

**ROAD MAP TO REFORM:
HEALTH**

**By Michael Goldsmith
and David Gladstone**

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FOREWORD

By Dr Eamonn Butler

Back in 1982, disappointed by the slow pace of reform by Mrs Thatcher's fledgling government, the Adam Smith Institute commissioned a series of policy reports in what became known as its Omega Project.

The reports involved the work of a hundred experts, including economists, policy analysts, journalists, and politicians. They covered every aspect of government — health, education, transport, local government, agriculture, welfare, taxation, employment, and more. The 500-page result was a complete blueprint for government; over a hundred of the ideas it contained later became government policy, though not all in Mrs Thatcher's time.

It is time to do the same again. New Labour's promised reforms have also been slow to become reality. So once more, we have recruited experts to cut pathways through the policy jungle, and help make reform a deliverable reality. Again, we are mapping those policy pathways in a series of practical reports that can serve as ministers' office manual for effective change.

Purpose of this report

In this report, we tackle the question of how to reform Britain's healthcare system, which is still largely rooted in a sixty-year-old model, into one that is fit for the 21st Century, with its new demands and technologies.

Health is both an individual good and a social good. Poor health leads to individual misery, social deprivation, even societal and economic breakdown. A good example of this is the effects of the ravages of AIDS in continental Africa and the disaster that uncontrolled illness has become there.

In this report our expert authors Dr Michael Goldsmith and Professor David Gladstone put the importance of health in context and seek to identify better ways to deliver it. They begin by exploring the drivers for change in the funding and provision of healthcare and go on to provide ideas for both.

The reformed system they outline respects the realities and achievements of the present system, and is designed to grow out of the existing structures in a controlled and practicable way. In such a short report it is of course not possible to describe in detail the highly complex factors behind our healthcare problems, nor calibrate exact solutions. This is a road map, showing how we can get from where we are now to where we ought to be, not a high-scale blueprint. But our map shows clearly the most promising directions in which to proceed, and we hope it will stimulate further exploration of the route and contribute to policy development and practical change over the coming years.

PREFACE

By Dr Michael Goldsmith

One of the main issues confronting policy analysts when writing a report such as this is the need to calibrate our own ideas against both the current political environment and the views of other experts in the field. When we started preparing for this work in the late summer of 2004, with the general election still some six to nine months away, we attempted to look back through an extensive research programme that has informed this work, and forward both through our own ideas and those of other well-respected thinkers in the health policy field.

To this end we started by arranging a think-tank seminar at the Adam Smith Institute in October 2004. This event was a wonderful day of free-thinking with the participants asking each other, “what if” in the best tradition of the ASI. David Gladstone and I were gratified at the number of key figures who gave up their time to attend, and the many who were not only generous with their time, but with their intellectual material too, including access to unpublished papers. We were all pleased at the huge level of consensus on the day and the excited feeling expressed unanimously that radical change is required if people in Britain are to receive both the quality and level of healthcare that they want and deserve.

We would therefore like to thank a number of people who helped us in the critical phase of marshalling our thoughts as we embarked on the wide-ranging analysis which follows. In particular, thanks go to: Professor Nick Bosanquet (Department of Health Economics, Imperial College London); Sir Cyril Chantler (Chairman, The Kings Fund); Roy Lilley; Dudley Lusted (Marketing Director, Axa-PPP) and Matthew Young (Special Projects Director, Adam Smith Institute). In addition, no serious academic work is possible without good research and we would like to acknowledge the support given by the Adam Smith Institute and in particular by Sam Nguyen in this respect.

What follows below is our best attempt to describe the serious problems with the current methods of funding and provision of healthcare in the United Kingdom and to provide a variety of workable ideas in order to give the upcoming government a stimulus to act with urgency and to get health policy right at last.

1. OUR ANACHRONISTIC MODEL

Illness potentially concerns us all. Its onset threatens individual security, generates anxiety, and creates disequilibrium in individuals' lives. Health — or 'the absence of illness' — is thus 'a basic necessity of the 'good life''.¹ It represents a benefit to the individual and constitutes an important pre-requisite of what is regarded as a 'normal' life.

Private — and public — benefits

Illness and health, however, are more than individual concerns. They both have a social dimension. A whole series of studies has shown the social dimension of illness and morbidity patterns in relation to socio-economic status, age, ethnicity and gender. But health too has significant social aspects that are inescapably political in a system such as the British National Health Service. The allocation of resources, the access to services, the quality and effectiveness of services — all are part of the socio-political agenda for healthcare in the future, just as they have been over the six decades since the NHS was created.

Since then, the NHS has become a popular icon, 'the jewel in the crown' of Britain's welfare state, a symbol of a world in which health and illness are no longer matters for the individual alone but conditions of shared social responsibility. For Beveridge, a comprehensive National Health Service was an essential prerequisite for his scheme of social security. Swift diagnosis of illness and its treatment, he believed, would ensure a double benefit: to the individual on the one hand and to the employer and the state on the other. It would help create the conditions for maintaining high levels of productivity, few interruptions to the payment of taxes and contributions, and a reduced need for long-term social security benefits. It would thus have benefits going well beyond an individual's own health experience.

Our changing society

In the intervening sixty years, British society has changed immeasurably. Post-war austerity has been superseded by a growing affluence; employment patterns for men and women have altered significantly; a far greater proportion of the population, than hitherto, now lives on into very old age.

Against all these changes, there are two important continuities in relation to illness and health. The first is that circulatory diseases remained the most common cause of death in England and Wales at the beginning of the 21st Century, just as they have been for the past ninety years.²

The other continuity is the iconic and symbolic significance of the NHS itself. In the mid-1950s an unnamed Conservative politician, cited in Webster's, *The National*

¹ Michael Bury, *Health & Illness in a Changing Society*, Routledge, 1997

² Office of National Statistics, London, 2004

Health Service: A Political History, opined that to meddle with the NHS would be political suicide.³ And despite some well-publicised criticisms, public support for the principles of the NHS has remained high. But successive governments — especially since 1974 — have ignored the unnamed politician’s advice and ‘meddled’ with the NHS, in terms of its whole organisational structure, management and financial arrangements. If some of the basic foundations of the NHS remain recognisable from its foundation in the 1940s, the superstructure certainly has a very different appearance.

In a short report such as this it is not possible to outline all the dimensions of change that have taken place over the past sixty years. But it is important to examine the main drivers of change that are currently shaping — and re-shaping — the healthcare agenda in modern Britain. As our analysis of those drivers will show, we believe that they demand a new role for government. While it may have been appropriate in the immediate post-war world for government to bind together disparate acute and chronic healthcare services into a state-run monolith, that model of provision looks increasingly anachronistic in the 21st Century world of exploding medical innovation and consumer choice. In such a world we believe that the new role for government should be to:

- finance;
- regulate; and
- educate for healthcare

but not necessarily to *provide* all of it.

³ Charles Webster, *The National Health Service: A Political History*, OUP, 2002

2. DRIVERS FOR CHANGE

There are a number of drivers for change in UK healthcare provision right now. All of them have an effect on the why, when, how, what and where of healthcare. It is important to understand them, and the inter-relationships between them, if we are to move forward on reform. Let us review some of the most important.

Demographics

The most significant item in recent UK demographic history is the ageing or 'greying' of the population. Such a transformation has an immediate effect on the demand for healthcare, since older people are the most frequent — and costly — users of healthcare resources. They are more likely to occupy a hospital bed, and for longer, and are also more likely to receive a home visit from a GP.⁴

At the beginning of the 20th Century, only one in twenty of the population lived beyond the age of 65. Now, one in five do so, with women especially surviving into very old age: men aged 65 in 2003 could expect to live to the age of 81, women to age 84.

Although more of the population have been living longer there is considerable discussion about whether the extra years are spent in good health. The Office of National Statistics (ONS) data sets, for example, suggest that between 1981 and 2001 *life expectancy* increased at a faster rate than *healthy life expectation*, with women especially living for longer in poor health; but then a review of the literature by Meena Seshamani concluded that, 'the additional years of life from increased life expectancy are more likely to be lived in health rather than disability'.⁵ Whatever the reality, it is, as Wanless suggested, 'a proximity to death rather than age *per se*' which is the driver of healthcare spending.⁶

While the number of older people is growing, the proportion of the population that is employed and paying tax is declining. Furthermore, competition from low-wage countries limits the ability of Western governments to raise taxes still further. These factors are bad news for a tax-funded healthcare system: hence, perhaps, the government's dash to exploit private sources of funding through the Private Finance Initiative.

With Wanless, we accept the importance for the public health function of the NHS remaining free at the point of need. But in endorsing that principle against the changing demographics described above, we recognise the need for funding mechanisms that ensure efficiency and effectiveness, and the development of capital schemes that do not threaten accessibility.

⁴ Office of National Statistics, London, 2004

⁵ Meena Seshamani, *The Impact of Ageing on Health Care Expenditures: Impending Crisis or Misguided Concern?* London, Office of Health Economics, 2004

⁶ Derek Wanless, *Securing Our Future Health: Taking a Long-Term View*, London, HM Treasury, 2002

Rising expectations and new medical technology

In the decades since the creation of the NHS, not only have the demographics re-shaped demand. There has also been a culture of rising expectations about what healthcare services are capable of delivering — which is itself, in large measure, the consequence of research in medical science and of developments in medical technology. As early as the immediate post-war years there was an acceleration of medical innovation in the developed world, especially in the United States, and the emergence of a culture in which new ideas and practices were swiftly diffused through medical and scientific communities.⁷

That post-war pattern of innovation and dissemination has had a continuing impact throughout the history of the NHS. New drug treatments, antibiotics, and developments in anaesthesia, immunology and medical machinery have revolutionised both primary care and surgical practice. Classic examples of such new operations include organ transplantation and open-heart surgery. Indeed, such pioneering operations have become increasingly routine, and medical research has moved on to new boundaries such as fertility treatment, stem-cell research, the hugely expensive modern chemotherapeutic regimes and biogenetic medicine. The human genome project too will have huge implications in the range and costs of healthcare treatment over the next decade and beyond.

Such innovations mean that conditions once regarded as ‘incurable’ can now be treated effectively, and a guarantee of an improved quality of life offered to many. But such benefits come at a cost, most immediately in terms of the cost of machinery and the specialist staff who operate them. Thus while such developments are of inestimable potential benefit to users, patients and their carers, they also create considerable extra costs in both hospital care and the drugs and medicines budget of primary care.

Like demographic trends, therefore, medical innovation and the culture of rising expectations heighten the tension between huge demand and finite resources. These are issues that could not have been foreseen in the post-war settlement of the late 1940s by which the NHS came into existence. But they are assuredly the dominant theme of the early 21st Century healthcare agenda.

Epidemiology

Medical research and technology may have heightened expectations and stimulated demand for increasingly intensive and costly care. But over the past century — and, therefore, throughout the years of the NHS — there have been changes in the pattern of illness and disease. These have had a significant impact on the practice as well as the politics of healthcare.

By the late 1960s deaths from common infectious diseases such as measles, whooping cough and diphtheria had all but disappeared, though new infectious diseases such as human immunodeficiency (HIV) viruses, hepatitis B and C, and AIDS (Acquired Immune Deficiency Syndrome) emerged, at least for a time, to generate panic threats of new lethal, pandemic infections. More recently there has

⁷ Anne Hardy, *Health and Medicine in Britain since 1860*, Macmillan/Palgrave, London, 2001

been a resurgence of tuberculosis (TB), partly because of HIV infection and partly as a result of immigration from other countries where infection rates are higher.

Circulatory diseases (which include heart disease and stroke) continue to be the most common cause of death in England and Wales, and are the biggest killer among those aged 65 and above. But cancers are now much more evident, and have become the most common cause of death for women aged between 30 and 44 and for both men and women between the ages of 45 and 64.

In addition to these disease factors, there are other distributional factors that drive the political debate about public access to healthcare resources. Data from the Office for National Statistics shows a considerable geographical variation in health experience, with a cluster of local authority districts with high levels of good or fairly good health in South East England.⁸ By contrast, the ten local authorities with the lowest rates were concentrated in parts of South Wales and Northern England.

The same data also showed considerable variation by socio-economic grouping. Unemployed people had worse health than those in routine occupations, while the health of those who had never worked was sixteen times worse than those in higher managerial or professional occupations.

Geographical location and socio-economic status have featured in many studies of health status and experience, and have generated many attempts to explain them. These have raised questions both about personal responsibility for health and the allocation of NHS resources.

Personnel factors

The NHS is the largest employer in Western Europe, currently employing 1.28 million staff. Its labour force is not only large: it is also diverse, encompassing professionally qualified medical and dental staff, nurses, midwives and health visitors, therapists and other health professionals, technical and support staff as well as health service managers. The wages and salaries bill is thus the largest item of NHS spending, and has risen by 12 per cent a year over the last two years for which data is available.

The commitment by the present government to increase staffing levels will obviously have a direct impact on the costs of the NHS. But, as Bosanquet argues, there are other factors that will tend in the same direction.⁹ These include the *Agenda for Change* re-grading of the whole NHS workforce, which is expected to raise the wage bill by up to 1 per cent in its first phase; while the new consultants' contract could raise that part of the budget by about 10 per cent.

Expansion of staff numbers, re-grading, and new contracts are thus all part of an upward movement in salary spend in the NHS. Meanwhile the increasing number of medical and nursing students currently in training will add further to those pressures as they graduate and enter employment in the second half of this decade. Extra doctors and nurses thus will come at a cost to the service, raising important questions about effectiveness. Bosanquet, for example, highlights the paradox of

⁸ Office of National Statistics, London 2004

⁹ Professor Nick Bosanquet, *The NHS in 2010*, London, Reform, 2004

recent practice, which has seen a disproportionate increase in the numbers of more highly-paid staff in the hospital sector just when it has become more practical to substitute with less highly paid staff.¹⁰ This, as he notes, is in considerable contrast to what has been the experience of the past decade in primary care, where the increase in GP numbers has been only one-third of that of practice nurses.

Political factors

With the creation of the NHS in July 1948 decisions concerning healthcare effectively became political decisions.

Governments, of course, had been involved with the people's health — notably the public health of industrial and urban Britain — before that time, especially by means of the sanitary legislation of the nineteenth century, and the national health insurance scheme created in 1911. The NHS Act of 1946, however, marked a decisive break with the past, since it offered a comprehensive healthcare service to all in the population without any barrier of cost. That was in considerable contrast to what had preceded it.¹¹

The legislation of 1946 was itself the compromise result of a bitter controversy between Aneurin Bevan, Minister of Health in the Labour government, and the British Medical Association, which has been well documented in histories of the period.¹² Its effect, however, was 'a health system unique in the western world'.¹³ The British NHS differed in its funding from the mixed insurance schemes that developed in continental Europe, while its mix of central planning and local administration set it apart from Scandinavian localism.

Since its creation, successive governments have played three main roles in relation to the NHS: funding, management and delivery.

The problem of *funding* a national healthcare system has worried the Treasury almost since the inception of the NHS. Before long, funding worries had led to the introduction of charges for spectacles and dentures, and then prescription charges. More recently, the present government committed itself to higher levels of spending and to raise the UK health spend to that of the European average (in Scotland, spending is now already above that figure). But such commitments require political trade-offs: for example, they have contributed to an actual reduction in the defence budget and a cut in the growth of social security spending.

The *management* of healthcare provision remained unchanged for the first quarter-century of the NHS. Since 1974, however, there has been a process of almost constant and continuous reorganisation and management change. The most significant was with the introduction of the internal market in the NHS and Community Care Act 1990, which made a distinction between the purchasers of

¹⁰ *ibid.*

¹¹ Charles Webster, *The National Health Service: A Political History*, OUP, 2002

¹² For example: Howard Glennerster, *British Social Policy Since 1945* 2nd edition. Blackwell, 2000; Professor David Gladstone, *The Twentieth Century Welfare State (British History in Perspective)*, Palgrave MacMillan, 1999; Nicholas Timmins, *The Five Giants: A Biography of the Welfare State*, Harper Collins, 1995; Charles Webster, *The National Health Service: A Political History*, OUP, 2002

¹³ Howard Glennerster, *British Social Policy Since 1945*, 2nd edition. Blackwell, 2000

services (such as District Health Authorities, Family Health Services and GP fundholders) and the providers (hospitals or community health providers), with contracts as the basis of the relationship between them.

Subsequent initiatives such as the transition from fundholding GPs via Primary Care Groups to Primary Care Trusts have introduced further changes in terminology and, to some extent, in service management. But it is the operation of this new management, and the heightened requirement to raise national standards and respond to local needs, which has produced most change, both in primary and secondary care.

Management processes can become an end in themselves. But, especially for the present government, they represent a means to the end of ensuring a more effective *delivery* of services. Indicators such as the length of waiting lists, waiting times before a consultation occurs, the development of national service frameworks setting standards for service delivery, and the Commission for Health Improvement (now the Healthcare Commission) monitoring operational practice, all reflect the political significance of ensuring an effective level of service delivery in terms of both quantity and quality.

Availability of information

Increasing availability of medical information has meant a revolution in both attitudes to their doctors and in the behaviour of the public towards ill health. The current public health debate about smoking in public places is a good example of the latter. Others include the more detailed description of the contents of foodstuffs and the ‘flagging’ of particular substances.

Meanwhile, there is also an increasing range of information sources from which individuals may gain knowledge about particular symptoms of ill health. Widespread access to the internet is just one example. But in the foreseeable future new developments in interactive technology contain the potential to transform and revolutionise the interaction between patient and doctor.

WHAT ALL THIS MEANS FOR THE NHS

Funding

Because health is a social good as well as an individual benefit, we suggest that healthcare costs should continue to be met principally from public revenue. But in view of the drivers for change outlined above — and particularly in view of their impact on demand and cost — we also have no doubt that Britain needs to utilise other sources of funding in addition to those provided by taxation.

There are a variety of ways in which such additional funding can be supplied. We recommend that these alternatives are explored more fully; and where appropriate, lessons should be learnt from the experience of other countries that use different methods to help fund healthcare provision.

Provision and delivery

The fact that the majority of healthcare funding will continue to come from public revenue does not necessarily mean that the state should continue to run hospitals and employ doctors, nurses and other health professionals. Here again, a variety of alternative systems are possible. As we shall explain, our preferred alternative is for a system of managed healthcare based on commissioning and operated via County Commissioners (bodies comprising elected representatives and some of healthcare professionals). And we will outline how such a system would work in relation to primary, secondary and tertiary care.

3. THE NEW MODEL: FUNDING

The primary issue for all observers of UK healthcare, in general, and the NHS in particular, is whether the central funding of healthcare by government is entirely immutable in the UK.

In post-war Britain, the answer to this question was unequivocally 'yes'. The 1948 Bevan NHS introduced a new type of healthcare that was almost fully comprehensive and available to everyone free at the point of delivery. Nevertheless, this ideal was soon breeched in both principle and practice by the early introduction of charges, and pressure on funding has continued ever since.

In the late 1980s, the increasing funding burden of the NHS (£36 billion in 1987 rising to £48 billion by 1996)¹⁴ led to a minute examination of the funding and provision of healthcare. Radical new funding arrangements were contemplated but with 'free at the point of need' being such a sacred cow, there was little real movement. The advent of the internal market did allow money to follow the patient, but the funding still came centrally, out of taxation. The only co-payments introduced under the Thatcher reforms were those for optical and dental treatments, and an above-inflation increase in prescription charges.

More recently, a Labour government has, paradoxically, led the public to accept that they might have to pay for an enhanced ability to obtain good quality healthcare that is more freely available where they live. The increased spending of New Labour has yet to extinguish the postcode lottery; meaning that there are serious geographic variations in the volume, quality, and menu, of what is available currently through the NHS. But the possibility of co-payment (or 'topping up') might allow people to obtain what they want when they want it without the need to migrate to a private only funding system.

So what then are the options for the funding of UK healthcare in the 21st Century? Logically, the possibilities range from total tax funding at one end to total private funding at the other. But in order to understand what are the *practical* ways forward, it is useful to examine the types of funding systems exist worldwide for payment for healthcare. Let us now do just that.

TAX-FUNDED SYSTEMS

What then are the different tax funding options for healthcare, and what are their pros and cons?

Out of general taxation

Since the inception of the NHS, both its capital and revenue funding have been provided out of general taxation at an ever-increasing rate of growth. By 2010 the UK will have the highest proportion of GDP spending of any OECD country, at a

¹⁴ Office of National Statistics, London 2002

rate of 10% of GDP compared with an OECD mean of 7%.¹⁵ On the positive side, this is a tried and tested funding method, and also a very simple one. On the negative side, it involves the government taking money from people centrally, and returning it to them again in the form of local healthcare services which can be wasteful and difficult to focus. There is also no limit to the volume of demand if healthcare continues to be 'free'. And political interference is inevitable in such a state-dominated system.

Out of hypothecated tax

Under the Beveridge proposals, National Insurance was intended to be a form of hypothecated tax; but for many years it has not been linked in any way with NHS or social care funding.

Although hypothecation has been suggested by some (including the former social-security minister Frank Field MP), we do not see it as a useful way forward. The British public does not currently differentiate between 'good tax' and 'bad tax'; hypothecation would not change this. It would also encourage people to demand to opt out of some spending (like defence) that they disagreed with, in favour of inessential but uncontroversial and popular alternatives. And it would leave less to the judgement of our representatives which in healthcare, for example, could lead to irrational expenditure on unnecessary, unscientific, or unwise treatment regimes.

Local taxation

In *Germany*, health insurance is one of the four branches of the social-security system. Most people have to join a *Krankenversicherung*, an official state-approved social insurer: only those earning above the national insurance threshold can choose to exempt themselves.

There is a choice of funds and members have a chance to change funds once a year. Contribution levels are determined solely as a percentage of pre-tax income up to the national insurance limit, equating to an annual salary of about £36,000.¹⁶

But there has been significant rise in cost over the last 15 years. In 1993, for example, the contribution rate ranged from 8.5% of pay to 17%. By 1998, the average contribution rate had reached 13.9%. And on top of this there are long term care contributions of 1.7%. The employer pays half of the total, so the average employee contribution is about 7.5%; but the fact that so much is paid indirectly in this way may have contributed to the escalating costs.

The system has certainly been popular, with 66% of electors reporting themselves satisfied or fairly satisfied with the system, compared to just 48% of those in Britain.¹⁷ The German system contains something of a price mechanism that helps control expenditure, but rising demand and consumer manipulation of the system fail to contain costs as well as in a direct taxation model.

¹⁵ Professor Nick Bosanquet, *The NHS in 2010*, London, Reform, 2004

¹⁶ David Green, *Healthcare in Germany and France: Lessons for the UK*, London, Civitas, 2001

¹⁷ Panos Kanavos and Professor Elias Mossialos, *The Methodology of International Comparisons of Health Care Expenditures: Any Lessons for Health Policy?*, London School of Economics, 1996

In *Sweden* the system is rather different. Healthcare funding is based on a countywide system of local taxation that reflects an individual family's income.

Counties assume the full responsibility for primary care and planned for the provision of services on the basis of an annual fixed budget, and each decides whether and how to reimburse private practitioners for services provided to local residents. This localised system means there are in effect 26 county-led planned markets for healthcare,¹⁸ each of which has developed in different ways.¹⁹

Several healthcare delivery implications arise from this local autonomy. First, duplication is a major implication. It means that two regional, county or district hospitals could be located very near to each other, separated only by county boundaries. It is also possible that one particular health treatment or technology could be duplicated at every regional or county hospital simply because the specific counties each want it available locally, even if there is no healthcare need for it.

On the other hand, local autonomy has bred innovation. St Goran's Hospital in Stockholm, for example, has been effectively privatised. It is paid according to the number and kind of patients it treats. This has given it greater independence and a clearer focus on outputs. It has been able to reduce staff costs, raise the number of care episodes, and increase time with patients. Indeed, its annual labour productivity from 1998 grew, while that Sweden as a whole fell. Salaries and work conditions are better. Medical and administrative staff and unions, originally opposed to the changes, are now overwhelmingly in favour of them.²⁰

Social insurance systems

Some observers have suggested social insurance as an alternative to either public or private financing. Social insurance might be thought of as the middle way, and there is considerable merit in this idea.

In *NHS Reform: Towards Consensus?*²¹ Anthony Browne and Matthew Young proposed a system of competing social insurance schemes that are independent of government, similar to those in the Netherlands, Germany and Switzerland. Membership would be compulsory for all citizens, and the social insurance schemes would be banned from refusing membership to anyone. Premiums would be proportional to income, making sure the system is as fair as general taxation, with the premiums for the very poorest paid by the state. Hospitals and other healthcare providers would be separated from the social insurers, with the government acting not as a manager, but as a regulator, making sure the system works fairly and efficiently. All services would remain free at the point of access, unless people chose to pay fees for service in order to reduce the monthly premiums or to buy extra services.

¹⁸ Howard Glennerster & Manos Matsaganis, "The English and Swedish Health Care Reforms", *International Journal of Health Services*, 24 (2) pp 231-251 (1994)

¹⁹ *Ibid.*

²⁰ Fredrik Erixon, Chief Economist, Timbro, *Swedish Health Care Reforms*, presentation to Seminar on Public Services, Edinburgh, 16 February 2005.

²¹ Anthony Browne & Matthew Young, *NHS Reform: Towards Consensus*, London, Adam Smith Institute, 2002

The authors maintained that certain rules would need to be followed to ensure the success of the system. First, it must be compulsory to buy social insurance (otherwise, only the sick and old would buy it, pushing up the cost and making it unaffordable to those who need it most — the problem that private medical insurance has in the UK today). This compulsion, already a feature of social insurance schemes in other countries, will provide the necessary cross-subsidy between the young and healthy and the sick and old.

We believe that the compulsion should apply to people of all incomes. As we have seen, wealthier people in Germany are not obliged to join; and the Netherlands actually expels higher-income earners from its social insurance schemes, forcing them to go private. However, letting the rich opt out will reduce the element of cross subsidy essential in any health system, and make it less progressive. It could also lead to a two-tier system, and reduce the political acceptability of reform.

If a social-insurance model is adopted in the UK, the individual should pay the full cost of insurance, as occurs in Switzerland. France and Germany have shown that relying too heavily on employers to pay social insurance creates a 'tax on jobs' that can damage employment. Focusing payment around the individual will also prevent the problems of the US system, where health cover attaches to a particular job, leading to 'job lock', reducing the flexibility of labour markets. An individual-based system also makes it easier for people to remain insured, and to remain with the same insurer, when they move between jobs or in and out of work.

The poor, of course, would pay nothing: their insurance premiums will be met, on their behalf, by the government. But to ease the cost burden of social insurance for everyone else, it should be combined with an income tax credit. This will ensure there is no sudden jump in deductions from people's wages.

European countries with social-insurance systems allow various degrees of competition, both on price and on the basic package of services provided. But it may take Britain some time to develop such variety and competition. We therefore envisage that in the early stage at least, UK social insurers would be limited in number and fairly closely prescribed in terms of the choice they offered to potential members.

Direct government payment for treatment

Under this system, healthcare providers charge the patient, but the government reimburses the patient for some or all of the cost, as happens in France, for example.

While all employed citizens of France pay into insurance schemes run by provident societies, mutuals, or private insurers, France also respects the principle of *médecine libérale*, which dates from the late 1920s. Patients are free to choose their own medical provider; and (except 6m of the very poorest) they pay their doctor, pharmacist, specialist, or clinic directly at the point of use. However, on application to the relevant government office, part of the cost is reimbursed: co-payments may range from 20% on consultation fees in hospital, through 35% on paramedics' fees and laboratory tests, to 65% co-payments for minor medicines.

The system has been criticised for its bureaucracy, with well over a billion claim forms being lodged each year; but the introduction of the new credit-card-sized *carte vitale* is helping to secure more efficient and more rapid repayment: patients give their card to the doctor, who swipes it and then automatically generates a reimbursement.

The system is complex but universally popular. It leaves patients with almost completely free choice, and produces a good deal of competition among providers, with few if any waiting lists for patients. It also has the advantage of making people realise that healthcare has a real cost — unlike the British system, in which most services are free at the point of delivery — and its co-payments, encourage people to look for best value. On the downside, it has a large bureaucratic cost, and any reimbursement by a third party can be cumbersome.

Voucher systems

The concept of vouchers in health and education — whereby all citizens are given the cost of the service but are free to choose whichever supplier they feel is best for them — was mooted in the 1980s and 1990s, and does not seem so far away from the government's evolving policy today. The idea has been given strength by the many practical examples that have sprung up in various parts of the world.

In Pennsylvania, for example, vouchers have been introduced in an effort to cut waiting lists. Two years ago, with proceeds from the state's share of the national tobacco settlement, Pennsylvania launched its adultBasic scheme, providing basic healthcare coverage for 36,000 poorer individuals who do not qualify for Medicaid. But waiting lists can be long. Now, however, thanks to a public-private partnership administered by the state, everyone on the adultBasic waiting list can obtain a \$100 voucher to help pay for healthcare costs.

Under the plan, the Highmark Caring Foundation has put up \$1 million for the vouchers and, along with the Jewish Healthcare Foundation and the Fayette County Community Foundation, hopes to raise a total of \$3 million. The vouchers can be used at any of 88 community health centres in Western Pennsylvania.

Meanwhile, in Auckland, New Zealand, vouchers are starting to be used to focus healthcare so that the right treatment is provided in a timely fashion at the point of need. Health minister Annette King endorsed the voucher scheme as, 'an innovative way of making sure people go to the right service at the right time' and helping to keep people out of accident and emergency rooms when they ought to be visiting their family doctor.²²

Finland and the Netherlands have also experimented with health and social care vouchers. And in the UK, Stephen Pollard, a noted health policy commentator, has more than once made the case for them in the left-wing *New Statesman* as a method of allowing money to follow the patient;²³ while on the right, the Conservatives' 'patient passport' ideas has some of the features of a voucher system.

²² *New Zealand Herald*, 27 July 2004

²³ Stephen Pollard, "Power to the Poor People", London, *New Statesman*, 1996 (reprinted July 15 2002)

Vouchers are a means by which governments can give people choice and stimulate the creation of new, competitive providers, while still ensuring that the poor have access and that costs are controlled. Vouchers also enable people to top up the state contribution, which increases the amount of private spending in the overall public-private mix. We view these as beneficial attributes. However, the management of vouchers and the bureaucracy of 'honouring' vouchers such that money follows the patient do involve some administrative cost.

Tax relief on private insurance

If the UK is to seriously embrace private insurance as part of the funding solution, there is a case for at least some tax relief for private health insurance premiums.

This was tried by the Thatcher government, which offered tax relief to the over-65s in order to encourage them to remain in private medical insurance once they had retired. The idea was that this in turn would reduce the burden on the NHS from a group of people who are high users of medical services.

However, tax experts argue that tax relief is an inefficient way of encouraging private spending, and hard to roll back once in place (though this did not prevent the incoming Blair government from abolishing the scheme). Insurers also complained that the Inland Revenue made the rules absurdly and expensively complex. And tax relief interferes in actuarial decisions by giving health-aware high-risk people easier access to insurance.

METHODS OF PRIVATE FUNDING

We have so far reviewed a variety of methods of tax-based or social insurance based funding. But individuals also make their own financial decisions and an increasing number of families are making private healthcare funding a priority. Let us review the main mechanisms.

Paying at the point of need

An increasing number of people already pay private healthcare costs out of their personal income. This is particularly true of low-cost care such as consultations and investigations in acute care, which may run to only a few hundred pounds. The same is true of minor surgical treatment, dentistry and ophthalmic care. However, most people cannot fund major medical or surgical treatment or in-patient care out of income, and low-paid or unwaged persons clearly cannot do it at all.

Consequently, this cannot be a universal alternative to state funding. And yet, it may have some role. Any encouragement of private spending by those who can afford it will boost the total spend available for healthcare and can reduce the burden on state funding at the same time.

Personal savings

Again, a growing number of people have been using *private savings* as a way to fund private health treatment. This is often instead of taking out private health insurance, with savings being treated by people in much the same way as they keep emergency money for household repairs. People keep cash in a building society or other savings account, which they use to fund the less expensive treatments as described above, or even more expensive surgical treatments that crop up only rarely. It is increasingly common for expenditures of up to £10,000 or £15,000 to be provided through this route, and “self-pay” market for private hospitals in the UK has been the fastest-growing market segmentation in the last decade. The public seeks a safety net to escape the long delays and indifferent quality of the NHS, and in many cases, they have chosen to pay for it.

Medical savings accounts

As earlier Adam Smith Institute reports have documented, a number of different countries have experimented with medical savings accounts.²⁴ These allow people to save for medical treatment of all kinds. The accounts usually attract advantageous tax treatment (as in the United States, for example) and can be used to pay for any allowable health-related expenditure including dentistry and long-term care.

An advantage of medical savings accounts is that they are a cheaper way to fund small medical expenditures than private medical insurance. They can also give the holder much more freedom over the choice of healthcare services and providers that can be accessed. A disadvantage is that they tend to compete against pensions for people’s savings. It is difficult to know in advance the right amount to invest to cover future health risks, and dedicated accounts for healthcare could leave people over-provided for medical care and under-provided for everyday living. (However, “claw back” arrangements can help solve this.)

Once again, medical savings accounts could provide a useful and cost-effective way of boosting private healthcare spend. But they are unlikely to provide a universal solution to healthcare funding.

Company cash payments and Return to Work Trusts

Many employers provide cash to fund their employees’ acute private care. Often, this is done for key workers whose absence from work while waiting for NHS treatment would be costly for the firm, or where early investigations and treatment could hasten a recovery and return to work.

The disadvantage of this type of funding is that the employee incurs a P11D tax burden for a “benefit in kind”, which is a disincentive. To get over this hurdle, employers are now using Trust-based solutions. The schemes are managed by insurers or by third-party healthcare administrators: a discretionary trust fund receives annual injections of money from the firm, and the employees receive private healthcare benefits authorised by the occupational health department specifically to aid return to productive work. Physiotherapy and MRI scanning are often provided through this type of funding.

²⁴ See, for example, Eamonn Butler and Synthia Ramsay, *Why Not a Medical ISA?* Adam Smith Institute, 2001

Insured cash benefits (such as hospital cash plans)

Hospital cash plans have been around for over half a century. The Birmingham Saturday Fund is a long-established example, and there are many other regular-contribution savings plans in the UK. The money collected on a weekly or monthly basis allows for a cash payout to help towards in-patient or out-patient treatment or other health benefits like spectacles, false teeth or physiotherapy. These are popular and efficient vehicles where funds are often collected through direct payroll deductions or union contributions.

Private medical insurance (PMI)

PMI plans include full and near-comprehensive health insurance such as BlueCross/BlueShield in the United States or BUPA, AxaPPP, Western Provident, or Norwich Union in the UK.

Thanks in part to the rise of company and union-sponsored schemes, private medical insurance has grown greatly in the last few decades. In 1971, some 2.1 million were covered; by 2000 it had grown to 6.9 million. Private medical insurers now handle over £2bn worth of claims.

Private health insurance is limited by the fact that it only covers acute (mainly surgical) care. But new types of policies might provide a serious enhancement to Britain's healthcare funding difficulties, particularly if such innovations were encouraged by tax relief or national insurance relief.

Future additional insurance products might include modest, European-style top-up policies to give people access to a wider range of services than is readily available through the NHS. At the other end of the spectrum would be comprehensive private insurance covering all aspects of healthcare and not limited only to acute procedures.

Insurance is not a solution for all health funding: it cannot do everything. It is inappropriate for minor treatments, for example, where the cost of managing the claim can be many times the value of the treatment itself. It may also be inappropriate for long-term or chronic care where the risk stretches far into the future and is hard to quantify. Rather, insurance is always best as a solution to disasters: it efficiently handles large expense items. PMI can be really useful for major and unexpected healthcare episodes; and we recommend its use as a long-stop to protect people when they take more responsibility for funding their healthcare needs themselves.

Partial private insurance

It is possible to take out insurance that does not cover every medical need, but only the big-ticket items such as surgical treatment or hospital conditions, or catastrophic needs that require protracted or expensive treatment. It is also possible to purchase baseline insurance, which will cover all claims over a certain figure (say £5000).

These are often called top-up insurance plans. In some countries they are used in tandem with medical savings accounts — using savings for the more routine medical costs and catastrophic insurance to provide against the unexpected but costly needs.

MIXED PUBLIC AND PRIVATE FUNDING

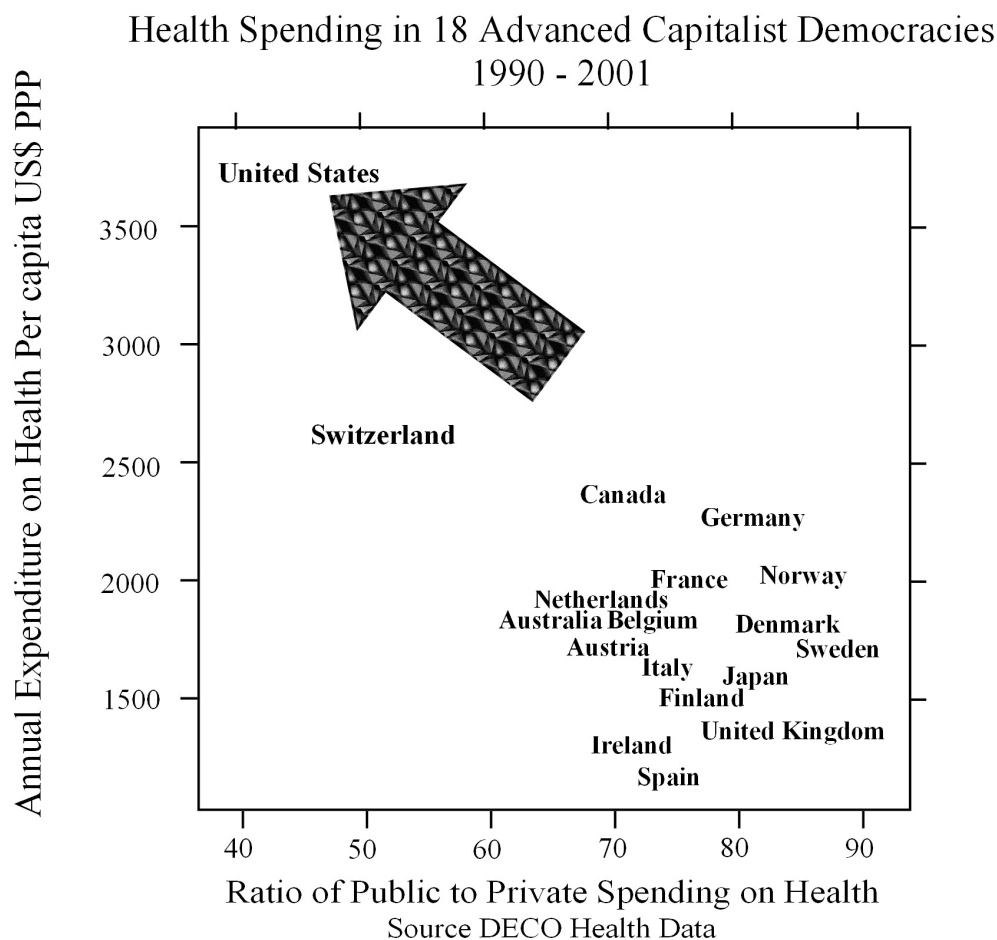
A mixed economy for health funding already exists in the UK.

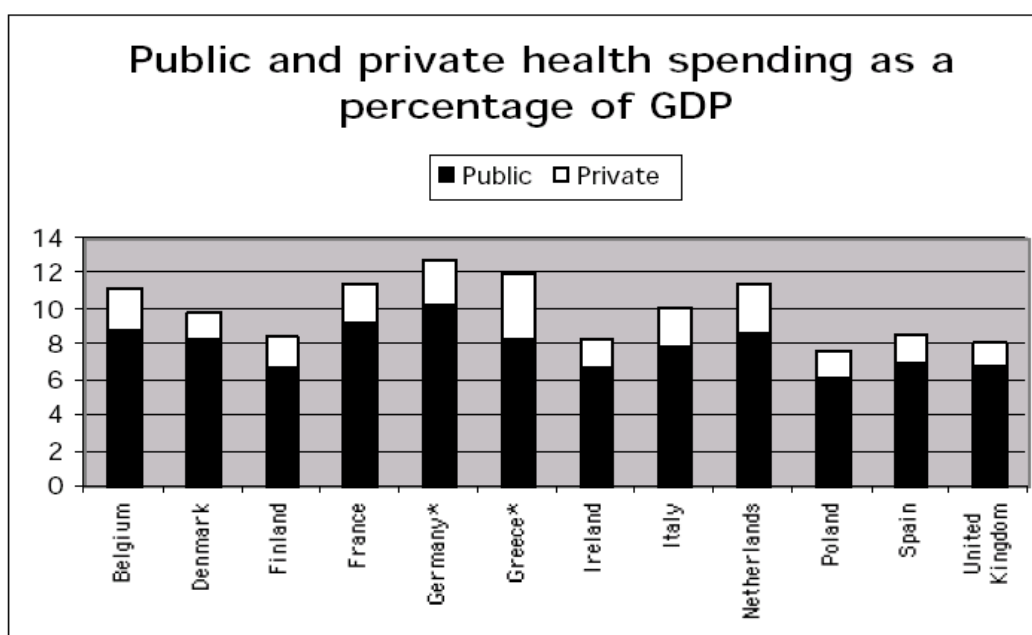
In addition to NHS-funded care, people (or their employers) can and do buy private health insurance to give them immediate treatment without waiting, specialist treatment from the consultant of their choice, and high-quality hotel-style hospital accommodation in a private room.

There is also a growing amount of 'out of pocket' payment for healthcare services, by which people pay out of income or savings.

Some private hospital groups also offer beneficial loan arrangements to help spread the high costs of private treatment.

Nevertheless, the UK not only spends less in total on healthcare than many other developed countries, but the proportion of that spending which comes from private sources remains very low, as the following charts show:





Source: OECD Health Data 2001

Many experts have argued that the element of private funding within the mixed economy should significantly increase. Only this is likely to raise the total sum of funding available for healthcare in the UK. And only then will the mixed economy flourish and generate major improvements in both the level of resource available for healthcare and innovative systems delivering it.

Thus the major challenge for any incoming UK government in 2005 will be to develop policies that significantly raise the proportion of private to public spend.

In capital terms, at least, a start has been made by using increasing amounts of private capital to build new health facilities through the Private Finance Initiative (PFI). Under this system, the government enters into long-term agreements (more than ten years and sometimes thirty years) with the private sector to design, build and maintain healthcare facilities like hospitals.

But very little has been done to encourage private spending on health. Indeed, some of the recent initiatives involving public-private partnerships have significantly damaged the private healthcare market by drawing away demand and by blurring the edges between public and private sectors.

Action is now long overdue. As long ago as 1988, Willetts and Goldsmith suggested the use of silent NHS facilities at nights and weekends for private care, increased involvement by employers in the funding of healthcare, and other methods of encouraging private spending and provision.²⁵

Another option might be to limit the availability to free NHS care according to a person's means. As we have seen, better-off people are not allowed to join the basic social-insurance scheme in the Netherlands, and membership of Germany's sickness funds is optional for them. About a third of Dutch and German citizens pay instead for comprehensive private insurance.²⁶

²⁵ David Willetts MP & Dr Michael Goldsmith, *A Mixed Economy in Healthcare*, London, Centre for Policy Studies, 1998

²⁶ David Green, *Healthcare in Germany and France: Lessons for the UK*, London, Civitas, 2001

Likewise, the mixed economy for healthcare in the UK could be deepened if those earning more than the national average wage were obliged to self-fund for acute healthcare services, or were given fiscal encouragements like tax relief to do so. Certainly we need to ask whether the government should be funding all healthcare for all citizens regardless of their means: we do not have national funding and provision other essentials like food and clothing, nor does anyone believe things would be better if we did. Why should healthcare be so different?

EMPLOYER FUNDING AND MANAGED CARE

Having looked at government funding and individual funding, another alternative to fund healthcare through employers. In the UK, some employers already provide their workers with private medical insurance (PMI) for acute care and medical treatment. But PMI is only a partial solution, which usually does not cover any form of chronic illness or condition or any form of social care for the disabled or elderly.

In the United States, pressures to make private healthcare insurance more and more comprehensive also led to it growing more and more expensive. In response to this, various forms of managed care have sprung up, the most common being Health Maintenance Organisations (HMOs).

Originally a model used to provide health cover for workers on the Hoover Dam back in the 1930s, an HMO is an organisation which contracts with an employer or a group of employers to provide a wide range of employee healthcare benefits, in exchange for a fixed monthly premium paid by the employer. The plan is managed by the HMO, which acts both as payer and provider, using either its own medical and nursing employees and premises or hiring them in from suppliers. The care is rigorously managed for quality and performance standards according to fixed protocols, ensuring that clinicians offer best-value, high-quality care.

However, while these organisations have helped to control healthcare costs, the main concern from patients is that quality may suffer in the process. These complaints resonate with users of the NHS in Britain.

Another method of employer funding is direct payment for 'running repairs' to get employees back to work. This can be seen in workers' comprehensive insurance in the United States and the emergence of 'back to work' plans in the UK over the last five years.

Finally, some pundits have suggested that the answer might be an employer-funded hypothecated tax, with the state picking up the bill for the unemployed and retired. This is a version of National Insurance as it was originally intended at its inception in 1911. Employers would pay a health tax for their employees, which would be used to fund NHS care. However, there are few advantages in this to the end user or to employers. It does make spending on healthcare more transparent; it might allow the government to put up taxes in a more palatable way, but it is essentially the same as funding health through central taxation.

WHAT ALL THIS MEANS FOR THE UK

So what are the realities for funding healthcare in the UK?

Our view is that healthcare will continue to demand a mixture of public funding through central taxation and some topping up through HMOs or through more comprehensive insurance policies from existing insurers. Central funding out of taxation is seen as the most equitable solution and the surest guarantee healthcare being free at the point of need.

However, real consideration needs to be given to focusing public funding on those who are not financially well off and who need more consumer protection, while allowing or requiring the comfortable middle classes to opt out and provide their own healthcare financing solutions. If there are concerns about people's willingness to fund healthcare themselves, then compulsion is an option: car insurance is compulsory, why not health insurance?

The reason that the UK remains so wedded to the *status quo* in terms of funding lies in sociology and epidemiology. The poorest socioeconomic groups continue to be the least healthy and the highest consumer of healthcare services. They use up more resources per capita than other groups and, because of an inability to pay or even to top-up, they require the most protection by government. They will always be the least able to contribute to the high cost of health improvement. In addition there is the concern that if you leave it to the people to pay for healthcare then resources will be spent first on alcohol and cigarettes, followed by food and entertainment, followed by 'luxury items' (cars, furniture) before any consideration is given to funding healthcare. In addition, most of the five million economically inactive people in the UK would be unable to pay.

For these reasons we believe that the government should ensure that essential healthcare is paid for by central government funding or at least funded at minimal levels set down by government. There may be a need to direct government funding to the poor, unemployed and low earners while others self-fund. But this government involvement in funding healthcare certainly does not imply that we believe that the state should continue to employ doctors, nurses and other health professionals or should run hospitals. The act of paying for something does not imply or determine that the payer also has to supply the service.

However, it may imply that the payer should be the regulator. In our model, we propose that local County Health Commissioners should be responsible for quality control relating to the commissioning of locally provided services. And we envisage that the Healthcare Commission will have an extended national regulatory remit.

As we shall set out below, the real change in healthcare surrounds the need to change radically the method of healthcare provision, so as to develop a new model suitable for the 21st Century. The 1948 model, as reformed by Thatcher and later Blair, is no longer viable for the levels and variety of service now required and enabled by the advent of new technology, science and understanding. What is more, the public are now so much more health-aware that they expect the new technologies to be available for them when they require them, and they will no longer tolerate the very poor standards current in parts of the NHS. Rationing by waiting is no longer an option.

4. THE NEW MODEL: PROVISION

Having reviewed the options for change in funding, we must now consider new mechanisms for provision and delivery. Given that the ideal is for the government to pay a fair proportion of the costs of healthcare but for patients (and the various commissioning bodies) to choose between a wide assortment of providers, just as they do now for food and clothing, let us explore the implications of that for the NHS.

In our mode, the NHS would be a regulating and standard-setting organisation. It would also commission health care and pay for it. Perhaps it could also be a social insurance organisation. Existing state provision would be transformed gradually into competing private provision from a multitude of sources. The competition for funds will ensure that patients get the best possible value for money and that consumer choices will determine where the money goes. Government will have less and less control over the day to day nuances of healthcare provision: this will be good for politicians because they hate having to defend themselves about delivery failures over which they have little day to day influence; and it will be good for consumers because regulated competition will drive up healthcare standards and improve access to modern healthcare systems and technology.

Under this system, fairness is still guaranteed because the state pays. But the state does not try to run an enormous and hard-to-control bureaucratic management structure like it does today. And that in turn will allow completely new delivery mechanisms to emerge, and unleash a great deal of innovation.

Not before time. In his recent paper entitled, *The NHS in 2010*, health economist Professor Nick Bosanquet explains that the various NHS Plans have ignored the real lessons of international experience which were recently summarised by the OECD:

‘Ultimately increasing efficiency may be the only way of reconciling rising demands for healthcare with public financing constraints. Cross-country data suggests that there is scope for improvement in the cost-effectiveness of healthcare systems. This is because the health sector is typically characterised by market failures and heavy public intervention, both of which can generate excess or misallocated spending. The result is wasted resources and missed opportunities to improve health...’

The distribution of healthcare resources in other countries (see the chart below) shows clearly that the UK currently has the poorest provision in all the countries analysed on almost every measure.

Note that France, which is generally thought to have a competent and effective healthcare service, has more than double the number of GPs compared to the UK, but fewer specialists (in spite of the total number of physicians being nearly double that of the UK and slightly more than that of the United States). It is therefore not clear that simply spending more money and doing more of the same will actually deliver us a better UK healthcare system: there may be better ways of doing things.

Healthcare Resources (OECD Health Data 2002)

Resource	France	Germany	UK	Scotland	England	US
Practising physicians per 1000	3.00	3.60	1.80	N/A	N/A	2.80
Specialists per 1000	1.50	2.40	1.60	1.50	1.20	1.40
GPs per 1000 pop	1.50	1.00	0.60	0.69	0.55	0.80
Nurses per 1000 pop	6.00 (97)	9.30	5.30	N/A	5.20	8.30
Acute beds per 1000	4.20	6.40	3.30	3.53	2.2	3.00

The UK, for example, has powerful controls on the numbers of physicians being trained and in practice. But all this central planning has not saved us from the huge manpower and skills shortages that are now adversely affecting the quality and availability of healthcare. This is particularly true in nursing, where nurses have to be recruited from abroad in ever-increasing numbers — a policy that cannot be sustainable in the long term.

In terms of finance, our agenda for change is based upon the continuance of public revenue alongside increased opportunities for ‘top up’ funding. In terms of provision and delivery, however, we propose a more devolved system of managed healthcare, based upon commissioning by County Commissioners. We outline this model in the next section. Before we turn to the details of our procurement model, however, we outline the current system of healthcare provision in the UK and what our more diverse approach to provision would mean for it.

CURRENT AND FUTURE STRUCTURES

What follows is a description of the current make-up of the NHS together with our comments on what would remain (and not remain) in our vision for the future.

The Secretary of State for Health in England and his or her opposite numbers in Wales, Northern Ireland and Scotland currently make the political decisions on healthcare in general; but more particularly they focus on policies concerning the NHS. These policies, some of which are agreed in Cabinet, are then translated into action at the Department for Health, the Scottish Executive Health Department, the NHS Wales Department of the Welsh Assembly and finally the Department of Health (DoH), Social Services and Public Safety in Northern Ireland. There are differences in the NHS chain of command in the four countries but they are all based on the English system, so that for the purposes of this report we will briefly describe the current NHS structures and then suggest how they should be reformed.

The Department of Health

This government department is responsible for overall planning, regulation and inspection of the NHS. Policies are developed here, agreed by ministers, and then promulgated down the NHS management, mainly through circulars issued to Strategic Health Authorities.

In our model, a refocused Department would be responsible for the public health but not for every nuance of the NHS. Ministers would no longer be responsible for the supply of healthcare free at the point of delivery, nor how it is delivered. They would be responsible for ensuring that funding was adequate, that funds were effectively delivered to providers, and for regulation, quality assurance and public health issues.

Strategic health authorities

Strategic Health Authorities (SHAs) are the successors to Regional Health Authorities, which were abolished at the end of the last Conservative government. They are currently responsible for healthcare provision and delivery in their region. They act as the link between the Department and the grass-roots NHS. They are responsible for ensuring that national health priorities and policies (such as cancer programmes and decisions made by the National Institute for Clinical Excellence (NICE)) are correctly implemented.

Our view is that the current 28 SHAs are too many in relation to the changes in financing and provision which we are recommending. In an NHS where the government's role will be limited to providing and distributing finance and regulating both quality and supply of healthcare, there will be no requirement for such a widespread network of controlling authorities. We need radical pruning of the NHS at this level, which will generate a huge saving in administration and bureaucracy as well as release day-to-day control from Whitehall to the grass roots. With the implementation of our managed care suggestions (described below) the advent of county commissioning will remove much of the need for SHAs.

Primary care trusts

Currently there are about 300 primary care trusts (PCTs) in England. They have evolved from the Blair government's reforms of the internal market designed by the Thatcher government of the late 1980s. They are a direct offshoot of primary care groups and have superseded the Family Practitioner Committees, which in turn superseded the Executive Councils designed in 1948. The PCTs make local decisions about local needs in terms of primary care. In their area, they are responsible for GPs, dentists, pharmacists, opticians, NHS walk-in centres, out-of-hours services, and NHS Direct. They also have a responsibility for local secondary care planning and decide on what services will be provided to the local population. They determine the quality, quantity and range of services to be provided, and which Hospital Trust will provide them. They also provide a link with local authorities for local health planning. Currently the PCTs receive about 75% of the NHS revenue released by the Treasury.

We would abolish PCTs entirely and have their purchasing responsibilities taken over by local commissioners. American experience in managed care over the last thirty years shows that the minimum population for enlightened and effective purchasing is 100,000 people, with 250,000 being the optimum. We anticipate at least two commissioning bodies per county that would handle all the roles of the PCT and give the public a measure of choice and competition. Our recommendations on county commissioning are outlined below within our comments on managed care.

Acute trusts

These bodies run the district secondary care hospitals, tertiary care hospitals and medical centres. There are also university trusts for some teaching hospitals. All these trusts manage the hospitals that offer acute and trauma care and the main specialties like accident and emergency, paediatrics, general medicine, general surgery, orthopaedics, gynaecology, neurology, radiology, and so on.

Such trusts will be obsolete under our proposals, in that the majority of NHS hospitals would be transferred to private, charitable or not-for-profit ownership, reflecting the situation in many European countries.²⁷ Such hospitals will be managed by their own boards. The only acute NHS trusts remaining will be those where the government has retained control as part of the transition from the old system to the new, and perhaps the teaching hospitals with university affiliations. The latter will not be so easily or readily transferred to private ownership and in order to retain high training and teaching standards, the Department of Health may have to retain control of them until the private sector can demonstrate its ability to develop future personnel as well as to provide high quality services in a competitive market.

Care trusts

Care trusts provide both health and social care; sometimes they provide mental health, social care, or primary care services. They tend to be set up where the NHS and a local authority wish to work closely together. There are only a few of them in England so far, but they have been said to be the local healthcare deliverers of the future. An example of one of the first, set up in April 2002, is Manchester Care Trust, which brings together social care and health services for adults with severe and enduring mental health problems, and provides NHS services for the elderly mentally ill.

We like the idea of removing artificial administrative barriers between health and social care and would recommend that this type of model be explored further. There is no reason why trusts of this type should not be delivered in the private sector and commissioned by County Commissioners (see the section on managed care below).

²⁷ In Switzerland, for example, about a quarter of hospitals are run by for-profit or non-profit groups; in France about a third are non-state, most of those being for-profit; in Germany roughly half are non-state, of which two-fifths are for-profit; while in the Netherlands about 90% of hospitals are private.

Mental health teams

These are specialist trusts that deliver local mental health services to the community. They co-ordinate a whole spectrum of services ranging from acute in-patient care for psychiatric disease, through chronic long-term care for the severely mentally ill, to out-patient and community psychiatric nursing support.

NHS mental health services have gone through major upheavals recently. The closure of the old Victorian “asylums” (which by the 1950s were treating 250,000 patients) led to patients being treated either in the community or in NHS district general hospitals. But as district hospital beds continue to close, more patients, around 32% of those who require constant supervision, are now cared for in the independent sector. About two-thirds of those independent beds are paid for by the NHS.

The private sector has proved more nimble than the NHS in securing planning consents for secure units, and raising the capital (averaging about £250,000 per bed) needed to give patients and staff better living and working conditions.

To re-structure mental health services at the same time as making major changes in acute service delivery is of course risky. We therefore propose to retain mental health trusts. But we recommend that alongside the services which county commissioners purchase from them, services from suitable independent providers should be purchased as well.

To facilitate this, a shift in purchasing from “spot purchase” single-patient contracts to service-level agreements covering block bookings should be encouraged. Second, we must dispel the myth that people with mental illness are incapable of making choices and respect their wishes to be treated in superior private-sector facilities where appropriate. Third, inadequate facilities should be forced to close or upgrade by making same inspection standards apply to NHS and independent psychiatric inpatient services alike.

Ambulance trusts

These trusts run the thirty or so ambulance services in England. They are responsible for providing emergency control centres, acute emergency ambulances, some air ambulances and non-urgent patient transport services.

These trusts appear to work well and, as one of the three emergency services, we believe that they could continue unchanged as a directly funded and managed NHS provider. However there would be nothing to stop them being put out to competitive tender and being managed wholly within the private sector. In Denmark, for example, the majority of ambulance services are run by a private insurance company which also runs the country's largest automobile recovery service. Many of the paramedics in one service double as mechanics in the other.

Additionally, non-urgent services such as outpatient transport should be compulsorily put out to competitive tender so that the growing private ambulance service sector can be utilised in NHS care.

Foundation trusts

In April 2004 some acute trusts were given 'foundation status' to allow them more freedom and financial flexibility with less central government control and monitoring. They are in theory owned and run by the local community (though voting at elections for their boards has been thin), and they enjoy easier access to funds for new investment and capital from the private sector. They are accountable to a board of governors, and an independent regulator monitors their performance. In these respects, they were intended to be analogous to foundation schools, which can set their own admissions policies and raise their own capital independently of the local authority. The left hate such ideas, but the right believe that foundation trusts are not independent enough of national and local government.

Our proposals for radical change will mean that this type of trust will be immediately obsolete, since it would be superseded by the large-scale transfer of state hospitals to the independent and not-for-profit sectors. Foundation trusts have not been seen as a success by any objective observers and although we espouse some of the ideals of the foundation trust concept, letting them survive a wider reform, simply for political or dogmatic reasons, would be unwise. We also believe that the management cadre is not sufficiently skilled or experienced in running autonomous structures to make foundation trusts work. In our diversified model, foundation trusts would be wholly unnecessary.

NEW FORMS OF PROVISION AND PROCUREMENT

So far we have outlined the current NHS structure and our specific recommendations for change. Now we outline the details of the major changes which we propose for the procurement and delivery of services, and which we believe would best enhance the supply of and quality of healthcare for the 21st Century.

Managed healthcare

Commissioning, as a concept, has been established over the last fifteen years since the Thatcher 'internal market' reforms of the late 1980s. One of the major principles of the internal market reforms that were developed during the Thatcher years was the need to commission healthcare from high-quality, best-value sources, and Mrs Thatcher was impressed with the early results of managed care in the United States, and persuaded that managed care was probably the future for the UK too.²⁸

A variety of types of managed care have been tried throughout the world but the main principles remain the same. As already described, the managed care organisation agrees to supply care to a large group of patients for a fixed monthly fee, and delivers that care either through its own clinicians and facilities or by hiring it in under contract from providers.

The apparent efficiency of managed care organisations is based on the fact that they compete for customers on the back of their reputation for the quality and accessibility of their care. There are various models, from staff models where the

²⁸ David Willetts MP & Dr Michael Goldsmith, *Managed Healthcare: A New System for a Better Health Service*, London, Centre for Policy Studies, 1988

organisations use their own hospitals, primary care centres and staff (a bit like the NHS) through to Preferred Provider Organisations (PPOs) where patients can choose from a variety of contracted providers. Whatever the model, managed care organisations use *medical direction*, with highly-skilled medical managers using protocols that enable them to maintain quality while controlling cost. Cutler and McClellan, in their major cost-benefit analysis of managed care, concluded that 'managed care has clearly reduced medical spending increases, at least over the short term'.²⁹

There are too many details to touch on in depth here, but the concept of managed care underlies our suggestions for commissioning. The types of commissioning bodies which might be considered in the UK context include:

- new county-wide managed care commissioners;
- existing PCT-style bodies; and
- health management organisations.

There are other possibilities too, but we favour the first of these three suggestions and will call them County Commissioners.

On the provider side, the County Commissioners could purchase healthcare from a very wide range of organisations, including:

- existing NHS Trusts;
- existing foundation hospitals, if they survive;
- private and public diagnostic and treatment centres;
- private or non-profit healthcare and mental-health companies; and
- other independent providers, such as partnerships of doctors and nurses and preferred-provider organisations.

Diversity and competition

Below we give a range of suggestions as to how the list of mechanisms we propose above can work in practice.

First, the government would delegate comprehensive commissioning for all aspects of NHS care to the county commissioning agencies. Of course, it is possible to have competition between commissioning bodies whereby people register with the commissioning body of their choice, as they do with HMOs in the United States. However, we are concerned that an immediate attempt to introduce competition into commissioning may over-complicate the system in terms of both its administration and public understanding. For this reason we do *not* advocate an immediate move to widespread choice in commissioning, but the development of one or two commissioning bodies in each area, running on sensible geographical areas.

These commissioners, which we have called County Health Commissioners, will commission, on behalf of local residents, all health services on a list of core services. It would in theory be possible for these core services to be determined at a regional level and chosen democratically by the electorate, just as they were in Oregon.

²⁹ D M Cutler and M McClellan, "Is technological change in medicine worth it?" *Health Affairs*, September/October 2001; 20(5): 11-29

However, we believe again that the early phase of any reform should be as simple as possible and the best policy would be to have a national list of core services determined by the government.

The commissioners' task would be to procure health services for their public, buying them in from the multiplicity of providers who would offer healthcare services and paying for them with cash provided by the central government. These resources could be augmented by the various top-up and self pay systems described above.

Diversity in primary care provision

Initially, GPs would be commissioned either singly or in groups or as limited companies in fixed geographic areas. This would be necessary to ensure adequate coverage by qualified and experienced primary care physicians and is the same mechanism currently in force under PCTs for the same reasons.

Such primary care practices could include:

- individuals or self-employed contractors (like most GPs today), tendering for local contracts;
- groups tendering for local or regional contracts;
- new kinds of corporate provision from the private sector; and
- new kinds of primary care from existing NHS sources (such as Guy's & Thomas' regional experiments in outreach clinics).

This diversity in primary care will undoubtedly drive other changes, such as the following.

Medical information: Soon, electronic patient records will become feasible. There is already huge IT investment within primary care, and 97% of GP practices are connected to the internet.³⁰ Around half use the internet to transmit records and pathology results. And the NHS is soon to have a functioning on-line appointments system.

Increasing numbers of patients too are using the internet for health information. The UK's high rate of broadband take-up will enhance the ability of patients to exercise choice over both their provider and the type and location of their treatment.

Home visits: Another change that is likely within the first few years of the new system is the phasing out of home visiting. No other country provides home visiting as an integral part of primary care and the British public have now got used to urgent care centres where they can go after hours, and the increasing use of specialist primary care triage at local accident and emergency departments. NHS Plus, a government-run call centre staffed by nurses, has also reduced the need for out-of-hours GP cover.

Core services from GPs will be set by commissioners through well-defined contracts. Patients will be able to buy extra services such as home visits, travel medicine, family planning services and other non-core services. In addition, parts of

³⁰ European Commission, *Eurobarometer*, June 2002

the core service will increasingly be provided not by specialist nurses, counsellors, psychologists, physiotherapists and other paramedical professionals, rather than by GPs.

Dentistry should become part of the core services again! Dental health has suffered because of the withdrawal of dentists from the NHS as a result of the unattractive NHS contract. Dentists working as individuals, in groups, or in private dentistry companies would contract with the local commissioners, but not necessarily on an area basis as for the GPs, and not necessarily on a fee-for-service contract, which encourages poor practice and discourages innovation.

Core treatments will be laid down in the contract, but there will be encouragement for patients to co-pay or top up through specialist insurances for extra services like the hygienist, restorative dentistry of extra quality (eg porcelain crowns), orthodontics and other more complex surgical work.

Ophthalmic services will also be provided as before through opticians and ophthalmic practitioners under contract to the local commissioners. All eye tests should revert to being free and basic glasses should be available with top-up from patients for designer frames and other non-basic aids. Children should have either contact lenses or reasonably modern frames available on NHS care.

Other primary healthcare services such as counselling, physiotherapy, podiatry and chiropody should be provided by a combination of individuals, professional, groups, private companies, charities, non-profits, or national provider organisations. They may sub-contract with GP practices or primary care providing firms or contract direct with county commissioners.

Pharmacy: We recognise the growing importance of pharmacists in primary care and also in the control of access to healthcare resources. Although the GP is always spoken of as the gatekeeper to secondary care, pharmacists have become the major gatekeeper to primary care.

The current arrangements for licensing pharmacists have produced a broad geographic spread. But the rules governing the distribution of pharmacists restrict competition. We agree that pharmacists should remain what they essentially are at present — self-employed contractors within the NHS — but a more competitive environment should be encouraged. Like other care providers, they require payment through NHS funds; and while there must be some regulation, the market should continue without *over*-regulation. There is absolutely no reason to continue with geographic regulation (which stems mainly from the desire of the Royal Pharmaceutical Society to ensure that its established pharmacists are not threatened by new entrants). Such regulated protectionism is not granted to other sorts of business, and we see no reason why it should extend to pharmacists.

There is a case that pharmacists should be paid a limited annual advice fee from the county commissioners to encourage active participation in primary care and to formally recognise the significant advice they already give to millions of patients each year.

The current policy of the Prescription Pricing Authority is a simple and cost-effective way of controlling prices and reimbursing producers. However, it

does restrict patient (and doctor) choice. We believe that the government should determine the maximum price it is prepared to pay for a particular drug treatment, and if patients choose a more expensive (perhaps more modern) version of the drug instead, they should pay the difference. This will encourage choice and innovation, while still ensuring that everyone has access to adequate therapies.

Diversity in secondary care provision

Existing NHS hospitals would contribute to the new system under wholly different methods of management and through new commissioning methods as delineated above. This would involve:

- retaining some NHS hospitals (eg teaching hospitals and some supra-regional specialist centres) and having the remainder of secondary care supplied by independent providers;
- converting the majority of NHS hospitals into autonomous providers, either by transfer to non-profit groups or by sale to private secondary-care providers.

Managed healthcare providers (MHPs) would then contract with the commissioners for an area or an entire county. They might buy or lease the current NHS trusts (together with all their hospital facilities and other resources) that the government released over a set term as part of a manageable transition plan. Or they might buy and build private hospitals and care facilities (including, for instance, diagnostic and treatment centres).

This would create a diverse provider market, which would be and would behave, much more like a natural market than the 'internal market' brought in under the Thatcher reforms. It would therefore contribute to the development of a genuine mixed economy for healthcare and encourage greater spend and innovation on healthcare services.

MHPs may come out of existing NHS trusts (acting singly or in combination), existing providers, new entrants from the UK or abroad, or new providers and investors; or they could be a combination of any or all of the above.

Today's NHS hospital trusts would, as we have indicated, be released from government management and control at a controlled pace, perhaps over five years. They would become totally independent and would be locally run with locally elected boards. They could be constituted as companies limited by guarantee, or friendly societies, or other not-for-profit arrangements (many HMOs worldwide are non-profit organisations).

Diversity in tertiary care provision

While most discussions about healthcare reform concentrate on the acute services of primary and secondary care, tertiary care is actually the most difficult and expensive to provide. In most countries in the world specialist services of a technical nature tend to be concentrated in regional centres of excellence where larger numbers of more complex treatments can be performed. Epidemiology and research on

outcomes demonstrates that success and survival rates for the rarer types of surgery are much better when teams of experts who stay together as teams for longer periods and perform large numbers of procedures.

Because tertiary care is expensive and there tend to be fewer experts than generalists, it makes sense to continue the *status quo* and concentrate these specialist services in supra-regional centres. The types of specialisms performed by such centres include oncology (cancer treatment) with its specialist radiotherapy equipment and chemotherapeutic scientists, neurosurgery, vascular surgery, transplant surgery (liver, kidney and heart) and cardiothoracic surgery. All the technology associated with these specialties is expensive and capital intensive. It makes sense therefore to concentrate them in tertiary centres. (Traditionally these have often been associated with university departments, often because of the teaching need at these centres.)

It is also clear that round-the-clock working would make better use of these expensive resources and we strongly recommend that tertiary care centres should be made to work in this way. Imaginative use of staffing hours will make this possible, given sensible negotiation with unions and other worker and professional representative bodies.

We recommend that this system of provision in tertiary units continue within the changes that we have already outlined. The complex relationship between university funding and the particular individual salaries of academic and NHS consultants would be unnecessarily complex to unravel. But tertiary care centres will become stand-alone units which may or may not be under Department of Health (DoH) control: there is no reason why some might not secede from direct DoH control and form themselves into not-for-profit bodies. County commissioners would then contract for different specialties with the tertiary care providers of their choice. These might be one-stop-shop arrangements or they might be more widely geographically separated according to their performance and the desires of patients.

There may be a need for some provider and manpower planning by the Department of Health. We therefore envisage a contracting mechanism that allows regional planning intervention by the DoH or by a regional public health planning body.

The future of community care

Community care is an important interface between health and social care, especially in relation to older people and the mentally ill. It is an interface that raises issues ranging from bed blocking (where more adequate social care could permit more efficient use of healthcare resources) to the relationship between care or group homes and their local communities.

For many decades now, politicians have supported living at home rather than in some form of residential care setting, though the specific preferred delivery structures have often changed. In the 1960s, the policy envisaged an expansion of statutory health and welfare services; in the 1980s, with the increasing recognition of a mixed economy in welfare, the range of potential suppliers significantly increased to incorporate the independent sector of formal voluntary and private organisations; and in the 1990s, community care became like the NHS, subject to contracts and an internal market, and no longer directly provided by social services departments.

Collaborative working may be essential to make a reality of community care at local level, though such arrangements have proved difficult to initiate and maintain. Furthermore, 'community care' has sometimes been seen more as 'community neglect' — a view strengthened by press reports of acts of violence by people with a mental illness who were theoretically under supervision, and by accounts of abuse and failure in the care of the elderly.

Because of our commitment to streamlining the interface of health and social care, we recommend commissioning by County Commissioners from existing service suppliers, mental health trusts, new private-sector entrants, and non-profit independent providers. The quantity and quality of such provision is a matter for regulation as described below.

The public health agenda

Public health has developed from its nineteenth-century concerns with water supply, drainage and sanitation, and now encompass a wider range of global environmental concerns such as the spread of AIDS and HIV, influenza, tuberculosis (TB), SARS etc.

In addition, there is increasing (though often contested) scientific knowledge as well as growing consumer awareness and concern about aspects of food production and packaging, including worries about BSE and GM crops. In all these ways, the public health agenda is increasingly compassing a health education and health promotion function.

For these reasons, we envisage a continuing and significant role for the Department of Health in relation to health education and information, and the provision of 'traditional' public health functions such as the maintenance of public health laboratories and associated research, and of hospitals capable of dealing with infectious diseases.

Occupational health

In previous reviews of the NHS, little has ever been said about occupational health. We believe that in the 21st Century the development of new ideas on the funding and provision of healthcare in the UK are essential in order to counter the increasing economic problems being brought about by occupational disease in general and sickness absence in particular. Sickness absence cost UK business £11.6 billion in 2003, with employers fearing that up to 15% of absence was not genuine.³¹

Peculiarly, the promotion of good occupational medicine seems to have become the remit of the Department of Work and Pensions rather than the Department of Health. But this is another area where 'joined-up government' is needed, but is sadly lacking. There is a strong need to move the agenda away from a crude health and safety focus and to create real change in the management of work-related illness.

³¹ *The Lost Billions: 2003 Absence and Labour Turnover Survey*, London, CBI, April 2004

We are concerned that by most estimates only 5–20% of the UK workforce has access to occupational health. Small and medium-size enterprises (SMEs) have even less access, due to a combination of ignorance, lack of motivation and scant resources. However, the Health & Safety Executive and the Department for Work and Pensions are currently developing innovative pilot initiatives to remedy this, which we applaud.

While we do not see occupational health as a core health service, it is an increasingly integral part of healthcare need and its supply needs to be addressed. There are serious manpower shortages and funding difficulties in occupational health because it is entirely employer-funded.

We believe that urgent incentives are required to pull all employees into the occupational health net. This would serve to fulfil Beveridge's aim in establishing a National Health Service, namely to guarantee a fit and healthy workforce. But two major hurdles have to be surmounted. First, increased effort and resources are required to improve the manpower shortages. In our opinion these are caused by inadequate entry levels and a lack of education facilities for occupational health physicians and nurses: many medical schools do not teach occupational medicine at all, at undergraduate level. Second, we must encourage employers to pay for this aspect of healthcare. The cost might be £30 and £50 per employee per year but employers might be incentivised to invest in it by means of tax reliefs or by ring-fencing part of their National Insurance contributions for the purpose.

OTHER ISSUES ARISING FROM REFORM

Cost effectiveness and clinical effectiveness and safety

Currently, clinical effectiveness (and to some extent, safety) is provided by the National Institute for Clinical effectiveness (NICE). There are concerns that NICE has simply become a rationing device: critics complain that it is slow to deliver judgements, that it is open to both political and industry pressures, and that its decisions are often equivocal.

We propose that NICE is abolished and its role subsumed into another body (see below).

Drug safety is the responsibility of the Committee on Safety of Medicines (CSM). This type of regulation appears to work rather better and we propose that the CSM's remit be enhanced to include all types of treatments and that it continues to function visibly outside of direct political control by ministers.

Cost-effectiveness is a wholly different issue, and we believe that research on cost effectiveness of healthcare treatments and methodology *is* the responsibility of government. This role should sit within the inspectorate role of the Healthcare Commission. It is an essential part of ensuring access, safeguarding the public, and delivering the best possible healthcare.

Personnel issues

As we noted earlier, under the present government there have been significant increases in the number of health service personnel, with more doctors and nurses working in the NHS than at any time before.

However, increases in technology and new treatment have led to a 'round the clock' demand for medical personnel that was not so prevalent two decades ago. At the same time, the European regulatory regime produced a new Directive on working hours which prevents the NHS continuing to rely on excessive hours put in by nurses and doctors. This has led to a shift system for doctors, a new working practice. Consequently, if service levels are to be maintained, more doctors at every grade will be required to supply the staffing need.

Another manpower-related issue is the hugely increased intake of women into medical schools. In the present — but more especially in the future — this may result in more part-time rather than full-time practitioners, as women increasingly combine raising their families with their professional careers.

We endorse the current trend towards increased places for medical and nurse education. We also propose that present and future manpower needs should be a continuing responsibility for the Department of Health. New measures should be developed to increase entries to postgraduate specialties like occupational health and others where shortages are causing bottlenecks and delays in treatment nationwide. We also propose that renewed attention should be given to efficient and adequate substitution of costly medical and nursing personnel when this is appropriate.

Regulation

We see regulation as an important determinant and guarantee of quality, providing assurance to patients that they will be 'safe in their hands'. But recent well publicised cases — such as Shipman, Ledward and Wishart — have demonstrated all too clearly that the current regulatory system, relying heavily as it does on professional self regulation with statutory backing, is inadequate, and fails to provide the necessary safeguards and guarantees to the patient.

A knee-jerk reaction to recent events is inappropriate. However, there is little doubt that the regulatory system needs to be re-examined and reformed. There are a number of alternatives that could be considered. These include:

- a GMC-type body with government appointees in equal numbers to medical professional members;
- an added role for the Health Care Commission (HCC); or
- a new regulatory body to adjudicate on matters of serious malpractice, while individual complaints of a less serious nature are the subject of no-fault compensation.

We believe that an excessive burden is placed on medical doctors for the purpose of revalidation, and we propose, without the sacrifice of quality assessment, that the quinquennium process should be conducted with a 'lighter touch'.

The Health Care Commission

We endorse the recent development and reconstitution of the Healthcare Commission, and believe that the effort now being put into the reorganisation of healthcare under the Care Standards Act (2000) should remain within the remit of the HCC.

There is, however, room for the integration in the HCC of a number of other bodies with overlapping responsibilities such as the Commission on the Safety of Medicines. We would now add to the remit of the Commission the inspection, audit and regulatory responsibilities of other bodies including the Audit Commission and the Health and Safety Executive.

We thus aim at simplifying and reducing the number of regulatory regimes in the healthcare sector, but without any sacrifice of the guarantee of quality to patients and their families. This, we recognise, will not be an easy task.

CONCLUSION

In this report, our remit was to design a roadmap for healthcare reform. We have formulated our recommendations against the background of several inter-related pressures that the system is facing now and will face more acutely in the future.

Our proposals are based firmly on the principle that everyone — however rich or poor — should still be guaranteed high-quality care free at the point of need. And we assume that the large bulk of healthcare needs in the UK will continue to be funded through taxation.

But we also recognise the limitations of this traditional model. The sad fact is that other countries now do many things better. There was a time when the NHS was the envy of the world; but no longer.

If we are to create the dynamic system of healthcare that a 21st Century public now demands, we will need to change. We will need new sources of funding, and new forms of managed competition that can deliver health care through an innovative and diverse array of providers.

Thinking about these issues over a long time has left us in no doubt that a healthcare system for the 21st Century will require innovation and serious change — change in finance, management, and delivery. And that in turn will demand nothing less than the modern equivalent of what Beveridge and Bevan did in creating the NHS in the first place — that is, bold, innovative and strategic action by policymakers, and a willingness to embrace change by all those who are engaged in healthcare delivery.