Adam Smith Institute
Omega Report

HEALTH POLICY

Adam Smith Institute

THE OMEGA FILE

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CONTENTS

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FOREWORD

The Adam Smith Institute's **OMEGA PROJECT** was conceived to fill a significant gap in the field of policy research. Administrations entering office in democratic societies are often aware of the problems which they face, but lack a developed programme of policy options. The process by which policy innovations are brought forward and examined is often wasteful of time, and unconducive to creative thought.

The **OMEGA PROJECT** was designed to develop new policy initiatives, to research these new ideas, and to bring them forward for public discussion in ways which overcame the conventional difficulties.

Twenty working parties were established more than one year ago to cover each major area of government concern. Each of these groups was structured so as to include those with high academic qualification, those with business experience, those trained in economics, those with expert knowledge of policy discussion, and those with knowledge of parliamentary or legislative procedures. The project as a whole has thus involved the work of more than one hundred specialists for over a year.

Each working party had secretarial and research assistance made available to it, and each began its work with a detailed report on the area of its concern, showing the extent of government power, the statutory duties and the instruments which fell within its remit. Each group has explored in a systematic way the opportunities for developing choice and enterprise within the area of its concern.

The reports of these working parties, containing, as they do, several hundred new policy options, constitute the **OMEGA FILE.** All of them are to be made available for public discussion. The **OMEGA PROJECT** represents the most complete review of the activity of government ever undertaken in Britain. It presents the most comprehensive range of policy initiatives which has ever been researched under one programme.

The Adam Smith Institute hopes that the alternative possible solutions which emerge from this process will enhance the nation's ability to deal with many of the serious problems which face it. The addition of researched initiatives to policy debate could also serve to encourage both innovation and criticism in public policy.

Thanks are owed to all of those who participated in this venture. For this report in particular, thanks are due to Dr Digby Anderson, Hugh Elwell, June Lait, Andrew Moncrieff, and Barbara Shenfield. All **OMEGA PROJECT** reports are the edited summary of work by many individuals, and should not be construed as the definitive views of any one author.

1. INTRODUCTION

Public choice theory is convincing a growing number of people that individuals can maximize their own welfare given free markets and a minimum of government intervention. The application of this principle to health care is often thought to be controversial, and is frequently misrepresented as callous: whereas in fact it should be the opposite.

A small minority of our disadvantaged people will always need some help from the rest of the community. But this will probably best be supplied by private markets and voluntary aid, although it may need to be paid for in part or whole from taxation. This kind of state welfare - giving those in need the resources to purchase services of their own choice - is manageable, and quite different from a 'welfare state'. It suggests that incomes should be supported to enable the handicapped to purchase the services they deem necessary, not those chosen for them by a distant and overworked bureaucracy.

The suggestions in this report are not aimed at reducing total welfare. Better health care, and better social services, will in our opinion result from a different system of financing and deploying resources. We do not comment on what level of help there should be: only how it can best be given.

It is understandable that those who are deeply involved in the health and social services - and those whose livelihood depends on its existence - should be suspicious or hostile when faced with any suggestion that the services should be restructured. But we should not forget that there are many people who are as genuinely concerned as they are about the poor and the handicapped, but who cannot justify the present system. In fact our proposals for change, we believe, will improve the lot of the unfortunate: and this should reassure those who are genuinely concerned.

The reforms we propose should not seem to suggest that we can offer some kind of 'solution' for all social problems. Many of these are complex and perennial and will never admit of any easy 'solutions'. All we can say is that what we recommend is more likely to use available resources to better effect, and will avoid some of the difficulties which have resulted from the welfare state approach. There may well be some disadvantages in our proposals, but we can only point out that they are minor and manageable compared with the scale of the failures in some of the present programmes.

Major obstacles to change

1. Interest groups. There are large interest groups who, when their influence and empires appear to be threatened, will resist change. Professional groups, trade unions, and civil servants,

are obvious examples. Not only do these groups exert influence on politicians as powerful concentrated pressure groups, but they also derive influence from their supposed professional expertise. For example, a health minister would hesitate before advocating any policy generally condemned by the British Medical Association. But although the **medical** expertise of the BMA is unquestioned, it is not always qualified to comment on the economic and political implications of new proposals in health policy.

2. **Politicians.** Politicians are activists, and are anxious to intervene, legislate, regulate and generally to be seen to be doing something about present problems. But often, it is simply impossible to improve things through political action. In many cases, the unplanned activity of millions of individuals brings about a better overall result than the well intended but insensitive attempts of politicians to 'plan' the whole activity.

3. **Restrictive legislation.** Some existing legislation restricts the freedom of individuals to pursue their own best interests. Yet more grants powers of intervention and regulation. In some cases, legislation disposes of the rights of people to care for themselves as they deem appropriate. All of this makes it difficult to grow new and better structures for health care.

4. **Inertia.** Inertia and social dislocation are well known enemies to managing change. This applies especially to proposals altering the social insurance system, with its forward obligations.

5. **Transition questions.** Concern about the mechanics of any reform is a major source of inertia. No one any longer extols the welfare state with the fervour of its creators (as exemplified by Aneurin Bevan's 1958 remark that the National Health Service is 'regarded all over the world as the most civilized achievement of modern government'). People on all sides are agreed on its shortcomings, they disagree only on what should be done to remedy them.

Arguments for a market-based system are now more widely known and favourably received than ever before: equally familiar are the arguments about the poverty trap and its disincentive effects on job-seeking, the cost of state services to the individual being greater than the value of benefits received, and the lack of choice when welfare is nationalized. The desire of patients and parents to make their own choices in health care and education can be demonstrated. And yet most politicians continue to protest their commitment to the present system of health and educational services, with only a timid admission that private markets could make a contribution, and with an assumption that new alternatives could never be allowed to compete with existing nationalized services.

While ideas for privatizing welfare, encouraging self-help, leaving social aid to voluntary organizations, and reducing state

aid to a selected clientele are very attractive, many questions remain as to how this is to be done. How, without intolerable hardship and social dislocation, can the universal welfare state be re-structured and how can we slip neatly from largely public to largely private welfare without some people, the most needy, slipping through the net? This is a difficult problem, but we must not underestimate our ability to deal with it at the time: and nor must we overlook the benefits of reform once achieved. It was the rhetoric, not the details, of the new social security regulations which first persuaded people that a welfare state was both moral and highly desirable. It is the desirability and superior morality of better health systems which should commend them, without our being sidetracked by alleged transitional difficulties which will undoubtedly be overcome quickly and efficiently in any case.

6. Appeal to the emotions. The most sophisticated arguments and the most carefully devised plans for change may founder on the simple feeling that what is proposed is not fair. Among the British people at large there is no conclusion, however illogical, more likely to lead to thumbs down than the elliptical statement that something is unfair. In the social services particularly, people's feelings can be worked upon easily - to the detriment of sound policy analysis.

An example is the theory that having more than one type of health care (via state **and** private systems existing side-by-side) must produce privilege and 'two nations': which is a deliberate appeal to induce emotions of guilt. But in fact it is the present system which, if any, should induce this feeling of guilt, because it certainly gives the poor a second-class service - an inevitable consequence when a service is politicized. Middle-class individuals, who know how to manipulate the system, do well from it. They can complain to get better attention, they can use their influence with politicians and others to jump the queues, they are more able to find out what benefits are on offer. Even the 1979 Merrison Royal Commission admitted that 'there is also evidence that the higher socio-economic groups receive relatively more of the expenditure on the NHS'.[1] And only recently Richard Titmuss, 'one of socialist medicine's godfathers' was quoted as saying in 1968 that:

> 'the higher income groups know how to make better use of the NHS. They tend to receive more specialist attention; occupy more of the beds in better-equipped and staffed hospitals; receive more elective surgery; have better maternity care, and are more likely to get psychiatric help than low income groups - particularly the unskilled.'[2]

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1. The Economist, April 28, 1984, p. 25.

2. The Economist, op. cit.

Indeed, their political influence often means that benefits are designed in the first place with them in mind. The politicians, who design and take credit for the service, also do well from it; and it supports a large management, administrative, and ancillary staff. But poorer people do not do so well: they have little political influence to make sure that the available services are designed for them; less knowledge of the benefits on offer; and very little power to complain effectively about inadequate or low-quality services.

The needs of the poor are the only arguable target for the services of a welfare state. The rich do not need state welfare: the middle and working classes (if they were not penally taxed) could provide for their own. It is only the poor and handicapped who need public welfare. If it can be shown that it does not help them in the best way, the present welfare state has lost its raison d'etre.

2. THE HEALTH SERVICE: PROBLEMS AND PROSPECTS

Many critics of the welfare state have suggested that its continued popular acceptance in principle, ('over 80% of the British people tell opinion pollsters they love it'[1]) in the face of many manifest practical failures to deliver what was promised, is not the product of rational argument, but the result of a very effective appeal to the emotions. Anything put forward as being conducive to improving the welfare services is uncritically accepted, and anyone who opposes expansion or suggests alternative mechanisms is often depicted as someone who wants to grind the face of the poor. The welfare state is, of course, dominated by self-interested groups whose advancement has been tied to its expansion. These strong words by Professor Dennis Lees sum up much of this feeling:

> 'The British health industry exists for its own sake, in the interest of the producer groups that make it up. The welfare of patients is a random by-product, depending on how conflicts between the groups, and between them and government, happen to shake down at any particular time.'[2]

But this cannot wholly account for its continued acceptance. How then, did it come about?

PRESENT DIFFICULTIES

Political objectives

In its early stages there appeared some very plausible rhetoric, and a certain amount of highly selective evidence which, *prima facie*, has gained considerable support for the idea that only with comprehensive public services will the whole community have a high standard of health care. But the more one examines the history of the welfare services of Britain and elsewhere, the more one is struck by the political ideology (rather than economic efficiency) which permeated even its earliest stage. In this country, it started with the implementation of the Beveridge Plan, which by 1949 had been embodied in a comprehensive social security system, extending to compulsory education, publicly-provided housing, and other subsidiary welfare services. There had been various social services operating before this time, but the one major radical departure which characterized the welfare state was that these benefits were not to be concentrated only on the poor; these were universal, comprehensive, and in some cases compulsory services for all citizens. That resources should be

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1. *The Economist*, April 28, 1984, p. 25.

2. *Ibid.*, p. 30.

used in this way, largely irrespective of individual needs, was justified on the grounds of social equality. Using the same services was said to be a common badge of citizenship; in future the poor would not be segregated or categorized, or given better or worse health care or education for their children. All citizens would share common services and pay for them with taxes according to their means.

This was the beginning of a powerful rhetoric about eliminating class barriers and promoting social justice, and this struck a chord in Britain at that time, just emerging from a wartime siege economy where equality of sacrifice and sharing of limited resources had been accepted as a patriotic duty. The idea of 'the same for all' was one which found ready acceptance.

Of course, this was never true, even in the beginning. The educational system included the grammar schools, which were the poor's entry to the professions, to higher education, and to the top levels of public life. These were abolished to make way for the comprehensive system. But the division actually **widened** between those who could afford to get better health care more quickly by paying for it privately, and those who had to wait in the interminable National health Service hospital queues.

But the concept of 'fair shares for all' was welcome to British ears, and coupled with the idea of the poor getting 'fair' treatment based on 'need' rather than monetary income received (and continues to do so) wide support. Even governments who propose cuts in expenditure on the social services, not because they think that the provision of public services irrespective of need is a waste of money, or counter-productive, or not achieving results, but because the money isn't there to spend.

The results of egalitarianism. The great break with the Poor Laws of the past was that instead of concentrating resources on helping the poor, whether by public service, or charity, or by volunteers, we began to feel that it was just as important an objective to equalize the treatment of all people. But very quickly the egalitarian hopes of leading politicians were overtaken by the less agreeable factors which one would expect when welfare came to be nationalized.

It was not surprising that monopoly power began to colour all the programmes and the way in which they operated. As the services grew larger and more centralized, the self-interest groups, those whose advancement and future depended on the expansion of the system, appointed themselves the exponents of welfare policies and had the greatest influence on their development.

In 1948, when the NHS was instituted, there was no shortage of hospital beds or doctors. Now there are fewer hospital beds than in 1948, but the NHS staffs them with twice as many workers. In the period between the two world wars we devoted six times as much of our resources in real terms to hospital building as we

did in the first two decades of the NHS - and that without government funding, and in a period of economic depression. As to the supply of doctors, there was a number unsurpassed in any of the Western countries, with general practitioners to be found in all districts, rich and poor. Although the income of the poor could not buy expensive hospital treatment, they could and did get treatment free or at a fee assessed by the almoner. The GP was available to lower-paid workers under the social insurance system established before the first world war, although admittedly this did not extend then to their families. The system was not perfect but with some modifications could have greatly been improved.

The very real health problems of the poor arose from their inability to build up and sustain good health by the purchase of an adequate diet, and their lack of resources and knowledge to give good protective care to mothers and young children. Even in this field, however, there were already good maternity and child welfare services, which had helped to make startling reductions in infant mortality.

The poor had to be helped because they were poor; they could not afford to take time off to follow treatment prescribed for them. But instead of putting all our resources into solving the problem of poverty (by sustaining a prosperous economy which could then afford to direct resources where they were needed), the post-war government instead managed to spread a very large part of our resources into the very expensive National Health Service. Today, nobody will be surprised to find that the government health care programme is quickly outstripping even the most generous calculation of prospective costs. In 1948 there were many people, under the influence of Beveridge, who seriously thought that under a system that took care of the health needs of the whole population, the community would become healthier and ultimately, health costs would fall!

The facts have contravened this for many years. An infrequently cited example deserving greater attention is that, 'In 1970 more cases of food poisoning originated in British hospitals than in all the cafes of the country'.[1] When costs do rise and cuts have to be made, roughly the same number of staff are retained (sometimes those with less political clout may be 'sacrificed') while the number of beds are reduced and the waiting lists rise. Sadly, we are wiser now. We know that medical health care costs rise both as more and more sophisticated and expensive medical techniques are developed, and as the concept of good health care is stretched from life-saving emergencies to almost any form of care that makes life more comfortable.

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1. The Economist, op. cit.

PUBLIC CHOICE OBSTACLES TO IMPROVEMENT

There is, of course, a very good case in Britain at the moment for spending more money on health. We have too many old and dilapidated hospitals; we have 704,500 (an estimate for the end of September 1983) people on hospital waiting-lists; and there are too many junior doctors working long hours. But competing claims on the public purse mean that the money is not forthcoming to improve these conditions. Even the 1974-79 government, whose stated policy was the best possible health care for everyone, could not produce the resources, because taxpayers were unwilling to be taxed any more heavily than they were already.

The consequences of escalating public expenditure cannot be ignored by governments, who have to consider public opinion for when the next election comes along. As voters, people may in fact vote for programmes which, as taxpayers, they are not prepared to pay for. As long as people believe that others are doing most of the paying, and as long as they can get something out of it for themselves, most people's natural inclination is to be generous towards the needy, the poor, the elderly. There is, then, an inbuilt tendency for services controlled by politicians to be subject to persistent expansion simply because of the vote motive.

This expansionary tendency in all public services naturally imposes budgetary problems on any government that is unwilling to raise taxes. But if the government tries to control or regulate the work of the medical profession, it soon runs into difficulty and because of the monolithic nature of the service. It becomes involved in the creation of an elaborate system of bureaucratic controls. Throughout the history of the NHS, there has been an inverse ratio between the number of administrators and the number of hospital beds actually available for the public.

It was originally supposed that the profession of medicine would become more orderly, more coherent, more disciplined under a national plan. But in fact the politicians quickly found that they had to placate a less than enthusiastic medical profession. In 1948, the health minister's announced solution was to 'stuff their mouths with gold'. The specialists and the consultants who were the leaders of the profession were promised their freedom to continue private practice and the facility of treating their private patients in paybeds in the nationalized hospitals. In addition, they were to be paid by the NHS for treating poor patients who in the past had been given treatment in a free or honorary capacity. So it is not surprising that they decided to collaborate with the new service. The practitioners in the poorer areas were able to use their knowledge and skills while the politicians and administrators could deal with the less attractive side of medicine: the financial side. But already the pious egalitarianism of the service had been frayed.

In the early years of the NHS, there was widespread acceptance that hospital doctors worked long hours for very low pay, and

were dedicated to giving the best possible care. But as they found persistent long waiting lists, low pay, and inadequate resources, morale quickly declined, and they and the nurses had recourse to the long-unthinkable method of strike action and abandoning their patients. It is in the very nature of this kind of system that it produces a feeling of being exploited: this happened particularly to the junior doctors and the nurses. Finally, even the consultants themselves came into conflict with the government: as the NHS had taken over nearly all the hospitals in the country in 1948 (allowing a few beds to be used by private patients), there were hardly any private hospitals. Some years later, the consultants were concerned about where they were to treat their private patients when the government of the day phased out pay beds. And there was speculation about whether the people who had paid private insurance for the last twenty-five years would be able to get their treatment.

Arrangements between the insurance and medical professions which hastened the building of new private hospitals were checked by the government announcement that it intended to regulate private care and make it subject to government authority so that it could not in any way compete with the NHS. A change of government allowed private hospital building to take place, but those in the profession realized that a subsequent change of government could reverse the position to one where all private medical facilities were again regulated.

Inevitability of decline

These developments were not just aberrations: they arose from the very nature of state medicine. They begin with the idea of the best free medical service as a right. But the facts of life dictate that there is no 'right' level of health care - patients can and do demand more or better services, especially if they are free. This tendency to infinite demand then forces the government to ration services by queuing or to impose some charges - for example, for prescriptions. Then they have to stretch the service, and private medicine becomes a more attractive alternative for an increasing number of people. The NHS began with encouraging words and generous treatment by the most influential groups within it; but economic reality forced them to mow down the weakest members - the junior hospital doctors and the nurses. Bureaucratic limits were imposed on the freedom of the general practitioners with investigations into prescription charges; and finally the privilege of allowing doctors to continue having private patients was invaded.

None of these things were predicted in the beginning: they arose from the nature of public sector medicine, where the government commits itself to promises it cannot deliver.

The greatest sources of organizational problems in the NHS therefore boil down to the fact that the service is politically motivated. In Britain, 95% of all health care spending is done

by the government. As a result, virtually all spending decisions within the NHS are subject to political pressures. Put simply, money spent on curing diseases and saving lives affect only a small percentage of the population and therefore influences very few votes; money spent on 'caring' services affect millions of people with millions of votes. In order to stay in office, politicians cannot ignore the political demands of their constituents. Thus the system is constructed to make life a little more comfortable for large numbers of people, rather than to provide emergency services for those whose need is critical. Some features of the service will illustrate the point.

* In 1981, there were 20.5 million ambulance journeys in England - almost one ambulance trip for every 2.5 people in the country. Yet only 1.8 million of these journeys pertained to genuine medical emergencies. This means that over 90% of ambulance rides are for non-emergency use.

  The great bulk of ambulance rides are little more than a free 'taxi service'. When a real emergency (such as a heart attack or stroke) does occur, however, the ambulance service is often poorly equipped to deal with it.

* Partly because of the lack of equipment and partly because of the lack of time, British doctors furnish very few of the preventive services that patients in other countries expect as a matter of course: general check-ups are virtually unknown; only around 8% of eligible women receive an annual PAP smear; there are low vaccination rates for children. Many of the 'non-urgent' cases wait for years in constant pain, while many others wait at considerable personal risk. And because capital expenditure can be allowed to decline without the public noticing until long after, hospitals are often out-moded, ill-equipped and understaffed. Over fifty per cent of all beds are in hospitals built before the turn of the century.

* In 1981, the NHS paid dentists out of public funds over £343 on dental services. It spent many more millions giving people 'free' eyesight tests, subsidizing contraceptives and providing a 'free' contraceptive counseling service. Yet each year many kidney patients may die because the NHS refuses to provide them with renal dialysis. (In the United States, by contrast, it is doubtful that **any** American patient dies because he is denied access to renal dialysis.)

JUDGING THE SYSTEM

One of the great arguments for the NHS was that there would be a more even distribution of resources, but there is no evidence that this has happened. Short of direct compulsion, one cannot ensure that doctors live or practice in a certain needy area. Endeavouring to realign the resources of the teaching hospitals shows a typical kind of problem that arises in the attempt to

organize the distribution of medical resources through some kind of centralized plan. A governmental decision in the late 1970s to spread medical resources more evenly and geographically led to the fragmentation of the great London teaching hospitals, in which some of the staff and resources were dispersed out of Central London or faced closure or substantial cuts in their budgets. These hospitals, long-time centres of medical research and innovation, had developed naturally over the years, around particular personalities at particular times, and they served people from all over the country by the very nature of their resources and the research they developed. The result of the break-up policy was that some of the staff did disperse, but not to places short of medical care in Britain: they dispersed overseas, to Canada, Australia, and to the United States. This loss was compensated, to a certain extent, by the importation of doctors, particularly from the sub-continent of India, but there is no need to stress that the substantial capital investment involved in the training of doctors over a generation.

It is difficult to understand why we persist with what is so manifestly a failure. In October 1974, the Presidents of the Royal Colleges and the Deans of the leading medical schools who delivered a warning - almost an ultimatum - to the government and the public, saying that standards were falling in a way which threatened the health of the community, and which, if not checked, could not be recoverable in any foreseeable term. That was the verdict, after a quarter of a century, on the Beveridge expectation of ever-increasing health for ever-decreasing costs. By 1974, many people who had strenuously denied, whether out of loyalty or political blindness, that there was anything fundamentally wrong with the NHS, as last agreed that the Emperor had no clothes. In an attempt to 'solve' the problems the government set up a Royal Commission. By that time the percentage of numbers of patients in hospitals had gone down, the waiting lists had increased, and the costs had escalated.

A checklist

We have inherited from all this a service which has never managed to deliver any of the things promised: medical services have not become evenly distributed; they are not more efficiently produced; there is not general satisfaction in the medical and nursing professions (there is little evidence to suggest that they are much better off than before).

But has no good come of the NHS?. Of course some good has come out of the health service - it would surely even be beyond the ability of any government to spend £16,000 million a year and not get something good from it! Since July 1948, when it came into being, a great many people have received a great deal of health care from the service. Some excellent medicine is practised, because traditions of excellence and high ethical practice die hard; there are individual doctors and nurses who without doubt have, and still are giving devoted service to their patients.

But to many, the overall impression is one of deteriorating standards and a marked failure in finding sufficient resources (or applying them well enough) to enable British medicine to keep abreast of the potential of modern medical techniques. The CAT Scanner is invented in this country but no-one can afford to make them here. There are more CAT Scanners in the Bay Area of San Francisco than we have in the whole of the United Kingdom.

Standards of measurement: equality

Has the cost barrier been broken? To remove the barrier of cost was one of the original objectives of the system. It has been broken, only to be substituted by the waiting barrier. But it is not much good having a free health service if individuals cannot get it when needed. If a man's child has an accident and is taken to hospital, only to find that it is closed due to lack of staff or funds; or if an individual has to wait two years for a hip replacement, then he may well wish to be able to pay for it somewhere else. Nor is there any benefit in having the services of a GP free of charge if he is too busy to give his patients more than a few minutes attention.

It has been shown that a growing number of people are prepared to pay for private health insurance, even though there is supposed to be a free service available. And it is not just the affluent few - increasingly, companies offer it as a fringe benefit to their employees. Membership of these private insurance plans is building very rapidly, no doubt because so many people want a better, more effective, and more reliable form of care than is currently available.

Have the poor been helped? The most pressing reason for the nationalization of health care was the alleged impossibility of providing satisfactory care for the poor in any other way. Well, the poor do get free care; the limited charges that were introduced have all been remitted for poor people. But for the most part, the poor had free medical care before 1948 and this could very well have been extended without the vast erection of the whole superstructure of the NHS. The avowed purpose was to improve on past experience by avoiding a separate and therefore lower standard of health care for the poor than enjoyed by others.

But is it fairer?. One of the unfortunate effects of universal free health care with limited resources is that the poor find themselves in competition, and at a disadvantage with the better off - not competing **with** another system, but **within** the system, with their own limited resources. In a competition between the educated, informed middle-class, and the less-well connected poor, there is little doubt who will secure priority. Those who have the resources, the connections, or the ability to write to their MP or their newspapers, or create trouble for administrators and practitioners will always find themselves at the front of the queue.

Standards of measurement: health

Has the service made us healthier?. There have been no spectacular gains over the country as a whole in the life expectancy rate, and it can be pointed out that infant mortality fell more in the six years before the introduction of the NHS than in the six years after. In Britain, people die of cancer, heart disease, cardiovascular diseases, bronchitis, pneumonia, and road accidents, much as they do in countries which do not have comparable health services. (See Table 1 below)

Table 1

	USA	W Germany	France	Japan	UK
Est 1984 health expenditure $ per head	1,500	900	800	500	400
Number of doctors per 100,000 *	192x	222	172	128	154
Life expectancy at birth *	75	73	76	77x	74
Infant mortality per 1,000 live births *	12	13	10	7x	12
Deaths from heart disease per 100,000 *	435	584	380	266x	579

Note: * - latest available years
x - shows most effective performance in that row

[Source: The Economist, op. cit., p. 24.]

Premature death from lung cancer or road accidents will not be significantly reduced by introducing a new way of financing health care.

Is public health better? Lastly, the argument goes that government should use public finance to run a service which is for the public good: it is over and above the advantage to the individual, and to the benefit of the community to contain disease and build up a more productive working population. This argument holds good in the case of public health measures aimed at the control of infection and contagious diseases, and perhaps in the case of preventive measures which have been a part of the

health services. But in Western societies, the great killer diseases which shortened a child's life and carried off young adults have largely been controlled. Modern medicine keeps alive the elderly, and although longevity is an achievement which we all welcome, there is no convincing argument that it must be achieved purely through state finances, as there is with the control of contagious diseases.

The breakthrough in modern health care is a feature of our living standards; it reflects what we can afford. It is not life-saving, it is life-enhancing. And, of course, it may be that people would have preferred other enhancements to life than the longevity the vast NHS budget has bought them - they might have preferred to keep their tax money in their own pockets to spend on better food, better housing, more holidays, or anything they chose, including a superior standard of health care in the private market. But there is only a very small market with a handful of private schemes. Thus there is no real way of measuring what people want with what they are getting. Unlimited demand leads to shortages, waiting lists, queues, and the difficulty of allocating services among an unlimited demand.

There is no evidence that the NHS, by itself, has generated great improvement in the health of the poor, which was the raison d'etre of the service. In its absence, people in the UK would probably have devoted **more** resources to health care, as they have in other countries.

TOWARDS A SOLUTION

Is more money the answer?

It would be easy to assume that the problems of the NHS are brought about by a shortage of money, and that they could be solved by an increased appropriation. It would be easy, but it would be wrong. The forces which determine basic spending policies within the NHS are the products of a system of public sector supply. An increase in the budget of the NHS would be an overall increase, and would still be subject to the misallocations which would prevent enough of it reaching the designated target areas.

For every pound spent by the NHS as a whole, approximately 74p goes on wages. This compares with 3p on drugs, 6p on equipment, and 2p on vehicles. With the bias toward current spending still in place, a major share of any new funding would find its way toward wages and salaries. Administrators would find themselves able to concede more easily on wage increases and restrictive working practices if there were more funds behind them. All in all, one would expect a tiny fraction of any budget increase for the NHS to make its way into spending on new hospital building, advanced equipment, or into the reduction of those huge waiting lists.

Because the NHS is inherently political in structure and operation, it will always suffer from organizational defects, and health improvements will be possible only when people are allowed to opt out and move to a new health supplier of their own choosing. Nevertheless, there is scope for great improvement **within** the present system.

The current NHS spending for 1982-83 in England amounts to £11,426 million, while within that capital spending is given a mere £686 million.

Table 2

Health spending 1982-83

	£ million
Headquarters Administration	380
Hospital Services	
Patient care services	4,273
Admin & general services	2,378
Community Health Services	
Patient care services	577
Admin & general services	151
Family Practioner Services	
General medical services	803
Pharmaceutical services	1,228
General dental services	399
General opthalmic services	168
Other Services (incl. ambulance services)	382
Capital expenditure	686
TOTAL	£m 11,426

[Source: Accounts 1982-83 of Health Authorities and Special Authorities in England and Wales, House of Commons Paper 399, Session 1983-84.]

Specifically in the 1982-83 year's appropriation, the £6,651 million on hospital services excludes only £540 million on the capital side of the account for providing new buildings, extra beds, and up-to-date equipment. This level of capital replacement is much lower than most general commercial enterprises, and lower than in private health systems elsewhere in the world.

In the hospital services allocation, direct patient care services absorb £4,273 million. An astonishing £2,431 million (less direct credits) goes on the 'hotel and general' costs of running hospitals, with over £1,083 million of this figure allocated to laundry, linen, catering, domestic and portering

services.

An examination of the appropriation accounts shows wide variation within the NHS in the costs of these ancillary services from region to region. Measured in costs per bed, there is a 20% variation in catering costs ('of the larger acute hospitals, 26 spend over £3.50 a day catering for each patient, while 140 spend £2.50 or less'), a 45% variance in domestic and cleaning costs between the 14 regional health authorities ('of these hospitals, 20 have domestic and cleaning costs above £2.50 per square metre, while some 30 spend under £1'), and similar variations with laundries which 'average £9.45 for 100 articles, but many hospitals spend over £12, many under £7').[1] These variations are reached on an item which occupies, as the overall manpower figures show, a major fraction of the health service budget. The total proportion of ancillary staff including maintenance workers, is 22.6% of the total, with a further 13.3% employed on administrative and clerical work (Table 3). The medical and dental staff, at 4.86% of the total, require nearly three clerical and administrative staff to each one of them, and nearly five ancillary staff.

Table 3

Numbers employed in the NHS

	Whole time equivalents as at 30.9.83
Nursing & Midwifery (incl. Agency)	397,000
Professional & Technical (excl. works)	68,700
Works	6,000
Maintenance	20,800
Admin & Clerical	109,900
Ambulance (incl. Officers)	18,400
Ancillary	166,000
Total Non-medical	786,800
Medical & Dental (incl. locum)	40,200
Total Staff	827,000

[NB: Figures rounded to nearest 100: percentage calculated on unrounded figures.]

Some variations are inevitable but these sizes in so major a

1. All quotes are from The Economist, October 1, 1983.

budget item indicate two things. Firstly, the mechanism for quality control and monitoring the efficiency of the service is clearly inadequate; and secondly, there is scope for huge savings to be made in these items, with consequent re-allocation of resources to the areas of more critical need.

And it should be stressed that even a 10% saving in this hotel and general budget could support, each year, the purchase of (approximately) 52,500 kidney machines, or 490 whole body scanners, or 51,000 extra nurses, or 17,600 extra doctors, or 740,000 King's Fund beds.

An examination of some of the services which go to make up the 'hotel and general' costs shows that the NHS has arrived at a position where it is expected to maintain an expertise in a wide array of services which have little to do with its primary function. NHS personnel perform all of these services at present, and do so with techniques and equipment which, like the hospitals themselves, owe more to what can be afforded than to perceived needs. The following ancillary services are all candidates for potential savings, given modern equipment and efficient management and manpower use: catering; portering; domestic services and housekeeping; administrative and personnel functions; estate management; linen and laundry; security; building and plant maintenance; architects, surveyors, and other professional services; general and specialist cleaning; pest control; and engineering, plumbing and electrical services.

The overseas example

An inspection of the hospitals in other countries shows that many of them manage a better allocation of resources by keeping down the costs of ancillary services and thereby concentrating more finance and more attention on their health care function. While hospitals in the United States, for example, spend roughly the same proportion as ours do on administrative and clerical work, they spend 2.24% more on medical and nursing staff, with 5.8% less on housekeeping services and 2.95% less on portering.

These figures do not reveal the full picture. US hospitals actually spend two-and-a-half times more than their British equivalents on their medical staff, and only two-thirds of the proportion on nursing staff. This is because some of the functions for which we use highly trained nurses, such as delivering meals to patients, are performed in the US by catering staff and other lower grade personnel. In 20% of US hospitals the catering is performed entirely by specialist contractors.

Domestic services in the US are contracted out in 18% of hospitals but, significantly, the figure is rising at a rate of 20% per year. Many US hospitals go outside for their estate and equipment maintenance and for their laundry and linen supplies services. Canada, Australia and New Zealand all have extensive contracting out of ancillary services, often tendered for in a

group by a specialist contractor. Many Swedish hospitals resort to outside agencies, especially for catering. Some Middle East hospitals contract out the entire package of services, including management. For domestic and housekeeping operations, the proportion of hospitals using contract services in Holland is 20%. For France and Belgium it is 50%, rising to 60% for Germany and Denmark, and reaching 70% in 'progressive' Sweden.

Cost comparisons

Cost comparisons between contractors and direct labour in Britain are difficult. Indeed, it is easy to suspect as one surveys published figures that the difficulties are deliberately fostered to prevent a like-with-like comparison. The public sector costings often take no account of the costs of providing, maintaining, or replacing capital equipment. Many omit the costs of heat, light, telephones, etc., and nearly all take no account of either the costs of recruiting personnel or of training them. Few include such benefits as superannuation; and some even conveniently exclude wages!

There is no evidence, either from Britain or abroad, to suggest that contract services are necessarily inferior. On the contrary, contractors can offer better value for money because they have to compete not only with each other, but with direct labour as well. Each contractor has an economic incentive to keep up-to-date with modern methods and advanced technology. Each experiences pressures to standardize his equipment and materials, and to develop suitable training methods in order to keep his staff up to standard.

But it does require care on both sides to ensure that contracting will work. All contractors are continually attempting to keep down costs; thus it is vital that there should be detailed specification of what service is required. The authority itself is able to achieve a better control over service quality than it can over its in-house service because it can monitor objectively and dispassionately, without having to pass adverse comments on working colleagues. Some of the manpower formerly spent in the minutiae of administration can now be spent in watching closely the achievement levels of contract service.

There should be pre-selection of tendering companies, on the basis of likely competence. A small and inexperienced company might well bid low to gain a contract and then find itself trying to cut corners later. This can easily be eliminated by a suitable pre-qualification procedure. The authority should similarly satisfy itself that the growth of services undertaken by a contractor does not out-pace his ability to supply both the equipment and the manpower required to deliver them to a satisfactory standard.

Ideally, some flexibility should be permitted, to allow the contractor to innovate and to try new organizational methods; but

the range should be well within the quality of service required. The contract document itself should set out some agreed arbitration procedure so that disputes can be handled efficiently and without rancour or misunderstanding. It could also include penalty clauses which should clearly specify what onus is placed on the contractor in the event of a default of service. A 'no complaints' monthly bonus could be built in to give incentive to management and workforce of the contracted service to achieve high standards.

Encouraging the alternatives

A series of measures could be introduced, many of them immediately, to set such a process in motion, and to enable funds to be directed to more critical areas of patient care. The following proposals could be considered:

* Health authorities could be empowered to carry forward savings they achieve. This would given them the incentive to achieve economies by letting them enjoy the benefits, and would also allow the efficient authorities to show others what could be done.

* Authorities could be instructed to price their direct labour services, and be issued with a standard format which lists all of the items to be accounted. These costings would be subject to independent outside audit.

* Selected hospitals could have their management performed by contract, as well as the ancillary services. There are British companies which already do this for hospitals overseas; they should be given the opportunity to show what can be achieved in Britain, in order to establish a level of achievement for others to aim at.

* The health service might be invited to establish a neutral monitoring and complaints body along the lines of the Press Council. It could act as a watchdog on contracted health services, and provide a vehicle for redress of grievances.

3. REFORMING THE HEALTH SYSTEM

There are a number of reforms suggested by our analysis. They range from minor improvements to major reorganizations of structure and financing, and cover most areas including management structures, service delivery structures, pricing and payment policies, and financial organization in general.

MANAGEMENT STRUCTURES

1. There is a strong case for **dissolving one tier** of NHS management - probably the regional health authorities. The district health authorities would report directly to the department of health, although they might form themselves into ad hoc groupings for certain functions better done in co-operation between authorities. While this might give rise to a number of new consultative bodies having no independent budgets, they would have to be supported by the district authorities themselves. The incentive will therefore reside in keeping the necessary co-operation procedures efficient.

In the longer term, the District Health Authorities may be reconstituted with executive boards capable of running them as independent commercial enterprises. But for the present a review should be undertaken of these Authorities with a view to amalgamating some of them to reduce their number. The District boards should have wide powers of discretion to manage their budgets.

2. Generally, however, the sizeable number of **health-related quangos** does seem to deserve urgent review. There seems to be some duplication - the Committee on the Safety of Medicines may overlap in scope with the Committee on Review of Medicines, and certainly there would be no justification in bodies which simply rework each other's findings. At the moment there is little co-ordinated information about health quangos, and a review would probably prove enlightening.

3. **Incentives for saving.** It would be wise to encourage the **contracting out to private suppliers** of as many ancillary services as possible and to extend this much further throughout the service. For example, pathology laboratories could provide services on a commercial basis to public and private users alike. The use of co-operatives formed by existing staff, operating as commercial concerns might be one useful strategy for extending competition and cost management throughout the service.

So far experience gained from contracting is not clearly available to all in any convenient form, and it would be useful to **establish a forum**, possibly sponsored by the government, so that health providers and potential contractors can meet to discuss the successes and the failures.

In addition, there is a clear need for **better guidelines** to

contractors within the health service. It should be remembered that much of the success of contracting depends upon a clear and workable contract being devised: and it is at this initial step of specifying precisely what is expected that authorities (and hence their contracting efforts) can fail.

The **savings from contracting** should remain within the hospital or the other units that make them, and should not result in reduced financial allocations from the centre. If savings were not retained, there would be no incentive at all to experiment and to make changes.

4. There is a case for requiring health authorities or individual hospitals and other health service units to **invite tenders automatically** for particular functions. Although the tenders may not have to be accepted, and the unit can decide to retain existing methods, the process would oblige units to undertake a thorough appraisal of their needs and how they are provided, so that sensible tendering could take place. It would also be revealing to them if and how their current structures can be improved on by outside experts.

5. **Experiments with management**. The actual **management** of hospitals could be contracted out. British firms already undertake complete hospital management abroad, and there is no reason why their new and technologically more advanced systems should not be introduced into the existing service on a contract basis.

In fact there is no reason why this could not be extended even further. Considering that there are 14 Regional Health Authorities and 192 District Health Authorities (and 9 Special Health Authorities which administer postgraduate teaching hospitals), there must be some potential for contracting out the management and administration. Taking this to its logical conclusion, there is no reason why, with careful planning and restructuring, parts of the Department of Health and Social Security that deal with the NHS could not be subject to the economic pressures of the tendering process.

6. There is a stronger need for **auditing controls and internal pricing** within the health service. At present, items are used by staff with no concept of their net cost; and some expensive items are used when very much cheaper ones would surface simply because none of the users know their relative cost, nor have any incentive to save it. Again, auditing and cost control are skills which can be bought in from outside, and there is a case for establishing such a contract, at least temporarily, in each health service unit.

7. A useful technique would be to commission a leading firm of chartered accountants to undertake an **external audit** of, say, at least three state hospitals (a teaching hospital, a large urban general hospital, and a smaller rural hospital) perhaps at the same time auditing two or three similar private hospitals. Depending on the findings, it may then be possible to sub-

contract the management of three general hospitals in different areas to private management firms for a two-year experimental period while the results were assessed.

8. A part of efficient management is the **management of capital assets.** It would seem wise to give local units the power to sell or lease all unused or under-used assets, particularly capital projects that are unlikely to be finished because of continued lack of finance, and those which may be completed but which current costs prevent from being introduced into services.

These facilities might be sold or leased to private health care firms, which would help to increase the total provision of health care by opening wards and other facilities that are presently unused or underused. Income from rents or sales could then be used to improve existing facilities for the benefit of all patients, and the provision of yet further accommodation for those presently on the waiting lists.

9. **Structure of the medical profession.** The BMA is a trade union whose restrictions over entry to the profession are effectively policed by the General Medical Council, which reflects the same general group of practitioner interests. This poses problems, especially when there is a demonstrated need for more flexible health care delivery systems (such as the use of 'paramedics' in ambulances and for certain other peripheral functions) and even for a closer scrutiny of 'alternative' or non-orthodox medical techniques.

Osteopaths, herbalists, and even pharmacists can and do give medical advice and services, although they cannot call themselves 'doctor' and the public is aware of the limits of their professional services. It seems reasonable that such a system - where there are practitioners at various levels, providing various specialist or minor general services - should continue, provided that the public is well informed about the qualifications of each. It does not seem improper that a pharmacist in a chemist's shop should give advice on routine ailments if customers ask, and it undoubtedly reduces the strain on qualified doctors' if routine ailments are in fact dealt with at this level.

Of course, it is both necessary and desirable that those with the power to prescribe potentially dangerous drugs and other treatments should be qualified by examination. But it is also desirable that patients should be able to choose other practitioners if they desire. A further separation of the 'trade union' interests of the medical profession from the 'watchdog' that controls entry to it is probably necessary if this multiple system is to be encouraged. It will require a series of examinations and levels of practitioner that at present it would be difficult to entrust to a series of bodies that have a considerable interest in keeping the size of the medical profession small.

10. **More GP-based care.** Many routine tests, such as X-rays, are done in hospitals on behalf of general practitioners. This requires bureaucratic communication between GPs and hospitals, travelling for patients from the surgery to the hospital, waiting time for patients at the hospital, communication of the results back to the GP, and a follow-up visit to the GP by the patient. The greater use of capital equipment and **testing facilities in GP's surgeries** would cut out much of this slack and duplication, and would make the whole process much quicker for the patient. In many cases, the GP could administer the tests on the spot and then advise the patient of required treatment all in the same visit.

The running down of capital expenditure is a chronic problem in nationalized industries but in the health service it imposes severe and obvious current costs (financial and otherwise) on the whole system and on patients. There is room for a **complete review** of how capital items and testing procedures can be moved from hospitals and into group practices. GPs may also be given the resources and incentives to undertake a broad range of treatment that is presently done in out-patient departments. A recent example, of a private clinic (opened in London), dealing with minor complaints, giving x-rays, check-ups, etc., shows the way forward for this.

11. **Ambulances.** Ambulances in the United Kingdom lack basic emergency equipment; often, they are little more than taxis. The bulk of ambulance trips are for non-essential purposes, and where no hardship is caused, it might be preferable to encourage the use of substitutes, such as public transport, taxis, or cars provided by neighbours and relatives.

In selective parts of the country non-urgent cases are handled by **volunteers** who use their own cars. Considering that over nine out of every ten ambulance trips are effectively free taxi rides, this is an option worth expanding.

An additional idea is to **re-evaluate the vehicle** itself. Other ambulances overseas, and even many of the private ambulances in Britain, are much smaller. Consideration should be given to experiments with different sizes and shapes of ambulances to establish the most efficient form. Indeed, the possibility of contracting out ambulance services should be considered; the savings abroad ought not to be ignored.

Savings from the reduced demand for non-essential trips, and from their reduced supply for such journeys, could be enormous. Some of it may be used on other capital expenditures (e.g., kidney machines, etc.) but some could go into upgrading the present emergency equipment on ambulances, particularly equipment for dealing with heart failures and other common emergency cases. Also, there is a need for the greater training (and use) of paramedical staff to administer emergency treatment in the ambulance.

All this would lead to a much more efficient service and would save lives.

12. **Purchase from the private sector.** Where a particular hospital or unit has difficulty in meeting the demand for its services, it may be possible for it to lease care from the private sector. This would be of particular benefit in cases where capital equipment shortages meant that patients had to be turned away even though staff were available. Facilities and personnel can be leased from agencies in the private sector to assist in such cases. Again, a survey of the scope and prospects for extending the range of services which the health service could purchase from the private sector would be beneficial.

13. One particular form of care that can be purchased from independent agencies is **sheltered housing.** Expenditure on such schemes may in fact reduce the numbers of older people relying exclusively on health service facilities and occupying beds that are intended for more urgent cases. Sheltered housing offered by independent firms, with a warden and trained nurse, alarms, and other facilities may provide a useful way of ensuring that care is provided in an effective way, albeit outside the facilities of the health service.

14. Alternative and comparatively minor expenditure by other government agencies might greatly reduce the dependence of many people on the national health service. For example, the installation of a **telephone free of rental charge** in many pensioners' homes would cost little, but would make them more self-reliant and help to ward off the depression and loneliness that accounts for so many hospital admissions. It would, furthermore, give access to a range of monitoring and emergency functions which use telephone links, and cut down on both the delays and costs of maintaining a response capability.

PRICING AND PAYMENT POLICIES

15. At present, many of the resources of the health service are spent on people who are quite able to pay their own way. Although such individuals have supposedly paid into a national 'insurance' scheme to provide these benefits, it nevertheless seems profligate to give completely free services to everyone, regardless of wealth. Charging, especially for non-essential 'hotel' services would seem a reasonable way of asking the more affluent to take up a greater part of the health care burden.

16. **Welfare exceptions.** Whatever charging structures are introduced, it is important that individuals designated as welfare cases should not have to pay the charge. A simple solution is to issue a **health 'credit card' or 'medicard'** to recipients of social security (pensioners would not **automatically** qualify because some may be sufficiently well off to afford to pay), or any other category of persons thought worthy of complete subsidy, which they can use to pay any charges levied. (However,

the temptation to exempt too many groups will defeat the whole object of the exercise - for example, some 31 million people are entitled to free prescriptions.)

Such a 'medicard' system would allow economic pricing (and where it was desirable, such as for GPs, fee income) to be maintained while exempting genuinely deserving cases from the costs. It will also help to reduce the present injustice whereby wealthy people who happen to be young or old are subsidized by people far less well-off than themselves.

As an associated point, to further permit the introduction of economic pricing, the possibility of using **discount cards** may be considered. Private medical firms offer discounts to some groups - there is no reason why the state should not do the same. It could operate in the same way that the OAP Railcard does for rail travel - there is some charge, but not a prohibitive one. It also allows there to be a middle ground between those who pay, and those with health 'medicards' who do not pay. (Although the 'medicard' could be encoded electronically to reflect different rates of payments, so that a unitary system was retained.) And by simply altering the percentage discount, the health subsidy can be adjusted quite finely. Most important of all, it represents a tool for assisting the chronically ill; those who may be able to afford health fees for a short period of time or up to a certain point (and therefore should pay) but, further than that, may be financially crippled because of the long-term nature of the illness.

17. **Types of charge**. Charges account for a mere 3% of NHS funding (a fall compared to 5% in the 1950s and 5.5% in the 1960s). At the very least charges to cover 'hotel' accommodation in hospitals strongly suggest themselves: 'the cost of hotel overheads - catering, laundry, and domestic services - is roughly £5 a day (at 1981 prices)'.[1] This would represent a charge in the region of £50 for an average visit to hospital. Food and other items would have to be found by the patient whether in hospital or not, and it seems reasonable that the service should not cover completely free non-medical services and comfort trimmings. It may prove necessary to set national guidelines, including maximum or minimum charges, but by and large this is better left to the hospitals or units concerned. An advantage of this might be that the idea of paying around £50, means that people would be putting the equivalent value on their health, as they do on a TV licence.

It may, of course, be possible for a hospital to offer **different standards of comfort** and to levy different charges accordingly. Again, as long as this does not affect the standard of medical care itself, it seems reasonable; and it might even generate extra income for medical services.

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1. Economist, November 12, 1983, p. 22.

18. There is also a strong case for charging the full cost of **family planning services** - again, welfare cases would have the fees waived or reduced by use of their 'medicard'. And given this arrangement, it is a short step to contracting out such services completely, with the fees for welfare users being reimbursed to the service providers directly by the exchequer.

19. Organized sporting activities, and **dangerous sports** particularly, present another case in which it seems unreasonable for those who are cautious should subsidize those who deliberately expose themselves to the risk of injury. It is for this reason that many private health policies demand higher premiums for people who engage in dangerous sports or activities. It would follow that (well-publicized) charges should be levied for treatment resulting from dangerous sports. The dangerous sports organizations themselves can no doubt be encouraged to take out group insurance policies for their members. It may be necessary to make such insurance cover compulsory, in the same way that basic car insurance is for motorists.

20. **Non-urgent ambulance journeys** can also be charged for, perhaps at the same rate as prescriptions. For welfare-case credit card holders, it might be possible to reimburse the cost of their journeys on public transport at a set rate which would, hopefully, be cheaper than the average journey cost by ambulance.

21. Non-essential drugs are another area where the absence of pricing leads to overconsumption, and a saving of several hundreds of millions of pounds would be possible if doctors were unable to prescribe non-essential medicines for hospitals or for outpatients. (In 1983 the NHS spent £4.5 million on appetite suppressants alone.) Belgium, for example, has three or four different categories of drugs, from essential life-saving drugs at the top to minor tranquilizers and so on at the bottom. It seems reasonable that everyone should be required to pay for mild tranquilizers or appetite suppressants, while life-saving drugs should be available free to all regardless of their resources.

22. Financing GPs. The suggestion that visits to general practitioners should be subject to a charge arouses understandable controversy no doubt because nobody would want to deter patients from visiting a GP on the grounds of cost alone when there might be something seriously wrong. The use of the 'medicard' system should ensure that those who are genuinely poor are spared the charge; while for others, a charge, or a partly-subsidized charge (using their 'medicard' or discount card) would discourage trivial use. The actual charge would have to strike the balance between deterring the estimated 40% of visits by people who are not ill, but avoid deterring those who may cost the NHS more in the future.

To assist in the paying of such fees, **health service fee stamps** could be used - in the same way that people buy stamps for fuel costs or their TV licence. There would be 'denominations of 50p or £1 each which families could be encouraged to buy on a weekly

basis. If the stamps were not used in any one year, they would be valid the next. For each visit to a doctor's surgery or hospital, the appropriate number of stamps would then be franked and cancelled.'[1] But this is probably best seen as an alternative to the medicard system, which would automatically assist the very poorest people.

23. An optional restraint on this problem would be to fix an **annual limit to the charge** which any patient had to bear in consequence of visits to or by a general practitioner. After the limit had been reached in any calendar year, subsequent consultations would not be charged. Once again while being an option, it may not be very necessary if welfare 'medicard' or 'stamp' mechanisms are introduced for the needy.

24. Income from fees would go to the general practitioner or his practice. There might be a case for reducing capitation fees to take account of this extra income. Alternatively it might be given as a simple boost, particularly in view of the fact that general practitioners might be asked to take on a number of procedures presently being performed by hospital out-patients departments. It is in general correct that practitioners should be paid according to the workload they handle rather than by a relatively fixed salary that bears little relation to how well or badly they perform.

25. **Extended pricing**. The pricing mechanisms so far discussed would be a first stage to begin the process of efficient allocation of health care, some of the components of which are extremely costly but not used sparingly or efficiently at present because of the complete absence of pricing and consumer choice. They reflect also that it is unreasonable to ask taxpayers to provide non-health benefits such as the 'hotel' expenses of hospital patients, especially where such patients are well-off in any case.

Thus, it is suggested that the first elements of pricing should be introduced to cover non-essential ambulance journeys, non-essential drugs, 'hotel and general' services, some GP services, and so on. Those who could not afford to pay would, in any event, be completely covered by their 'medicard' which would provide services freely for them by remitting the charges made.

Once this step is accepted, it makes sense to extend the pricing principle more deeply into medical care, and to begin charging for a number of minor medical services. Once again, the poor would be covered because of their 'medicard' facility; those who were slightly better off might pay only a small proportion of the charge; while those who were better off would be expected to pay the entire charge.

26. **Universal access to private medicine**. A very attractive

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1. The Economist, November 12, 1983, p. 23.

feature of a welfare-based 'medicard' is that it can greatly extend the access to private medicine. There is no reason why a poor person with a 'medicard' should not use it to buy medical services from private practitioners if he or she chose to do so. There would need to be only some system of recognized charges for particular services (for example, for GP visits, prescriptions, ambulance rides, etc) which the state was willing to reimburse to the private practitioner once he had accepted a 'medicard' in lieu of payment. Otherwise it would seem unobjectionable and advantageous to allow this universal access to the private market.

It may be that some 'medicard' holders would prefer to pay a little themselves towards the cost of private services if their cost was more than the state's recognized maximum. That would reduce the pressure on the NHS, and would still maintain a strong element of consumer choice.

The 'medicard' idea, under which genuinely poor people receive free health care while those who are better off pay at least some part of the cost of routine services, therefore brings a twofold benefit. It allows some basic pricing system within the NHS that is not there at present, and so improves allocative efficiency; it ensures that resources are increasingly diverted to those who genuinely need them; and it gives even the poorest people a chance to purchase services, through their 'credit card' system, from the private sector, reducing the strain on the NHS and the choice available to the public.

REFORMS OF THE FINANCIAL BASIS OF HEALTH CARE

27. The costs of the national health service are very large. In 1984 it will reach around '£17,000 million or £303 a head, and is three times higher in real terms than the cost of the service in 1949'.[1] this represents 6.2 per cent of the gross national product. Costs are driven up by increases in manpower - 'in 1951 there were an average of 348 nurses for every 1,000 available beds. By 1982 this had risen to more than 1,100'.[2] Costs also rise due to many people who are quite well-off still demanding the 'free' service; no doubt because they have to pay for it through taxation whether or not they seek treatment privately.

New ideas are needed in order to encourage better-off individuals to withdraw their demands from the state sector and allow the resources thus freed to be used on people who really need them. Tax deductions or tax rebates for health expenditure suggest themselves as two possible mechanisms.

28. The principle of **tax allowances** for private group health insurance premiums already exists, (introduced in the 1981

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1. The Times, 26 March, 1984.

2. The Times, op. cit.

budget, such that from 1982-3, tax relief applies to all those with earnings of less than £8,500 a year) and has encouraged many individuals and groups, including trade unionists (around 350,000 are estimated to be with BUPA) to take out private health insurance. Those covered privately were an estimated 4.2 million including dependents at the start of 1983. There is no reason why this (or a similar) concession should not be spread in terms of the range of incomes over which it can be claimed, and in terms of being available to individuals as well as groups. The extra incentive of the tax concession can be expected to tempt large numbers of middle-income individuals at the margin to enter private schemes and therefore remove much of their burden from the overcrowded nationalized facilities.

29. **Tax rebates.** A better proposal, in our judgement, it to encourage exit from the state system by offering a **cash rebate** to those who opted into private insurance and placed no strain on the national health service. Thus, an individual who opted for private coverage would receive an end-of-year indexed rebate of (say) £50, in recognition that he was saving the national health service from having to accept him for treatment, and as an incentive for him to leave. Each person who left the health service would then save the system a potential £150, (less when non-variable overhead costs are considered), and these resources could be used to improve treatment for the genuinely needy.

An individual who elected for private insurance would, of course, almost certainly have to pay more than £50 per year for an acceptable policy. But there are undoubtedly large numbers at the margin to whom the incentive - representing about 25%-35% of the cost of an average private policy - would be crucial, so quite a sizeable exit and potential saving can be expected.

30. Rebates would be available only for insurance covering certain **basic items** under this scheme. Principally, it would have to cover general practitioners' visits, accident and emergency treatment, and hospital accommodation. It may be desirable to have smaller rebates for those who took out only partial policies, for example, insurance schemes covering general practitioner services only (some such services, offering home visits by the same radio-linked doctor each time, are already being established).

Of course, individuals would be free to add more money from their own pockets to purchase policies that offered treatment beyond the normal range (for example, free check-ups) or accommodation that was more luxurious (home nursing, private wards, and so on). But as long as the basic requirements were covered, the rebate would be payable as a reflection that the state service was not having to take on the risk.

31. **Cost of rebates.** A universal tax rebate given to everyone with private insurance should pay for itself because of the large saving which each leaver makes possible within the national health service. However, there are already a number of

individuals already in private health schemes, and the rebate would be 'lost' on them, because they are not imposing costs on the state scheme in any case and need no inducement to leave. However, the size of this 'lost' portion is modest. A rebate of £50 over the 4.2 million people in private schemes amounts to £240 million. (If those already going private were a source of political objections to the rebate, it could be means-tested during its introductory stage.)

The rebate would encourage large numbers to go private, especially those who anticipated that they might need health care soon. If the average saving to the system were £50 per head (given that some overhead costs cannot be saved in the short term, the figure would not be the full difference between the average cost and the rebate), it would take only a 7% exodus from the state service for rebates to pay for themselves. But in reality, there are likely to be much larger numbers at the margin to whom the incentive would be convincing; so the total savings to the taxpayer could be great indeed. In our estimation, it would be realistic to predict that the rebate would recover its own costs from the third year of its operation, and would go on to take significant strain off the NHS thereafter.

Naturally, estimating the actual numbers leaving may be difficult. Those choosing to withdraw their demand from the state system could not be predicted at first. But as their numbers grew to a more established percentage, it would be easier to make rationalizations and savings within the state sector.

The boost to private health services which this would bring is considerable. Many of those presently working in the state sector would find it congenial to transfer and there would be considerable scope for private sector firms to take over complete NHS installations for their own use, further improving the revenue available to be spent on deserving cases by the state system. But the proportion of care organized privately would probably change only gradually, so that the transition should be manageable by any standards.

32. **100% rebate for the elderly.** While most individuals are acceptable risks to private insurance groups, those with chronic illnesses and those of pensionable age are either unacceptable or charged at an extremely high premium. The £50 rebate would consequently be of little use to them, although they might require the benefits of private treatment more than most.

One option for the elderly and chronically sick is for the government to cover the entire cost of private insurance premiums (or the entire cost above some small 'excess'); making it effectively free for the beneficiaries. This total subsidy would not be available for wealthier individuals among the elderly, however, and some testing would be required to decide and establish who should be eligible. If the scheme proved attractive, it would succeed in removing some of the most costly patients from the national health system's facilities. It would, at the same

time, provide genuine choice to patients and would introduce the spur of competition to producers.

Similar arrangements can be made for those welfare recipients holding the 'medicard' or the discount card. It would be easy for the state to provide aid or even completely purchase private insurance for them simply by allowing them choice of insurer and reimbursing the insurer for each risk taken on. The 'medicard'/ discount card number would provide a convenient check against fraud.

33. **Cost control**. The insurance paid for by the state under these arrangements would be limited to basic services only: the taxpayer would not be writing a blank cheque for rising costs or a superior service (though the individual might wish to add to the state subsidy in order to raise the quality). A government **loss adjustment process** could be initiated, either under a government-appointed comptroller or under contract with outside agencies.

Such a system for controlling costs - or at least for setting limits on what the state is prepared to pay for through tax rebates - could be extended to deal with the same problem whereby 'medicards' are used for or towards the cost of private health services. The setting of standard charges which the state is prepared to reimburse under the 'medicard' scheme would be one element of the government comptroller's task.

34. **Towards universal insurance**. A more radical alternative involves the reconsideration of the entire basis of private insurance. This is the idea that private insurance should be compulsory, like motor insurance, but that companies should take on every new risk unseen: that is, chronically ill patients or the elderly would be charged precisely the same premium as every other customer. Insurance companies would have to absorb the costs of their poor risks along with the income generated by the good ones. While this is a very coercive intervention in the marketplace, it may nevertheless be a useful step towards universal private insurance, since it eliminates the problem of uninsurables. The role of the government in such a world would be to underwrite the premiums of those who could not afford them, thus concentrating its resources exclusively on the genuinely needy, while allowing choice to everyone from the neediest to the richest.

35. **HMOs**. One objection to universal medical insurance is that of spiralling upward costs, since there is no pressure on doctors (and a distant incentive on patients) to ensure that treatment is done at the lowest possible cost. We have already suggested some proposals that would contain costs under private insurance systems, and we believe that these could be made very effective. However, there exists another organizational option that may well provide a long-term and powerful method of keeping down the costs of a non-nationalized system, and that is the HMO.

In the United States, health maintenance organizations provide both primary and hospital care en bloc, in return for a subscription from a company to cover the health costs of their employees and sometimes also those of their dependents.

A successful health care system must have the interests of the patient, the doctor, and the insurer all moving in the same direction at the same time. The HMO does this by making sure that it is in the interest of all three to have treatment done immediately, cheaply, and properly. The doctor, because he is sharing in the profits of the HMO, is keen to see that the expenditure is not excessive but appropriate, since otherwise the profits of the HMO will suffer. On the other hand he does not wish to do his job badly because it will be much more expensive to correct afterwards and he might even be sued. He aims to get the patient well and out of hospital at the earliest appropriate moment, in order to prevent the costs of the hospital side of the HMO from rising.

Let us compare the various systems by taking an example of an adult man, aged over 45, who goes to his doctor with a chest pain. He is pale, sweating, and clearly needs a cardiogram. In the National Health Service he might at worst be brushed off with a mild drug and asked to return if it is ineffective. Or alternatively he could be given a letter to take to the hospital which requests them to see the patient because he has chest pains. The GP will not give him a cardiogram because the vast majority of GPs do not possess them: instead, they require the patient to make a lengthy and inconvenient trip to the confusing world of an out-patients department.

Under present systems, if all GPs did buy cardiograms then in fact they would be reimbursed by the state, because the state does guarantee to reimburse the average cost of their expenses. But there is simply no incentive for GPs to make such investments, however much money they might save taxpayers and however much effort and distress they might save patients.

On the other hand in an unregulated private sector, based on insurance, there is the fear that the GP will perform a cardiogram now, check it again later, and do another one the next day and take some blood tests for good measure. So the patient has three visits to the doctor when one would have been quite sufficient. In this situation it is in the interest of the doctor that the patient is spending more and more money. Undoubtedly, it is possible to check this trend - such as by asking patients to bear a percentage of the cost of tests and so putting some disincentive on excessive insurance claims - but it is inconvenient and cumbersome.

In the case of the patient belonging to an HMO it is in the doctor's interest to perform the necessary treatment (one cardiogram) as soon as possible but without additional expense. Appropriate treatment is in the interest of both parties.

The establishment of HMOs in the United Kingdom could be a straightforward matter if it were organized initially by larger firms. The schemes could be extended to the general public through a subcription scheme. However, there is presently no basis of any arrangement of this type, and its establishment would take much effort to encourage. There may be a case for extending tax rebates to HMOs, and for allowing state reimbursement of HMO subscriptions for the less well-off population through the 'medicard' scheme.

The HMO arrangement is an attractive solution to the problem of containing medical costs while providing greater consumer choice and high standards of care. It is most likely to spring up in an atmosphere where private insurance is widespread - and therefore the principles of subscription medicine and private practitioners are common - than from the bedrock of socialized medicine. Consequently, the optimal strategy would be to encourage and help grow the existing elements of universal medical insurance, and then to let HMOs or other beneficial systems develop out of it.

4. PERSONAL SOCIAL SERVICES

THEORETICAL CONSIDERATIONS

In postwar Britain, government and local authority intervention and sponsorship has proliferated, often with adverse, expensive, and unforeseen consequences. Precise expenditure can be hard to calculate because the actual expenditure on personal social services is left to the local authorities to decide, 'taking into account their statutory obligations and local circumstances and priorities'.[1] However, the recent trend has been for an increase in real terms of over ten per cent in the last five years.

Table 4
Personal Social Services Activity Statistics: England

	1978	1982
Day nursery place	29,100	30,700
Day care places for elderly & disabled and mentally ill (including training centres)	84,800	96,600
Home helps (whole-time equivalent)	44,700	47,300
Residential Accommodation (residents)		
- Elderly and children	152,400	143,100
- Mentally ill and handicapped (incl. younger physically handicapped)	28,000	29,500
Community care services		
- Boarded out children	33,100	36,900
- Home helps (whole time equivalent)	44,700	47,300
- Social workers (whole time equiv.)	22,200	23,000
- Main meals served	41,075,000	40,290,000

[Source: Cmnd. 9143, February 1984]

There has been very little analysis by outside economists of the social services and their effectiveness. Clear views about how they should be reformed do not really exist. Therefore it is useful as a starting point to apply market perspectives to the social services.

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1. Politics Today - the Social Services, (London: CRD, 1984), p. 109.

Optimal resource use

Benefits from competition are possible if welfare and related services, where they are judged necessary, one provided through the market mechanism. Thus, instead of **providing a free service to all** regardless of their means (and therefore wasting valuable resources on those who are quite capable of obtaining the service for themselves in the marketplace), the object should be to **concentrate the provision** of the service on those who really need it, and to ensure that the service is **provided competitively.** Being concentrated in application, social services might have a much better claim to legitimacy than the undiscriminating NHS or state education. But they have tended to stifle voluntary or professional alternatives, not encourage them.

It is as George Gilder said about the American case:

> 'The rise of welfare and public-service programmes has also displaced other modes of support for the poor and dependent. Before 1935 over half of all welfare came from private charity. Now the figure is less than one per cent. Before the boom in social security, many children cared for their parents. Now there is evidence that parents are more often induced to care for their needy children on into adult life, as they bear the increasing social security tax... The defenders of the welfare state at its current level usually seem to assume that without the public systems the sick, the poor the elderly, and the young would be left to their own devices; that the welfare state has a massive effect on the condition of the needy, but little impact on their willingness and ability to fend for themselves. Much evidence, however, indicates the opposite: that the programmes have surprisingly little beneficial effect, but they do have a dramatic negative impact on motivation and self-reliance'.[1]

Market economic thinking is also uneasy with the provision of services that are apparently free at the point of consumption. Where a good or service is free of charge, so that the user does not pay extra for any increased use, demand will naturally increase, tending upwards beyond the power of suppliers to satisfy it - a familiar problem in health care. Furthermore, free provision destroys the market and gives no incentive for innovators to provide alternative services more cheaply (why, for example, should anyone want to rent a house privately when they can rent one from the state at low or zero apparent cost?). Thus, where possible, the market economist would elect to subsidize **people** rather than **services:** to ensure that everyone can afford the ordinary services provided by the market by giving those in need cash or vouchers to do so.

While this solution might work easily enough when applied to

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1. George Gilder, Wealth and Poverty (New York: Bantam Books, 1982), p. 137.

education, to welfare services generally (through, say, a negative income tax arrangement), to housing, or even to health, it is difficult to apply to social work. This is because many of the cases involved probably do not realize that they are in need of counselling or assistance. But nevertheless, many of the functions of social services departments could indeed be satisfied by some application of market mechanisms.

Public choice issues. Public choice theory suggests strongly why we should wish to move to this approach of satisfying welfare needs through the market rather than by bureaucratic provision. Simply stated: those supplying the service have a powerful interest in maintaining it and for arguing that it should be extended. Their interests do not necessarily match those of their clients nor of the taxpayers who finance them. However dedicated they might be, it would be contrary to human nature for all of them to argue for a diminution in their budgets, however clear the necessity might be to outsiders. So with any service provided in the public sector, there builds up a powerful lobby urging its extension and increase, a lobby which is supported by other providers of state services. The tendency is therefore always to spend more, and by building up administrative structures more and more, services are provided less and less efficiently.

Problem of evaluation. In the social services, these tendencies are very hard to check. Even if the public supports the provision of better services, it is not clear that increased spending will always have this effect, since such things are notoriously difficult to evaluate. Certainly, the interests of the 'new class' of service providers do not lie in organizational simplicity and efficiency: larger administrative structures mean better career prospects and an easier working life, something which it is difficult even for the most dedicated to resist. Those controlling the finance, however, are outsiders who have the incentive to look for savings and improvements in efficiency, but do not know the details of the organization. Consequently, any proposals they introduce tend to be implemented in perverse ways by the providers themselves in order to convince the public and the politicians that no further trimming is possible. Reductions in budget tend to show up in reduced services rather than in reduced bureaucracy, much to the distress of the public: but this is precisely the intention (whether conscious or not) of the service providers. The Detroit customs official who cut out drugs searches rather than administrators when his budget was trimmed - causing a fierce public outcry - is a case in point. But once an administrative structure is in place and is given monopoly power over the provision of services, it is often impossible to reorganize and improve.

Part of this difficulty is the evaluation of the 'output' of some services themselves. Where there is no clear standard against which to judge success, it becomes easily possible to spend large amounts of time, resources, and personnel producing very little, or even producing less than before. (Some schools,

for example, have introduced new methods that have actually led to a decline in examination passes, the traditional measure of success, but have attempted to withhold or reject these results, arguing that other factors are more important. That may well be true: life is not just about examinations. But it is impossible to judge whether this is the right approach unless some kind of systematic evaluation of the other factors is undertaken. Otherwise, we may simply be spending resources on the new methods to no avail.) Most social service problems are both genuine and tragic, but it does not help to throw manpower and money at them blindly. Only if we have some reason to suppose that our commitment of resources will be effective can we justify their use. But one of the most disturbing features of social work is that there is little agreement even on strategy (budget cuts have been effected in widely different ways from one authority to another), and little prospect of practical evaluation of results.

Evaluation is needed not only in terms of output, but also in terms of cost. The opportunity costs of providing a particular service might be very high, and it is only if we are sure that such a service really outweighs other needs that we can ensure that our money and other resources have been spent in the most effective way. This kind of cost-benefit analysis is not needed only within a service, but between services, since there might be other agencies that are demonstrably better at achieving the same results. Other state bodies might be more efficient; contracting with private service firms might save costs and sharpen output definitions; insurance may relieve many problems; charging may reduce marginal demand; and the ratio between administrators and groundworkers must be reviewed to keep it at the most efficient level.

The role of social workers

To some extent, social service providers themselves deny that evaluation and the assessment of priorities is possible at all. Others acknowledge the need and can point to some successes, but are more hazy when asked to pass on any practical understanding of how it is achieved, or how it can be replicated by departments elsewhere. In the first case, it is only the treatment of social service providers as a profession that gives them the stature to reject any critical appraisal of their work. This is a striking contrast to the situation thirty years ago when 'social work was not a "profession". Diverse groups of people performed "social work". They were poorly paid, mostly middle class women (save for the probation officers), and badly organized.' Today, there is 'an array of social workers, qualified and unqualified, with a powerful trade union-cum-professional body, the British Association of Social Workers (BASW), and a quango, the Central Council for Education and Training in Social Work (CCETSW)'.[1]

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1. Maurice North, 'Social Work - A Profession?', Journal of Economic Affairs, Vol. 1. No. 2 (January 1981), p. 113/114.

Professionalism is thought to be a mark of expertise with which the general public cannot argue, and in most cases, the expertise is demonstrable and the professionals' judgements about how to solve a particular problem are respected. But no such feature exists in social work, making it harder to accept them as truly 'professional' or to respect their judgements upon how public resources should be allocated.

In the second case, it is not the practitioners as such but the trainers, courses, and certificating bodies that have promoted this 'professional' insulation from public scrutiny. In this instance, it is the CCETSW which has the main task of validating courses (both in and out of universities) leading to the Certificate of Qualification in Social Work (CQSW), which it awards. But the amazing thing is that unlike the other 'professions' there is no need for a licence to practice, and no register of practitioners - in fact 'a social worker can be qualified or unqualified.'[1] This quasi-professionalism ignores the basic lack of understanding and classification surrounding social workers. Their motives can hardly be questioned, but when questioned over what their skills might be, or what they are supposed to do, a clear answer is not forthcoming. So, without a more clear understanding of methodology, this claim to professionalism seems premature.

REFORMS AND NEW METHODS

There are four main areas that the personal social services deal with: the elderly, child/juvenile care, disabled people, and the mentally ill and handicapped

Care of the elderly

A variety of services are provided by both statutory and voluntary bodies and 'may include the advice and help of social workers, domestic help, delivery of cooked meals, sitters-in, night attendants and laundry services as well as day centres, clubs and recreational workshops... Social service authorities also provide residential accommodation for the elderly and infirm'.[2]

Kent Social Services Department, in 1976, recognized they would be unable to cope with the growing needs of the elderly people within the community. Not only was the elderly population increasing, but the pattern of care needed was changing: no longer were the elderly prepared to be quietly institutionalized - a vociferous political lobby was now able to articulate their

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1. Maurice North, 'Social Work - A Profession?', JEA, Vol. 1. No. 2, (January 1981), p. 113/114.

2. Britain 1983, (London: HMSO, 1983), p. 133.

needs.

By 1971, there were five people over the age of 75 in residential care for every one person in 1951. That enormous increase was financed by a vast input of resources. Then between 1970 and 1975 the unit cost of keeping an elderly person in residential care went up by fifty per cent.

Kent realized that they could not cope with the increasing numbers and their growing costs of residential care, so they decided upon paying people to look after elderly people in their own homes rather than putting them into residential care. This very simple idea is also representative of technical innovation, and a move away from the old ways of doing things. The idea of caring for the elderly in their own homes, helping them to dress, get in and out of bed, doing the garden, and so on, is not without practical difficulty. But the reasons for it are, first of all, to reach more people (the high cost of residential care means that not all elderly people can be cared for in this way); and second, to help postpone or prevent residential care altogether.

Operation of the scheme. The helpers, who answered advertisements in the local paper, came forward spontaneously; in fact, there was an embarrassingly high number of people who wanted to help. The majority of those recruited had never been involved in any form of welfare or social care, and thus new people were brought into caring for the elderly - ranging from housewives to mini-cab drivers. The amount they were paid by the local authority was an enabling rather than an incentive payment, and because they were paid, the council was able to formalize its relationship with the helpers in a way which would have been difficult in a scheme involving volunteers. The scheme was carefully integrated with existing social services, and, to take a simple example for a person who requires little support, would run as follows. A helper would arrive in the morning to assist in the preparation of breakfast for the elderly person, and at lunch-time would provide a meal and help with household chores. Later in the afternoon a visitor from Age Concern would provide social stimulus, and in the evening the helper would return and assist the elderly person to prepare for bed. It is important to remember that all the elderly people in the scheme were those who were classified by the social services as extremely frail and highly dependent people.

Evaluation. The scheme was monitored over a period of four years by the Social Sciences Department of Kent University, which one might have thought would be unlikely to be enthusiastic. However, their report said: 'It would be no exaggeration to claim that for many of the elderly people involved, the quality of their lives has been transformed'.

The scheme was subject to a control experiment: results were compared with elderly people benefiting from this scheme and those in residential care. The cost savings ensuing were in

excess of 20%, and one argument says they may even be as high as 50%. The incidence of loneliness, anxiety, depression, and low morale were all severely reduced, and even the survival rate was much greater; people in their own homes appeared to live much longer than those in residential care.

Comments from the elderly beneficiaries themselves are the most persuasive arguments: 'Before they came ... weekends were just like a rehearsal for death.' said one, while another said, 'I am able to talk to her about my worries and she tells me about her family, and that relieves her a bit, too. Even if she stopped being in the scheme she'd probably still visit me as it's become a friendship. Sometimes it's like having a daughter - she'll ring me in the evening to see if I'm all right, but sometimes I try to beat her to it!' It is clear that there is a considerable benefit in social terms as well as cost savings from this reform.

Child/juvenile care

These services cover quite a diverse area: from the provision of day care facilities for under-fives to offering advice and assistance to 'families in difficulties' to promoting the welfare of children, to placing children 'in care'. Again, Kent County Council have led the field, improving the quality and results of juvenile care while cutting costs.

The Kent scheme for placing of delinquent juveniles with special foster families rather than in institutional care, has been practised for five years, and has been the subject of detailed analysis. The aims are firstly to improve the standard of rehabilitation, and secondly to achieve cost savings. According to a recent study on residential care for delinquent juveniles, community homes have a success rate in terms of 'breaking the careers of delinquents' (the euphemism commonly used) of only 20%. Eighty per cent leave the institution as bad as (or worse than) they ever were.

To give an example of a particular case study: a young boy named Reggie. At fourteen he was in an impossible situation. He loved his mother but was in open warfare with his stepfather. As a result, he had run away from home and had been fostered without success, and placed in a children's home. He repeatedly ran away, stole goods, vehicles, and money, for which he was finally remanded in custody. He was introduced to a family living in the country, who signed a contract for two years with the local authority. Reggie attended school regularly and kept in contact with his own family. At sixteen years (the school-leaving age), the contract was renewed for a further two years, and Reggie found a satisfying career at a later date. His stepfather had come to respect him, and the old wounds were healed. The ultimate achievement was the leaving of the foster family for independent living, a step the family's own children were taking at that time.

What is interesting about that particular case is that, while the scheme was underway, schools were asked to monitor progress, with interesting results when compared with a control situation. Academic achievement improved tremendously, the ability to mix with other children improved, and class behaviour improved. Although not every case was as successful as Reggie's, of the 156 boys and girls who were placed under the scheme, 71% reached the criterion of 'breaking their career' as delinquents, compared with 20% in residential care. The costs involved were less than half of those for residential care. In summary, this does seem to be a further example of the quality of care being enhanced while costs are reduced.

Disabled care

Local authorities have an obligation to find out the number of disabled in their area. They must also give reasonable publicity to the services they provide, which include 'advice on personal and social problems arising from disability, assistance in overcoming the effects of disability, adaptations to people's homes (such as fitting ramps, and ground floor toilets) and various aids to living. In certain circumstances a telephone or a television set may be installed'.[1] While voluntary and private assistance (especially from the family) should first be encouraged, there will probably always be a need for state assistance of one kind or another. Wherever possible this should be channelled through voluntary or private groups: the Kent model for care of the elderly seems perfectly appropriate in many of these cases.

One area, however, that does look promising is the latest development of new technology.[2] It is now possible for fire, burglar, and other emergency alarms to be channelled through telephone lines (and in the future, through TV cable lines). By introducing this technology into the homes of disabled people, they will be given the independence they want - but help will not be far away should it be needed.

The mentally ill and handicapped

Local authority social service department services include: 'training centres for the mentally ill, as well as social centres and a variety of residential care for the mentally ill and mentally handicapped of all ages'.[3] In any modern society, there is a duty to 'help those who cannot help themselves'. There is

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1. Britain 1983, (London: HMSO, 1983), p. 132/3.

2. See Omega Communications Report (London: Adam Smith Institute, 1984), Appendix III, p. 60.

3. Britain 1983, op. cit., p. 133.

also a duty to see that any help is concentrated on those who need it, and that it is not wasted on the way.

While recognizing the considerable achievements and effort that occur in both this and other parts of the personal social services, there is no reason to isolate them from economic reality. If any savings made could be retained, there would be a great opportunity to improve the quality and level of service - without any additional demands on the taxpayer.

We therefore suggest two strategies (which where possible can be applied to the whole of the personal social services) that we believe will enhance the quality and quantity of services, without the need for additional funding:

(1) wherever possible, to consider the 'Kent solution' as an alternative to placing people in homes. Not only is it more humane, but the individuals concerned appear to be happier, to perform better, and it costs less;

(2) where this is clearly not possible, e.g., in the case of severely handicapped or mentally ill people, we propose that the homes and institutions be subject to competitive operation.

It is often too easy for the authorities to use hospitalization as a means of disposing of handicapped children rather than as a genuine method of treatment; and any use of the hospital system, public or private, for this purpose is regrettable. There is certainly a need for a thorough review of the use of hospitalization on mental grounds to see whether those individuals could in fact make their way in the world without harm to themselves and others; and a systematic study of the alternatives to hospitalization such as 'Kent'-style solutions.

Education. Some studies in recent years have revealed that most mentally handicapped children can in fact acquire language, reading, writing and basic numerical skills. This may take time, and it certainly requires continuity in teaching . It therefore seems wrong to end the schooling of such individuals at their chronological age of 16 when their mental 'age' may be less and where they could benefit from additional attention.

Personal social services funding and voluntary effort

A sizeable amount of funding is being channelled on a joint-financing basis, which involves District Health Authorities being able to make grants to local authorities to assist them with their social services functions. It was only £8 million in 1976-7, when it began, but will reach around £99.5 million in 1984-5[1] - 'the DHSS under all the various schemes will give grants to the voluntary sector amounting to some £25m in 1983-

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1. Hansard, 31 January, 1984, WPQ, c. 183W.

84'.[1]

There is a case for promoting the greater use of private charities, voluntary effort, and local families. Increasing reliance on state operations of course depresses the effective role of private charitable alternatives, and so the scope for reliance upon them, in the absence of a number of state activities, is probably larger than might be expected. This use of voluntary bodies also brings in its wake the benefits of diversity of which government institutions are rarely capable. As John Stuart Mill put it,

> 'Government operations tend to be everywhere alike. With individuals and voluntary associations, on the contrary, there are varied experiments and endless diversity of experience.[2]

The role of government, therefore, should at best be to encourage and benefit from this 'endless diversity of experience' rather than attempt to undertake all the necessary social service functions itself. On the other hand, it would not be desirable to make voluntary bodies totally or even mainly dependent on state funding, because their distinctive diversity will tend then to disappear.

There are various ways in which this compromise can be achieved. We suggest that the following be considered:

(1) individuals and private firms be given tax relief on donations to charities providing personal social service functions;

(2) a minimum for the percentage of social service funding (whether it be local authority or DHA) that must go through a private concern - defined as a family, a charity, a private volunteer or a private firm running an institution. This would apply to hardly anyone at first, but could then be increased in each subsequent year.

CONCLUSION

When considering the appropriate policy towards voluntary bodies, towards personal social services, and even towards medical care itself, it is important to be aware of the easy trap in which the compassion of a nation is automatically associated with the amount of public money it is prepared to spend on the problem. Yet the amount of good that is done cannot be measured as a figure in the government's expenditure plans. Nor does it matter whether the resources are monetary or in terms of the voluntary

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1. Hansard, 14 December, 1983, c. 509.

2. John Stuart Mill, On Liberty (London: 1859).

donation of time and effort - provided that they are used efficiently.

There is more than enough evidence that the resources devoted to health and social services are in fact used very **in**efficiently. In some areas, there is not even an attempt to assess objectively what good, if any, is done; resources are used up in treating the well-off that are desperately needed for the poor; inefficient structures make care costly and often unresponsive to genuine need; political control squeezes resources into inefficient but politically-desired areas; and universal state provision crowds out alternative methods and consumer choice.

Our strategy throughout this report recognizes that the structural problems in the existing state services, including the political environment that constrains them, make them very resistant to change. There are certainly areas where greater efficiency is possible. But the key to reform must be to encourage completely new structures by enabling people to choose more freely than is possible at present, and to promote that 'endless diversity of experience' that will eventually guide us towards more effective structures of providing health and social services available to all.