A better way for hospital care II [1]

Written by **Miles Saltiel** [2] | Sunday 9 June 2013

Two years ago, the ASI?s No Need to Flinch [3] set out a raft of proposals to shake up the NHS? demand side. We called on the NHS to treat people as individuals with less heavily aggregated risk pools, we called for funding options to be widened, and we made the case for allowing co-payment on procedures the National Institute for Clinical Excellence would not otherwise fund.

Under this system most would be obliged to purchase insurance?like the car insurance regime in the UK?while end of life care and accident and emergency would be paid for by the state, as determined by a political consensus. The issue then becomes reform on the supply side?hospitals.

Governments have grappled with this for generations, giving rise to perennial complaints about ?NHS reorganisation?. In fact, hospital doctors always see the civil servants off: they?re the smartest guys in the room, furnished with the best data and ruthless in exploiting the fear-factor. But the public would be best served if the components of secondary care were broken up to embrace a variety of approaches, so that best-practice emerged continuously from what Tim Worstall?s recent blog post[4] called ?market processes ?an endless repetition of experimentation?.

This would include all secondary care: ambulances, labs, specialist clinics. Most of all hospitals, although it is often argued that full service calls for concentrating the required skills in big operations. There is something in this, but not so much as to render integrated hospitals beyond competition. In the first place the argument misses the mark. Even now, we accept some specialities in regional if not national settings. Meanwhile national guidelines impair the experimentation which makes for progress. More to the point, even the largest hospital is susceptible to competition. This is because even small reductions in demand threaten the specialist functions which justify its existence.

Disposals also promise relief to the Chancellor. ASI?s 2010 study of the UK?s intergenerational obligations, On Borrowed Time [5], showed Britain?s secondary healthcare to be worth around £200bn. Considering corporation tax reductions and market increases since then, it could now be worth £300bn.

Let?s recast integrated outfits to maximise choice for scheduled activities where patients have discretion. Let?s also contemplate several business models: overseas groups, newly-listed companies, professional co-operatives and charities or universities. And finally, let?s set aside a fraction of receipts for practitioners, following Bevan with the consultants when he ?stuffed their mouths with gold? to win them over to the NHS. So the Exchequer might only get half the headline sum. That would be £150bn, not quite fifteen

percent of the national debt, but well worth having.

Best of all, if hospitals failed to attract referrals from GPs, already at arms-length, even the largest would shortly find their specialist functions at risk: market discipline would enforce reform, something beyond seventy years of NHS control. So let's free up the rigid UK healthcare system and inject some innovation, competition and diversity in.

Links:
[1] http://www.adamsmith.org/blog/healthcare/a-better-way-for-hospital-care-ii
[2] http://www.adamsmith.org/authors/miles-saltiel
[3] http://www.adamsmith.org/sites/default/files/resources/NHS-briefing-paper.pdf
[4] http://www.adamsmith.org/blog/economics/23-things-were-telling-you-about-capitalism-xvi
[5] http://www.adamsmith.org/sites/default/files/resources/On_borrowed_time_ASI.pdf
[6] http://disqus.com/?ref_noscript
[7] http://disqus.com