On 11 January, as a welcome change from Trump and Brexit, Red Box focused on the sustainability of Britain's NHS and referred to it as a "blame game". The game being played between the health secretary, Jeremy Hunt, and the chief executive of NHS England, Simon Stevens, over money is like the rattle of two drying peas in the same pod; they both want to bring to England the costly US healthcare system.

The US system in 2014 spent 17 per cent of GDP on national healthcare, public and private, as compared to 9 per cent for NHS and private spending in the UK. In the US the Institute of Medicine in 2009 admitted some 30 per cent of this health spend "was wasted on unnecessary services, excessive administrative costs, fraud and other problems". We are fast repeating that American pattern here in England.
Simon Stevens worked in the US healthcare sector for ten years and lobbied for it in Washington. He has modelled his Sustainability and Transformation Plan (STP), or "44 footprints" since he dare not call them areas for fear of legal challenge, on accountable care organisations.

Our English politicians, whether Conservative, Labour or Liberal Democrat, have set a course heading for the costly US system, though only very few ever acknowledge this. They do not seem to realise that the STPs coming soon are, in private, planning considerable hospital bed closures at a time when the Royal College of Surgeons has said that we cannot manage with less beds. They also plan on reducing services across the board. These cuts are to finance a costly, predominantly US-designed external market healthcare system that our politicians have been introducing since 2002. They have done this with the support of newspapers who are headlining every NHS scandal. This includes, shame on them, the hand-wringing Guardian. Very few in England are daring enough to admit that the direction of travel is towards a US healthcare system and Red Box should call them out.

These same politicians talk of a honest discussion with the electorate, while increasingly saying or hinting that the English model is not sustainable. What is not sustainable, given our own high deficit British economy, is for the UK to divert public and private spending of 17 per cent GDP towards NHS England and private healthcare as happens in the US. The Americans hitherto appeared to be able to absorb such a large spend but the state of their infrastructure is starting to call into question that priority where President Trump won in the rust-belt states. Nor is it rational to put all the blame for inadequate health funding onto the fact that people are living longer when we are also much healthier and more active well into old age. We need, as does the US, better old age housing and caring facilities, better design and more social services integrated with health. Because these are achievable most geriatricians and nurses are confident that we can sustain a publicly planned NHS England as people live longer. Also financial arrangements for handling old people's savings and assets are starting to be more imaginative. It is a profound mistake to believe that the British NHS model, largely unchanged from 1948 to 1990, is not sustainable and at far lower cost than the American model.

The NHS was, and largely still is, judged to be easily the most cost-effective healthcare system in the world. Even in 2014 a study of 11 different health systems put the UK top in terms of efficiency, quality of care and access.
We may quite soon be negotiating with the US and Canada a more wide-ranging and sophisticated North Atlantic Free Trade Area (NAFTA). We must not allow our politicians to continue to lose sight of our British values and principles on the NHS as has happened since 2002. On health we must stick to the recently agreed CETA language in any NAFTA. We

will no longer be under pressure from EU market and competition policies to marketise our NHS and we and Canada must be ready to demonstrate to the Trump administration that the way to lower the US health spend is not through the American model or losing the cost comparison of our different, but less costly, systems.

PThe rot in the English NHS started in 1990 with the rigid separation of the trust hospital from the community it served. This made the division between the NHS and local authority health services far, far harder to manage. Hospital fragmentation was soon followed by the PFI, leading to a substantial financial burden in paying back private debt. Barts Health Trust, my local in the East End of London, is the largest in England and incurs £1.15 billion PFI debt costs representing 11 per cent of its annual budget, which they cannot pay back. Prior to PFI, Barts and others borrowed for capital spending at a far lower cost from the Treasury. These PFI costs were carried by the NHS when central government expenditure was relatively higher in 2005 to 2010 without damaging other services. Today, these extra PFI commitments are met at the expense of other NHS provision and care contributing hugely day by day to the present funding crisis. Why so little outcry from the House of Commons? Answer: most of them voted for this monstrous scheme.

Then came the massive additional administrative costs of the purchaser/provider split. Reporting in 2010 the House of Commons select committee, looking back over the past 13 years of Labour government, said: “Whatever the benefits... it has led to an increase in transaction costs, notably management and administration costs.” Research commissioned by the Department of Health but not published estimated these to be as high as 14 per cent of total NHS cost. Whereas before the 1980s NHS administration costs were below 5 per cent, by 2005 they were pushing 14 per cent and are still rising. These costs are, as in the US, totally market-related. Tendering, comparing bids, all takes time and money and on top of this there has to be a profit for shareholders. The NHS purchased £8.72 million worth of healthcare from independent sector providers in 2015-16. Why again no wish in the House of Commons to revert back to the old, far less costly, system? Answer: most of them voted for this fundamentally flawed system. Scotland wisely escaped the worst changes when health was devolved and to a similar extent so have Wales and Northern Ireland.Totally undeterred by all these substantial increases in health budget costs not related to frontline care and despite considerable opposition within the NHS, the coalition government in 2012 passed the Health and Social Care Act creating an even larger externally marketised health bureaucracy. Shock horror headlines followed in many areas. First, over redundancy payments and re-employment. Huge numbers of outside consultants, mainly accountants, were appointed, again at considerable cost. This year’s shock horror headlines: 97 people in NHS England were earning more than the prime minister.

All these compromised politicians and administrators can do now is argue about more money. The simplest action in order to cut costs is to stop all these market reforms immediately. Slowing appears to be happening but that is not enough, most of the marketising bureaucracy has to go. We must renegotiate away and end PFI contracts. Even after these cost savings are lifted from NHS England, however, the chancellor will have to find money from elsewhere to meet the cost.
Why not, in the next budget speech, make all those over-65s who continue to work pay national insurance? It would raise, I am told, over £1 billion. I worked in business for 12 years past the age of 65 and could easily have paid national insurance. My generation were allowed to set mortgages and any related endowment insurance schemes against income tax. It was far easier to become a homeowner at an earlier age then. The elderly still working in

England are now, I suspect, ready to pay more to return the NHS in England to the sustainable planned model that they have relied on for most of their life.

Lord Owen is a former doctor and health minister in the Wilson government