War broke out, the family was unable to maintain it and donated the property to the nation, and 61 Culverden Down has gone through many changes.

Ernest Douglas Mabbett lived in the house in much the same style as he would have in India. By the fireplace in the living room another clue remains of life in the 1920s and 1930s for the comfortably off. By the press of a button discreetly placed at the side of the mantle piece, a bell ring would have sounded outside my room, which

was once the kitchen. Then, the maid or butler, dressed in smart uniform, would have walked briskly to the master to find out his needs. Probably, however well-served Ernest Douglas Mabbett was, things were never quite as good as they had been in India, and the Second World War changed everything. There was a shortage of servants, and it became almost impossible to employ them as so many people were called up or needed for war service at home. I wonder how well Ernest Douglas Mabbett lived in those years. Perhaps his ageing friends met when they could in one of the many hotels in Tunbridge Wells, to drink away whatever was left in the cellar, and perhaps an unmarried female relative came to look after him. Someone, at least, made wonderful blackout blinds, which still survive in the sitting room.

After the war, the house with its half-acre garden had probably lost much of its glamour, with mounting costs of maintenance and the loss of servants. It was sold in 1968 to Robert Orange Bearne and his wife Mary Harvey Bearne, who divided the house into two flats. The staircase in the hall was removed, the garden and house were split and much more. The things that had been designed for a rich man with a cook, maid and a butler were now not needed and they were removed and adapted. Only the living room and the gentleman's bedroom remained completely unchanged. The upstairs bedroom, now part of the first floor flat, still has a wonderful veranda to sit out on and absorb the view, while the living room downstairs is adorned with its original wall plaster work and has a view through French windows to the garden.

When the building work on the house was completed, the ground floor flat was sold on to Jemima Michie Hoyd. She lived there for several years before selling to a Reverend Kingston and his wife, a retired couple who

had spent many years travelling with the British Army. He was obviously well respected for, at Christmas time, a stray card or two still arrives from distant parts of the world. He and his wife had a large family who would come and visit. They decided to buy a townhouse, closer to King Charles the Martyr Church, where they worshipped for many years.

The Bleasdale family bought our flat and modernised it. The large garage for a pre-war car and the sun-room that adjoined it were transformed into a large kitchen and breakfast room. Today, this is where family and friends can sit and eat for hours, something which would have been unthinkable when the house was built. The door to the old kitchen was bricked up and this and the store-room became children's bedrooms, and sinks were added everywhere. Mrs Bleasdale, being a nurse, obviously believed in the importance of washing hands! However, just as the work was completed, Mr Bleasdale was obliged to re-locate to another town and this is when my newly-married parents viewed the flat and fell in love with it. They too, though, have adapted it. An extension has been added to provide a further bedroom and another room and garage. However, when we exchanged our new Volkswagon Golf to replace an older model, we found the car had been redesigned six inches wider. This makes it almost impossible to use the garage, except as a store or 'dump' room, so my mother is trying to persuade my father that it should become a second sitting room for three growing teenage daughters, and perhaps a place for another bookcase. The last suggestion appeals. I think the house will change again but not so soon. My father takes his time, and my story would not be complete without adding that the history of a house is also the story of the people who live there.

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