THE HEALTH OF NATIONS

Solutions to the problem of finance in the health care sector

By

Dr Madsen Pirie and Dr Eamonn Butler

CONTENTS

First published in the UK in 1988 by ASI (Research) Limited (c) Adam Smith Institute 1988

ISBN: 1 870109 17 1

1. INTRODUCTION

Symptoms of malaise

In recent years, the problems of the National Health Service seem to have grown at an accelerating rate. Those working inside the Service have complained, almost since its inception, that they had insufficient budgets or that a large part of the resources allocated to health care were wasted.

Recently, however, worries about the standard of care the NHS can deliver have spread outside the Service itself. Today, ordinary, embers of the general public are fully aware of the financial and organizational strains that exist within the NHS.

The symptoms of the malaise have indeed become difficult to, overlook. Wards have been closed in hospitals all over the country as health authorities complain that they simply do not aye the cash to run them. New hospitals and diagnostic units, with all the latest high-tech equipment, lie unused because there's no staff budget to run them. Waiting lists continue to be high and the government has had to attempt remedial action to educe them. The Auditor General revealed that half the nation's operating theatre time was wasted because staff were unavailable. The heads of the royal colleges have pleaded for more spending, while doctors have sent mass petitions to Downing Street.

Delays and shortages have hit the headlines. The case of a young boy who had waited months for vital surgery (although he was generally fit and active) concentrated the 1987 general election campaign on a debate about waiting lists. Shortly afterwards came reports of a hole-in-the-heart baby whose operation had been 'postponed five times because of insufficient intensive care facilities. Meanwhile, London consultants admitted freely that they were advising patients to take legal action to ensure that the NHS provided the treatment they required. Consultants and even nurses became accomplished at putting their case to the media from the dark and bleak surroundings of closed wards.

Looking for the cause

It is hard to judge whether these incidents are symptoms of some sudden change for the worse in the condition of the NHS. They could just as easily reflect a growing trend for those inside and outside the Service to use political tactics in the attempt to shape its future. Whatever their source, the number and increase of the media reports have generated a widespread feeling that the NHS is underfunded and in decline.

However, the fact of the matter is that NHS spending stands at all-time record of roughly £21,000 million, an increase of 30% in real terms since 1979 and almost £400 per man, woman, and child. As a proportion of GNP, health spending in the UK might well be lower than that of many other developed countries, but it has nevertheless increased from 4.8% to 5.5% under the present government. There are 51,000 extra nurses, 30% better paid in real terms. The capital budget is up by 40%, and some 200 major hospital buildings and 150 new X-ray rooms have been

completed in the last eight years. Treatment levels are also a record: in-patient cases treated rose by 20% in the period 1978-86, while day cases nearly doubled.
The ward closures, waiting lists, and staff shortages, therefore, cannot be explained by the popular belief that there have been budget cuts. Indeed, and worryingly, the complaints from inside the Service have reached their crescendo precisely at the time when funding and manpower levels have been boosted faster than ever before.

Cash shortage or structural deficiencies?

Optimists might argue that a higher dose of public spending now It bring some temporary remission of the problems if properly targeted -- the government has already devoted £50 million over years to help reduce the waiting lists, and nearly £100 million extra to specific services, for example -- although on a large budget, cash injections in the billions would be led to have a noticeable general effect.

Even among those inside and outside the Service who argue that more money is needed immediately, however, fewer people than ever before believe that massive increases of the public sector health let will actually cure the problems over the long term. The economists' theoretical dictum is now an established fact: that when the price of a service is zero, demand tends to infinity. As medical science advances, each new breakthrough simply adds to the number of people who can be helped by the medical profession; yet further investment is required to meet that new demand.

The debate on the NHS, therefore, would be sterile indeed if it focused only on funding levels. Any long-term solution must look at the actual mechanisms of funding and service delivery, to see her there are inherent deficiencies that can be remedied only by structural reform.

An opportune time

The fortieth anniversary of the NHS is an appropriate time to undertake such a structural review. It reminds us of just how many years the Service has been operating according to the same set of principles.

Yet much has changed in the interim. The founders of the Service actually predicted that expenditure on it would decline over the years, as we all got better. Instead, the demand for health care has mushroomed, and the cost of providing it has kept pace. Comparatively few people in 1948 lived long enough to contract the cancers that require so much expensive research and treatment today; costly dialysis and transplants now save kidney patients who presented no burden to the Service in 1948 because it could do nothing for them. Our ageing population- the product of better diet, the elimination of contagious diseases, more widespread health education, and new medical technology is more expensive to care for than that of forty years ago.

And importantly, rising wealth makes people demand more of their health care, as they demand more of any product or service. They demand treatments, including cosmetic surgery, far beyond the life-or-death basic which the NHS was founded to provide. Once those basics have been taken care of, there is literally no limit to the

amount which could be spent in making people slightly more comfortable through increasingly marginal treatments.

In addition, today's health care consumers demand more privacy, more comfort, greater convenience, and shorter waiting times. Modern communications and better education makes them more aware of new and alternative treatments, so they demand choice. In this customized age, people are much less willing to accept a 1940s production-line approach to health or any other service.

All this must raise doubts on whether the original structure of the NHS, with its principles of universal and equal access to free services, remains the most effective way of delivering health care. The very success of those principles in eliminating the basic threats to health requires us to make harder choices about what additional services we should provide: decisions upon which each health care consumer will probably have a different view. The time is right, then, for an objective assessment of the benefits and deficiencies of the National Health Service, and a wide-reaching search for new structures that are better able to deliver the sophisticated and diverse forms of health care demanded today, while preserving the ideal of universal access.

2. THE PRESENT HEALTH CARE SYSTEM

STRUCTURE OF THE SERVICE

The National Health Service employs 980,000 people, making it one of the largest organizations in the world. It delivers by far the bulk of health services in the UK, although about 7 per cent of hospital treatments (and 25 per cent of elective surgery) is carried out by the private sector. Its resources come directly from the Exchequer rather than through some form of compulsory insurance, as is common elsewhere.

Central management

The central management of the Service is exercised through the Health Services Supervisory Board under the chairmanship of the Secretary of State for Health and Social Services, and the NHS Management Board under the chairmanship of the Health Minister. Under this management, the NHS is organized into three parts: the Hospital and Community Health Service, the Family Practitioner Service and the Central Health and Miscellaneous Services.

Hospital and Community Health Service

The HCHS is responsible for all hospital care, district nursing, and other public health services not provided by GPs. Its resources, over £11,000 million in England and Wales, are allocated through 14 Regional Health Authorities to 191 District Health Authorities (in Scotland, Health Boards constitute a roughly similar mechanism).

The overall HCRS budget has grown by 26 per cent above inflation since 1979, but demographic changes and historical differences in funding levels has led to a disparity in the level of patient care between the regions. The Resource Allocation Working Party (RAWP), which was set up to correct this imbalance, sets targets for each region and attempts to reallocate resources towards the worst-off -- although such switching has itself caused transitional budgetary crises as the better-off areas find their flow of funds diverted elsewhere.

Paradoxically, the recent increase in capital spending of 41 per cent above inflation has also caused budgetary problems. Some 200 hospital projects of more than £1 million each have been completed since 1979, and another 500 projects are underway. Yet some authorities find that they are unable to divert from existing budgets the funds and manpower necessary to run the new facilities: hence the spectacle of new wards and operating theatres lying idle.

Overall, however, the numbers of patients treated has increased. During the years 1978-86, out-patient cases rose by 1.3 per cent per annum, in-patient cases by 2.2 per cent per annum; and day cases by 8.1 per cent per annum.

Within those figures, a number of important treatments have been boosted preferentially: kidney transplants in the UK have increased by 60%, from 941 in 1978

to 1488 in 1986; coronary bypass surgery has grown from 3,000 cases in 1978 to nearly 11,000 in 1984; hip replacements are up by roughly 10,000 in the same period; cataract operations have risen by 20,000.

Nevertheless, many patients still face long waits for treatment. Current hospital waiting lists stand at 688,000. Although most patients are admitted within eight weeks, some have waited more than a year. Although the figures might overestimate the numbers of people needing treatment, because some of those waiting will go private, get better, move, or die in the interim, they are sufficiently worrying that the present government has set up a special fund to help reduce them. Specific allocations for hip replacements, cater act operations, more day surgery and weekend operations are included in this initiative.

The management structure of hospitals has changed recently, with the appointment of general managers in place of the panel of nursing and medical personnel formerly responsible for each unit.

The Family Practitioner Service

In England and Wales, Family practitioner Committees have been established as authorities in their own right, independent of the DHAs. They are responsible for the services provided by family doctors, dentists, opticians, and pharmacists. Nearly half the Family practitioner Services budget of $4720 million goes on pharmacy, nearly a third on general medical services. Just under 10 per cent of the budget is raised by charges to patients.

These services constitute the bulk of primary health care sector, the patient's first contact with the health system. In addition, DHAs are responsible for community doctors, dentists, nurses, midwives, and health visitors. Voluntary groups and Community Health Councils take on some of the same burden. Current government proposals for the primary sector include new incentives to encourage family doctors to educate their patients about good health and to give them check-ups and other preventive treatments. Family doctors may also be encouraged to carry out minor surgery that would be more expensive to perform within the hospital sector.

Central Health and Miscellaneous Services

Central Health and Miscellaneous Services have a budget of £555 million. About a quarter of it goes to nursery schools, a fifth to care for disabled people, a sixth to mental health services.

Health promotion

As well as providing services to people in ill-health, the NHS promotes good health through, in particular, the Health Education Authority -- one of the 'special' health authorities, without a geographical limit to its activities. Immunization and health screening are also being encouraged by training programmes and public information campaigns.

3. EVALUATING THE PRESENT SYSTEM

STRENGTHS

The strongest argument for the NHS is probably that it provides all kinds of health care and provides it for everyone. Thus, any individual can rest calmly in the knowledge that, no matter what the ailment is, he or she has access to the same care available to almost everyone else in the country. .
Furthermore, since there are no charges at the point of service (except for prescriptions, dentistry, and a few other items), the care provided is available regardless of personal circumstances.

Since the Service provides continuity of care, its supporters note that even when lengthy hospitalization or aftercare is required, the patient's financial circumstances pose no barrier.

On the other hand, these arguments may be thought not to count for much if the theoretical universality and instant availability of treatment has been replaced by practical rationing by means of waiting lists, as the figures suggest. A free, equal, and round the-clock service is of little value to someone who cannot obtain it at all.

Those who do obtain treatment report themselves to be generally satisfied with their level of care, though people worry that standards might fall. Since most people have no experience of alternative delivery systems against which to judge, however, it is doubtful how significant such poll findings can be.
Insofar as the public service ethic is a positive attitude, it is certainly true that the NHS depends upon, and harnesses the skills of, tens of thousands of employees who are dedicated to the provision of health care and who work long hours, sometimes on low salaries, to achieve it. This feature has won the NHS a great deal of public respect and political support.

DEFICIENCIES OF THE SYSTEM

Patterns of patient care

In the practical evolution of the NHS, the principle of equal access to equal care has not been achieved satisfactorily. Some care is very good, some is very poor; despite RAWP, a patient's place of residence and the particular ailment from which he or she is suffering from still makes a difference in the quantity and quality of care that can be expected. Unfortunately there are few incentives .for the less good doctors and hospitals to improve their standards of service delivery, or to attract good GPs to the inner city areas where the quality of care is presently lowest.

While NHS staff may have a strong public service ethic, there is little sense of customer service alongside it. Patients are not thought of as customers by GPs, consultants, or ancillary staff, nor are services designed around them. For example, the referral process -- in which patients must go from their GP up to hospital for

tests, back again for the results, to hospital once more for a consultant's opinion, back to the GP for temporary care, up to the hospital once more for treatment -- is irksome, protracted, and worrying for the patient. A great deal of human effort could have been saved if GPs had been encouraged at the outset to have their own diagnostic and minor surgical facilities.

The centralism that is so common in large organizations has drained resources from the communities and into larger hospitals, resulting in a system that is inconvenient and bewildering for the patient -- although the present strategy is to reverse this trend. Nevertheless, centralized decision making and resource allocation means that although national budgets and manpower levels are rising, there are troublesome pockets of underfunding and understaffing which the allocation mechanism is not sensitive and flexible enough to correct; Although we have 51,000 more nurses than in 1978, for example, there are still many places where nurses (particularly those with special skills) are in very short supply.

Another deficiency of the present system is that patients have little choice. Resorting to private treatment can be expensive for people who have to pay for the NHS through their taxes, whether they use it or not. It is difficult for patients to change GPs or to determine which hospital they will visit; and low level of information given to the public about doctors and hospitals does not help.

Lack of cost control

The principal vehicle for health care delivery in the NHS is the hospital, and over the years, services have tended to become less local and more concentrated in the district general hospitals. This reliance on larger hospitals stems perhaps from the 1940s production-line psychology of when the Service was created, reinforced by the giantism of the 1960s. Unfortunately, it gives the NHS an inherent cost disadvantage when compared with other health systems. Day surgery, out-patient care, small operations, and tests done in the GP's surgery are all likely to be more flexible and more cost-effective than services in very expensive general hospitals.

With rising income, people have demanded a greater quantity of health care, moving from essential services to more and more marginal ones. This escalating demand has been reinforced by the ability of medical technicians to provide a wider range of treatments, including those for conditions that were previously untreatable. The fact that these services are free at the point of consumption turns a high level of demand into an overdemand that cannot be met under present funding arrangements. When faced with patients whose lives can be improved or even saved by the application of new medical technologies, those within the Service obviously feel it right to demand more and more resources from the Exchequer. And since the continuing advance of medical science means that newly treatable groups will always be appearing on the horizon, no theoretical budget limit will stem such demands.

Poor cost awareness reinforces this pressure on resources. While the recent move towards the general manager system for hospitals and the appointment of 800 new managers have made consultants more aware of the cost of the supplies and personnel they use, this budgetary discipline rarely permeates down to other staff. Costly supplies are used once and thrown away because nobody knows their value;

family doctors prescribe tests or treatments of marginal value to patients, ignorant of the hospital staff costs involved; capital items have always been considered as free gifts and are not properly accounted for in hospital budgets; expensive pieces of equipment lie in store rooms until they are so obsolete that they have to be given away to developing nations as part of the UK's foreign aid programme.

Patients too are unaware of the costs of medical treatment, and because it is delivered free to them, they tend to regard it as costless and act accordingly. Thus, individuals strongly demand new, high-biotechnology or labour-intensive treatments that open up the possibility of relief, however slim the chance and however temporary the outcome. Lawyers and press campaigners might be marshalled to support their demand: but in almost every case they remain totally unaware of the resources that would have to be drawn away from the treatment of other patients. A course of interferon might extend a cancer patient's life by two years, for example, but could the £10,000 it costs each time be expended in ways that give more people a surer chance of greater numbers of happier years? Unless patients and providers are both aware of the alternative applications for such resources, there is simply no rational way to judge.

Efficiency and objectives

Just as the consumers of NHS care have little idea of how much its inputs cost, the providers have scant awareness of what they are producing. Contact with patients is lost once they are treated, so hospitals have no information on which to judge the long-term outcome of their procedures, no results that would tell them how to choose between alternative methods of working, no data on outcomes that would show where resources could be applied to the greatest effect. There is no systematic appraisal of the spending on specific treatments in terms of the median extension of life years, or quality of life, or quality-adjusted extra life years, that can be expected. Yet such output measures are essential for the efficient allocation of budgets of any sort of organization.

There are few incentives within the system for any doctors or hospitals to operate more efficiently, though this is perhaps changing slowly. At present, hospitals which show they can work within budget simply find their funding reduced in the next round; national wage agreements make it impossible to attract the best staff to where they are needed; restrictive practices make it hard to introduce new working techniques; family doctors are under no pressure to provide a better and more convenient service to their patients.

Political decision making

To the extent to which actual costs and outcomes are scantily understood or are even unknown by those using and providing the service, resources cannot be allocated rationally. Consequently, many key decisions are made politically.
The top management structure of the NHS, with its boards of civil servants, ministers, and interest groups from inside the Service, is symptomatic of the confusion of management and political objectives. At District Health Authority level, one finds the same thing: the typical authority will have a political appointee as its Chairman, a third of the members will be nominated by the local authorities, the rest

coming from the Region, and including interest groups from within the Service such as consultants, general practitioners, nurses and trade unionists. Managers complain that impassioned political speeches to the gallery are more likely to influence such a body than a rational appraisal of difficult allocation alternatives.

Given the nature of this decision-making structure, the growing politicization of the Service is no surprise. Unfortunately, it leads to patients often finding themselves being used as hostages against which some authority, hospital, or specialist can claim more resources for their own work. Thus, DHAs respond to tight budgets by closing wards or hospitals -- even though 70 per cent of their costs are salaries which will not be saved anyway, even though patients will face longer waits, and even though more money will have to be spent later to clear the backlogs or allow weekend admissions -- rather than considering alternatives that might offend their political principles, such as contracting out some treatments to the private sector, sale and leaseback methods of raising capital, or ending restrictive practices.

Public choice issues

Partisan politics might account for much of' the irrationality of health spending in the UK, but political manoeuvring in the wider and non-partisan sense is another major problem. Thus,' the resources which are available often find themselves diverted preferentially towards those consultants and other groups within the Service who can campaign most effectively in support of their own branch of interest.

Not only does this cause resource use to be less efficient, it produces a two-tier health system, with patients who are able to put their own case articulately and effectively being more likely to receive faster and better treatment than those who cannot. If a patient at the foot of a waiting list is confident, educated or even well-connected enough to complain to the health authority or to the local MP, the chances of admission can rise spectacularly. Those who fear that complaints may prejudice the attitude of their doctor or hospital towards them, who do not know how the NHS is organized, or who lack the ability to deliver effective complaints, can only accept the unsatisfactory service level.

A review of the range of services provided by the NHS reveals the extent of the distortion caused by public-choice imbalances. A great deal is spent on making large numbers of people just a mite more comfortable, starving of funds those acute services that are likely to be demanded only by the minority. The vast majority of ambulance journeys, for example, are generally equivalent to free taxi services; only a small minority are emergencies, and the ambulances are inadequately equipped and ambulance staff have too little paramedical training to make those journeys as secure as they should be. However, the large numbers of supporters gained from the widespread but marginal care delivery are useful allies to the public health care system: those who know and complain that their emergency or acute care has been inadequate are far fewer in number and less cause for provider concern.

Or again, there are few incentives to practice preventive medicine within the NHS. Nobody notices the effect of money spent on prevention, however beneficial it might be, but the outlays on remedial treatment are easy to see and those who receive them

can judge the effects. The weight of political and public pressure, therefore, is always on curing rather than preventing illness.

The same general principle explains why the NHS, like many other parts of the public sector, is so obviously undercapitalized, still using old buildings and equipment that are so evidently inefficient to run. Again, a diversion of resources towards capital replacement and improvement may take years to show its effects and will win no friends in the interim; on the other hand, preserving wage and manning levels, or boosting the numbers of cases dealt with,. wins instant applause all round.. So over the years, the capital budget tends to be starved so that current spending can continue.

Another example is that when the NHS was founded, a number of concessions had to be made to secure the agreement of the medical profession. Hospital consultants were particularly favoured, with paybed wings being set up in public hospitals so that they could continue to treat their paying patients in a very convenient way. Another, and remarkable, concession is that their contracts are at the regional level, so they have little incentive to accede to the cost-control demands of hospital managers.

The large number of people who work within the Service can unite into a powerful voice that can resist reform. Managers wishing to reduce the staff employed in ancillary services, even if they do so in order to improve the pay and working conditions of the remainder, find themselves blocked by the threat of deteriorating personnel relations that could lead to strikes and closures. At the other end of the scale, modest proposals to limit the range of drugs what doctors could prescribe and use cheaper substitutes where possible were greeted with almost overpowering outrage from the medical profession.

4. LIMITED REFORM STRATEGIES

There are a number of policy strategies which might well bring some improvement to the present health care system, but could each be of only temporary or marginal effect.

FINANCIAL AND MANAGEMENT INITIATIVES

Budgetary increases

The calls for budget increases, financed by a new tax or even by a national lottery, are legion. However, it is difficult to believe that the effect would be more than a temporary, one-time improvement, because increased funding of whatever level still does not solve the fundamental organizational problems.
Thus, the work of administrators has a habit of expanding to use up whatever budget is available; consumer demand for health care will still be infinite; larger resources leave untouched the problem of how to allocate those resources between alternative uses; no matter how large the budget, there will still be patients who could be saved by the expenditure of just a little more, and decisions will continue to be made in response to I political pressures rather than rational managerial principles.

Politicians and managers

Making the Service less political may help to solve some of these problems. At national level, it might be better to run the NHS through a board which, like other nationalized industries, does not include the direct involvement of government ministers and does not allow their day-to-day involvement in the running of the industry, but is ultimately responsible to them.
If the Regional Health Authorities are to be retained at all, which is a matter of debate, they could exist as branch offices I of such a quasi-independent national board. Alternatively, their staffing levels could be reduced and their operations could be made more flexible by the greater use of contracting rather than in-house expertise.

Perhaps a better candidate for abolition or reform, however, would be the tier of District Health Authorities, which is where the confusion of managerial and political objectives is most evident. This could be done by turning the DHAs into what are effectively district management teams, and strengthening the Community Health Councils to act as consumer watchdogs for service standards.

Management could also be improved by giving unit managers more power to set pay levels, conditions or work, and charges. Such flexibility would help them attract more personnel to parts of the system that were understaffed, and to generate income by marketing their services to the private sector. Restrictive work practices which do not allow any overlap between the functions of technicians, nurses, and porters (for example) will have to be tackled, however, if managers are to achieve

much as a +result of such new powers, and political problems may thwart that. Putting consultants on five-year contracts with full assessment at the end, or making hospital managers and not regions responsible for the contracts of consultants who work in their unit, would also encourage improvements in the management of medical services.

The exact size of the problem that has to be managed could become more clear through a policy of closer monitoring, updating, and computer analysis of waiting lists, possibly by using private sector data processing contractors. At present, double-counting of patients on more than one list, the fact that some people die, move, or go private before they reach the top, and possibly the desire of doctors to have waiting lists as long as possible so that patients can be encouraged to consult them privately, all produce some overestimation. Furthermore, the time of surgeons and operating theatre staff is wasted when patients, for one or another of these reasons, do not turn up on their appointed day for surgery.

Charges to patients

Prescription charges raise a small percentage of the Family practitioner Services budget at the moment, though it is large in cash terms. There are presently proposals to introduce charges for GP visits that could choke off some of the excess demand and bring in extra resources. At the more radical level, some people note that patients are increasingly willing to pay for comfort and convenience, and suggest that a charge towards the cost of laundry, meals, and other 'hotel' services offered by hospitals would be practicable and beneficial.

However much it can be demonstrated that patients today are indeed willing to contribute something towards their health care, the imposition of any charge has always lead to the most caustic political arguments. The natural desire of all governments to avoid such storms must seriously limit the prospects of charges for NHS services becoming a major contributor to the overall budget.

Furthermore, in order to reduce demand systematically, charges would have to reflect the relative cost of each different procedure: charging for check-ups while leaving remedial treatment free, for example, may reduce the demand for check-ups and increase the demand for other services as a consequence. But the cost of hospital treatment is often so large that no politician would dream of endorsing a universal charge for even a small proportion of it. Patients might be asked to pay up to some limit, or to pay near the time of their operation rather than immediately; but the exemptions that would be required and the inevitable hardships that would be caused by a general policy of charges do not help politicians to feel more warmly to the idea.

The internal market

There is, however, an increasing recognition that there must be more of an internal market within the NHS -- that those units and districts with excess capacity or with some particular expertise should be more able to market their services to others who need them. Again, present structures do not encourage this: the two year settlement

system means that a district which is actively providing services to another pays all the costs but does not get the benefit until much later.

With a direct charging mechanism, with hospitals as cost centres, and with the use of management budgeting techniques by which each service provided by a hospital can be properly costed, such an I internal market could be vibrant. Hospitals could trade their excess capacity, or districts could consolidate their use of I hospital space and market the facilities of a complete hospital unit to other districts or to the private sector. There would, of course, have to be arrangements to make sure that patients did not face excessive travelling costs or inconvenience from the policy of buying in services from outside the immediate locality.

To bring the full benefits, however, it would need care to ensure that the full cost of procedures was being charged out, so that rational trading decisions can be made by those selling and buying the service. The government, or health administrators, might have to specify precisely what should be included and how -- and that capital costs, for example, are not left out. Some older, costly to run, high-rated central city hospital might be at a clear disadvantage in such an internal market, and politicians would have to decide whether to accept that and encourage them to move to new and more efficient sites or to adjust the accounting formulae to eliminate overheads and so protect them.

THE PRIVATE SECTOR'S CONTRIBUTION

The public-private partnership

The political and management reforms which would make NHS better able to compete and co-operate with each other would leave them in a position to be better able to compete and operate with the private and voluntary sectors.

Private hospitals, undertaking 400,000 operations per year, have a number of special strengths: they are particularly experienced at hip replacements, for example, because many older people who have saved to make their retirement comfortable happily spend the money on going private rather than waiting for two years or more in the public sector. Buying in such operations from the private sector -- with NHS patients going to private hospitals for their treatment, but continuing to receive it free of charge -- could be a cost effective way of clearing the waiting lists.

Dialysis and other longer-term medical treatments have also been bought in from the private sector, more cheaply than they can be provided in-house. Intuitively, one might suppose that the private sector is necessarily more expensive for all treatments, but this is not so. The absence of the restrictive practices that permeate the NHS can reduce costs by improving staff flexibility. As a major customer, the NHS can in addition achieve volume concessions on the services it buys in. Furthermore, patients with a choice tend to avoid holidays and weekends, so private hospitals have spare capacity at these times and may offer a good deal on their use.

Diagnostic services such as magnetic resonance imaging are already bought from the private sector, while some hospitals share the purchase and use of costly equipment with private hospitals and insurance companies. Once again, however, because there

is no direct consumer pressure to provide these facilities, nor financial reward for doing so, most of the initiative has come from the private companies. Budgetary and incentive changes will be needed if such partnerships are to flourish.

The traffic need not be all one way, however. For example, the compulsory tendering exercise has caused many hospital laundries to become much more cost effective, and it has been suggested that they could well market those facilities to schools, private hospitals, and hotels; Some managers recognize that restaurants and shops selling flowers, stationery, and other items might wish to rent retail space in hospital waiting rooms, or advertise within the hospital. Others argue that this is outside the Service's central objective of delivering health care and diverts management attention (although the simple solution there is to hire more managers to exploit the opportunity). Nevertheless, the income to be generated from such initiatives, although very important, is generally seen as insufficient to bring major improvements to the overall level of service.

The private sector has always been a principal source of research funds and co-operation there is commonplace. More could be done on the personnel level, however, such as sharing the training and recruitment of medical and support staff.

Occasionally, public hospitals and private companies share expert staff so that they can both undertake complicated, costly, or pioneering procedures that would be hard for either to sustain individually, Better budgetary incentive structures are needed to make this a common practice rather than the exception.

The private sector may also be able to help in terms of raising capital for new facilities. In areas where medical treatments have been contracted out, one of the first actions of the private sector providers is commonly to scrap existing buildings and equipment and start afresh with facilities that are less costly to maintain and more pleasant to work in. Sale and leaseback arrangements might well be a good way of raising capital for the public hospital and simultaneously contracting out certain forms of care, such as long-stay care, which the private and charitable sectors might be better able to provide anyway. Contracts with private consortia to design, build, and operate complete hospital units on behalf of the Service would seem to be a logical extension of present practices. In addition, they could provide an interesting source of new approaches to medical care.

Opportunities for contracting in management

Many health managers are well aware that they could deliver the same or better standards of service at lower cost. They know the opportunities which exist for eliminating inefficiency and waste I inside hospitals, but are unable to make the necessary changes I because of the political and institutional context within which they must operate. As a part of the family of National Health Service workers themselves, they find it hard to carry off the dispassionate objectivity that is needed for effective management I decision making. Traditional ways of doing things can be hard to change from within.

In a small number of hospitals new methods and new management budgeting techniques are being tried experimentally -- and with a good measure of success. Perhaps one of the most exciting new ideas, however, is the concept of management

by contract, which works well abroad and is just now being tried out within the NHS.

The customary version of contracting is found widely in local government and in the provision of NHS ancillary services, where it has saved an estimated £100 million in two years. In this version, particular functions such as catering or cleaning are performed under contract by commercial companies (or worker cooperatives) rather than by an in-house staff of NHS employees. In this new version, however, it is the managers who are under contract, rather than the front-end service workers. The skills needed to run each function come not from in-house managers but from outside experts, hired under a contract of finite duration. They must achieve whatever targets are negotiated and agreed at the beginning of the contract, or risk losing their work to a competitor.

For example, rather than attempt to manage its own paybed, wing, a hospital can invite a private-sector company to organize the whole business -- raising and investing whatever new capital they think would help the enterprise, buying in the staff, marketing the facilities through the Service and to the public so that high levels of utilization prevail. Indeed, this has already started to happen in at least one NHS hospital. At a similarly modest level, the management of certain ancillary services, such as porters, receptionists, and technical workers, could be provided under contract, and companies such as Service system (which manages 1000 hospitals in the United States and 50 in Japan among others) have already started to bid for such work.

However, there is no reason to limit the principle of management by contract to discrete functions only: the entire management of a hospital can be contracted out. Not only is this quite common in other countries, but British companies are among those doing it, fighting off stiff domestic competition to provide a complete and efficient hospital management service.

In its 1985 paper, Public Hospitals, Private Management, the Adam smith Institute charted the progress of a loss-making Canadian I hospital at Hawkesbury, the management of which was put out to 'tender. The successful bidders, AMI, raised the capital needed to rebuild the hospital, and by the use of energetic and skilled management, turned the large annual loss into a surplus, improved I the speed and quality of services, and raised staff morale. Firm budget and service quality targets, making all staff aware of the costs of the facilities and equipment they use, involving the workers and negotiating more flexible practices, and other simple approaches all contributed to the enormous improvement. Much the same could be achieve in the United Kingdom.

The concern of present hospital managers and staff for their own security and public doubts about the success of new methods would certainly pose major political obstacles to any proposal for a broad switch to management by contract. Consequently, no matter how successful the principle is acknowledged to be abroad, the first problem is how to get it established here.

One method might be to limit the approach to particular parts of the hospital service. The management of non-medical services would be a good place to start, because administrators, cleaners, caterers, porters, secretaries, receptionists, technicians, and personnel officers are managed by private sector companies of all kinds as it is, so

there should be no doubt that the necessary expertise can be found. The management of the hotel and general functions of many hospitals could be contracted out quite simply. And restricting the changes to these supporting functions will generate less worry and opposition from the public and the medical profession, concerned that new methods could jeopardize the standards of medical services provided.

Contracting out the management of an entire hospital, including the medical services, could lead to greater opposition, but on, the other hand it might be seen as a lifeline to units that are threatened with closure because of demographic changes, smallness or obsolescence. New managers (or even the existing management team turning itself into a private company or cooperative), with the private sector's access to new capital, could save them. As in all cases where an entire hospital's management is contracted out, they may require some guarantee about the numbers of cases that the DHA will assign to them, but increased efficiency alone should make them attractive centres for treatment. And however large or small the experiment is, there must be constant active monitoring by NHS managers, and some fallback facilities in case the results are judged inadequate.

Health Service managers might raise three main concerns about a system of management by contract: the division between managers and other staff that it presumes, the problem of setting contract standards and objectives, the discontinuity when managers may be changing every five years. However, the experience from abroad is that contracted managers work more closely with medical and other staff -- many have a medical background of their own -- and that they must involve everyone if they are to make solid decisions and carry them through. Second, the present objectives of public hospitals are confused and imprecise, but good managers require and set definite targets so that they can measure their effect: precise objectives should in fact be easier to set than they are at present. Lastly, contracts can be of any duration, though five years is a workable minimum: and because a good management team may be renewed more than once, the contracting system can actually produce a lower turnover than the present situation in which staff and management morale is low.

Encouragement of private insurance

There has been a sizeable growth in private health insurance over recent years. Originally affordable only by a wealthy few, it is now a popular perk with companies and even with trade unions. An increasing desire for choice, growing affluence generally, media stories about the length of NHS waiting lists, the willingness of more and more people to pay for comfort and convenience, and modest tax concessions for low-income group insurance schemes, have all played their part in the growth.

It would certainly be possible to encourage the take-up of private medical insurance by the extension of tax concessions. A small concession, in fact, could lead to a disproportionately large number of joiners as the premiums become affordable to the great bulk of people at the middle of the income-distribution curve. The more new entrants, of course, the more defenders of private insurance there are in any political arguments about its future.

An increased reliance on private insurance would drain at least some demand away from the National Health Service, and thereby create a breathing space within which improvements could be made. A new wave of private-hospitals would also provide a much better base for comparison between the public and private sectors, stimulating each to improve itself.

The extent to which such a policy could be part of a general reform package is discussed at more length in Chapter 6.

CONCLUSION

While many of these partial reforms to the system of health care delivery in the UK could bring urgently needed benefits, they do not seem to be the full answer. However much they do improve particular aspects of the NHS or encourage the deeper penetration of private money and expertise into health care, they leave in place the most important organizational problems. Given the political cost of introducing such changes, they seem hardly worthwhile if the improvement they bring is marginal or, worse, temporary.

The recognition of this fact has made many people search for more fundamental reforms, to which we must now turn.

5. MORE RADICAL SOLUTIONS

UNIVERSAL PRIVATE INSURANCE

Among the more radical reforms that have been proposed for health care delivery is the principles of universal private insurance.

The universal insurance principle

At present in the UK, car drivers are required to have a motor insurance policy that compensates other people in the event that they cause damage or injury in an accident. Similarly, it is argued, we could meet the health needs of everyone without the need for the government itself to provide health services through the NHS, simply by requiring that all individuals have medical insurance cover for a range of services that are deemed to be the acceptable minimum standard of health care. Of course, those who wished to have a superior standard of service could take out a more extensive policy: there would be no Objection to individuals insuring themselves for additional or more costly services, as long as the basic requirements were met.

The actual provision of health care services in such a system of universal private medical insurance would be undertaken by private sector doctors and hospitals, and the nationalized health sector in the shape of the National Health Service would lose its reason for existence.

Benefits of universal insurance

A key advantage of the universal private insurance approach is that individuals have much more choice and that the insurers and health care providers face far more competition than the NHS faces at present. Although people are obliged to have a minimum level of medical insurance cover, they can shop around between insurers and decide which provides the best value for their premium money. Because there is competition, they can decide which insurer's particular package of services is most suited to their individual needs, instead of having to accept the standard service provided by the NHS. In addition, they can spend more on their health care, if they judge it worthwhile, than is presently spent on their behalf by the government, so new resources will be brought into the health care system.

Likewise, there will be choice and competition in the actual provision of health care services. Although the insurance firms might prefer patients to use particular doctors or hospitals with which they have negotiated special arrangements or discounts (just as motorists are asked to have accident repairs done by 'approved' repairers in whom the insurers have confidence), the choice is still likely to be very extensive. Competition between service providers would put a downward pressure on costs and encourage greater value for money. And because the insurance is universal, that choice is extended to everyone, no matter what their means.

Problems of implementation

Despite these benefits, the universal private insurance principle would be very difficult indeed to put into practice. Anything which presumes the sudden and complete disintegration of the NHS is bound to face concentrated opposition from the health industry and to produce worry and consternation among the public. And the sudden growth of demand for private medical services would take time to accommodate, because new private hospitals cannot be built (nor can old state hospitals be turned into new private ones) overnight: there could be serious transitional problems.

Another objection that could block any move towards a universal private insurance system is the experience of rapid premium cost rises in the United States. Because patients are fully insured, they do not care about the cost of the health services they are consuming, and naturally demand as much as is feasible. Doctors and hospitals can raise their charges and perform marginal or unnecessary tests and treatments, safe in the knowledge that it is not the patient but a distant insurer who is paying the bills.

True enough, this cost escalation has been largely contained in the United States by insurers monitoring the treatment given to their clients much more closely, so that they can keep premiums under control. Nevertheless, it remains a difficult problem to deal with. Motor insurers have mechanisms to keep down the level of claims, including the no-claims bonus (premium reductions for years in which no claims have been made), the excess (where the motorist agrees to meet the first EIOO or so of any claim), and co-insurance (where the motorist meets a specified percentage of any claim). In medical insurance, such methods are hard to institute, and it is interesting that the insurers in existence today have not used them very widely. The excess principle is certainly in use, and because it reduces the numbers of very small claims, it keeps down administration costs. However, large claims continue undaunted, because the co--insurance principle which would inhibit them is generally thought unacceptable -after all, treatments costing £25,OOO or more are not uncommon, and a co-insurance element of only 15% would produce a sizeable sum for the individual to bear.

Another problem is knowing how to provide the necessary insurance cover for individuals who cannot afford to pay the premiums. The easiest method is simply to have the government pay private insurance premiums for everyone presently drawing social security or unemployment benefits, and possibly for pensioners. However, many pensioners are well-off -- many already have private medical insurance -- and paying the premiums of them all might be thought an extravagance and an injustice. There are also difficulties at the level of welfare beneficiaries: the government would have to decide the upper limit it was prepared to pay towards people's insurance premiums, because the costs of the basic cover might' vary considerably. This might produce a conflict between the cost that the state was prepared to contribute and the level of service it demanded as a minimum.' Furthermore, we would not want to build a new poverty trap by making those whose earnings rise £1 beyond a certain line suddenly liable for the whole of a major outlay on compulsory private insurance premiums. To avoid the disincentive to work or to earn more, there would have to be a sliding scale at the margin, with the state paying a falling proportion of the cost as each individual's circumstances

improved. This all contributes to making the system difficult and messy to put into practice.

THE VOUCHER

The principle of the voucher has been suggested as a way to introduce choice, competition, and private resources into public services such as health, while avoiding some of the problems of implementing a completely universal private system.

Operation of the voucher

Under this idea, each individual would receive from the state a health voucher, equivalent in value to the average per caput sum that is presently spent on providing health care. The voucher can be used towards the purchase of private health insurance or exchanged for treatment within the public sector health system.

Through this mechanism, the state honours its assumed obligation to ensure that everyone has access to health services. Those who opt into private insurance can use the voucher to pay their premiums, and the insurance companies then collect the cash value of the voucher from the government. This guarantees that everyone can afford at least a basic level of insurance cover, and (perhaps more importantly) it allows each individual a choice between different insurers and insurance packages, no matter how rich or poor they might be. However, people who decide that health care is particularly important to them are free to add to the amount covered by the voucher and thus purchase more expensive forms of insurance, perhaps covering more unlikely risks or providing superior standards of comfort or convenience.

The voucher does not force people into private insurance, although it certainly makes the option of going private instantly available to everyone. Those who want to use the state service will continue to receive it, their voucher being their ticket to free treatment just as their national insurance number is at the moment. Under the more modest voucher proposals, that is the end of the story, the NHS continuing much as before -- though perhaps losing some customers to the private sector that has suddenly become so much more affordable to all. In more radical versions of the idea, however, patients are given a wider choice about the
NHS doctor and hospital they want to treat them, and the average per caput health expenditure represented in the voucher actually follows them when they choose. Thus, the pressure of competition is introduced in the public sector as well, because those doctors and hospitals which are popular with patients will be taking in more vouchers and thus getting a larger share of the government's health budget. There are strong incentives to improve standards of care and to regard the patient more as a paying customer who must be satisfied.

Problems with the voucher

It is interesting that in the field of education, the voucher idea has been around a long time -- at least since the proposal of the education 'ticket' in the middle of the

nineteenth century. In the 1960s it enjoyed a new vogue and some detailed studies have been initiated.

However, with the exception of very limited trial areas in the United States, the education voucher remains in the realms of theory rather than practice, and it is interesting to ask why.

Public choice theorists have little difficulty in answering the question. The education voucher is bewildering to parents: it requires them, for the first time and perhaps without adequate information, to make a choice about which school is best for their own children. It poses problems for the administrators of state schools, who suddenly must act just as if they were private schools, improving their appeal and marketing themselves to parents. It is a threat to teachers, their salaries and future no longer secure from the state but dependent upon where parents choose to send their children and spend their vouchers. And the idea provides an excellent focus for egalitarian objectors who argue that those parents who are prepared to top up the voucher could secure educational advantages for their children. Thus, any proposal to introduce vouchers produces instant consternation among every group involved in education: it is no wonder that even the most sympathetic governments and ministers have had no success with it.

In health, the problems would be similar in many respects but even greater in others. Patients, administrators, doctors, and hospitals would all be concerned about the decisions and changes they must make. Modest versions of the health voucher idea, by leaving the NHS as a unitary whole, tackle neither the problem of overdemand for services that would still be perceived as free, nor the lack of competitiveness within the Service. The radical version, where resources go into those parts of the Service that are most popular with patients, would certainly be resisted by NHS workers as a sizeable threat to their future security; and it poses the additional problem of how to split up the voucher allocation between the many different doctors, clinics, and hospitals that a patient might use in the course of a year -- a difficulty not generally faced in the education field, where a child goes to only one school at a time.

The conclusion must be that, whatever benefits of choice and competition the voucher might generate for health provision, it is perhaps even less likely to be adopted as a practical method of reform than the education voucher.

HEALTH MAINTENANCE ORGANIZATIONS

Another mechanism which might help to introduce the benefits of competition while avoiding the cost escalation objections against a purely private insurance system is the principle of the health maintenance organization.

How HMOs work

The operation of health maintenance organizations, and their rapid growth in the United States as an alternative to costly conventional insurance, is described in some detail in the Adam smith Institute's 1986 report, Good Health.

Fundamentally, HMOs offer a complete health care delivery service to groups of individuals in return for a fixed and prepaid annual premium. A group, such as a group of employees contracted into the HMO by a company, pays a premium on joining the scheme, and for that the HMO guarantees to provide each member with all the GP and hospital care that may be needed in each case. The scheme managers will in turn contract with the doctors and hospitals they need in order to provide this whole-care service.

HMOs have grown rapidly in the United States because they have proved so good at containing costs while providing the high standards of health care that Americans demand. Because they work within a fixed budget, the HMO managers must keep their eye on costs. Instead of having an incentive to practice the most expensive procedures, as exists within the traditional fee-for service insurance sector, their desire is to keep patients fit and away from the surgery, and to treat them as speedily and efficiently as possible when they do need care. The HMO doctors are rewarded when they can keep within budget, reversing the traditional incentive structure; and the use of costly hospital facilities, valuable equipment, and costly drugs are all closely monitored by the management team.

The result is that HMOs offer a less costly style of care than the traditional sector. Hospital visits tend to be shorter and fewer, 'but a wider range of basic surgery is done in GPs' own clinics; staff time and the use of capital equipment is more effectively managed: doctors are kept more aware of the cost of their procedures and referrals, and asked to consider the use of cheaper drugs or less costly new procedures where these are as effective as the traditional ones. Competition between HMOs forces them to provide high standards of care and to market their strengths effectively to the public, while keeping costs as low as possible.

Problems of implementation

The HMO concept developed naturally within the context of the US health care market, based on widespread private insurance as it is. However, it would be much more difficult to introduce into the UK, for several reasons.

The first obstacle is explaining the HMO principle to the general public. While the idea of private insurance, like that of state provision, are broadly understood, the HMO principle is novel. While HMOs can be characterized as competitive little NHS systems, providing the security of whole care with the stimulus of competition, it is hard to explain why they should be so much of an improvement, and the extent to which their tight management techniques are important for cost-effective service delivery.

There is also the problem of how to start up new HMOs. One plan is to use tax concessions to encourage new HMOs to start up, and then, once they are established, to give them a further boost by contracting NHS patients into them if they can provide a whole-care service more cheaply than the public sector (just as the US government contracts in its Medicare patients if an HMO can save 5% or more of the cost). But new HMOs are likely to be slow to develop, because they 'put an element of risk on the doctors and managers involved, because they would still be limited to those who want and can afford private health care; because only large cities would have a catchment large enough to keep the initial risks down, because there are no

existing structures that can be used as the core of the new approach, and many other reasons.

The HMO principle in the state sector

Again, the emergence of private HMO arrangements might serve some benefit to the NHS by siphoning off some demand into popular new private sector delivery systems, but it is perhaps more important to ask whether the principles of choice, competition, and tighter management control that typify the HMOs can be introduced into the state sector by some appropriate restructuring.

For example, we might break down the NHS delivery system in a particular city or area, transforming it into a series of competing whole-care delivery plans on the HMO model, whose budgets were allocated on a per-patient basis rather than from a DHA grant, and who contracted with their own doctors and bought in the necessary hospital treatment from the private or public sectors.

However, difficulties remain. There are still no obvious structures presently in existence within the NHS which would provide the nucleus around which new HMO-style systems could be grown. Some group -- managers or doctors -- have to accept the risk that they can deliver a complete health care service within the per caput budget, and neither group currently working inside the NHS is likely to accept that new challenge with much pleasure. In fact, staff at all levels would be worried by the prospect of their service being divided into competing units.

Even if a new structural arrangement could be devised, there would be the problem of how to allocate residents to each of the new plans. A free individual decision to stay with the present structure or opt for the new plan might be dangerous in the initial stages at least, because those in most need of treatment might self-select. Thus, it would be a case of compulsorily transferring patients from the existing structure into the new plans, which again might not be a popular proposal. Any move to explore the possibilities of how best to do this, however, would undoubtedly meet loud objections against using NHS patients as guinea-pigs for some new organizational theory.

CONCLUSION

Although the radical reforms that have been proposed to improve the health care delivery mechanisms could well yield benefits, it is less certain that any of them could ever be instituted. The public choice pressures favour a slow and progressive reform of the system, rather than a sudden and dramatic upheaval.

Any proposed introduction of universal private insurance, for example, is certain to make the debate about health provision even more politically charged than it is at the moment. Even if its virtues were appreciated, it would be hard to carry through. Opposition from within the health care industry would be the most formidable obstacle to the voucher idea; and because it assumes a growth in private insurance, the coarse political argument would start up again. The private-sector HMO would be equally hard to encourage in the UK. However, the introduction of HMO methods into the NHS might be a possibility, if a suitable structural vehicle could be

devised. A deeper consideration of how this might be done leads us on to the HMU alternative.

6. THE NEW STRUCTURE

INCREASING TOTAL HEALTH EXPENDITURE

A comparison of the proportion of GDP allocated to health by the different advanced economies suggests that people might be ready to contribute more individually than they would be prepared to pay through taxation. While it is true that countries such as the United States, France and Germany spend more per head on health, it is also true that a proportion of that is paid individually in either health charges or insurance.

It is possible that people might be readier to pay more if the additional funds were to be spent directly on themselves and their families. Additional taxation might meet with less support because of the difficulty of ensuring that the proceeds would be spent on health, would be spent efficiently, and would bring direct benefit to those who paid them.

Opinion polls have been cited which claim to show willingness on the part of the public to support higher taxation in return for more spending on the NHS. Detailed examination of these alleged findings has been done by Lord Harris of High Cross and Arthur Seldon. Their survey shows that people support the idea of higher taxes on the assumption that these will be paid by others. When asked to nominate how much extra tax they would themselves be prepared to pay, the claimed majority rapidly becomes a minority of vanishing small proportions.

It is thus possible that the way to increase the percentage of GDP spent on health lies in admitting discretionary funds spent by individuals on themselves and their families. There are, as already discussed, problems involved in using compulsory charges to increase NHS funding. An obvious alternative is to take steps which increase the level of voluntary private insurance.

Tax incentives

Private medical insurance has been increasing, albeit at a modest rate, as society has become wealthier. People have been prepared, despite the availability of a universal state health service, to pay extra for additional benefits and comforts. The degree of choice within private medicine has proved attractive, and greater numbers have opted for it.

There is very little tax incentive to encourage more people to take this route. Sir Geoffrey Howe restored in 1981 a concession which permits health insurance to be tax deductible if the person concerned earns below £8,500 per year, and if they are entered in a scheme by their employer. Given those narrow limits, the health premiums can be paid as an untaxed benefit.

The salary limit has been clearly outdated by a general rise in wage levels, and now applies to a smaller group than originally intended. All those above that limit, and those who enter schemes other than through their employer, pay premiums out of taxed income. Inevitably, this keeps down the number to those who feel able to

afford to pay twice in full: once for the state system which they choose not to make use of, and once again for the private system which they prefer.

Tax concessions could be used to increase the numbers making use of private medical insurance, and thus to increase the total of funds entering the health sector. One great advantage to the NHS is that private insurance relieves pressure on the state system. The fact that some individuals are treated outside the NHS means that waiting lists are shorter and less demand is made on limited facilities. Many of the conditions treated under private health insurance are the routine and predictable operations such as those for hernias or varicose veins. People opt for private treatment because they value being able to select the date and to make advance arrangements, as well as preferring the private ward and the bedside telephone. Every person treated outside the NHS means that resources are released for the treatment of those who rely only on the NHS.

Allocation of funds

An argument raised against tax incentives for private insurance is that it would represent inefficient allocation of funds. With complaints already coming from within the health service about cash shortages, it is argued that tax incentives would direct funds toward the comparatively better off. The objection misses the point. Tax incentives can be constructed in such a way that a little public money is used to pull much greater private funds into medicine.

For private health insurance, as for every commercial service, there is a body of demand which cannot quite afford the current cost. A small reduction in that cost would take them over the threshold to make their demand effective. Two features are required of any tax incentive which is offered. In the first place it must be pitched at a level to increase the total funding which comes into health. Secondly, it must be at such a level that there is a net saving to the NHS. If tax revenues have to be foregone, even to a slight extent, there must be a saving to public funds caused by the transference of demand outside the public sector.

Given these two preconditions, the parameters of a tax concession are already evident. The proposal is that it should be set at a modest level so that only a small concession triggers an increase in the demand for private insurance. This will achieve the first objective of increasing the total amount going toward expenditure on health. The actual level of concession could be determined by the use of market research techniques. What the government has to find is the number of persons who would be instigated to opt for private insurance at each given level of tax concession.

In fact, as already mentioned, tax rebates of quite modest levels could encourage a sizeable rise in the numbers of those freely choosing to make a contribution to their own health expenditure, as private insurance becomes newly affordable to the large numbers of people at the centre of the income distribution. The rebate mechanism has the added advantage of being susceptible to a gradual rise, allowing private medical facilities to grow to meet the rising demand.

A tax rebate of £50 for those who chose private health insurance would undoubtedly increase the numbers who did so by pushing over the margin those who find it just too expensive at the current level. A rebate of £l00 per year would obviously

constitute a greater incentive and would stimulate even more to do so. Since the annual cost of private insurance is several times these sums, the effect would be to bring additional funds into health care.

The second condition requires that the saving to the NHS of that demand being taken outside it must be greater than the cost of inducing it. Although the average per capita expenditure on the NHS is of the order of £400 per head each year, the removal of demand by one person would not save anything like that amount, since overheads and salaries would still have to be met.

It is also true, however, that the reduction in demand caused by the exit of larger groups will enable some savings to be made. It would be an unusual claim that no NHS saving is possible even if large numbers opt out.

Setting the level

The Treasury traditionally objects to tax incentive proposals on the grounds that while revenue losses are real, any savings are only notional. There is some point to this objection if the incentives are offered first, with no clear estimation of the response to them. If, however, the level of tax concession is fixed only after careful market research, there will be reasonable expectation of its effect on demand and of the savings it will make possible.

One possible way of meeting the Treasury objection would be to take the cost of any tax concession from the next year's budget allocation to the NHS. If it were indeed at a level which brought savings greater than its cost, this would result in the NHS having more funds available for each patient within its care. In 'this way the charge of misallocating scarce resources would not apply. Not only would the tax concession bring a greater saving than its own modest cost, it would also bring extra private funds' into the total expenditure on health.

The level of tax concession which is offered can be increased from time to time in order to set in motion a rate of transfer to the private sector which lies within the limit that increased facilities there can cope with, and which guarantees that there will be a net saving to the NHS in consequence.

RESTRUCTURING THE NHS ITSELF

The use of tax concession techniques can make a contribution to increasing the total proportion of GDP going into health, and in increasing the funding available for each patient remaining within the NHS. There are limits, though, to the rate at which the private sector can expand to cope with the demand -- it takes time to build new private hospitals and to train and recruit the necessary staff. Even if the private sector manages to double, or even treble, will still leave roughly eighty percent of the country dependent on the NHS for health care. Any major reform has to come within the NHS itself.

The problem is not to be solved by taking demand outside the NHS, even though this approach does have a positive contribution to make. It lies in introducing a market within the NHS so that choices can be made, so that there are pressures

toward adopting cost-effective procedures, and so that funds are allocated on the basis of the expressed needs and preferences of the patients.

The use of tax concessions to tempt more people into private insurance can buy time for the NHS. It can take the pressure of demand off public funds and can bring additional money into total health expenditure. In isolation, however, it does not solve the problem. What is needed in addition is a restructuring of the NHS itself so that public funds are themselves spent effectively and in ways which respond to consumer demand.

Health Management Units

The combination needed within the NHS is that of good management, choice at every level of supply, and a method of allocating resources which directs them to those service delivery structures that satisfy demand efficiently. These are among the characteristics of a market, and the problem is one of introducing them into a tax-funded system that is free at the point of consumption.

Although the idea of introducing a market within a state-funded system is new, it is not unique. The elements of the education bill of 1987-88 will achieve it in some degree. The separate strands of that bill will bring a considerable degree of autonomy to state schools, under the leadership of head teachers and school boards dominated by parents. With that independence will come variation. A further tenet of the bill brings much more open enrolment, with parents free to choose a school instead of being offered a place only in the local comprehensive. With schools able to opt for direct funding based largely on enrolment, the system will direct the state's resources to follow the choices of parents. Successful and popular schools will be able to expand, and others will have the incentive to copy their methods.

These separate strands together constitute the elements of a market. The problem in health is to achieve a similar effect; to introduce variety and choice, and to make resource allocation depend in some degree on the choices made. As the money will be able to follow the child in education, so it should follow the patient in health care.

It is important that such a reorganization should preserve the most valuable features of the NHS, including the sense of security which it brings that treatment will be available no matter how serious the ailment or how poor the patient. It would also be useful if the changes required were those which followed the trend of existing improvements, building upon them to achieve the new structure.

One of the most attractive features of the changes which serve to introduce a market into state education is that each of the individual strands which together achieve that end is valuable in itself. The separate elements each secure worthwhile reforms such as variety, choice and efficiency. Their combined effect is made in addition to the value of each individually. The same should be true of NHS reforms: each should create improvement while also forming part of a new system.'

A further value of the education reforms is that they do not force change upon everyone. Choice becomes available to those who wish to avail themselves of it. Parents who prefer the place in the local comprehensive are free to accept it as before. It would be an advantage if any restructuring of the NHS similarly offered its

patients choices and improvements, while allowing those who wished to continue as at present to do so.

Operation of the system

The key to reform of the NHS, as in education, lies in reorganization of its management structure. In place of the Regional Health Authorities and the District Health Authorities there should be management bodies which have every incentive to spend resources in ways which are cost effective and attractive to patients. These bodies should be funded from taxation and should have the responsibility of proving a full health care service for patients. They should distribute resources to general practitioners at the primary level, and to hospitals and consultants at the top. They will be, in effect, Health Management units (HMUs).

The new NHS structure will thus have general practitioners with whom patients enrol, very much as at present. A key difference is' that the GPs in the NHS will have to enrol with a Health Management Unit. The HMU will pay them on the basis of work done, with a scale of fees for various aspects of their work. They will be paid for each consultation and each course of treatment. Very much as dentists are paid at present for NHS work, the GPs will be paid for the work that they do.

This will give doctors an important flexibility of income. Just as young dentists can do more work and earn more fees, NHS GPs will be able to do the same. Older ones will have the choice, if they wish, of a less exacting work load and a lower level of pay. The proportion of remuneration 'which derives simply from having patients on their books will disappear, leaving payment only by results.

This is a useful change in its own right. The present system to some extent rewards doctors for having as many patients on their lists and doing as little as possible for each of them. The new system will link reward to work and can, of course, include the important element of fees for preventive medicine and check-ups.

The general practitioners, by joining an HMU, take their patients with them. The patients still see their GPs as before and the treatment is still free at the point of consumption. The difference lies in the method of payment of the GPs and the route by which the treatment is funded.

When the doctor recommends the patient to see a consultant or to undergo hospital treatment or tests, it is the HMU which will select the appropriate sources of treatment and pay for it. The hospitals will operate as independent management centres, and will cost the various services they perform. They will in effect sell their services within the NHS. If some hospitals can operate in highly cost-effective ways, these might well be preferred by HMOs for the services they offer. An HMU will not want to pay twice at one hospital what an X-ray costs at another.

The HMU will thus receive its funds from the Department of Health on the basis of the numbers of patients who, through their GPs, are members of it. It will pay GPs for their work at the bottom, and choose and pay for the appropriate work of hospitals at the top.

The replacement of Regional and District Health Authorities by the new HMUs will introduce incentives at several key points. In the first place doctors will have the incentive to work for their patients because it will be the basis of their remuneration. The hospitals will have to be managed efficiently and offer services cost-effectively, in order to attract the HMUs to send patients to them. The HMUs themselves will have to provide total health care on the basis of an average annual allocation per patient. They will have the incentive to make sure they get value for money from the GPs who subscribe to them, and for the hospital and consultancy work they obtain for their patients.

Choice is also introduced at several important points. Patients will be able to stay with their present GP, or change to another one. In changing, they can select a doctor who subscribes to a different Health Management Unit, and thus change their HMU by changing their General Practitioner. The GPs themselves will be able to choose between different HMUs, taking their patients with them unless the latter decide to change doctors. The HMUs will be able to choose between different hospitals and courses of treatment, taking efficiency and cost effectiveness into account.

An important feature of the HMU system is that resources follow choices. When an HMO selects a particular hospital to treat a patient, it is that hospital which receives the payment. When a doctor chooses an HMO, that same HMU receives the annual health allocation for each patient. When a patient changes HMUs by going to a new doctor, the money follows the patient to the new HMO and the new doctor is paid for any work done.

These constitute the elements of a market within the NHS, and one which allocates resources according to choices made, with built in incentives for efficient operation.

The task of the HMUs

The HMUs will be licensed non-profit bodies responsible for the total health care of the patients registered with their doctors. They will be management bodies, drawing upon the existing skills of health managers. As the Regional and District Health Authorities are replaced, an incidental bonus will lie in the removal of the political 'appointees from health management following the change.

The new Health Management Units will be able to decide, each for itself, what is the optimum size in terms of the numbers of GPs and their patients registered with them. The optimum size will vary according to geography and demographic make-up among other factors.

The HMUs will be required to buy hospital and specialist services for their patients as required. They will be able to take part in building and supplying equipment. The example of other advanced countries suggests that there is a lack in Britain of facilities intermediate between GPs and hospitals. The HMUs will probably act to fill that gap by investing in group diagnostic facilities and providing the demand for efficient day care clinics and outpatient centres.

The payment and monitoring of their GPs will be part of the task of HMUs, and will be performed in ways which ensure value for money. Cost details of GP work will be compared, and action taken where necessary to improve efficiency. HMUs will be

vigilant in the selection of specialist and hospital services for their patients. They will be concerned to provide these on the most cost-effective basis they can, because the less they pay for each service, the more services they 'will be able to offer to patients' and the more attractive will be the rewards they can offer to personnel.

The HMUs will not operate on a simple least-cost basis, but on a most cost-effective basis. Patients and their GPs will have the choice to move to an HMU whose services are more attractive, and will take with them the state's allocation per patient. It will be very much in the interest of the Health Management Units to lower the cost per patient by timely preventive work and early diagnosis by regular check-ups.

The move to HMUs will have a dramatic effect on the costs and the efficiency of hospital treatment. As hospitals go to independent management they will have to cost each service and will need to be aware of precise cost information. They will be very much more flexible in their management and method of operation. Pay scales will be more flexible and will be negotiated on a local basis instead of the rigid system of national scales and procedures. It is doubtful if restrictive practices in operation at present in the NHS will survive the changeover. There will be an incentive towards efficiency and flexibility, as well as to specialization.

In some areas it is quite possible that HMUs will send their patients to the private sector for some categories of service and treatment. Where private clinics offer better value than state hospitals, there will be every incentive for them to do so. What certain hospitals do in particularly effective ways they will be able to sell widely, leading to the expansion of what each does well. The result will be for a new partnership of private and public medicine, with the services of each available to NHS patients on the basis of their comparative efficiency.

An early result of the switch to HMUs will be the development of specialist low-cost treatments. Existing NHS hospitals and new intermediate facilities will have every incentive to develop methods of treatment which can bring economical results. Again, the example of other advanced countries and the private sector in Britain suggests that new methods will be pioneered which involve shorter hospital stays, more localized services, more preventive medicine, and a generally less costly style of care. The incentive will be there with HMOs seeking to provide health care efficiently.

HMUs and hospitals will be able to undertake new capital projects with a combination of central grants and monies raised or saved locally. Funds from the private sector might well be attracted to areas which promise a saving on current expenditures. GPs acting singly or in groups will have the incentive to add facilities, perhaps leased from their HMUs, in order to compete with the cost of more expensive hospital services. Some of the work which now has to be done in hospitals will move out to smaller and lower cost treatment centres, some in the surgeries of doctors.

Financing the HMUs

The basis of funding will be the annual health allocation for each patient registered through their GP with an HMU. The problem of starting a new system such as

Health Maintenance Organizations is largely avoided by keeping patients with their present GP. The resources go to the HMU selected by the doctor, although the ultimate choice lies with the patient, who can change HMO by going to a doctor registered with another one. The resources are thus directed to the HMOs which are most favoured by doctors and patients.

The size of the average health allocation will be set each year, and there will be pressures to keep up with an advancing standard of living. A major difference is that there will be internal competition, with some HMOs managing to offer a greater range of services than others do on the same per caput budget. There will be the option available to vary the health allocation for each patient according to the local health costs. Geography will play a part, but so will the age pattern of the population. It may be desirable to vary the allocation by category of patient, on the grounds that older patients are more expensive to care for. This is not different in degree from varying the central funding for each age group of child in the education system.

It will be important to prevent HMUs from selecting patients by picking the one's which cost least to treat. HMUs will be required to accept patients who register with their doctors, without any selection permitted other than on the basis of optimum size of the HMU. Even here, where patients are refused because an HMU is at its optimum, waiting lists will have to be established with new patients admitted in order of application as places become available.

The role of the HMUs has been considered thus far in terms of treatment, including preventive medicine and check-ups. It would be possible to add such sums as were deemed necessary for the additional functions of research, teaching and general health promotion, where these could be done efficiently by the HMUs. In some cases it will prove more appropriate to have these functions performed on a national basis, however.

National controls

With the management of the NHS switched over to HMUs instead of Regional and District Health Authorities, national supervision of the HMUs will be necessary. A ministerial body will license each HMU and specify the standards which they are required to attain. It will also have the responsibility of ensuring that the levels of service reach those required. It will publish the criteria and compare the performance of HMUs across the country. If the HMUs make use of sub-contractors for certain aspects of health care, these, too, will be required to attain what are deemed to be the appropriate standards.

One of its functions will be to ensure that information about the HMUs and the hospitals is widely available. Both GPs and patients will have access to information about the levels of service which are achieved by the different HMUs. An important function of the national body will be the comparison of costs and services in different parts of the country. These will point to inefficiency and identify areas where savings can be made.

A fully operational complaints procedure must operate at all levels. Patients should be able to take up questions about their GP and any hospital treatment with their

HMU and be guaranteed a prompt response. Difficulties or complaints about their HMU can in turn be taken up with the national supervisory body. Central to the effectiveness of any complaints procedure, however, is the ability to make alternative choices at all levels of service.

The future

It is central to the HMU concept that moves can be made toward the new system, each of which is an improvement in itself. The changeover need not be sudden or dislocating, but can be brought about by a series of piecemeal reforms each necessary in its own right, as well as making up a new system.

The move to payment of doctors for work done is an improvement by itself. The move toward full costing of each hospital service will be very useful. The introduction of flexibility in decisions of management will constitute an important step forward. All of these can be done gradually to achieve convergence on the new system of organizing the NHS.

The introduction of choice and competition will set in motion the means for systematic improvement of the Health Service. The new partnership between public and private sectors will bring the resources and skills of each to the benefit of patients. The effect will be to retain all of the advantages of a free service while removing many of its drawbacks.

Perhaps the greatest advantage lies in the flexibility of the new system. In place of the rigid demarcation between a public health service which does what it can on a take-it-or-leave-it basis, and a private system for the rich which offers choice and competition, the distinction between the two is blurred. They begin to overlap, each on the territory of the other. The public sector HMUs, taking responsibility for total health care of NHS patients, are not too far removed in structure from private insurance and management bodies. The funds for premiums are publicly provided, but the same competition and incentives operate, and the same choices are made available.

This convergence is one of the most attractive features of the change which HMUs will bring. The HMU principle lays the groundwork and the basis for further changes at a later stage, but it brings its benefits immediately. Most of the groups involved in health care stand to gain from its introduction, the patients most of all. It is from realities such as this that change is made possible.