General Certificate of Education
Advanced Level Examination
June 2012

Critical Thinking CRIT4/PM

Unit 4 Reasoning and Decision Making

Case Study Source Material

To be opened and issued to candidates on or after 1 April 2012

- The material consists of eight sources (**Documents A** to **H**) on the subject of the **National Health Service (NHS)**. These documents are being given to you in advance of the Unit 4 examination to enable you to study the content and approach of each extract, and to consider issues which they raise, in preparation for the questions based on this material in the examination.
- One further source (**Document I**) will be provided as an insert within the examination paper.
- Your teachers **are** permitted to discuss the material with you before the examination.
- You may write notes in this copy of the Source Material, but you will **not** be allowed to bring this copy, or any other notes you may have made, into the examination room. You will be provided with a clean copy of the Source Material at the start of the Unit 4 examination.
- This is a controversial subject, and feelings on many aspects of it can run high. The examination questions will ask you to *critically consider* various claims and arguments, and to make a *reasoned decision* of your own.
- You are not required to carry out any further study of the material than is necessary for you to gain an understanding of the detail that it contains and to consider the issues that are raised. It is suggested that at least three hours' detailed study is required for this purpose.

Document A

History of NHS reforms: A state of permanent revolution

Whether they have billions to invest or need to dramatically cut budgets, few governments can resist imposing their own blueprint for reform on the NHS, with the consequence that in the past two decades health service staff have had to endure almost endless upheaval.

1948: Labour overcomes opposition from doctors' leaders to establish the NHS, effectively nationalising healthcare and providing treatment free at the point of use, financed by central taxation.

1962: Conservative health secretary Enoch Powell launches a grandiose hospital building plan with the ultimately thwarted ambition of placing a general hospital in every community.

1974: A large-scale administrative reorganisation of the NHS in England planned by the Tories is implemented by an incoming Labour government, placing all health services into regional and area health authorities.

1987: Conservative prime minister Margaret Thatcher commissions a review of the NHS, amid concerns over growing financial pressures. This leads to the creation of the "internal market" in 1991 under the auspices of the then health secretary Ken Clarke. The market splits health authorities (which commission care for their local population) from hospital trusts (which compete to provide care). GP fundholding, which gives some family doctors budgets to buy care on their patients' behalf, is introduced.

1997: New Labour under Tony Blair is elected with a promise to scrap the internal market and GP fundholding, and to replace competition with collaboration.

2000: After the NHS staggers under the pressures of a winter hospital crisis, Labour responds with an ambitious "NHS plan" and massively increases investment. It re-adopts the principles of competition and markets, expands the PFI, or private finance initiative, to build scores of hospitals through private enterprise, and hires firms to provide some clinical services, while drawing up a vast array of performance targets and national guidelines in an attempt to create uniform standards of care. Primary care trusts are created to purchase healthcare on behalf of GPs.

2010: Prior to the election, the Conservatives promise to avoid "massive structural reorganisation", but the health secretary Andrew Lansley has drawn up radical plans which will give spending power back to GPs, sideline primary care trusts, give the private sector a bigger role, and dismantle much of the architecture of regulation and targets introduced by Labour. Commentators call the proposed changes the biggest reorganisation of the NHS for decades.

Source adapted from Patrick Butler, 'History of NHS reforms: A state of permanent revolution', *The Guardian*, 10 July 2010

Document B

The NHS braces itself for privatisation

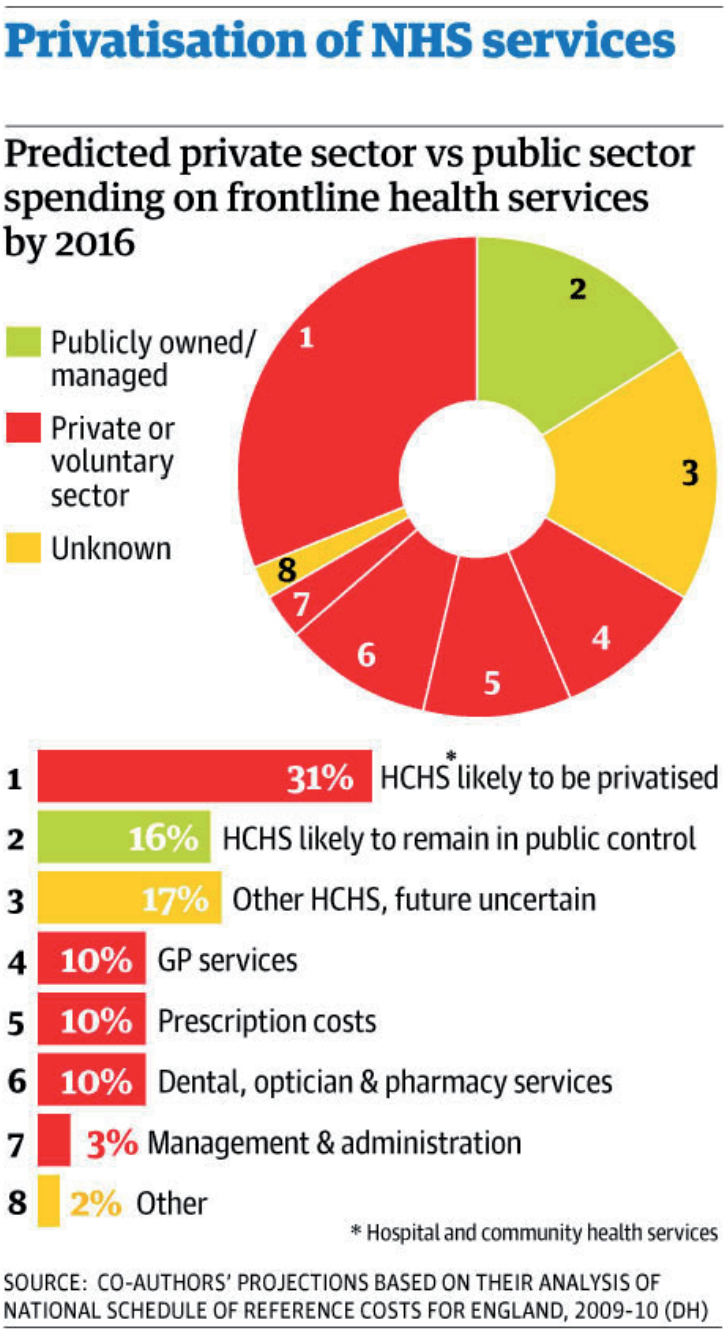
There are some areas (of the proposed health service reform) where the government is not prepared to listen: the commitment to abolish primary care trusts, to transfer major powers to commission services to GPs, and the ambition to vastly increase the participation of the private and, in theory, voluntary sectors in providing health services. In future, the NHS will continue to be funded from taxation and (for the time being) will be free at the point of delivery, but the government will step back from running the service.

Private sector involvement in the NHS is not new. Dentistry, worth £2.1bn, opticians and pharmacies are already in the private sector. GPs themselves are effectively private contractors, accounting for £8bn, or almost 10% of the entire NHS budget. Under Labour, private involvement was extended via independent sector treatment centres (ISTCs), handling mainly non-emergency elective treatments, as a way to bring down waiting lists.

But the current proposals are much more bold. Plans are under way to further outsource central services, such as workforce development (total budget £5bn) and procurement management. Even NHS Direct (worth £146m) is in the firing line.

The shift to create more than 200 GP consortiums in England will generate further opportunities for private firms. Notably, this will be in the management of commissioning, worth £1bn. Firms such as Tribal, Humana, United Health and Aetna already offer referral management services that promise to help consortiums slash their costs by as much as 15% and turn savings into profits.

But what about core and non-core clinical services provided by NHS trusts and community health organisations? These could be harder to outsource. This is especially true of the most complex, unplanned hospital admissions that are costly and inherently difficult to plan for. The Department of Health's (DH) own statistics show these account for approximately £12.5bn of a total budget for "hospital and community services" of £51.5bn. But that still leaves £39bn that could potentially be subject to private sector competition.



Turn over ▸

All of this will not be privatised immediately. DH statistics show that just over £750m is contracted out to “non-NHS providers”, spread across the full spectrum of planned NHS care, including elective inpatient services, day cases, mental health and outpatient services. Initially, it is in these areas where further encroachment by private firms might occur.

From available statistics, it is relatively straightforward to identify up to £25bn of NHS care that the private sector could be expected to bid for. This means that, whereas today about 31% of the frontline care budget (currently allocated to PCTs) of £80bn is held in private hands, in future that could rise to 64% or more.

This trend is surely cause for concern. The first wave of ISTCs, for example, were found to be 12% more expensive than the NHS when carrying out the same work. Available evidence suggests that, while the NHS is loved by the public, the service from GPs and dentists (essentially private contractors) leaves much to be desired – hardly a promising omen for the future.

What will become of those unplanned services requiring complex and expensive treatments where it will be hard for private firms to make a profit? Most likely, the government will be left to shoulder the burden. But will the resources left to manage them be sufficient to maintain clinical standards at the current level? Will prices also rise, forcing patients to pay more from their own pockets?

David Cameron has made a commitment that he will not place the NHS at risk. But increasingly this seems hard to reconcile with the plans to reorganise the service. All the signs are that taxpayers could end up paying more for less.

Christopher McCabe is professor of health economics at the Leeds Institute of Health Sciences at the University of Leeds. Ian Kirkpatrick is professor of work and organisation at Leeds University Business School.

Source: adapted from Christopher McCabe and Ian Kirkpatrick
‘The NHS braces itself for privatisation’, *The Guardian*, 12 April 2011

Document C

What's happening to the NHS?

The NHS is changing.

Some of these changes you can see, like the new computer system 'Choose and Book' which lets you choose which hospital you go to if you need an operation. Other changes you can't always see but are just as important because they could change the way the NHS is run and the quality of care it provides. The recent White Paper for the NHS continues to emphasise a role for the market and private providers. One proposal is to abolish the cap on the amount of income that foundation trusts may earn from other sources (e.g. private patients), and the paper advocates an 'any willing provider' model for NHS services.

The British Medical Association (BMA) believes that market reforms are costing the country money it can't afford, are not always in the best interests of patients and could threaten the public service ethos on which the NHS depends. Many have been introduced either without proper public consultation, or in the face of public opposition.

Whilst the NHS is not perfect it is appreciated by and depended on by many people – for some it's a much loved institution. Its success is due in part to doctors and other health professionals working together in the best interests of their patients and the personal relationships between doctors, patients and their communities, often going back many generations.

But all this could be at risk if the changes in the way you receive your healthcare continue.

We want to tell you about some of these changes and why doctors, with the backing of the British Medical Association, are worried about them.

- Companies from the private sector are allowed to bid for contracts to supply NHS patient care on behalf of the NHS. This could be a local GP practice, hospital or community health service such as health visitors.
- These are generally large, multinational companies. They are attracted to providing NHS patient care because they see it as being profitable for them.
- Any profits they make from providing NHS patient care may not always be invested back into the NHS. As profit-making companies, they need to make profits to pay dividends to their shareholders. So it is their shareholders who benefit, not the NHS.
- Private providers who run treatment centres are allowed to 'cherry-pick' the clinical services they provide which means that they concentrate on those that are most profitable for them. This tends to favour the more routine treatments, like hip replacements and cataract operations, leaving the NHS to pick up the more complex, costly treatments.
- These treatment centres have been guaranteed payments even if they don't treat the numbers of patients they have been paid to. Millions of pounds have been wasted this way – money which could have been spent directly on patient care.
- As they have to pay dividends to their shareholders, there is even less incentive for commercial providers to invest money in training or research. The advancements in health care and the quality of today's NHS doctors are a result of yesterday's research and training. If that investment is reduced today, it could affect the quality of healthcare in the future.
- As well as being affected by lack of investment, doctor training could also be affected by lack of opportunity. As NHS hospitals lose routine procedures to commercially-run clinics, students and junior doctors are losing out on opportunities for practical training.
- Allowing commercial companies to provide NHS care, in addition to the NHS itself, means that there are now more providers of patient care. In some areas of the country there are more than are actually needed, which is wasteful and an expense the country can't afford.

Turn over ▸

- It can also lead to unwelcome competition, as NHS organisations compete with each other, and against private providers, for patients. Some NHS Trusts may advertise to attract patients, money which should and could be spent on patient care.
- Patients are now able to choose where to have any elective treatment (i.e. treatment their GP says they need to have). Included in this choice will be commercially-run clinics or private hospitals which are contracted to provide NHS work, as well as traditional NHS hospitals.
- If a patient chooses – or their GP makes the choice for them – to have that treatment in one of these private hospitals or clinics, the funding for that treatment goes with them – i.e. it is taken out of the NHS.
- Private providers are encouraged to take on more routine NHS work to reduce the burden on the NHS and to help cut waiting times. If NHS hospitals lose too much of the routine work to commercially-run clinics, and the funding that goes with it, it can mean that some may not have enough money or patients to justify keeping certain departments open, or they may have to cut their services.
- If NHS hospitals lose too much funding, it can make it difficult for them to plan their services as they don't always know how much money they'll have.
- Some GP practices are now run by profit-seeking companies. Their contracts are short term which means that turnover of doctors and other staff may be more frequent, with the risk that patients lose that valuable doctor–patient relationship – particularly important for the elderly and those with long-term health problems.
- The private sector is also involved in the building and running of NHS hospitals in England under a complex scheme called PFI. The Private Finance Initiative was originally introduced by [the] government as a way of funding expensive public sector building projects such as hospitals, schools and roads, using private sector money and expertise. Private developers build the hospitals which the NHS then pays for over a period of 25–30 years – a bit like a mortgage. But these costly contracts have left many hospitals with crippling debts which, it is feared, may lead to cuts in healthcare services as hospitals struggle to make their PFI payments
- Some of these private developers are also struggling to meet their financial commitments (they often need bank loans to fund the projects) – but instead are saved by a government which would rather use public money to bail them out than see their unpopular PFI policy fail. So what was once promoted as the answer to funding public projects is increasingly discredited.
- Many patients value their district general hospitals (DGHs) which are easily accessible. DGHs provide consultant-based care in the main specialties (e.g. 24-hour A&E, surgery, anaesthetics and intensive care) and for that reason provide safe, all-round care. **Private treatment centres often lack the back-up of key departments such as intensive care and so cannot provide the same level of care as DGHs**. DGHs also provide training for junior doctors and other NHS staff.

The NHS is likely to face cuts as the recession bites. Doctors want the government to cut the cost of private sector involvement in the NHS, and the cost they see this as having on patient care.

Source: www.lookafterournhs.org.uk

Document D

Abolish NHS, says right-wing think tank

3 December 2001

THE NHS should be abolished in its present form in favour of a mixed system of funding and providing, a Right-wing think tank says today.

Dr Sheila Lawlor, director of Politeia, says the NHS is not only failing now but also "as politicians have known from the start" has always failed in two fundamental ways.

She says there has never been, and never will be, enough money from tax alone to pay for the NHS and that a centrally planned, bureaucratic structure cannot meet patients' needs.

Dr Lawlor accuses governments of concealing the truth about the NHS, behaving as if there was no alternative and pretending that with a little more funding the NHS would be "safe in their hands".

She wants a "mixed health system" which would be mainly funded by tax but also open to raise extra cash from private and voluntary sources. "The aim would be to make freely available a comprehensive health service, to allow for satisfactory funding and introduce a structure which makes for the right balance between clinical freedom and a mechanism for accountability to patients," she said.

Source: adapted from Celia Hall, 'Abolish NHS, says right-wing think tank', *The Telegraph*, 3 December 2001

Turn over for the next source

Document E

BBC News

Q&A: US Healthcare Reform

US President Barack Obama made reform of the American healthcare system his top domestic priority when he entered the White House.

On 21 March 2010, after a weekend of intense debate, and last-minute appeals to Democrats from the president, the House of Representatives passed the biggest reform of healthcare in the country for 40 years.

But the house was deeply divided, with no Republicans voting for the bill, and a number of Democrats also opposing it.

What is the current situation?

There is not a universal system of healthcare coverage. There are federally funded programmes, the biggest being Medicaid and Medicare.

But generally it is up to individuals to obtain health insurance. Most get coverage through their employers, but others sign up for private insurance schemes.

Under the terms of most plans, people pay regular premiums, but sometimes they are required to pay part of the cost of their treatment (known in the US as a deductible) before the insurer covers the expense.

The amount they pay varies according to their plan.

US HEALTHCARE SYSTEM

Medicare: government-funded healthcare for over-65s

Medicaid: government-funded healthcare for those on low incomes

Employer-funded health insurance: paid by salary deduction

Military veterans: receive healthcare via government-run scheme

State Children's Health Insurance Programme: coverage for children whose parents do not qualify for Medicaid

Uninsured: treated in emergency rooms only

So what are the problems with the US system?

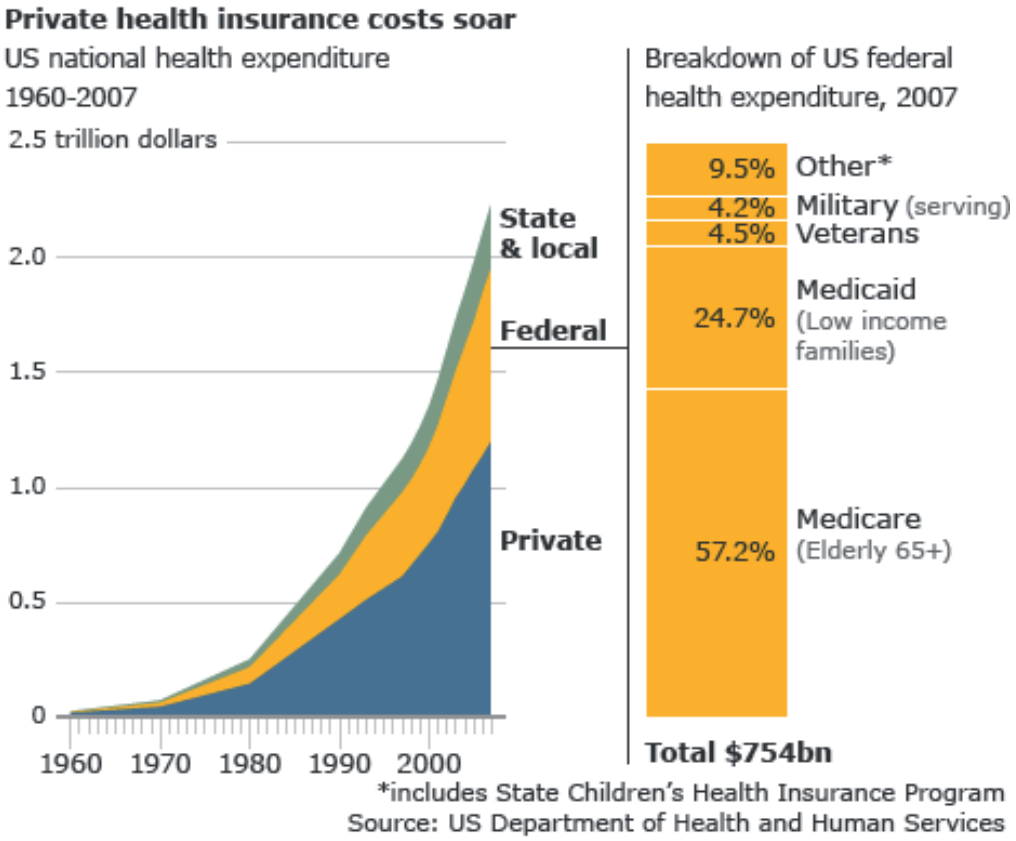
Firstly, cost. As a nation, the US spent some $2.2 trillion (£1.36 trillion) on healthcare in 2007. That amounts to 16.2% of GDP – nearly twice the average of other countries in the OECD (Organisation for Economic Co-operation and Development).

Second, coverage. The US Census Bureau estimates that 46.3 million people in America, out of a population of 300 million, were uninsured in 2008.

However, this includes 9.2 million non-citizens and 18 million people who earn more than $50 000 a year.

There are also millions of Americans who are deemed "under-insured".

US HEALTHCARE AND WORLD COMPARISONS



Healthcare reform is a priority for Barack Obama. The US spends about $2.2 trillion a year on its system – which includes private, federal or employer schemes.

What are the effects of rising health costs?

When someone without insurance (or with inadequate cover) falls ill, they are obliged to pay their medical costs out of their own pocket. Half of all personal bankruptcies in the US are at least partially the result of medical expenses. Rising costs also mean the government is spending more and more on Medicare and Medicaid.

US government spending on the two schemes is projected to rise from 4% of GDP in 2007 to 7% in 2025 and 12% in 2050, making rising healthcare costs one of the biggest contributing factors to the spiralling US budget deficit.

So what changes were proposed?

The broad outlines of the House and Senate bills passed late last year were similar on many issues.

The bills:

- favour tougher regulations for insurers
- establish a rule that you must get health insurance
- set up insurance exchanges for those who do not have coverage provided by employers
- offer subsidies for the less well-off – although their exact size varies from committee to committee
- pay for most of the reforms by cutting waste in the Medicare programme

What about President Obama?

Mr Obama laid out a relatively broad plan for healthcare reform at the beginning of his presidency, saying he would leave Congress to hammer out the details. But faced with stalled legislation and broad opposition from Republicans, he outlined a more detailed blueprint for healthcare overhaul in February.

Mr Obama said that the proposals would make healthcare more affordable and health insurers more accountable.

The changes, he said, would help to reduce the federal deficit by $100 billion over the next 10 years, by tackling waste, fraud and abuse.

Source: adapted from Q and A: Healthcare Reform, BBC News Channel, 22 March 2010

Document F

NHS vs USA: The great healthcare face-off as seen by the BBC's former man in Washington

We can prick Sam's fingers for free. This, for me, is the true glory of the NHS. For the parents of a child with a life-threatening auto-immune disease – type 1 diabetes – the relentlessness of the task of keeping his blood sugar under control can be overwhelming. Doubly so when – on top of everything else – stony-faced pharmacists are telling you that you have used your allocation of test strips.

But that, until we left America to return to the UK this summer, was normal life.

'I am not doing this for fun,' I felt like yelling. 'We got through a box of strips last night because we couldn't get him under control. He is not bleeding on your precious strips for the hell of it.'

Family matters: Justin Webb with son Sam, right, daughter Martha and baby Clara in 2004

Sam himself, as a nine-year-old student of drama, used to be amused by our adult tantrums at American pharmacy counters.

But for us it was no joke. We had good insurance, which in theory guaranteed us any healthcare we needed with no questions asked. So the initial hospital bills when Sam was diagnosed – thousands of dollars' worth – were eventually paid.

But there's small print. And in the small print there are annual limits on expenditure and constant payments that the ill person needs to make before any service is provided. If you need a weekly supply of drugs and kit, as Sam does, you have what amounts to a constant battle to get it.
So we were in combat with the organisation that, in theory, was looking after our son's health. The view of the insurance company was that Sam was a nuisance. A perfectly healthy little fellow, who cost them no more than the odd flu shot, suddenly became a major expense. And, as in any other business, expenses are to be minimised.

So when our eight years in America came to an end this summer, our final holiday in California had to begin with a call to the insurance company. May we please – pretty please – have extra supplies of the insulin that keeps Sam alive and the testing paraphernalia that goes with it?

Turn over ▸

We were going to be on the road for a few weeks and then return to the UK. All right, came the answer, after a morning on the phone. But we were made to feel really rather lucky. ‘Just this once’, was the unspoken warning.

California was stunning. Big Sur, Lake Tahoe, Los Angeles: there is no finer place on Earth. So when we flew from San Francisco to start our new life in South London, we were not exactly throwing our hats in the air.

Until the news about the test strips. For despite reports this week that the NHS is so underfunded that women are giving birth in hospital corridors, the situation is not all grim.

Presenting ourselves at the local NHS GP clinic, we signed on and explained Sam’s condition. Not an eyebrow was raised. Prescriptions were written there and then.

‘Have what you need.’ Those were the words the doctor used. I will remember them for ever. We can prick Sam’s fingers as often as we deem it to be necessary. We are free of the tyranny of the insurance company.

And this is not profligacy, either – better control of diabetes (any type of diabetes) reduces the complications that maim and cost huge sums to treat – so the NHS, by encouraging Sam to test his blood often, is doing him and future taxpayers a favour.

Rule Britannia. And yet ... There is another side to the American healthcare system that any fair-minded assessment must include. Mine certainly should because Sam benefits from it every day.

Boon: Sam Webb kayaking this summer while wearing his insulin pump, only available in the U.S.

There is a company based in New England that makes his life a million times more enjoyable than it would otherwise be. The company makes a special kind of insulin pump that has no tubes. Sam forgets it is there. In California he went kayaking with it on.

Guys, as the Americans would say, this company is not a charity. It is run for profit. In fact, I saw it tipped recently as a smart move for investors playing the markets.

In other words, the same profit motive that is such an upsetting part of the insurance industry (those bloody test strips) leads to innovation that, in the UK, just does not exist.

I rang the boss of the company and asked him about the chance of a UK launch. Zero. No money to be made here.

The NHS spends its money on test strips and basic care. Fancy American pumps are out. In fact, pumps of any kind are out for many British children. Injections are cheaper.

So to spell it out: the British system provides the basic care and does it with no fuss and no cost to the hard-pressed family. Having a child with type 1 diabetes will make you sadder, perhaps wiser, but it will not make you poorer. And, medically, Sam is as well looked after here as he would be in any fancy American hospital.

But American technology and zest for lifestyle improvements in the area of diabetes, as in every other area of human endeavour (a zest born out of zest for profit), add something to Sam's life. That something is denied to those who depend wholly on the NHS.

So the argument goes on and, as a family who have lived with both systems, we can only say that we are grateful to the doctors and nurses on both sides of the Atlantic who devote their efforts to making Sam – and hundreds of thousands of other children with type 1 diabetes – healthier and happier than they could otherwise be.

When I went to the White House earlier this year for Barack Obama's first interview with a British broadcaster, we talked while the cameras were being set up. Not about the Middle East, which was the big topic of the moment, or the world economy, or even the whereabouts of the bust of Winston Churchill that used to sit in the Oval Office.

We talked instead about type 1 diabetes. Mr Obama has friends whose children suffer from it. He was knowledgeable and sympathetic. He wrote a note to Sam and to his sisters, Martha and Clara. 'Dream big dreams,' he wrote.

His dream for America's health service is that it resembles the NHS when it comes to fairness. Test strips for all who need them.

But he claims as well that the best of the American system – the innovation and the choices available to well-insured Americans – will not be put in jeopardy.

Is that a realistic dream? This is the question at the heart of America's debate.

Source: adapted from Justin Webb, 'Have A Nice Day – A Journey Through Obama's America', published by *Short Books*, 2009

Turn over for the next source

Document G

USA versus the NHS

When Bobbie Whiteman moved to the United States from Britain, she did not give medical insurance a thought. She had no cover for six months and it was only when she was offered a job at Variety, the Hollywood newspaper, that it became an issue. It was part of her salary package and she had to decide between several schemes the company had on offer.

Seven years later, in 2007, the value of the scheme she chose became all too evident. Suffering from persistent backache – which doctors initially attributed to being "unfit" – she was given an MRI scan which showed she had a string of cancerous tumours down her back.

Instead of heading for home and the National Health Service, she had treatment in America – and is glad she did. "Every time you go for any treatment here, they want to see your insurance card and check every detail they have about you and that is wearisome," said Whiteman, 49. "But I've had some terrific treatment."

Little expense was spared in having the necessary scans, tests, radiation treatment and drugs. So far her cancer is stabilised. "There are all sorts of things you have to be aware of: some treatments you part-pay for and you have to choose a doctor who is approved by your insurer. But it's not all about money here. The doctors are doctors – they really want to help you."

About 84% of Americans have health insurance (compared with just 10% in Britain) and value the care it buys. So proposals by President Barack Obama to reform the system, extending cover to those who lack it, have sparked uncertainty and fear. Uncertainty over where the changes might lead and fear that standards might fall.

In the furore, Obama's critics have been damning about the concept of universal state-funded healthcare, accusing the National Health Service of poor standards and being "Orwellian".

Charles Grassley, a Republican senator from Iowa, said (wrongly) that Ted Kennedy, 77, would not have been treated for his brain tumour in Britain because he was too old. The National Center for Policy Analysis said Britain was "infamous" for denying state-of-the-art drugs to cancer patients. Sarah Palin, the former vice-presidential candidate, said Obama's proposal that a panel of medical experts should rule on cover for specific conditions – in the way the NHS restricts some treatments – was "downright evil".

The criticisms were so strident that they spurred Gordon Brown to react even while on holiday. Via Twitter, the prime minister said that the NHS "often makes the difference between pain and comfort, despair and hope, life and death. Thanks for always being there". Also leaping to its defence was Andy Burnham, the health secretary, who claimed it is "world-class".

David Cameron who, like the Browns, has had extensive experience of the NHS through having a sick child, declared the Conservatives were "the party of the NHS" and improving the service would be his "No 1 mission" in government. Yet Daniel Hannan, a Tory MEP, lambasted the service, telling an American television station that he "wouldn't wish it on anybody". However, US President Barack Obama's stepmother said last night that she owed her life to the NHS. British doctors and nurses saved Kezia Obama, who lives in Berkshire, when she suffered kidney failure. "If it wasn't for the NHS, I wouldn't have been alive to see our family's greatest moment – when Barack became president and was sworn into the White House," she said.

Who is right? Does the NHS trail the United States as portrayed and what lessons can each side learn from the other? Amid the outpouring of support from many Britons for the NHS last week, there were acknowledgments of its problems.

"Most people value our health system and wouldn't be without it," said Michael Summers, vice-chairman of the Patients Association. Investment in recent years has improved it, he says, but it remains far from perfect: "We are still worried about waiting times, mixed sex wards and the restrictions imposed by the National Institute for Health and Clinical Excellence."

Last week, Professor Kefah Mokbel, a London cancer specialist, warned that a lack of resources meant women were not being properly screened for breast cancer. The government target is women aged 50 to 70 to be checked every three years. Some areas screen more than 90% of eligible women within the target time; in others, only one in five is checked. Mokbel believes women should be seen every 12 to 18 months.

Although the once horrendous waiting lists of the NHS have been drastically reduced after huge increases in spending, more than 230 000 people are still waiting at least 18 weeks for treatment. NHS productivity has fallen by at least 4% over the past decade. In addition, the gap in life expectancy between the most and least deprived areas of England has widened. Concerns also remain over restrictions on expensive or experimental treatments.

When Andrew Lawson, a consultant in pain medicine at the Royal Berkshire hospital, was diagnosed with an aggressive lung cancer two years ago, he had no time to lose: the average life expectancy for people with mesothelioma is 12 months.

He decided that allowing the NHS to take its course was not enough. Researching his condition on the internet, Lawson, 50, found a trial of a radical treatment at the University of Pennsylvania hospital in Philadelphia. He was impressed by what he saw and took part in the trial. "Most doctors in Britain, if they've worked overseas, will admit that somewhere like America has the best of the best. What it doesn't have is the breadth of coverage," he said.

"Ours is an equitable, morally cogent way of doing things. But looking at the amount and quality of research into my cancer, there was a clear difference between Britain and the United States."

Thanks to the vast sums poured into the US system, those Americans with insurance undergo more X-rays and other diagnostic tests than British patients, which appears to have some impressive spin-offs. America's superior survival rate from prostate cancer – 92% after five years compared with 51% here – is probably down to diagnoses being made earlier.

Indeed, in the United States the complaint is sometimes too much healthcare, not too little. "Over-consumption or overprovision of healthcare is a huge problem in the States," said James Gubb, director of the health unit at Civitas, the British think tank. "You get paid in some cases for each X-ray you carry out or each operation and, clearly, if that's happening, then there's a big incentive to over treat.

"There is unquestionably more of a sense of customer service in the States – that it is important to look after the patient as a customer and provide the services they want – than there is in the NHS."

What are the problems and why is reform needed? In essence, the US system costs a fortune yet fails to cover everyone adequately. Insurance that provides for the majority of Americans costs about $12 000 (£7 300) per year for the average family. At least part of that cost is usually picked up by an employer. But some 47m people do not have insurance.

The British tend to think this means they are left out in the cold. Care can be limited, or charges high, but as one expat returned to the UK explained: "It's not as excluding as people think. If you get run over, the ambulanceman will rifle through your wallet for an insurance card. But if you don't have one you won't be left by the road; you will be taken to a public hospital.

"That's what many people are afraid of – that if Obama gets his way, it will all come down to the level of the public hospitals, in other words, the level of the NHS."

The bigger problem is that healthcare bills threaten to be crippling for the state and for people who have limited insurance. Some 60% of bankruptcies in the United States are related to healthcare costs. Companies complain that the costs are making them uncompetitive.

Although the system is market-based, insurance has the effect of encouraging costs to rise. The bureaucracy is enormous: for every two doctors in America there is one administrator, working either for an insurance company or for a firm that sorts out billing, or which arranges treatments on behalf of patients.

At the same time, the costs of Medicare, a government-run scheme to provide cover for the elderly, and Medicaid, for the poor, are rising sharply. Half of America's health spending comes through Medicare, Medicaid and a body called the Veterans' Health Administration.

In total, the United States spends in the region of 16% of its gross domestic product (GDP) on healthcare – nearly twice the percentage spent in Britain. At the top it can boast the most advanced treatment in the world – but overall its health outcomes are no better.

"Anybody looking at the American system from the outside would say it needs radical reform," said Anna Dixon, director of policy at the King's Fund, a medical think tank. "America is spending more than anyone else, yet millions of people are either uninsured or underinsured. That's not sustainable. The signals have been there for some time, with companies wanting to pull out of providing employees with insurance."

Does it mean reducing standards to those of the NHS or is there an alternative? Both the United States and Britain could learn from other European healthcare systems, says Gubb. "There are insurance-based systems in Europe which provide universal coverage," he said. "In Switzerland and the Netherlands, for example, every person has to have health insurance cover and every patient is ensured cover by the state if they cannot afford it.

"They have a choice of health plan and there's a minimum standard of care those plans have to cover. For me that sort of idea would make a lot more sense in terms of the US debate than looking at the NHS."

Neither the United States nor Britain compares well with the results achieved by some European countries. The model of compulsory insurance for all, used by France, has led the World Health Organisation to rank it the most efficient service in the world. France spends 11% of its GDP on health; yet its infant mortality rate, life expectancy and mortality rate for cardiovascular illness are all better than in the United States and Britain.

The diagnosis seems to be that both Britain and the United States are in need of treatment – and a European-style combination of insurance backed by a government safety net may be the best outcome.

Source: adapted from Margaret Driscoll and Roger Waite, 'USA versus the NHS', *The Sunday Times*, 16 August 2009

Document H

Health, wealth and falling trees: Who (or what) really makes government policy?

The clamour for Parliament to do something about the NHS poses a familiar dilemma for politicians. It is not just a matter of health, nor even just about money, as people tend to think. For the government of the day, it is a question of political pragmatics, of framing a Bill which will not only succeed in the House of Commons but which will also least upset the voting public and the media, especially with an election looming on the horizon.

Getting the Press onside is always one of the key objectives, given the enormous influence newspapers exert on public opinion. *The Sun*, it is claimed, rightly or wrongly, has determined the result of at least two elections in its 40-odd-year history: one for John Major; one for Blair. The UK's best-selling tabloid is not averse to changing its allegiance to suit its own interests, or for that matter its own whims. The Murdoch empire, which includes *The Sun* and *The Times*, probably has more power of persuasion than the Government and the Opposition put together. It is ironic that an Australian, who does not even have a UK vote, may be the one person whose opinion matters most.

It is easy enough to say that a government should not be swayed by public opinion when matters of principle, and (literally) life-and-death issues, are at stake. But it is not quite as simple as that. For a political party to be in a position to apply its principles at all, it must be in government, and must have a workable majority. That requires securing or retaining around forty per cent of the popular vote. Once out of office, all that a political party can do is make a noise; and what, you might say, is the use of principle then? Hence governments often try to gauge public opinion – in other words 'float the idea' – before introducing some new and controversial piece of legislation. If the planned measure looks likely to arouse too much opposition or anger among the voting public, the best option may well be to drop the proposal; or at least to water it down. The trouble is, that too has risks.

There was a classic example in February 2011,when the environment minister announced a proposal to sell off a large part of Forestry Commission land. The protest was so loud that the Prime Minister announced to the Commons that the plan would be dropped, prompting an Opposition MP to shout: 'Timber!' On that occasion the Government survived, but not without damage to its reputation. That is the dilemma in a nutshell. It is why, presumably, politicians – like football referees – so rarely reverse a decision, or apologise, or admit they were wrong. It may be what the protesters want them to do, but they despise them when they do it. To use that horrible but apt expression: 'It's *lose lose*.'

That is also why the debate over NHS reforms will probably rumble on, while whichever party holds office tries to decide which of the options will cost them least votes, rather than which will serve the doctors, patients, and the nation best.

Jacqueline Costain
May 2011

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