



Partnerships for better health Public, private... and people

Despite a supportive government and half a century of above-inflation budget increases, the National Health Service is still under strain. In the past few weeks alone, doctors have criticized it for long waiting times, diagnostic mistakes, and its poor record on treating heart disease, cancer, and other serious illness.

Everyone accepts that we need to upgrade and modernize UK healthcare. But to do that most effectively we must develop a wider involvement in the process — with real partnerships between the NHS, the private sector, and patients themselves.

The effectiveness gap

- **Our spending on healthcare is small.** At 6.8% of GNP, our healthcare spending is 1% below the OECD average — lower than even Portugal and the Czech Republic.
- **We depend more on the state.** Germany spends 10.7% of GNP on health; France 9.6%; the Netherlands 8.5% — but most of the extra comes from *private* sources.
- **Our performance on the killer diseases is particularly alarming.** Survival rates for cancer are far higher in the US; Britain's are only a little better than Poland's.
- **Our record on heart disease is poor, and performance is patchy.** Only 5% of hospital consultants have access to a specialized stroke unit.
- **Our poor performance spreads across almost all the main types of serious illness.** Mistakes continue to be made in cervical smears and other diagnostics.

- **Access is unequal.** Patients in some districts have a 50% greater chance of receiving dialysis or heart treatment than those in others. Some patients resort to buying life-saving medication themselves because their health authority will not fund it.

Clearly, if we are to deliver better-quality and more equally accessible healthcare in the UK, it is time to talk more honestly about our performance to date, and to think more imaginatively about exactly how we go about delivering this goal.

Serious obstacles

Serious management and resource strains stand in the way of the NHS providing comprehensive, high-quality, accessible healthcare. They include:

- **Underfunding.** NHS resources are inadequate to the task of delivering a fully comprehensive free healthcare service to an increasingly demanding population. Is there a third way, apart from raising taxes or cutting services?
- **Overdemand.** Many people waste doctors' time on trivial ailments, making others in real need wait. But there is no financial incentive for people to use services more carefully, or to adopt healthier lifestyles — nor for doctors to help them.
- **Insularity.** Though there are some highly effective partnerships between public and private sectors, jealousy and suspicion are more common, with NHS staff seeing private medicine as a threat, rather than a potential resource.
- **Planning.** NHS services are still largely unaccountable to patients. General priorities are set by distant planning bodies; case priorities may be set by doctors, but the process is opaque.
- **Motivation.** Though there are legions of managers in the NHS, staff time is still poorly incentivized and managed. High-quality staff time is wasted on inefficient, unfocused activities.

Organization, not ideal

The founding ideal of the NHS was to give rich and poor equal access to high-quality essential medical care. At the time, it was thought that the best way to achieve this end was through nationalization and central control of our health services.

Half a century on, the *ideal* has become completely fused in the public mind with the specific *institution* — the NHS — through which we still strive to achieve it.

This confusion makes it hard to critique any aspect of the NHS without (wrongly) being accused of rejecting the ideal itself. Yet if we are to achieve *any* end, we *must* be open-minded about the specific *means* we employ to do it.

Practical initiatives

Once we accept the founding ideal, but become open-minded on how to achieve it, a number of new options opens up.

- **Bring in new money.** Private spending shares more of the healthcare burden in many countries, rich and poor. It could ease pressures within the NHS too, if done in publicly acceptable ways.
- **Bring in new expertise.** Accepting a greater diversity of providers and strategies in healthcare delivery would improve the range and quality of services available to the public.
- **Devolve more decision-making** down to patients and away from distant planners. In most industries, it is the direct pressure of customer demand that determines where resources are invested. Can we replicate such user-driven mechanisms for health?
- **Incentivize patients** to use NHS resources wisely — while ensuring that chronically sick or poorer patients are not disadvantaged.
- **Define the boundary** of the state sector. NHS services are covertly rationed. For new funding and provision to come in, we must be honest about where the limits to free healthcare should lie.

Dividing the task

In thinking about practical reforms, it is helpful to break down the task into three separate segments:

- *Provision* — who actually delivers services to patients, and how;
- *Payment* — who pays for healthcare, and how;
- *Planning* — who prioritizes care and investment resources

The provision partnership

Existing achievements. Health services are already delivered by a mixture of public and private providers. This pluralism is particularly pronounced in:

- **Services for people with learning difficulties**, which involve private-sector and voluntary providers, housing associations and other groups;
- **Long-term care**, where there are now around 450,000 places (by far the majority) in private and voluntary nursing or residential homes; and
- **Home care services**, where the hours put in by private and voluntary providers is now 40% of the total, and are cheaper and more flexible.

Unfulfilled potential. In other areas, however, today’s partnerships tend to be patchy, led by individual managers, or crisis moves to plug gaps in NHS care.

Potentially, the private sector could fund and provide major improvements in UK healthcare, but this grudging approach offers no incentive to invest for the long term. So patients suffer, particularly in:

- **Cancer treatment.** A longer-term view is needed if patients are to benefit from a real collaboration between the NHS and companies who are developing new therapies in the private sector;
- **Heart disease.** Inexpensive private interventions, such as counselling and nicotine patches to help people give up smoking, are already having a positive effect. Much more could be done;
- **Severe mental illness.** Private hospitals give patients better accommodation, newer drugs, and better support. Many can be discharged quicker. Yet at present the NHS tends to use private hospitals merely as an overflow;
- **Waiting lists.** Patients would face shorter waiting times if the NHS brought more spare capacity from private hospitals. But to bring forward real investment, this needs to be a long-term strategy, not just *ad hoc*.

Duty to promote pluralism. Achieving the potential of this *managed pluralism* requires much more open and farsighted policymaking within the NHS. Indeed, the NHS should have a duty to develop a greater diversity of funding and supply.

Determinants of the healthcare system		
Provision	Payment	Planning
state employees private doctors voluntary work pluralism	tax-funding insurance vouchers MSAs pluralism	planner push patient pull centralized localized

Payment: new funding partnerships

Funding problems. Politicians are understandably reluctant to ask taxpayers to fund a major step-up in NHS funding.

But private funding causes concern too: there is a deep feeling that essential care should be freely available to all.

Limits to insurance. Most people imagine that the only alternative to state funding of healthcare is private insurance.

Insurance is a good way to provide for unpredictable and costly events, but it is an expensive way to provide for common and small items, where the cost of the paperwork can exceed the claim itself.

The NHS is a tax-funded insurance system that attempts to cover us for large and small events alike. So it spares us the cost of major medical treatments, but struggles to deal cost-effectively with the millions of minor demands we make on it daily.

A more optimal arrangement would be to focus the insurance element — private or state — on providing for the big items, with patients themselves paying for the rest out of their pockets or savings.

This principle already exists in NHS prescription charges; and surveys show the public increasingly willing to pay for small or discretionary healthcare items. But what happens to people who cannot afford to pay even at this level?

A solution. One solution could be *medical savings accounts*. The idea already works very positively within the US private insurance sector; it could work within our tax-funded insurance system too.

Thus the big and expensive items would remain free on the NHS, but patients would pay for smaller items. Since the latter are disproportionately costly to provide and manage, the savings to the NHS would be very significant.

These savings can then be passed back annually to the public as cash accounts which they can spend as they wish on their own medical care. Access to care remains universal, and access to essential care remains free; but efficiency soars.

Other benefits. Medical savings accounts would also enable people to choose new providers or different forms of care that are not presently available on the NHS. They also curb overdemand, by making patients aware of the cost of healthcare, and incentivizing them to become careful and informed consumers of services.

Other ideas. Of course, there are many other ideas, such as vouchers, to boost efficiency in healthcare while preserving the principle of free access for those who need it. The point is that it is time to think open-mindedly about such innovations.

Planning and resource allocation

A move to pluralism in provision and payment will change resource decisions radically. Instead of resources being *sent out* to where planners think they should go, resources will instead become *drawn* to where patients are demanding them.

This in turn will encourage greater diversity as new suppliers step forward to capture some of that patient demand.

Many ‘back office’ functions (such as catering/hotel services, drugs, pathology) already come from private or voluntary suppliers. Extending the same principle to other functions (such as supplies, logistics, and waiting-list management) could reduce bureaucracy and improve performance.

Could we even contemplate a ‘virtual’ NHS that co-ordinates and finances healthcare services, informs patients about choices, and promotes best practice, research, and training — but leaves most of the actual provision to others?

A successful health service

The NHS ideal cannot be met by the NHS alone. It will require a genuine sharing of responsibilities between public, private, and personal sectors on the basis of long-term, strategic vision.

There are enormous potential gains — in cancer, heart disease, mental illness and waiting times in particular. But it needs an honest debate about what each sector is best at providing.

Well-constructed pluralism in finance too will improve cost-effectiveness and give patients the power and the incentive to take more responsibility over their own healthcare choices.

Where resources are allocated through the demand-pull of patients, bureaucracy at the centre can be cut.

Some in the NHS might see all this as a threat; but we cannot afford to protect the Service itself against modernization. If we are to achieve the NHS ideal, we must be prepared to think open-mindedly about the institutions we employ to achieve it.

Further information

A Successful National Health Service by Nick Bosanquet (ISBN 1-902737-04-0: £14) available from the Adam Smith Institute, 23 Great Smith Street, London SW1P 3BL.
www.adamsmith.org.uk