MANAGING BETTER HEALTH

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INTRODUCTION

The government's review of the National Health Service is taking evidence on a variety of methods of reform. Central to any change is the need to improve the accountability of the NHS, to take up measures which give it better value for money, and to incorporate a means of allowing it to develop in response to changing demand.

The NHS seems to have slipped from the headlines, aided perhaps by the development of other news and by the pay awards to nurses and other health workers announced in April 1988. Its departure from the front pages does not mean that reforms can be forgotten. On the contrary, the case for changes to the way in which the NHS operates and the way in which it is funded remain strong. The gap between expectations and supply will open up again if nothing is changed.

In many ways the National Health Service is among the last of the giant institutions to feel the wind of modernization and reform. The changing nature of the British economy and society has recast many aspects of modern life. The nationalized industries are gone for the most part: the state utilities are being updated outwith the state sector. The pattern of housing is totally altered, and major reforms in education are at 1aSt under way.

Against this background the National Health Service has survived until now in a form not dissimilar from the shape it had at birth forty years ago. It is still characterized by central planning on the large scale, administration through a series of boards, and a delivery of service which largely separates the supply from major considerations of cost. Pressures upon the NHS forced it onto the agenda late last year: it would be a missed opportunity if the chance to implement reform were now to be passed by.

Some of the current discussions on health have stressed the need to expand the area covered by private medicine, and have pointed to the increase in that sector over the 1980s. There may indeed be a case for more private medicine, but since nine out of ten people are dependent on the state sector in health, improvements must be sought in the NHS itself.

Some of the suggestions for change in the NHS have been concerned with the way it is financed. Health vouchers, stamps and visible health taxes have been advocated. There is, however, a strong case for changing the management structure of the health service, whatever means are chosen to finance it. There is good management already within the NHS, but very little in the way of incentives acting upon that management, and too little authority placed into its hands.

An initiative to save unnecessary expenditure is rewarded all too often by a subsequent cut in the budget. In too many cases there is insufficient power to ensure that available funds are spent in the most cost effective ways.

The HMO versus the HMU

There is much that might be learned about the application of new management techniques and the development of novel systems which incorporate them. The United States has enjoyed major success with Health Maintenance Organizations, providing for total health care on the basis of an annual subscription. These HMOs arose in response to the problems of a largely private sector health care system, and no-one suggests that they could solve the different problems encountered by the British public sector system.

If HMOs cannot be transplanted unchanged onto the British scene, however, there certainly are features about them from which we can learn. The HMOs and their sister bodies, Preferred Provider Organizations (PPOs), have achieved important results in cost efficiency which could bring huge benefit to the NHS. They divide to some extent the separate functions of health supply and health management. They introduce a degree of competition in supply, and make use of choice, peer comparison and incentives to keep costs low and quality high.

The Health Management Units suggested by the Adam Smith Institute are not HMOs. They are NHS management bodies which would allow some of the merits of HMOs and PPOs to be incorporated into the health service. As proposed for Britain, they would be publicly funded, and health service patients would continue to receive their treatment free of charge.

The big difference is that with HMUs there is an internal market within the NHS, with managers exercising some choice in where to obtain health services. Hospitals and doctors receive their funds on the basis of the work purchased from them by management teams. In other words they incorporate choice, competition and incentive within a national health service.

One feature which the government's health service review will be looking for is a method of improvement which minimizes the degree of dislocation to the present system. The proposal recommended by the authors can be implemented in stages, growing naturally out of the present service. It has the advantage furthermore of being compatible with whatever method of funding is eventually chosen.

One possibility would have the District Health Authorities as the initial focus of the HMUs. If the work of the Family Practitioner Committees is merged with the districts, and regional authorities disappear, the DHAs become the new health management units. Their responsibility would be to provide full health care for patients by buying the health services of doctors and hospitals within the assigned budget. This achieves competition in supply, one of the central features sought to achieve cost effectiveness.

Even so limited a change will bring substantial benefit and set in motion pressures to restrain costs. The tendency will be for producers to specialize, each expanding the services they do best and most cost effectively. Such a system of fund allocation and management will encourage the innovations seen in the

American HMOs, with small operations taking place in doctors' surgeries and a division between intensive treatment and recuperation beds.

If competition in supply were all that was achieved, the change would be beneficial. But further steps could be taken once the new structure was functioning. At a later stage the district HMU could be split into two or more units, giving patients or their doctors a choice between management units. With funding coming from government on the basis of patient numbers, the choices made would determine where the funds went. Indeed, at an earlier stage it would be possible to allow district HMUs to purchase services from beyond their geographical boundaries.

The essential principle of managed health care is that the supply and the management are separated, and that health services are purchased from competing sources. It allows management control to replace control by producer pressure. The point about such control is that it not only restrains cost by rewarding efficient. producers, it also enables decisions to be made more rationally. The allocation of funds takes place much more by overt priority decisions than by pressure from producers for more resources.

The government's review is looking for ways to make the NHS more responsive, more able to ensure value for money, and capable of adapting to evolving priorities. Some of the changes implicit in managed care systems are already beginning to emerge within the NHS. There are trends already for better identification of costs, for more flexibility for management, for procedures which make allocation follow priorities. Managed care systems go with the grain of recent developments in the health service: they can be grafted onto the present structure without major upheaval, and without risk to the achievements of the NHS.

It will be surprising indeed if the review does not conclude that improvements can be made to the NHS within the context of managed health care.

MANAGED HEALTHCARE SYSTEMS

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A Plethora of recent papers and also press reports and television documentaries have discussed the possibilities of Health Maintenance Organizations (HMOs) as the new model for a reformed NHS. Depending on which side of the political divide the reader sits, these studies have either demonstrated that the US system of health care is in even more of a mess than ours or that the HMO is the only solution to the US problems and thus automatically will solve ours.

The truth lies somewhere between these extremes and in this paper I shall attempt to point out the salient important points about managed health care systems and, in particular, the important cost efficiency features of HMOs and Preferred Provider Organizations (PPOs), their insurance industry cousins. I shall also attempt to show that there are serious and important lessons to be learned from all the managed health care systems which are at present in use in the USA and that the criticisms which have been voiced are not all relevant to Britain or are, in some cases, accurate or fair.

How long have HMOs existed?

Although HMOs date from 1929 (Roos Loos Clinic), their significance in the US health system dates from the early 50s when socially-minded doctors set up pre-paid group practice care in an effort to deal with the rapidly rising costs of fee-for-service care. HMOs are organizations which contract with groups of employees or trade union members to provide total health care for a fixed annual prepaid premium.

Patients do not in general have to pay for their care, which is prepaid by the employer, but the patient may be asked for a copayment for certain services like prescriptions and visits to the health centre ($2 or $3 at most). Under the contract the HMO for its part guarantees to deliver good quality care and indeed all necessary care through its network of GPs and Hospitals. The HMO might employ the doctors directly at one of its wholly owned Health Centres (staff model) or contract with outside providers who work under strictly defined terms of service and costs (group and IPA models).

PPOs are similar to HMOs but have been produced by the health insurers (indemnity plans) in response to the competition provided by the HMOs. In PPOs patients have a choice of provider from a preferred list and can go to an outside provider if they are willing to top up the fee differential. HMOs have grown very rapidly in the USA and now cover approximately 30% of people.

They were in 1984 assessed by various American health experts (Paul Ellwood, President of InterStudy, an HMO think tank, Arthur D Little, and 'Business Insurance' and others) and it was thought that the 30% penetration would not be achieved before 1995. The fact that this has been achieved in half the estimated time shows their strength of popular appeal. Estimates from other experts (Group Health Journal Vol 6, No 2, P17) suggested that PPOs would have 25% and HMOs 20% by that date.

In a think tank report of January 1984, the Sanford Bernstein financial organization reported on the success of HMOs as follows: "Health Maintenance Organizations appear to be the ideal solution to the cost escalation problem facing the country. They can achieve a high degree of cost effectiveness by integrating all aspects -- primary, secondary, tertiary -- of health care delivery... The primary care physician is given incentives to provide as much of the required treatment as possible, using outside specialists [consultants not directly employed by the HMO] sparingly, treating more serious illnesses on an outpatient basis where possible, and minimizing length of stay when hospitalization is needed. The net result: patient days in hospital per 1000 members is approximately 350-450 and sometimes less compared to 700-750 under the current fee-for-service system." This puts the case most eloquently and, I hope, begins to point the direction of interest for comparisons for NHS reformers.

What are the effects of HMOs on quality and availability?

The effect of the setting up of the HMO system in the USA has been to introduce competition, not only for the individual provider but also for the delivery systems themselves. Not only do individual HMOs have to compete with each other to get employers to agree to pay for their employees' membership, but HMOs also have to compete for individual employees and their families themselves because companies offer a choice of more than one HMO for their workers.

Not only this, but employers also offer indemnity insurance plans (Blue Cross/Blue Shield) which offer health care on a fee-for-service basis and may even use PPOs, all alongside each other. Thus the patient gets a choice of system, then a choice of provider, and then a choice of doctor within the HMO or insurance plan. The providers themselves compete to contract with managed health care organizations.

All this competition means that quality rises and costs fall. Instead of having a financial incentive to involve patients in

These programmes are not only phenomenally successful for the US government in terms of cost saving and holding pricing ceilings, but are also popular with the old folk. They are bombarded by HMO marketing men with offers of free teeth, free spectacles, and other 'goodies' to encourage them to sign over their Medicare to that particular HMO. On top of this, the HMOs themselves are making a great deal of money out of what they perceive are more generous government

payments for the elderly than the rates obtainable in the competitive market for employers groups of patients.

How are these efficiencies achieved?

The two most important management tools in all managed health care systems are utilization control/review and peer audit with quality control systems. Utilization control, which is critical to all types of HMO, PPO and EPO (exclusive provider organizations which are even more controlled than PPOs), is a system whereby the work of individual doctors has to conform to laid down norms of protocols.

This means that a hierarchical system of doctors observes whether the methods of treatment are both efficacious and efficient and prevent waste. For instance, if a surgeon decides to admit a patient for surgery on varicose veins, he must conform to a laid down protocol which ascertains that the surgery is both necessary and safe. A Medical Director then arranges for swift admission to hospital if he is satisfied that the surgeon has adhered to the protocol (which has been designed by his peers rather than by the HMO management). This means that there are no unnecessary waits for surgery (very small waiting lists).

Most HMOs are managed by skilled managers who have post-graduate management degrees and who manage in tandem with members of the medical profession. There is often a matrix system of management under which a managing doctor (or area chief), who is in charge of all the medical team in anyone specialty, shares the clinical responsibility with a local Chief of Service who is in charge of doctors at anyone site.

This means that there are two different doctors observing the work of their peers, and who are available at all times for consultation over problems. This is then true of utilization control, where these managing doctors can see that the others are observing the protocols which have been peer designed to avoid accusations of clinical interference by lay management just to squeeze costs.

The guidelines within which HMO and PPO doctors must work are rather narrower than those prevalent in the NHS. In addition to the utilization control procedures, the doctors must also work under conditions of medical audit and peer review. Generally it is considered to be good practice within the caring professions worldwide that they undergo peer audit.

However, nowhere is this system as well developed as in the managed care systems in the USA. Committees of doctors review the work of their peers to ensure that the medicine practiced is up to scratch and that, in particular, financial incentives are not causing medical shortcuts. At the same time, there are also checks to make sure that unnecessary treatments are not being undertaken.

These types of peer review are not just an efficiency measure but form part of the formal review procedure for HMOs to get their federal qualification licenses. The

results of the formal reviews have to be forwarded to the Office of Health Maintenance Organizations (OHMO) as part of the rules governing federal regulation. OHMO is extremely strict and has been known to withdraw federal qualification when standards have repeatedly dropped below acceptable standards.

What other methods of cost control do managed systems have?

Since January 1985, when 'Marketpu1se and Hospitals' surveyed the Fortune 500 companies in the USA on their cost containment strategies, there has been an continuous increase in the use of cost containment methods by these companies in order to control the ever-burgeoning hea1~h care bill. Over 85% now encourage day-case surgery and 80% use pre-admission pathology testing, where patients are not admitted until after their pathology tests have shown that they are fit for operation and require appropriate surgery in the first place. This latter may seem obvious but both in the NHS and private sector in Britain, patients are still admitted without tests, only to be sent home one or two days later.

Other methods include second opinions from independent consultant surgeons about the need for surgery, cost sharing and co-payment from the patients and concurrent review, where the HMO makes sure that treatment which is going on in hospital is both necessary and being expedited at a sensible rate.

One of the most important factors in the reduction in hospitalization rates mentioned earlier is the use of utilization discharge nurses. Each HMO employs skilled nurses to be present on the wards of hospitals where patients belonging to the HMO are being treated.

Their job is to make sure that the hospital provider, which may be totally separate from the HMO and often contracted on a bed-day basis, is not prolonging the stay by slowing the rate of investigation. The nurse monitors the progress of the patient and makes sure that all investigations and treatment are expedited as quickly as possible. He or she also prepares for the patient's discharge by arranging the necessary help at the patient's home and avoiding the need for prolonged admission purely for socially convenient reasons.

Managed health systems also use beds in hospitals which are graded for cost and dependency. Patients only stay in any level as long as is required. It is the job of the utilization control staff under the direct supervision of the medical director to transfer the patient from intensive care unit to high dependency unit to general acute ward and eventually, if appropriate, to sub-acute nursing facility (Snif) to finish their recovery.

The latter grade of ward is often in a different hospital and, on the negative side it is sometimes thought unfortunate that many elderly social problem patients end their days in a Snif. For this reason they are often called "Snufs" in the vernacular.

The Fortune 500 survey showed that impressive reductions in hospitalization rates could be obtained by using utilization control, pre-admission and concurrent reviews. MCA Inc. showed that when they introduced these programmes, employee admissions dropped 40% and hospital bed days fell 21% to 493 per 1000 population. These need to be compared to 1400 in fee-for-service medicine and 875 in the NHS in Britain in 1986.

What then are the lessons for the British NHS in 1988?

Very few informed and sensible observers have suggested that the HMO or its cousins should be translocated across the Atlantic and set up in their present forms as an alternative to the NHS. Many of the individual management methods and systems, however, need to be tried as they would genuinely solve some of our present problems.

Both the Government and NHS managers have been examining and have expressed attraction to an 'internal market'. This was first suggested by Professor Alain Enthoven after his visit to Oxford in 1984/5 following which he wrote his pamphlet, *Reflections on the management of the National Health Service*. The competition described above, between different providers at both hospital and doctor level would be one way of introducing just such an internal market.

A new management structure would be required but this could be instituted using one of the structures suggested already by various experts. The Adam Smith Institute has suggested the Health Management Unit in two studies by Drs Pirie and Butler entitled *The Health of Nations* and *Health Management Units* (Adam Smith Institute, London). This author has also described the Managed Health Care Organization (MHCO) in a pamphlet co-authored by David Willetts entitled *Managed Health Care: a new system for a better health service* (Centre for Policy Studies, London).

In both of these structures, an informed management would buy in hospital services and also contract with doctors in the same way as HMOs and PPOs do now. Competition between providers would make services more cost efficient and consumers in a new internal type of National Health Service market would have choices which they legally have now but which are not to any real extent present.

Systems of utilization and peer review would become the norm as they are in other countries now. Indeed the Royal Colleges of Surgery, Physicians, and Obstetricians and Gynaecologists are even now beginning to talk about peer review as a bargaining counter to the Government to try to persuade them to inject more money into the NHS. Situations in the NHS now, where a particular consultant may have decided to discharge the patient but is thwarted because there is insufficient social support for the patient, would not be tenable using HMO management methods.

Similarly the recent CEPODs enquiry into surgical deaths would not have

highlighted such appalling statistics (eg only 27% of general surgeons attending local mortality/morbidity meetings or where as many of 20.5% of anaesthetists failed to visit their patient pre-operatively to examine them) if peer review on a formal basis were the norm.

The idea of accepting protocols before carrying out surgery or accepting criticism from peers may seem like anathema to some doctors now, but our American colleagues not only accept these systems as everyday life, but also respect and enjoy higher standards because of them.

Similarly GPs in Britain would become true independent contractors rather than the self-employed 'government employees' which they are now. They would have to work to an enforced contract (which might be a shock to many) but which would reward them well for efficiency and high standards. The incentives in managed care for primary care doctors are enormous.

In June 1984 Professor Alain Enthoven wrote an editorial in the New England Journal in which he said "... thus, the idea of a national strategy for control of health-care costs based on competing medical care organizations, each employing or contracting with a limited panel of providers, has considerably more plausibility than it did seven years ago or even when Ellwood et al [Health Maintenance Strategy Med. Care 1971: 29:250-6] first proposed it in 1970."

I believe that this statement has started to come true for Britain also, and that we must urgently try to show doctors, politicians and economists alike that combination of free market competition coupled with strong managed health care systems is the only way for a reformed National Health Service to deliver good quality health care for all, free at the point of delivery.

THE HMU FRAMEWORK

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One of the central requirements of innovative thinking is that one should not only come up with the right answers, but that one should start with the right questions.

When our attention turned to the finance and organization of the Health Service we noted that everybody was asking what was wrong with the NHS. So we thought we would start by asking what is right with it. In finding out the things that are most valuable . and worth preserving, one might be pointed in the direction of the most efficient method of improvement.

The strengths of the NHS

We took as a central feature of the NHS, the security which it has brought. Since the National Health Service was introduced, people in Britain now have the assurance that they will receive health care no matter how sick they are and no matter how poor they are. This is a fundamental achievement of the National Health Service that is not to be dismissed lightly. Any proposal for change which puts it at risk is probably not going to succeed. This perception is spread so widely in Britain that it would be politically damaging to put it at risk. Any reform must preserve that basic security for all which has been characteristic of the system thus far.

Another of the central virtues of the National Health Service is an astonishingly good record of primary health care. Internationally there is general admiration for the system and for the quality with which primary health care is delivered in Britain.

Thirdly, within the National Health Service, there is some extremely good and talented management. Any reforms should preserve that management and seek to provide it with better opportunities and the capacity for self-improvement.

Fourthly, the present system is not all that expensive. Critics of the NHS point to the low proportion of gross domestic product which is spent in this country. Meanwhile, politicians overseas look with envy on that low figure as a major achievement, and may wish they could move theirs in the same direction. While one could say that not enough is spent on health as a proportion of the national wealth, one could also say that the present system at least contains costs, and any change to the system should not put at risk that capacity to restrain costs.

Opportunities for improvement

There are areas in which the NHS could use improvement. The first is responsiveness. The capacity of the NHS to respond to the needs and activities of those within it, both the professionals who administer and provide the supply, and the patient, is not large. The NHS does not have the type of organizational system which makes it very responsive: it is relatively slow and inert. Its capacity for estimating the needs and the wishes of those involved as producers or consumers could be improved. As part of this there could be much more scope for incentives to efficiency within the National Health Service. This means rewarding the efficient and giving them some tangible benefit to encourage them to do better.

Broadly speaking, the proposed reforms of the National Health Service come into two categories. One is to change the method by which health is funded. After all, the NHS gains 85% of its budget from tax sources.-Critics have proposed devices such as health stamps, health vouchers, a health tax, and even national lotteries. The other main category of reform is the method by which the NHS is organized and administered, and that is to a great extent where the Adam Smith Institute turned its attention.

Given that there are two types of reform, there are obviously four combinations. One could either reform both the finance and the organization, or neither: or one could reform the one and not the other, or the other and not the one.

The education parallel

There is a very strong parallel with what was done in education. Education is also dominated by public supply: 90% depend on the state service and none other. It is also funded from taxation. It is also free at the point of supply. It also lacked incentives to efficiency and responsiveness to the demands of both consumers and producers.

Nevertheless, although for many years a voucher system in education was widely canvassed by those on the free-market right, the reform eventually adopted was not a voucher system, but an internal market which has many of the characteristics of the voucher system. The fundamental features of the Baker Bill are that schools acquire much more local independence under head teachers and parent dominated boards. Parents are given much more choice between them, and the schools, by opting out, can make the funding which the state provides follow those choices. It has the characteristics of a market without there being any physical pieces of paper called vouchers. Resources are redirected as a result of the choices made by consumers.

The Adam Smith Institute put forward a health proposal early in December 1987 based on these education reforms, and called the HMU, or Health Management Unit proposal. It called for separation between the management of the funds and

the supply of health services, and for a creative tension between them. It has been taken up subsequently by others under different names, but the central core of it remains the attempt to have the money follow choices made in a framework of competition.

Under it the National Health Service remains tax funded and remains free at the point of consumption: but the route by which the money reaches its destination is changed. The proposal calls for the replacement of the present three-part structure of regional health authorities, district health authorities, and family practitioner committees. The functions of those are taken by new free-standing management bodies called Health Management Units. The state funds are routed through those bodies. They spend the funds to provide the services of family practitioners at the bottom, consultants and hospital services at the top. The aim is to introduce choice, competition, and incentives at every stage of health care.

The system in practice

It is instructive to run through such a system at work and look at the choices made. The patients, of course, remain with their general practitioner if they wish, and have a choice of GP as at present. The general practitioners have to register with one of these management HMUs but have a choice between them, and can change at periodic times if they are dissatisfied with their current one. The Health Management Unit pays the doctors, and has a choice of hospital suppliers. It can choose which sources of treatment to obtain for the patients registered with it. Finally, the hospitals have much greater independence and control of their own operations because they are, in effect, selling their services to free-standing management units.

The funding follows the results of choice. The budget assigned to each Health Management Unit on behalf of a patient changes if the patient moves to a different HMU: while the funds going into hospital treatment move according to the choices made by the HMUs. So the basic principles of the education reform are already present: the funding follows the child in education, the funding follows the patient in health.

Consider the point of view of the participants in this process. There need be very little change for the patient. The patient continues to see his or her GP as be fore, receives treatment as before, which is free as before. People continue to receive the services of consultants and hospitals as required, and it remains free as at present at the point of consumption. From the point of view of the patient, this is not a major and dramatic overhaul of the National Health Service. It is still there, still tax-funded, still providing care regardless of an individual's wealth or poverty.

It is from the point of view of the professionals, particularly the managers, that most of the changes present themselves. The funding is made by an Annual Health Allocation on behalf of each patient. The NHS costs roughly £360 per patient per year, so an annual allocation on behalf of each patient goes to the

Health Management Unit which that patient is registered with. Perhaps the doctors should make the initial choice: that is, the GPs should select the HMU and take their patients with them. The patient retains an override choice, since by changing doctors he or she can effectively change the HMU.

The Annual Health Allocation would not be the same for every patient. There is no reason why it should be, and every reason why it should not be. It obviously costs more to treat old people than it does younger people, so the Annual Health Allocation can be varied by category, particularly by age. It can be varied by geography. If it costs more to treat patients in some parts of the country than in others, this can be reflected in the AHA.

Such weighting is routine in education, where it is just assumed that a child of eighteen costs more to teach than a child of seven, and that a child in an inner city with more language problems costs more to teach than a child in a rural area.

There is change from the point of view of the general practitioners. They would have to register with a Health management Unit, which would then become the source of their remuneration. They would be paid by the HMU. This could be organized on the basis of work done, with an agreed schedule for particular courses of treatment and with additional payments for preventive treatment.

The managers would initially be drawn largely from the existing management, mostly from the district level. The envisaged size of an HMU might work out at about three per district. The smallest might be one-third of the size of the largest, but in overall averages there could be about six hundred HMUs, each with forty GPs registered, caring for anything from 50,000-120,000 patients. Although the regions and the district authorities disappear, there is plenty of scope for skilled and talented management to constitute these new bodies.

The hospitals form the most controversial element of this because they become effectively independent, either singly or in groups, and sell their services to Health Management Units. This means that they must know the full cost of everything they do, including capital and overheads, and that health managers will shop around between hospitals to find the most cost-effective sources of supply. If one hospital charges twice as much for an X-ray as another one down the road, it is to be expected, other things being equal, that health managers would prefer the less costly sources of X-ray procedures, and that the first hospital would then tend to concentrate on and expand the X-rays which it was doing so cost-effectively.

From the point of view of government the change expected would be greater output of services for the same budget. Taxpayers' money would be spent more cost-effectively.

The Annual Health Allocation would have to be determined annually, and there would be pressures as society grew wealthier and as medical technology made new treatments possible, for the annual health allocation to be increased and to

include more treatments. As the UK grows wealthier it is only natural that people should want to spend more on health: and with an ageing population it is perhaps only reasonable that more funds should be made available. While there would be pressures for more funds, they would be controllable pressures, and they would emerge at a distinct point in the system: the annual review of the Health Allocation would be the point at which these decisions are made.

Technical issues

The great advantage of moving to this HMU system is that it can be done in stages, and that each of the elements which go to produce it are beneficial. It is obviously a good thing that hospital managers should know the cost of all of the services they are providing. It is obviously a good thing that we should be able to make comparisons, both within districts and across district boundaries.

It is quite possible that the move to a system operating under these principles might start with the existing districts as its basic units. With the abolition of the regional authority and the merging of the FPC functions into the districts, the latter would already resemble HMUs. By purchasing health services they would act like them. The similarity would be extended if they were able to employ the services of doctors and hospitals beyond their own boundaries. In this way progress could be made towards the full proposal. But the proposal is only a framework, and there are still many areas where the fine print must be filled in.

Selection

For example there is the problem of selection. What would prevent a Health Management Unit trying to concentrate on patients who were relatively inexpensive to treat, recruiting as many as possible, and then using its health funding free from the burden of high-cost patients? The answer might be to prevent any kind of selection, and to require HMUs to take patients as they applied. If there were to be a limit in terms of total numbers, they would have to establish a waiting list, and patients would be admitted in order of application.

Core curriculum

The priorities under such a system might be spelled out. It is a corollary of the government's education reform that there will be a core curriculum. If public funds are spent by quasi-independent bodies, which is what will happen under the education reforms, then government will want to ensure that the public and the taxpayer receive a minimum standard of service. This involves the equivalent of a core curriculum in health: the publication of a scale of treatment which every patient has a right to expect, and the maximum waiting times which are permissible. There are many advantages in publishing such a list, although it would need constant revision as new techniques became available.

In the first category would obviously come those conditions which are life-threatening or contagious. Fairly low down the scale are conditions which might improve life for the patient, but which have no life-threatening consequences. Finally, at the very bottom come things which perhaps might not be treated at all under the Health Service, like hair transplants perhaps, or sex change operations, which are largely a matter of consumer preference and do not really have a very large claim on the priorities of a state-funded system.

Other services

There are questions to be asked about how research and training would be funded under contract, and provisions would have to be set out. Accident and emergency treatment at hospitals would have to be arranged, particularly in view of the fact that there are a number of patients not registered with GPs whose contact with the Health Service is when they appear at accident and emergency.

Insurance

The system might be compatible with top-up insurance. Those suffering from a condition which is of low priority because people whose lives are at risk come ahead in the queue for treatment, might take top-up private insurance to secure private treatment. This would represent extra funds coming into health without distorting the major and more serious priorities.

The future

This type of system restructures management, sets incentives to work, allows choices, and has resources following those choices. It results in a closer mix of public and private provision. After all, when hospitals are independent, selling their services, how do state hospitals differ from private hospitals? They do, but less so than at present. How do these Health Management Units differ from private-sector managers? They do, but less so than at present. In other words, the boundaries between public and private would become blurred. Further down the road new possibilities would emerge, including a move to allow people to opt out of the state provision on the model of the state earnings related pension scheme. The Health Management Unit idea is a very serious contender for the type of change that is needed. It does not involve adverse political consequences, and it protects most of the achievements that are the greatest value of the NHS. The first steps on the road may start soon. In the future they may lead to a continued Health Service, funded out of taxation, free at point of supply, and one which will genuinely be the envy of mankind.