

THE HEALTH ALTERNATIVES

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London
1988

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First published in the UK in 1988 by ASI (Research) Ltd.
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ISBN 1-870109-23-6

Printed in Great Britain by Imediacopy Limited, London SW1

1. THE FINANCIAL OPTIONS

The National Health Service has, in its fortieth, year, attracted a good deal of attention. The way in which it provides services and the way in which it funds them have both come under scrutiny. The initial complaint from within the system was of inadequate funding levels. It may have been the intention of those who drew attention to gaps in NHS provision to create a climate conducive to larger appropriations. In fact the result has been to launch a much broader examination of the entire service.

The National Health Service is very large indeed for one entity. It employs nearly one million persons and with funding levels which approach £22 billion per year, must rank among the major consumers of national resources. Analysts have rightly pointed to the unlimited requirements which are made of it. The National Health Service is expected to provide treatment for any citizen who comes before it, and for any illness.

As life expectancy lengthens and medical technology advances, one problem for the NHS has been that of rising expectations combined with rising costs. More people survive longer and expect the more costly treatments available. Without infinite resources, the NHS has to ration, as all health services do. Some have controlled demand by price, the NHS has chosen to do it by queuing. Waiting lists have emerged as the means of allocating fixed resources to an escalating demand. Given a limited supply, some must wait.

Critics of the current funding levels have acted as though extra resources would solve the inherent problem. In fact when funding has been increased the demand has risen to outstrip them. Special allocations to cut waiting lists have succeeded in the short term until General Practitioners responded to shorter waiting lists by referring more patients.

Broadly speaking the analysis of the NHS has been divided over two areas, critics have suggested changes to the way in which the NHS is funded, or to the way in which it is structured. Reforms have been put forward to change either its financial basis or its system of organization.

THE AIMS OF REFORM

On the financial side, several targets have been set out as the goals to be sought by reform. It has been taken as one of the prime objectives to link demand to cost. The aim has been, in other words, to make those who demand health services aware of the additional costs of meeting the extra demand.

The present system is criticized precisely because there is no such link. The consumers demand more and better health services without any awareness of what it will cost them as taxpayers. The health producers refer patients for exotic treatment without any awareness of the cost effectiveness of what they are

advocating, or of what other treatments must be foregone if the resources for them are pre-empted.

Changes to the system of NHS finance might limit expectations by allowing people to see the costs incurred by their actions. If it were known what people would have to pay in taxation if certain treatments were made available, people might limit the demands on the system.

It is often taken as an aim of reform that it should make overt the kind of priority decisions which are unconsciously made as a result of their actions. In choosing to provide some operations, for example, the funds are used up which might have paid for others. Under the NHS as presently constituted, the decisions are not made to reflect rational choices in the light of full knowledge, but appear instead of the unintended consequences of other actions. Changing to a system which allowed choices such as this to come into the open would achieve another objective.

Many of those proposing change take it as axiomatic that greater funding is needed, and that a system which brought more money into health spending would be preferable. This is not a universal view. There are those who regard the NHS as good value for money, and who see the present ability to constrain costs from the centre as one of its great virtues. A change which would make it easier to bring extra funds into health would be widely welcomed within the profession however.

Public opinion is ambiguous. A poll conducted by the Institute of Economic Affairs showed public support for increased taxation and increased NHS funding. Further examination in detail caused the IEA to conclude that people only supported extra taxation if they thought that others would pay it. When it emerged that they would have to pay extra themselves, the enthusiasm of the respondents quickly diminished.

One possible aim which achieves extra spending without forcing up taxes is that which seeks to encourage additional private spending on health. The low British expenditure in terms of GDP per head (about 6%) is often compared unfavourably with spending levels in other European countries. In fact a good part of the difference derives from the higher private spending achieved outside Britain. If private health expenditure in Britain could be boosted to the levels of other advanced economies, spending could go up without taxes having to be raised. Thus a further aim of reform might be to promote greater private money going towards health.

Yet another aim of changing the financial structure might be to allow more variation of spending pattern to suit a corresponding variety in the level of value people put upon it. Given such a choice, some people might opt for a basic level of service which satisfied health needs. Others might choose a greater degree of comfort, including better appointed wards or greater privacy, and might wish to include less essential services in their package of health care. A system which allowed people to give effect to that kind of preference would certainly be more

flexible, and would enable greater numbers to obtain the level of service they thought appropriate.

Changes to the finance of the NHS might facilitate opting out of it. It would be difficult under the present configuration of the system to allow people to choose private provision and finance it independently of the state. Reforms which made the contribution they made to the NHS more visible could make it easier to allow part of it to be remitted if people wished to opt out. It could be an aim of reform to encourage those capable of making their own provision to contract out of the state health service.

Finally, it can be taken as an aim of reforming NHS finance to achieve a system which does not generate an atmosphere of crisis and clamour. If a smooth running system can be achieved in which suitable funding levels can be attained, this would be regarded by many as preferable to one in which participants had to compete for attention and could only secure additional funds by making a nuisance of themselves. In other words, it might be an aim of any reform to de politicize the system of financing health care.

2. TAXATION ALTERNATIVES

Several different ways of organizing the finance of health care have been put forward. The present system can be described as one of centralized non-specific public funding. People contribute to the costs of the NHS in three ways. Part of their National Insurance payment goes to the health service. Some payment is made via charges for NHS services, and some revenue from general taxation is allocated to the NHS.

The National Insurance element accounts for about 13% of spending on health and is comparatively regressive. Above the lower limit of £41 per week, National Insurance is paid on all earnings up to £295 per week. NI is not charged on income above that level, or on investment income. The element from charges which have to be paid on such things as dental work and prescriptions is in theory very regressive, in that the charges are fixed. In practice only about one third of the population pay them. Low income groups are exempted, leaving the better off to pay comparatively more. In any event, they raise only a small traction of NHS resources.

By far the greater part of NHS finance is from general taxation, most of which derives from Income Tax and Value Added Tax. Taxes on income are progressive, taxes on spending regressive. A result of this mixture is that no one has an real idea of how much they are paying toward the NHS. Very few people know if the amount they pay annually is sufficient to cover their own health costs, or if they are supported by the contributions of other. Very few know either the degree of progressivity in revenues which go to the health service.

The IEA survey implied that most people suppose that "the rich" pay for health services. This is not the case. Most taxation is paid by people near the level of average incomes. Since the NHS funds do contain regressive elements the majority of people probably contribute the bulk of its funds.

Several alternatives to centralized, non-specific public funding have been advocated, and some have been submitted as proposals to the government's review. Broadly speaking the new proposals for the finance of the NHS come under the headings of a hypothecated health tax, user charges, a repayment mechanism, tax relief for private insurance, compulsory private insurance, health vouchers and credits. Parallel proposals accompany some of them to permit people to opt out of the public system and use at least part of their contribution to it on alternative private health services.

HYPOTHECATED HEALTH TAX

In essence a hypothecated health tax is a separate tax earmarked for public health expenditure and clearly identified as such. In such a system there would be general taxes to finance government spending on all other items, and a health tax to finance only the health service.

Different ways have been proposed to arrive at a specific health tax. The most straightforward is that a part of income tax should be separated off and assigned to be a health tax. Present levels of spending would involve somewhat more than half of all income tax going to constitute the health tax. This is suggested by John Redwood, among others. He points out in the CPS booklet *In Sickness and in Health* that such a tax would be progressive and related to income. Presumably the Health Tax would be subject to the same allowances and levels as ordinary income tax, and would be levied at two rates.

Others, notably Leon Brittan, have opted for a Health Tax which is to be reconstituted out of National Insurance Charges. Under this version National Insurance payments are to be wholly made over to health care, with the Social Security funding going over to general income tax. In this way NI becomes the new Health Tax. The proposal would require NI payments from employees to be raised to provide current funding levels, but would offset such increases by corresponding reductions in Income Tax.

The tax is more regressive in this version, unless the basis of NI payment is simultaneously changed. This is not necessarily a drawback, since there are some who would advocate that a highly progressive Health Tax will lead to a general belief that it is paid for by "the rich," weakening the link between demand and cost.

Another version of a Hypothecated Health Tax might finance the health care of children and the elderly from general taxation, using the hypothecated tax to fund health care provision for all those of working age. In this version also the NI contributions would have to be increased to provide the necessary revenue.

All versions of the Hypothecated Health Tax are designed to make health spending highly visible to those who pay for it. The idea is that those who might demand more and better health services will see straight away the effect upon their own payments, and will be able to make a rational preference. Professional pressure to increase health spending would then come up against the desire of taxpayers to minimize the burdens which fall on them.

Hypothecated taxes undoubtedly achieve the "transparency" sought for the relationship between services and costs. The findings of Public Choice theory suggest, however, that this transparency might not be completely effective in curbing demand. The theory posits that the recipients of a large benefit will campaign more vigorously for it than with the larger numbers who suffer a small cost are prepared to campaign against it. The large benefit to the few which is

implicit in much of health care has greater weight than the small cost to the many.

A Hypothecated Health Tax requires the supposition that health is uniquely different from other goods and services, or it could be used to demand the hypothecation of other items. It could be argued by some that education is no less important, and should also have payment for it hypothecated. There have already been a few cases in which individuals have tried to withhold tax payment for that part of the budget which goes toward defence. Pacifist opinion has sometimes sought to avoid association with defence spending; a Hypothecated Health Tax would provide an important precedent toward their case.

It remains perfectly possible to avoid the thin-end-of-the-wedge argument by insisting that health care is *sui generis*. It could be pointed out, though, that any version which makes the whole of National Insurance into a Health Tax gains greater transparency for health by losing it for social security. This objection is by no means fatal. Proponents of hypothecation for health can still argue that the social security element is not very visible in fact, and that few of those who pay it readily connect increased benefits with the higher payments required. The connection may exist more in the folk] are of civil servants than in the minds of those who pay it.

CONTRACTING OUT OF A HEALTH TAX

Hypothecated Health Taxes are not only urged for the visibility which they bring. Central to the notion is the idea of opting out of at least part of the assigned tax by those who prefer to make independent arrangements. The model often chosen is that of the State Earnings Related Pension Scheme (SERPS). Those who enroll in pension schemes no less generous than the state's provision are permitted to opt out of the state scheme. They receive a tax concession for doing so, set at a level which makes it attractive for many workers to leave the state scheme. The younger the worker, the greater the benefits of leaving.

Parallel to the proposal for a Hypothecated Health Tax is the idea that those who seek alternative provision will be excused some part of the payment toward the state health service. It will only be possible to remit a part of the state health payment. The Hypothecated Health Tax has two components; that part which pays for health facilities and services which the payer might use, and that part which provides them for non contributors such as those on low incomes or children.

While it may be possible to exempt the taxpayer from paying for facilities he or she does not use, there is still the fraction which pays for the health care of others. In practice the higher income groups tend to make less use of health services, and it is quite possible that the amount designated for their own care could be a small part of their payment. This might make the rebate available to them very small, a figure of £50 has been one suggestion, out of the average of

about £400 per head spent on the NHS.

Proponents of opting out will respond, correctly, that there are those for whom private health is only marginally too expensive. A modest rebate might tip a number of them over to become consumers of private health.

There are attractions to opting out, not least that it allows for gradual growth of the private sector as more and more feel able to make the jump. It should be borne in mind, however, that those most likely to opt out are probably those less likely to use NHS services. The departure of quite large numbers might have to take place before a significant impact was made on the supply of state health.

A system which permitted people to opt out of part of a Health Tax would have to check that the private alternatives offered a service deemed to be acceptably adequate. State regulation might be necessary to ensure that those enrolled in private health were not left without provision if their insurance company defaulted. These present no great obstacles. There are models already in other industries such as pensions and travel agents which could readily be adapted to the health field.

One argument always comes forward in response to any kind of opting out system, it concerns the so-called "deadweight" effect. Since there are already about 10% in private medicine, any reward or encouragement to tempt people into that sector could involve making payments to those already there. This means expenditure of public funds without buying additional health care. Moreover, it could well mean using scarce health resources to make payments to the better off those able to afford private medicine.

The effect is described as "deadweight" because incentives have to be given to those already in private medicine as well as those to be encouraged to go there. While those newly entering private care do take some demand pressure from the NHS, those already in private care cause no additional drop in demand. In practice, the payment to those already in private schemes could cost several hundred million pounds before any new people left the NHS.

This objection can be countered. It could be pointed out that any change to the encouragement of private supply will always involve a deadweight. Mortgage interest relief on private house purchase might never have been given if this argument had triumphed. Those already in the private housing market would have been difficult to separate from those to be encouraged to join it. Inevitably, funds had to be directed to existing home owners as well as new ones. Remortgaging provided ready access to the tax relief by those already embarked on private purchase.

Yet mortgage interest relief has helped Britain to an all time record of home ownership, with nearly two out of three homes in private hands. Similar success might be hoped for in health care once the deadweight costs have been absorbed. The argument about could, if it were to dominate, exclude the possibility of changing from a bad system to a better one.

Even so, with pressure on health finances as it is, the argument could well lead government to seek an opting out solution which offered its benefit to the groups it wished to encourage most. In other words, a finely targeted version might be sought.

While it may be desirable in the long term to switch over to a system in which people are encouraged to make their own provision and in which the state's role is more one of looking after those who cannot do so, the rate of exit is an important factor. There is a limit to the speed with which the private medical sector can expand to accommodate new demand.

About 10% are in private medicine. If that figure were to double it would mean many more hospitals, many more private doctors and nurses, and much more equipment. Even if this could be achieved within a short time frame, this would still leave 80% dependent on state medicine. The rate at which new facilities and staff can be provided is a factor in the expansion of private medicine.

One way of handling this factor would be to phase in the opting out incentives over a period of time which allowed facilities to develop. The rate of exit from the public sector could be limited by gradually increasing the incentive level, the proportion of a health tax which leavers were excused from paying could be varied to control the rate of departure to the private sector.

There are concerns over the impact on NHS funding of opting out schemes, not least because of a "stickiness" in cost reduction as demand falls. More resources are sought as demand increases, but few are released when it diminishes. The NHS might find itself hard pressed to make any reductions in budget requirement despite the exit of sizeable numbers. The tendency of low users to exit first and the deadweight problem both reinforce the downward "stickiness" of cost saving.

These worries might be assuaged by a policy which limited the remission of the health tax to the saving made possible to the NHS by the exit of each person. This would satisfy the concerns over the NHS budget, but would limit even further the value of any health tax concessions, and perhaps put at risk their value in encouraging people to seek private provision. This does not imply that hypothecated taxes and opting out systems cannot be successfully introduced, only that provisions to deal with these points might have to be incorporated. A SERPS type of solution remains the most attractive in many ways, since it preserves the NHS for those who need it, while giving maximum opportunity for those who prefer to make their own provision.

3. CHARGES AND REPAYMENT MECHANISMS

CHARGES

One group of proposals for changing the way of financing the NHS calls for the extension of charges throughout the system. Charges have existed within the health service from the beginning, though their impact has changed from time to time.

The NHS at present features charges on selective items, with reductions or exemptions designed to benefit lower income groups. There is no payment required from the patient for consultations or treatment with the general practitioner. Similarly no payment is required for NHS hospital services or for the work of its consultants and specialists. No charges are made for diagnosis or for preventative medicine.

There are charges for some aspects of dental work, for doctor's prescriptions and for spectacles. Recent proposals have extended them to include dental check-ups and eye tests. Dependent or vulnerable groups are excluded from most NHS charges. Unemployed persons, those on social security or old age pensions and others are exempted from charges. This has meant that increases in the level of charges have had less impact on lower income groups. The prescription charges, for example, are paid by less than one in three.

Proposals for extending charges within the NHS have been put forward to act as an inhibitor on demand, especially on such as can be termed frivolous or trivial. They have also been advocated as a source of revenue and a means of bringing more money into total health spending.

A proportion of the time of general practitioners is taken up by those simply using the service without thought because it is free to the user. It is alleged that people see their doctor to obtain support for unnecessary absence from work, or to take up time on conditions which could be dealt with by themselves, such as by taking aspirin for minor headaches.

Proponents of charges claim that a statutory charge for visiting the doctor, even of only a few pounds, would deter these trivial demands and relax the pressure on limited resources. This may well be true, but it does raise questions of just how trivial a complaint has to be, or how many people might be deterred by them from dealing with a potentially serious complaint at an early stage.

The main group of proposals other than the nominal charge to see a General Practitioner fall into the category described as "hotel" charge. in hospitals. The point is that patients in hospital are receiving food and accommodation in addition to health care. Even if they were not ill, they would have to make some provision for these items. A leading suggestion is therefore that there should be charges for them, even if the health care itself continues to be free.

There are some points which have to be dealt with before these kind of charges can be introduced. In the first place there would need to be large scale exemptions for groups who might find it difficult to pay. The elderly, the unemployed, and those on low incomes might all find payment difficult. They are, to some extent, the groups most likely to make use of health resources. The higher income group, and those of working age and in work are less likely to need health care. This could mean that only a small proportion of patients would actually pay these charges.

In any case, the sums which could be achieved from these areas could not serve as the major source of NHS funds. It would amount to a small sum in terms of the overall budget. This does not mean that charges might not be an important source of new funds. Those who argue that the NHS needs only additional money could point to charges as a possible source of it.

Charges have an additional advantage in that they could well lead to greater exit from the NHS. They are most likely to be applied to the groups which can afford them. Such groups, if not already covered by private medicine, might be tempted to seek such cover if the cost difference between public and private treatment were to be narrowed in this way. If a person faced "hotel" charges in an NHS hospital, they might prefer the greater choices available in the private sector.

No doubt the ability to pay NHS "hotel" charges could be extended by a variety of schemes of easy payment. Health Saving Stamps have been suggested as one way, much as TV licence stamps are currently used. It should be pointed out that hospital charges would be much higher than TV licences, however.

More realistically, perhaps, the combination of credit sale and extended payments can be advocated, with patients making monthly payments after treatment in much the same way that utility bills for gas or electricity can now be paid. The general unpopularity of charges must make them a difficult prospect, however. When a service has been provided without user charges, people think of it as a right and resent the switch to a direct payment system. This probably extends to those in health, including the "hotel" elements in hospital stay.

It could be argued that this type of payment is not a very fair or a very efficient way to limit demand or to raise revenue. It may well limit access to those who need hospital attention most, and not limit it to those who could go private. In any event, the Prime Minister has indicated that such hospital charges are not a major contender within the lifetime of the current Parliament.

An alternative form of charges suggests that instead of charging for "hotel" services, there should be charges for non-essential items of treatment itself. The argument here is that the NHS is spending some of its time and resources on operations which are not necessary to save life or to make patients healthier. Critics suggest that expensive operations to change the sex of a patient, or such work as in vitro fertilization, are consuming resources that might be better spent on life-saving heart operations or in relieving painful conditions by hip replacements, for example.

The suggestion is that there should be charges for work which does not have a major "health" component. This would act firstly to limit demand, and secondly to bring in additional funds for mainline work to save life or bring relief from pain. A possible justification lies in the fact that the National Health Service has limited funds but potentially infinite demand. Non-essential services can have only a low claim on priorities while there is a waiting list for urgent treatment.

There already are services which, the NHS does not offer. It does not cover hair transplants, for example, because these are not counted as necessary for 'reasons of health. Other operations that fall into the non-essential category could be subject to a charge as an alternative to not offering them at all. One advantage of such a procedure is that as well as the saving of resources and the extra finance, it would draw attention to the whole question of NHS priorities, and force consideration of what the service should or should not offer.

REPAYMENT MECHANISMS

A variant of proposals to impose charges is one modeled on the system which prevails in France. Under this version there would be charges for NHS treatments, but these could be recovered later from public funds. The difference between this system and the NHS as presently operated is that it creates an awareness of cost.

The fact that something has to be paid at the point of treatment does act to inhibit demand, even though the sums are recoverable subsequently. It further makes those involved aware of the costs incurred by different types of treatment. The fact that the doctors and the hospitals have to put a charge on items means that the costs must be known and visible. This, in turn, enables comparisons to be made to see where some sources of treatment are more expensive than others.

The patients are also made aware of the cost of the treatment which is performed for them, and are less likely to engage in frivolous or trivial demands on the system. The effect of charges followed by recovery from the state would thus be to limit demand to some extent, while at the same time creating pressure to steer costs toward those of the most efficient producers within the state system.

Against these very worthwhile advantages it could be said that many of those who make most use of health services would not be able to pay bills, even if the cash were subsequently recoverable from the state. Furthermore, the very fact of payment and reclaim from the state would add extra administrative costs which would have to be borne by the NHS. There is a cost, in other words, to knowing the cost.

It might well be that the downward pressure on costs would more than outweigh the additional administrative costs of setting out the charges. It might also be that the costs of a system of pay and reclaim would be compensated for by the reduction in demand which it produced. The point is that any such system would need to pay careful attention to these factors. It may be that the inability

of some patients to produce up-front payments would leave only marginal gains from such a system.

It is not without significance that the operation of this within French health care provision has not succeeded in keeping costs down. The French spend half as much again as Britain on health as a fraction of GDP. The UK system for all its faults does at least enable spending to be kept down.

4. INSURANCE, TAX RELIEF, AND THE VOUCHER

Some critics of the public service have asked why we cannot move to compulsory private insurance in its place. They point out that we require insurance cover for people to drive a motor vehicle, yet the state is not itself the insurer. Why not use a similar system in health? The answer is that compulsory private insurance is not a very practical alternative to the National Health Service. It lacks the redistributive element whereby those who can afford it pay for the health care of those who cannot.

It should also be pointed out that it might not restrain costs if the subscribers were captives in a compulsory system. In the USA, where most of those in private insurance have employers paying the premiums, the costs of the system rapidly went out of control and led to the rise of Health Maintenance Organizations as a more manageable alternative.

If compulsory insurance is not practicable, however, the same is not necessarily true of voluntary private insurance with some tax incentives to encourage it. The problem in Britain is that those in private medicine pay twice, once for the public service which they do not use, and once for the private one which they do. This means that private insurance has been limited to the better off; only 10% use it.

Tax relief on private insurance is designed to encourage more and more people to exercise the choice to seek their own provision. Its justification, apart, from the desirability of self reliance and choice, is that those who make that choice thereby take their demand away from the NHS, and free its resources to those who depend on it.

Many of the arguments which apply to opting out of a health tax also apply to tax reliefs for private cover. Again, one has to ask if education and other services are to be treated in the same way, and how any difference in treatment can be justified. The question again arises as to the capacity of the private medical sector to grow sufficiently fast to keep pace with the demand. And again the problem of a possible deadweight occurs, with some relief going to those already in the private sector. The question is raised here also of whether we can afford to redirect some resources toward the well-off without buying any extra health.

These are serious questions which have to be answered, but as has been pointed out, they could have been used to prevent the highly successful grant of interest relief on house purchase mortgages. A possible solution might be to introduce tax relief in stages, starting with groups least likely to cause the above problems.

It is possible to argue, as the No Turning Back Group of MPs has done, that tax relief for private insurance should be introduced initially for just the elderly. The reasoning is good. It is that this is the group most likely to leave private insurance if no help is given. As people reach retirement age and their incomes go down, this is the very time when the premiums for private cover go up. By granting some tax concession to the elderly, it will make private insurance more

affordable and encourage more to take that route.

Furthermore, it is from people in this age group that there comes on increasing demand for health services. This means that those encouraged to leave the NHS are not the low users who might leave first if the tax reliefs were given generally. In other words the move would help people to exit from the state scheme and take a significant demand with them. It would free more NHS resources for its own patients, instead of involving huge "deadweight" sums paid to those who would be in private insurance anyway.

Increasing numbers of older people are taxpayers. Tempted by some tax relief, still more might embark upon plans to use some of the equity built up in their homes. It is significant that new plans from the private insurance market are specifically designed to be attractive to older people. Tax relief could make them available to greater numbers.

From the point of view of a government concerned about precedent, there is the added advantage that targeting the elderly for tax relief on health insurance avoids the comparison with education. Very few people in that age group will have children of school age.

The general arguments which have to be answered for opting out of health taxes or for general tax reliefs on insurance, do not have the same force for specific concessions aimed at the elderly. It could be possible to introduce them for the elderly, and extend them to other carefully targeted groups at a later stage. This might provide a way into the encouragement of private provision without the disadvantages which would otherwise be risked.

VOUCHERS AND CREDITS

Vouchers and credits are suggested as a means of combining choice for patients with greater provision of health services. Basically they are pieces of paper which are valid for some forms of health spending. They are issued by government and can be used variously to buy medical services or health insurance from either public or private sector producers.

The central aim of this type of proposal is to increase the amount which is spent on the private sector. Proponents point to the low level of private health spending in Britain and urge the use of vouchers or credits to raise it. They represent at least part of the health allocation made for a patient within the public sector. By allowing it to be spent by the patient, or on behalf of the patient, the choice of either public or private sector is permitted, and the possibility of topping up with the patient's own money presents itself.

In the simplest of voucher schemes, everyone receives a voucher from the government representing a year's health allocation. This would vary with age group, since some cost far more than others. The patient then uses the voucher to secure insurance cover from either the NHS or the private sector, adding his or

her own funds if desired. The voucher is sufficient for the cost of NHS cover, but may need money added for some of the private alternatives.

The patient now has choice, not just between public and private sectors, but between a variety of types of cover. While all basic health needs must be included, or otherwise there would be a risk of people being thrown back upon the state's resources, different levels of comfort and convenience can be chosen. Some might wish to pay extra to obtain single rooms in hospital, or to cover some operations not offered by the NHS. New types of private scheme would emerge in response, and patients would find HMOs on offer, as well as conventional services. Some schemes might provide house calls by doctors, others at lower cost might restrict them.

People would be more ready to add to the basic allocation, and would increase the total funding going towards health. These are the outlines of the idea, with different versions of it setting forward different possibilities.

Treatment credits are suggested in a CPS paper by John Redwood and Oliver Letwin and propose credit notes for patients needing hospital treatment. These would be issued by the GP, and would be spent at the choice of the patient. They would cover the cost at NHS hospitals, but might require to be added to for private treatment. NHS hospitals would move over to funding based on the credit notes received, on the basis of the work done in a year. Private hospitals would accept them perhaps as part payment and redeem them from the government.

There would thus be competition between hospitals, both NHS and private, to attract patients and doctors. This would increase efficiency as well as choice. The resources of hospitals would be matched to their workload.

Some problems would have to be solved before such a system could work. It would have to be decided if the credit note were to cover the NHS hospital cost whatever it might be, or whether it would need to be set in advance, and if so, on what basis? The value of the credit note at a private hospital on the other hand, would presumably be whatever the cost would have been at an NHS hospital. This would have to be determined.

It is possible that if the credit notes were to pay the cost of NHS treatment, whatever it was, there might be no incentive to be effective. On the contrary, NHS hospitals might vie with each other to attract patients by offering more luxurious and more expensive treatments. If there were cost limits these would have to be determined, and this could present problems in turn because of the wide variation between different hospitals.

If people used their NHS credit notes in part payment of items for which they had private cover, there would be the deadweight cost of public funds going to people already in the private nectar. This could be prevented, but it would probably have to be policed, and might add further costs.

There are ways of solving all of these points, the only drawback is that a viable treatment credit scheme becomes more complicated and may cost more than a simpler version. One way of escaping the difficulties is to use the credits or vouchers to buy insurance cover instead of treatment itself.

The proposal put forward by Ray Whitney calls for people to be given health vouchers based on the average NUS allocation for their age group. People would use them to buy health insurance from approved providers, both public and private. These could be insurers who paid the cost of any health needs incurred by the subscriber, or they could be HMOs providing full health care. In either case they would handle all of the patients' health needs. NHS doctors would be allowed to set up HMOs, subcontracting the necessary hospital work, and people would be able to top up their vouchers with extra funds to buy a higher level of cover. Public funds would top up the insurance of vulnerable groups making high use of health services.

The merit of using vouchers for insurance as opposed to treatment is that the actuarial risk is spread. The insurers would be large enough and would have enough subscribers to spread the burden of high users. Like many of the proposals to reform the NHS, this measure would have hospitals acting independently in competition with each other, and would blur the distinction between public and private sectors.

This is a radical proposal which would completely transform the National Health Service in Britain. Its biggest drawback is the high deadweight cost involved in allowing those already with private insurers to use their NHS allocation in part payment. If the deadweight costs could be absorbed, however, the scheme would introduce choice and competition, bring opportunities for more people to make their own provision, and would encourage the input of extra private cash into total health spending.

In common with some of the other proposals. there would be a need to have the annual allocation at a sufficient level to pay for health needs. It would perhaps be subject to annual review and negotiation, and criteria would have to be established for making sure that top up funding was available at the level necessary for high users such as the chronic sick.

Perhaps to avoid the complete upheaval so profound a change would bring to the NHS, David Green in "Everyone a Private Patient" by the Institute of Economic Affairs has suggested a more gradualist version. The vouchers for health insurance would only be used by those opting out of the state system. They would be age-weighted, to reflect the average cost of NHS provision for the group.

The NHS would continue as a public funded organization supplying free health care, but those dissatisfied with it would be able to draw a health voucher for use with private insurers. Ingeniously, the patient would not spend it personally, but would take it to an approved Health Purchase Union which would negotiate terms for private cover. This additional proposal protects the patient in an

uncertain market, and brings not only skilled knowledge but bulk buying power to bear on his or her behalf.

Those who opted for the voucher and independent supply would have to renounce all claim upon the NHS, including the use of it for emergency services. This, too, would be covered privately. The proposal thus introduces vouchers for those who wish to leave the NHS, but leaves the public service in place for those who wish to stay with it.

Since the exit from the state system would be gradual, this idea allows the private supply to build up gradually to meet the new demands upon it, and involves much less of a total change. While the proposal does not introduce competition and choice within the NHS, it does give more and more people an alternative to it.

Some means of handling the deadweight problem might be needed, since the first people to draw their health vouchers would be those already in private insurance. They could be expected to use the new health purchase unions to obtain equivalent cover to that they already had, but with the public sector now paying a major fraction of the cost. As with other schemes to promote greater use of private alternatives, the start-up costs could be quite high because of this.

If a way were found to ameliorate this source of objection, this version of the voucher could see private insurance spreading very far down-market, instead of being the preserve of the well-to-do.

It may be possible to begin this process with the elderly. This dramatically curbs the initial deadweight cost because this group is one which finds private provision difficult to afford without any kind of incentive. An innovation which allowed the NHS annual a location for members of that age group to be used for private sector supply could well be the most attractive way of starting the move toward a voucher system.

There are those who object to any attempt to encourage greater private spending on health, on the grounds that this might lead to a two-tier system with good service for those who could afford it, and a second-rate health service for the rest. It could be argued in reply that the present system is already a two-tier one, with the articulate and self confident middle classes much more able to use it to their advantage than are the poor.

The present system causes both groups to be confined together in the NHS, effectively putting them in competition with each other for limited resources. In any such contest the disadvantaged will not win. The most attention and the best service will go to those equipped to demand it. By creating many more opportunities for such people to seek cover within the private sector, the public sector resources are released for those who have to depend on them. The competition from more capable people is to a large degree removed.

More importantly, proposals to change the basis of NHS finance offer the

opportunity for contracting out. They permit people to make choices about the type and level of health care they seek. They introduce competitive pressures as a spur to efficiency, and permit more rational allocation of resources. Most importantly, they bring the promise of increased funding by encouraging the addition of private resources. And it is of no small consequence that they bring the opportunity for more and more people to take care of their own health provision, even while retaining services for those who cannot do so.

5. MANAGEMENT CHANGES AT THE NATIONAL LEVEL

There are several proposals for changes in the way the NHS is constituted, organized, and managed at the national level. For many years prior to the most recent round of reforms, it was felt that the comparative lack of strong management at the point of service provision was due greatly to the absence of solid management structures and clear objectives at the top. The heavy dominance of elected politicians over the national structure meant that objectives changed completely when new governments, or even a new Minister, took office.

Long wrangles over policy issues such as pay-beds made it hard for local health managers to plan rationally for the future. And new priorities were added, or old ones changed, in order to respond to short-term political difficulties, the objectives became less and less clear.

The institution of the NHS Management Board was an attempt to reduce this politicization of the Service and to introduce more solid and objective management at the national level. It has undoubtedly had positive effects in consolidating the management structure; but there is less confidence in its ability to protect the NHS from the possibility of changing political fashions and from day-to-day political interference in its work.

Many of the proposals for managerial reform at the national level, therefore, are designed to address this need for clear and durable objectives.

GREATER INDEPENDENCE

One group of proposals would aim to solve these problems by putting greater distance between politicians and management.

An idea that has been in discussion for some time is to reconstitute the Health Service more like any other nationalized industry. Thus, its national board would comprise members who were chosen on the strength of their management expertise, rather than because they happened to represent political causes or particular interest groups from within the Service. Regional and district functions would again be overseen by managers instead of by panels of local politicians and vested interests. To carry on the analogy even further, those managers would be appointed by and answerable to the national board. And the Minister would be responsible only for board appointments and issues of strategy – being unable even to answer Parliamentary Questions about the day-to-day conduct of the industry's affairs.

A recent proposal along these lines has been made in a Centre for Policy Studies paper by Oliver Letwin and John Redwood. They argue for the establishment of the NHS as an 'independent trust', entirely separated from the DHSS. In calling for an 'apolitical board', they might well be proposing that national politicians have no power of appointment at all; but certainly, their concept would place

health care even further from political interference than the nationalized industries can be.

Certainly, any such change would put a distance between political debates and management decision-making. Managers at every level would have clearer lines of responsibility, they could plan for the future with greater confidence; they could take businesslike decisions, free from lengthy bickering, and they could do what is necessary, rather than what is merely popular.

Logistically, such a change would not be difficult to institute at the national level. All it requires is that ministers should be prepared to stand back from the management process, and to appoint a more independent board of directors and executives. The trade union and professional groups within the Service would find themselves making representations on policy matters to the NHS Chief Executive or Chairman, rather than the Minister of Health or Secretary of State but this might well be accepted with relief rather than rejected with outrage.

Although one can be reasonably confident that a new and more independent management structure would help decision-making in the NHS to become more brisk and businesslike, and so to deliver better value for money, it may not meet other objectives.

For example, the Service may well remain largely politicized. Although other nationalized industries are supposed to be run at arm's length from their sponsoring departments, political control over their finances and the fuzzy boundary between 'day-to-day' and 'strategic' functions have always left politicians free to interfere quite widely.

Indeed, if the politicians were genuinely committed to making the structure more independent, they would face an immediate problem -- that of specifying what performance standards they expected. Since the managers are only indirectly accountable to Parliament, the public, and patients, they will need the discipline of firm budget targets and output objectives, set down in advance. In the case of other nationalized industries output may be simple enough to specify -- tonnes of coal or steel of different grades, for example. In health, however, 'output' is very much harder to describe and the verdict on whether or not it has been met can take years or decades to come in.

Furthermore, a reformed management structure will not by itself solve problems such as long waiting lists. It might well reduce the importance of waiting lists as a political weapon, and thus prompt a reassessment of how bad the problem really is. It might allow managers to direct resources onto the problem more quickly, and even to tackle the absence of controls over GPs' referral. However, many inherent pressures -- such as rising expectation and the excess demand because services are free -- would remain.

A BETTER MANAGEMENT STRUCTURE

The relative success of the new approach to management within the NHS has led to suggestions that the Griffiths proposals should be carried to their logical conclusion and that the management tier should be strengthened throughout the Service.

One boast from defenders of the status quo is that administration costs, at less than 5% of the budget total, are considerably lower than for most other health-care systems, where such costs commonly cluster around 10% and can rise to 15% or more. However this might not be a virtue, but an indication that the Health Service is considerably under-managed.

Many of those who have been recruited from the commercial sector to bolster NHS management (including those who have subsequently returned disillusioned) would confirm this view. Managers have a hard enough time even collecting the information they need to manage resources rationally – although great strides have been made. It is even harder to communicate management principles throughout the Service, particularly through the clinical professions which have defended their freedom from such pressures for so long. Bridging that attitude gap might well require a new injection of manpower and resources.

One proposal which might help to stem the exodus of the new generation of health managers back to the private sector would be the establishment of a recognized career structure for health services management. Already the Institute of Health Services Management exists as a respected association, but the recognition of the importance of the management function could be spread even more widely. Business schools might be prompted to provide relevant courses, for example, and professional bodies and associations should be requested to admit Health Service general managers.

Another proposal is to bridge the attitude gap by giving clinicians a greater appreciation of management issues. Thus, GPs and hospital doctors would receive training in resource management, and would be kept informed about the relative costs of different procedures and resources. Their contracts might even require them to seek low-cost options in treatment and referrals.

Many successful health-care systems overseas do not expect doctors and nurses to become their own managers, but nominate management leaders from within the clinical professions. It is their job to keep a foot in both camps, and to improve the communication between them. Thus, only a few doctors need to work closely with managers, but they will be key members of the management team. Similarly, some individuals who are primarily managers maintain their credibility with other doctors by remaining in clinical practice. This bridge between the two different approaches breaks down any potential suspicions and intransigence, promoting better-informed management decisions.

BETTER INFORMATION

Although the Health Service is collecting much better management information than it has ever done in the past, much of what is collected remains difficult for those working within the Service to digest. The Korner management information systems now running in the health authorities, and the performance indicators amassed at the Department of Health and Social Security, are both very complex. The latter may even miss the crucial points which the NHS ought to be aiming at. It is doubtful whether such systems and statistics can be used seriously for management purposes or to help politicians and civil servants decide the optimum strategy for the Service.

If information is to be used effectively, it must be understood. There is a strong case for sharing more management information with GPs and consultants, for example, but it would need to be in a form they could digest and act upon. The next stage of the management revolution, therefore, must be to make the information that is collected digestible to all and to give people the incentives to act upon it.

REVISING THE CONTRACT STRUCTURE

One incentive obstacle blocking better management of resources is the curious contractual position of GPs and hospital consultants in England and Wales.

With Family Practitioner Committees being responsible for primary care, there is a management gap between the primary and secondary sectors, and services do not always merge smoothly. Hospital managers have to honour blank cheques on their resources, since they have no power to control GPs' referral practices.

Furthermore, hospital managers have little control over the consultants who work within their walls. Given privileges to buy their support for the introduction of the NHS back in the 1940s, consultants remain contracted with the region, insulating them from the management disciplines proposed at district and unit level. Hospital managers know that their best consultants have five times the output of their worst, but can do little or nothing to change things.

Scotland has a better framework for improvement, with contracts being held by a single body. However, it might be beneficial to go further and to have hospital consultants contracted not by a health district or board, but with the hospital itself. Thus, managerial discipline would be truly localized. Politicians who attempt to make such changes naturally expect to come up against the solid opposition of the consultants. Today, however, it is questionable whether such professions could make a convincing case for their peculiar privileges and whether they are really self-confident enough, in the light of the management evidence now in, to press the matter to breaking point. Some change in the contractual arrangements could well be seen in the future.

OUTPUT MEASURES

Although the Health Service has a reasonable idea of how much it is spending, there is much less knowledge about what it is producing. We simply do not know what we are getting for our money. Indeed, some NHS officers doubt whether it has really made us much healthier at all -- any perceived increase in longevity being the result of better diet and improved pollution controls rather than the Health Service!

There is a strong need, therefore, to know what the Health Service is achieving. Only then can we set new targets and hope to achieve even better results.

Of course, there are immediate problems. It might take many years before we know whether a particular course of treatment has really made someone better. Only actuarial evidence at the end of a generation can decide whether our life expectancy has been improved, and even this evidence is confused by factors which are completely outside the power of the NHS. Sometimes, the quality of life which patients enjoy after their treatment could not be expected to be as high as before, but the concept of the quality of life is necessarily subjective, not open to objective measurement.

Despite these difficulties, there is a growing demand for clear and simple output measures from the Health Service. Existing measures are complex and of limited value. Other ideas, such as the number of extra 'quality-adjusted life years' (QALYs) that can be expected from particular treatments, developed at the University of York, might provide a more businesslike basis for choice, and this must be high on the reform agenda.

INFORMING THE PATIENTS

Whatever output measures are chosen, however, they will bring no changes to the working of the Service if they merely lie unread in the House of Commons Library or on the shelves of DHSS statisticians. To have an effect, they must be communicated to those who work within the NHS, and incentive structures must be built upon them to encourage staff to strive for improvement.

The communication of output information to those who work within the Service is an obvious enough aim. However, some commentators have suggested that information about service quality and output performance should actually be communicated directly to patients themselves. Thus, all registered patients would receive an annual report, showing how resources have been deployed, what the results have been, and how the performance of their district compares with others. If patients have no power to go elsewhere. Of course, the dissemination of this information is useful only in putting moral pressure on managers and health workers. If the structure of the NHS is changed to give patients the power of exit, however, such information could be a useful basis for patient choice.

A CORE CURRICULUM

Output issues raise the question of what services the NHS ought to be providing in any case.

Certainly there is widespread agreement that accident and emergency services should be provided to all comers, free of charge. The same is true of many acute services. However, as medical advances enable us to concentrate a growing proportion of health spending on procedures that are not life-threatening – such as cosmetic surgery, in-vitro fertilization, and so on – the policy problems multiply. Since the main beneficiaries are the individual patients themselves, and since there is no limit to the range of such services that we might provide, should we expect taxpayers to fund their provision, free of charge, on demand?

All resources, including, money, skill, time, and equipment, are scarce. Decisions have to be made about how can best be allocated between different possible uses: in other words, there must be some rationing system.

At present in the NHS, the rationing system is very real, with doctors making daily decisions about what treatment should be provided, and to whom. These priorities are decided on an ad hoc basis as cases arise, rather than in any systematic or rational way. And because they remain shrouded by the catchphrase principle that everyone has equal access, there is generated a demand for services that the NHS cannot possibly satisfy.

The idea of the 'core curriculum' in health, which we raised in our earlier report *Health Management Units*, is to work out a rational set of priorities and to make them explicit instead of being hidden behind false claims of equality and plenty. Such a listing might well encourage the greater use of the NHS by those with high-priority conditions who see their rights clearly stated for the first time -- although this can hardly be decried. On the other hand, much larger numbers of people would probably withdraw their demand for procedures that were clearly accepted as being of low priority and involving a potentially long wait. Thus, NHS resources would be systematically concentrated upon genuine priority cases.

If NHS reforms involved increases in the number of health providers or funding agencies, as seems likely, the core curriculum would be a necessary safeguard for the Treasury. In the education reforms, the possibility of a school staying within the state sector but providing its own management requires us to impose on the new managers certain minimum standards so that we can be sure they are giving the taxpayer good value for the money they receive. Similarly in health, if reforms including steering state funds through a diversity of new management bodies, as seems likely, the government must be sure that certain priorities and standards are being met.

Accident and emergency cases, and illnesses which were immediately life-threatening or contagious would necessarily be assigned the highest priority,

with immediate admission being required. On the second rank would be conditions which caused pain or acute discomfort, for which short waiting times only would be tolerable. Third might come conditions which were not immediately life-threatening but which could deteriorate if left unattended. Other categories would be added below this.

Defining these priority bands will be no easy matter, requiring both medical knowledge and management knowledge about the feasibility and cost of the necessary procedures. Furthermore, the needs of different patients, even with the same medical condition, can be very different, depending on their age, history, and disposition. And judgments about, say, whether the mental well-being of patients needing cosmetic surgery is more or less important than the physical well-being of arthritis victims, would be difficult.

Technical developments mean constant shifts in the feasibility and cost of different care strategies, so perpetual updating of the priorities would be necessary. And shifts in resources, such as the arrival or departure of a skilled surgeon, will force local reassessments of the service levels that it is realistic to provide.

However, such forces can be made to work positively. To work, the core curriculum must include redress for any patients who find they have not received the necessary treatment within the stipulated maximum time. Perhaps the patient can demand to be sent to another area, or even to go private, and bill his or her own health authority for the cost. To avoid this commitment being open-ended, authorities will want to negotiate terms with other suppliers, just in case they have too long a waiting list at any time. Nevertheless, it represents a cost to them, and they will naturally attempt to manage their resource use optimally so that this cost can be avoided. ~~This~~ These benefits the patients and keeps waiting times down.

6. THE REALIGNMENT OF NHS STRUCTURES

Some proposals start from the (quite defensible) proposition that the 1974 Health Service reforms incorporated a number of mistakes. In England and Wales, the district authorities that were supposed to be nearer to the people have in fact become more remote as they have centralized their resources into large-scale district facilities, the old authorities were too big to work without plenty of local delegation. And then, it is said, the regional authorities have little to do and are an unnecessary bureaucratic tier which Scotland works happily without.

The list continues. Family practitioner committees are not properly integrated with the secondary care system, causing a harmful bifurcation of the Service into primary and secondary sectors, with its gaps, overlaps, and lack of cost information and control. Community health councils, for their part, have little power or influence, and many people wonder why they exist at all.

Arguments on these points continue, but one thing is agreed, nobody in the NHS wants to go through yet another structural reform. Thus, it seems likely that major structural reorganization of the NHS, going back to area health boards for example, will be avoided at this stage. However, that may not rule out the complete abolition of one tier or modest changes in the power of different elements within the existing structure.

SPLITTING THE DEPARTMENT

The 1988 ASI report *A Change of Government* discussed the idea of splitting the Department of Health and Social Security into its constituent elements.

One possible gain from this would be the new post of a Secretary of State for Health with Cabinet rank, which would reflect the increasing importance of health care in the modern economy. However, this status change could undoubtedly be made without the administrative complexities of a full-scale departmental reorganization.

One advantage of a more independent Department of Health would be that it would provide a clearer home for responsibility over community care services, and could more easily grow to accommodate that responsibility than an already over-large DHSS. Many long-stay services are at present provided by local authorities, leading to a confusion of responsibility and the loss of strategic thinking in areas of care that are of growing importance.

Another benefit which departmental division might bring would be the wider understanding that health care is not exactly like welfare services.

Firstly, the payments systems and other programmes we need for the alleviation of poverty are quite unlike the institutions we have to deliver health care. Indeed, they seem to be nearer in form (though opposite in structure) to the

systems we have to tax those who are well off. Separation of social security into its own department would make it clearer what is being spent on that element, increase the pressures for cost-effectiveness in its provision, and probably make it easier to move to a more rational and integrated tax and benefit structure.

Secondly, it is valuable to be reminded that much health care is a consumer good, unlike welfare benefits. There is no objective quantity of health care that is needed to keep people 'well' – with a greater and greater expenditure, we can make people fitter and fitter, more and more comfortable. Whether some procedures, such as cosmetic surgery, should be carried out is largely a matter of individual choice.

ABOLITION OF THE REGIONS

Working down the NHS structure, regions would seem likely candidates for abolition. Their role is principally a strategic and planning one, but less formal groupings of district managers might achieve the same functions with less cost. In all likelihood, the information and allocation services of the regions could be performed more cheaply by firms of advisers and administrators under contract to districts.

Scotland manages without this upper tier; so if there is indeed any information-collecting and strategic planning gap that results, it would seem that the Ministry of Health could do the same to plug it in England and Wales that the Scottish Office does in Scotland.

RECONSTITUTING THE DISTRICTS

The district authorities, however, have much more to do and seem much more in need of reform. The typical authority has a ruling panel comprising representatives from the local authorities, the ~~unions~~ ^{trade unions}, nurses, doctors, and others. The management decisions they are supposed to make are inevitably coloured by political prejudices and the special pleading of the interest groups concerned. Hard management decisions are put off because those who play to the gallery win the votes.

It may not be necessary to abolish this tier completely, but reform seems very desirable. Broadly, if the districts are to make management decisions over budget allocation, resource application, or both, political and section interests should not be included at a controlling level. It would be a district management board, mainly or exclusively comprising professional health managers, where responsibility would rest.

There may be objections. Trade union and professional groups, and local authority representatives in particular, are likely to resist any reduction in their say over the shape of local healthcare provision, the replacement of their 'democratic' decisions by the dictatorial rule of NHS managers.

Of course, local managers are unlikely to get far in any decision strategy they undertake unless they can carry with them the local community and those who work inside the Service. Decisions are likely to be just as 'democratic' in this sense, but a good deal quicker and more definite. Nevertheless, the local political threat to reform remains real.

Some local accountability of a non-partisan sort might be achieved in three ways. The first would be to have the management boards presided over by an elected chairman who could bring an appreciation of local popular feelings into management debates. Another route would be to keep the tenure of office on the boards rather short (allowing each member a tenure of three years, followed by a compulsory one-year break, perhaps). A third possibility might be to strengthen the influence of the community health councils. Presently just another tier of bureaucracy which has to be kept informed by all the other tiers, the CHCs could be used to provide a local forum to keep NHS managers aware of changing local needs and to regulate their performance, along the lines of OFTEL or the nationalized industry consumer councils.

FAMILY PRACTITIONERS

Another element in district reform could well be the integration of the family practitioner committees into the district management structure. This would have the advantage of putting the responsibility for all doctors' contracts under one roof, and thereby improving the management of clinical skills. Of equal benefit would be the removal of the artificial distinction between primary and secondary care, which could lead to the strengthening of primary care facilities and one-stop surgeries. Care would be brought closer to the patient -- and because of the expense of providing facilities in district hospitals, probably at lower cost.

7. PRICING WITHIN THE PUBLIC SERVICE

THE INTERNAL MARKET

There is much agreement that the NHS would work more efficiently and with less waste if there were more of an 'internal market'. This concept, however, covers several distinct possibilities within the same family of ideas.

At the most basic level, it would probably help the efficiency of resource application within the Service if those working for it knew something of the cost of what they used.

Throughout the Service today, doctors are largely unaware of the cost of the drugs they prescribe; nurses use costly supplies once and then throw them away rather than sterilize or prepare them for re-use, hospital stores groan with unpacked equipment, some of which will become so obsolete that it can only be given away to developing countries; the country's operating theatres are only half used; that nurses' and doctors' time is underemployed.

But if doctors, nurses, and all other NHS workers were informed about the cost of what they use, they would probably be much more careful to avoid waste and profligacy, using up resources only when they felt the need was justified.

Some hospitals, on an experimental basis, have already started to give clinical leaders more responsibility for the management of their budgets. Naturally, they put a pressure on their colleagues to watch costs, a pressure which is probably more effective than that which is possible from more distant (and non clinician) managers.

The next step along this route is probably for managers and clinicians to set up yet stronger budgeting controls. Peer review, whereby a doctor has to justify excessive resource usage to his or her colleagues, could end profligacy in prescribing far more acceptably than an official drugs blacklist, for example.

A mechanism of protocols which clinicians must satisfy when they commit resources to patient care could be worked out at the local level. Likewise, there could be protocols determining when a patient should be discharged from hospital or moved into a less expensive mode of care. The doctors might have the final say, but such a mechanism would require them at least to justify their decision in an open forum.

To work, such a system would have to be simple, although there must be many factors taken into consideration. Costs need to be assigned to overheads, to staff time, to equipment, to transport, and to drugs, among other things. Simply knowing the cost implications of different procedures and care structures can help staff to choose the most cost-effective routes.

REAL INTERNAL PRICING

Incentive structures will also help. The easiest is to make the resource costings real, and to organize a budgeting system accordingly. If a particular department or practitioner can keep the proceeds of more efficient resource use to spend on other things, such as better facilities or more staff, costconsciousness will be improved even further.

Already, experiments are going on with these kind of budgeting techniques and the initial results seem very encouraging.

CONTRACTING

Often, discussion of how an 'internal' market might be introduced into the NHS really covers the broader concept of a producer market, where resource use is determined by prices in the non-NHS sector as well as internally. If the costs of deploying different resources within the NHS are compared, and then those costs are compared yet further against the price of buying in services from the private sector, there is yet more scope for saving and improved cost-effectiveness.

Of the various approaches that come under this heading, contracting-out is probably the most familiar. This is already applied widely to ancillary services such as catering and laundry, under compulsory tendering rules.

Some -- including those opposed for political reasons, those affected by any change in service provision, and even contractors involved in the tendering exercise -- would argue that the exercise has not worked as smoothly as expected, despite the £100 million savings that have been generated. Consequently, it is not a very good advertisement for the contracting principle.

The patchy difficulties that have accompanied the savings benefits could almost certainly be avoided in any extension of the tendering procedure, however. The fact that all authorities were seeking tenders at the same time put a strain on the contract companies, the fact that many authorities were not serious about the exercise and had no intention of changing from direct labour added to the burdens of the contractors, and convinced them that the potential rewards were completely insufficient for them to commit resources heavily towards it.

Nevertheless, these problems could be overcome in the light of the experience of both sides, and indeed, the list of non-medical services that could be done under contract is large. There are already proposals from some hospitals to contract out reception and clerical functions; and the 1982 ASI paper *Reservicing Health* suggested not only catering and laundry services, but portering, housekeeping, administration, personnel management, estate management, security, maintenance, pest control, and engineering.

There is, of course, no reason why the contracting principle should be confined to non-medical services -- and indeed, it is not. Already, NHS managers buy in operations from private sector sources: to reduce backlogs, take advantage of excess capacity (private patients like to be treated during the week, so weekend admissions can be offered cheaply to the NHS, and even where NHS facilities are temporarily unusable because of infection).

This interaction of public and private sectors is welcome, given the excessive political divide between the two that some people would like to encourage. At present, not enough partnership goes on, partly because there is little incentive for district managers to shop around, and partly because districts aspire to offer a complete health service themselves where possible. Fortunately, very modest adjustments in the budgeting system would overcome both of these barriers.

Whole procedures, in fact, can be contracted out. A paper by John Peet has described an example: in Wales, dialysis treatment is done under contract by a private facility which, because it uses personnel more efficiently, can provide the procedure at less than half the cost of NHS hospitals. Again, incentives are needed so that managers are encouraged to fashion this kind of arrangement.

It can be a two-way process. The NHS has a great deal of expertise that can be sold to the private sector, or can be used jointly with it. For example, the private sector might provide costly equipment or facilities (which it can generally do much quicker and on a much bigger scale), while the NHS provides top specialists. Again, this happens quite widely: but without a working internal or producer market system, and in the absence of effective consumer pressure, there seems little reason why managers should choose to bother to foster partnerships that are by nature more difficult to manage than in-house efforts.

MANGEMENT BY CONTRACT

A last form of contracting which has not been tried in the UK, but which is working well overseas, is contract management of hospitals. Here, the staff in the hospital do not necessarily change; what changes is the management team, who are hired under a contract of perhaps five or ten years.

The working of this arrangement in Canada, which has a health system otherwise rather similar to the NHS, was charted in a 1985 paper from ASI, *Public Hospitals, Private Management*, and in more recent articles in the literature. On all measures that can be taken, including waiting times, quality of non-medical services, the addition of new services, staff morale, and the involvement of the local community, the contract arrangement seems to bring benefits.

Rather than closing down smaller hospitals, it may be possible to save them through contract management, and at the same time provide the public with a useful pilot study of how contract management might work more widely.

SEPARATION OF FINANCE AND PROVISION

It may be possible to move yet faster. One proposal that is growing in strength is the idea of turning hospitals into independent trusts, deriving their income from the services which they sell to the NHS, instead of through block grants.

A hospital so constituted could build up far more of a local identity than one which was merely part of a large, monolithic Service. Managers would probably have a stronger say in how the hospital was run, but trustees chosen from the community would provide an input of local views. The best structure would be one in which the hospitals were still part of the NHS and bound by its general objectives and principles, but where the management was sufficiently free of public-sector financial rules that new capital could be raised on the private market.

There are many details to resolve, how the trustees should be chosen (it would be important to minimize partisan and interest group politics on the trusts), whether some hospitals might not be viable by themselves and how packages might be assembled, and so on. However, managers have a sufficient amount of cost information today that they are almost ready to undertake the challenge of being paid by results.

This change would certainly put a pressure on hospitals to contain their costs and offer a cost-effective service. Quality too would be under constant review. Knowing that district managers could go elsewhere, hospitals would want to provide the best possible service, and district managers would monitor hospital performance carefully to make sure that the public were getting value for money,

Some decisions would have to be made about the financing of research, training, and capital under this payment-by-performance system. Much research is already financed through the universities, and would be unaffected, but much research goes on in the wards and operating theatres as different new strategies are attempted. It could be argued that research will not suffer, because it is a prestige activity which the trustee-controlled hospitals would want to be involved in -- and certainly there is much American evidence and some UK examples of private hospital chains buying over and capitalizing whole academic research departments because of the prestige they confer.

Similarly, locally controlled hospitals may well be more sensitive to the need to recruit and train new staff, so that would not suffer either. Capital should be easier to raise locally and can come through the private market. Hospital trusts once again will be mindful of future needs and there should be no greater tendency to put off capital expenditure than in the present system, and probably much less. But if it was thought to be a worry that trusts might price their services so low that they generated insufficient income to replenish capital stocks, the checks and regulations needed to prevent the possibility would be straightforward enough to institute.

Although this sort of separation between payment and provision brings a useful tension into the Health Service, one that should help control costs and raise service quality, the more scope for diversity and choice that can be introduced, the greater power patients have to leave parts of the system they regard as unsatisfactory, the greater are the competitive benefits likely to be. This point has led the Adam Smith Institute to explore methods of making the allocation of public funds dependent upon the choices that are made by patients and practitioners within the system -- ways of making the payment follow the patient.

8. THE HMU OPTION

Today's high-tech economy can deliver to people choices that were simply impossible in the era of mass production. Naturally enough, people are now demanding goods and services that are more closely tailored to their own special needs and wants than the standardized ones of the past.

The market already gives us enormous variety, as a walk down any High Street will confirm. But the government sector has been slower to change. Only the rich have been able to afford choice in state-dominated services such as health and education. However, the opportunity surely exists to widen that sort of choice to everyone. Giving more choice to NHS patients would not only help the pursuit of cost-effective and high-quality service, but is desirable in itself.

However, after forty years in the public sector, it might be difficult to grow alternatives that bring choice to patients. Vouchers, health credits, a hypothecated tax, or compulsory private insurance might all promote choice, but they represent major political changes to a service that is very sensitive politically. Although welcome proposals, they might well fail at the hurdle of political decision-making. It may be significant in this respect that the present government did not introduce the idea of education vouchers (for example), despite the fact that it had been widely canvassed for many years. So it might be even less likely to introduce a sweeping privatization programme into the health sector, where egalitarian ideas are even more entrenched.

Furthermore, we cannot expect that the private health sector, today covering only about 10% of the population, could grow in size ten times overnight. Even a market which grows quickly suffers strains as new contenders come and go, and the political aim in health is probably in the direction of more cautious but systematic development of private-sector alternatives.

THE EDUCATION ANALOGY

If the state sector will be meeting the needs of the vast majority for some time, it is the organization of that sector which we have to get right. And given the political boundaries to reform, the present government's three-pronged reforms to the state education sector, canvassed in the 1983 ASI Omega Project report on *Education Policy*, could well be instructive.

First, the education reforms take management decisions out of the hands of those with sectional or political interests, making schools and headmasters much more responsible for their own educational policy. Second, the reforms give parents a free choice over which school their children should attend. Third, the money to finance state education will follow the child, and so will be drawn automatically to the most preferred schools.

To this has been added the concept of a 'core curriculum', which is necessary to

ensure service standards if public money is to be spent on the government's behalf by newly independent schools.

THE HMU APPROACH

The Adam Smith Institute's idea of Health Management Units proposes exactly the same strategy for health. Our 1986 report *Good Health* explored ways in which some such structures could be introduced within the public sector, and the idea was developed in the 1988 reports *The Health of Nations*, and in *Health Management Units*, which filled in many of the details and explored how HMUs might be established. Since then, the idea has been developed even further by ASI and others.

The proposal follows the education reforms exactly. The first element is to get politics out of management by replacing the district authorities with their monopoly control over budgets and service provision in geographical areas. Regional authorities, for their part, would have little function in the reformed mechanism and could be disbanded at this stage.

Second, hospital managers should run their own hospitals, or groups of hospitals, and should be able to set up public-private partnerships, or make savings by contracting out medical and non-medical services, free from political meddling. They would not be hamstrung by national agreements that do not suit local conditions, and would be able to negotiate salaries and conditions directly with their staff and contracted personnel – paying more to attract nurses and doctors to where they are really needed, for example. Consultants' contracts would be held with the hospitals in which they worked, providing a more direct management route than presently exists.

Third, instead of the public budget being allocated in the form of grants through the DHSS, regions, and districts, the healthcare purchasing function would be separated from the function of health-care provision. New, smaller management teams -- Health Management Units -- would be responsible for buying in the best services for their patients, using a budget allocation coming from central government and based broadly on the numbers of patients they could attract.

There might be three or four HMUs in a typical district, although these management teams do not have to be based in a small geographical area to buy in services for their patient members – they could be broad national bodies. However, it would be easier to start with geographical bodies, with management power awarded under franchise to applicants just as local radio licences are awarded.

When HMUs start up, of course, those patients most in need of better service might affiliate with it disproportionately, placing a strain on its budget. To avoid this, we recommended that the HMUs should be constituted on the basis of GP lists. GPs would not be in charge of the budget, that would be the work of professional managers' but GPs would be required to register with an HMU of

their choice, and would take their patients with them. Thus, large and fairly balanced groups are allocated to each HMU straight away, and patients could still change HMU by moving to a doctor affiliated with another. Probably, choice can be devolved further to the patient in due course, as others have emphasized, although mechanisms to avoid self-selection will be necessary.

The HMUs will be financed directly from government on the basis of the patients registered with them, an average health allocation, weighted by age and local morbidity statistics, and any other elements within the RAWP (Resource Allocation Working Party) calculations that were thought important. Out of this total budget, HMUs would be required to provide at least a 'core curriculum' of health-care services to their members.

To do this, they will not provide treatment themselves. but will buy in services from their doctors, and from hospitals in the public or the private sector, as they deem appropriate. They will, of course, have every incentive to act efficiently, since their overall budget is limited. If they can pick cost-effective hospital and specialist treatment, they can provide a wider range of services for patients, and so attract new patient groups. Likewise, hospitals and doctors will be under pressure to provide HMUs with the best possible packages of care in the most cost-effective manner. And taxpayers' money will follow the choices made by the patients and the management teams.

There are many advantages to such a reorganization, not the least of which is that improved management incentives are automatic within it. Patients continue to see their doctor as at present, and to be treated in hospitals as at present. The service continues to be tax-funded, and free at the point of use. The difference is that the choices and competitive forces within the new system will bring better value for money in the allocation of the NHS budget, and allow more services to be delivered within present spending levels. And since managers can shop around, the sterile barrier between the public and the private sector will be broken down.

REACHING THE NEW MECHANISM

All of these are powerful arguments for reorganization. A further advantage is that the new mechanism can be approached by a series of improvements that are all worthwhile in themselves.

For example, it is right that hospital managers should know the costs of what they do and have incentives to control those costs and manage their care delivery efficiently. It is beneficial for doctors and hospitals will be paid by results. It is helpful that managers should be able to select the best value for patients, instead of being constrained to use monopoly local suppliers. And it is desirable that patients should be given the power to get new management teams to buy health services on their behalf if they feel that their present one is inadequate.

The No Turning Back group of MPs, mindful of the political obstacles to creating

completely new management structures within the NHS, have proposed that the HMU principle should be retained, but based on existing district boundaries. Thus, existing managers would be separated functionally, into those running hospitals and those allocating the budget. The budget would go to the financial management body -- let us call it a District Health Purchasing Agency -- which would purchase GPs and hospital services on behalf of the patients it covered. Thus the foundations of a competitive supply framework would be laid, without the need for major changes in structure.

While separation of the purchasing and supply functions might put new pressures on providers, however, more needs to be done to ensure that the purchasing agencies spend in a cost-conscious way, and some degree of choice for patients is the only way to ensure this. The HMU or DHPA ideas are quite compatible with funding changes such as a hypothecated tax from which the payer can contract-out and go private, so exodus to the private sector of those unhappy with the DHPA managers would be one possibility. Or as a first step, it might be possible to allow some choice at the margins, for example, GPs presently located in one health district could take their patients into a DHPA in another if they felt that their patients would get a better service as a result.

Once the system was established and seen to be providing the initial benefits of competition and (limited) choice, it would be possible to extend the opportunities for choice by splitting the DHPA into two or more competing bodies. This need not be a geographical division, but an overlapping geographical coverage that would give patients everywhere a genuine choice between at least two purchasing bodies along the HMU model.

9. CONCLUSION

The review of the National Health Service has received different types of recommendations from several sources. Broadly speaking, they fall into two categories. Either they propose changes to the management and structure of the NHS, or they seek to reform the methods by which it is financed. There is a prima facie case for supposing that change is needed in both areas, in that criticism has exposed weaknesses in each of them. The current debate and the review provide opportunities for improvement which should not be wasted. They represent the most thoroughgoing examination in the 40 year history of the Health Service; it would be a pity if so searching a review brought too small a return.

There is, nonetheless, a strong case for evolutionary instead of revolutionary reform. The NHS has made major achievements which should not be discarded or put at risk. The opportunity exists to build upon them by adding a judicious mix of competition, choice and incentive. Not only will this improve the efficiency with which health care is delivered, it will enable people to select a level of health care appropriate to their own situation and their preferences. It will also make it possible for the total spending on health to increase if people wish to put in more of their own resources.

Some of the proposals made would serve to accentuate trends which are already taking place within the health service. There are moves already toward ascertaining the costs of different items of treatment, for example, and toward comparing the cost variations between districts.

On the management and structure side, the health service should be modified in ways which allow internal markets to operate. The finance of health care should be separated from the provision of it, so that they interact with each other. This means giving to those who manage the finance a choice between competing suppliers of health services. This combines the encouragement of efficiency with a redirection of resources towards successful producers. If patients and doctors can then be given a choice between different management groups, they become the Health Management Units which the Adam Smith Institute pioneered.

The best way toward this aim is to use existing health districts as the basic unit. In the first stage the family practitioner committees should be merged into the districts, and the regional authorities should disappear altogether or assume an advisory role. These District Health Purchasing Agencies would be publicly funded as at present, based on the number of patients within their care, weighted by age group and with any regional adjustments. Their task would be to obtain health care on behalf of patients from health producers. Patients would see their family doctors, as they do now, and obtain any hospital treatment needed, as they do now.

Under this realignment the hospitals would become independently administered, perhaps with the status of charitable trusts. There would be more incentive for local businesses and charities to aid hospitals in their area, and for

communities to "adopt" the local hospitals and clinics. The district bodies would pay them for the work they did, probably buying most health services under bulk purchase agreements.

The first stage achieves a choice between suppliers. When it has been achieved it will be possible to move to a second stage which brings choice between management teams for patients and doctors. In the second stage, to be reached after the initial changes have settled down, the District Health Purchasing Agencies can be divided up. Each could be split into two or three units. Patients would be assigned to one of the units in the first instance, with a careful balance of young and old, healthy and sick, rich and poor, to each of the units. The division of the District bodies should be not be a geographical one, but into equal numbers of patients assigned by category and spread throughout the district. One year after the initial allocation, patients would be free to change.

This achieves in two stages the principle of Health Management Units. There would then be choices between health producers by the management teams, and between the management teams either by the patients themselves or by their GPs. The initial routing of funds would be through the nearly 200 district bodies, reconstituted as financial management teams. After their subdivision in the second stage, it would be through the 500 or so Health Management Units. The money would follow the patient.

It should be stressed that each of these two stages will bring important advantages, and that a continuation of public funding within the National Health Service is assumed throughout.

On the financial side many of the proposals speak of closer links between the public and private sector. Many of them seek greater opportunities for people to spend more on their own health if they wish, and to bring the private alternative within range of a higher proportion of the population.

The most practical opt-out proposal is that suggested by the No Turning Back Group, that some tax incentive should be available in the first instance to elderly people taking private insurance. By limiting it to the elderly in the first instance, the problems posed by "deadweight," by adverse selection, and by the argument of precedent are all avoided.

Furthermore, the use of tax concessions to give more elderly people the option of private care allows the private sector to grow at a pace commensurate with the rising demands upon it. Once the principle has been accepted and is seen to be working, it will be possible to extend incentives to bring in other groups of the population, until perhaps the option is available generally. This allows precisely the kind of phased change which permits the market, both public and private, to adjust gradually.

The aim is to enable everyone to have the option of making their own arrangements and using private sector alternatives, but as the government found in its policy on council housing and labour reform, changes which are made

incrementally can be made securely and at a pace which avoids the shock that holistic schemes might bring.

There is a further type of opting out which merits attention. In the United States funds allocated for health care of the elderly under the Medicare programme can be assigned to a private organization if it can cover all of their health needs for 95% or less of the average per capita expenditure by the public sector. This means that there must be a saving of at least 5% to public funds.

This is effectively a voucher scheme for the aged, and there is a case for examining a version of it for Britain. The aged might be allowed to take 90% of the average per capita health allocation for their group into a private body which undertook to provide for their total health care. It could be like one of the "Health Purchase Unions" described by David Green. Again, if it were to be successful, it could be extended in stages to other groups of the population.

All of these proposals are steps upon the road to a radical overhaul of health care provision in Britain. The aim at the end of this process is for a system of health care responsive to the needs and wishes of the population. Within the NHS there will be choices, competition and incentives, and the greater part of the population will find the option of private alternatives within their reach. Despite the radical nature of the goal, the changes are to be made in stages which allow for steady adaptation. Each one achieves a valuable improvement: cumulatively they allow the choices of individuals to achieve the growth of a new system.