

The New Shape of Public Services

Volume 1: Health & Education

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The Adam Smith Institute

London

2001

Bibliographical information

Published in the UK in 2001 by
ASI (Research) Ltd, 23 Great Smith Street, London SW1P 3BL
www.adamsmith.org.uk

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ISBN: 1-902737-23-7

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Published in the UK by Immediaprint Ltd, NW1.

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1. Introduction

“Of course you cannot just sling money at any problem in order to solve it.”

– Tony Blair, May 23rd 2001

A broad consensus is beginning to emerge over the state of Britain’s public services. The old split between left-wing support and right-wing hostility is being replaced by a more considered approach from both sides, an approach which admits elements and arguments from each camp.

It is now recognized, for example, that money alone is *not* a solution to public service problems. Faced with recurrent crises over the years, politicians of both major parties have occasionally responded by injecting cash into whichever service was putting them under political pressure. That the additional cash did not result in significant and lasting service improvement is evidenced by the recurrent nature of these crises, and the fact that large numbers of people in Britain find the present state of public services to be less than satisfactory.

The need to modernize

There are problems inherent in the structure of state services which lead to that noted under-performance. Indeed, during two decades in which the state of Britain’s industries, both manufacturing and services, were utterly transformed, the public services seemed to become gradually worse — though not for want of spending. The new private services became modern and responsive, profitable and competitive, and capable of sustaining international comparison. But the public services, once hailed as models to the world, did not modernize, and slid further down the league table of international performance.

Britain’s **National Health Service** was still described by some, even ten years ago, as “second to none,” “the envy of the world,” and other flattering epithets. The current position is that no nation aspires to a health service like the British one, no country chooses to adopt our “enviable” system, and if it is used for an international example, it is of one to avoid.

Britain’s **schools** were once hailed as world-beaters too, and its education system was held up as a model to the world. The facts now are that British children fare quite poorly in international comparisons. They score less well on reading ability, writing skills, mathematics and science than many of their foreign counterparts. Too many leave school with no meaningful qualifications, either academic or vocational. And the proportion of people who leave without having mastered even the basics is far too high. After 11 years of schooling, about seven million adults cannot find the right page for a plumber in the *Yellow Pages*. A fifth of all adults cannot read or write at the level expected of an 11-year old, while two-fifths are less numerate. The Skills Task Force estimates that illiteracy and innumeracy cost the UK £40 billion a year.

Even Britain's **benefits system**, once held up as a modern, enlightened way of offering a helping hand to those indeed, is regarded as poor by international standards. It traps people into dependency, encourages cheating on a grand scale, and fails to assist the genuinely needy in meaningful ways. It manages to combine two adverse features simultaneously: it gives people an exaggerated idea of their entitlements, while managing to humiliate them at the same time. Far from focussing on those in need, it has evolved into a system where two-thirds of UK households are dependent on some kind of means-tested benefit.

In **pensions** there is a stark contrast between the highly evolved products of the private market, and the inadequate and inflexible pensions provided by the state. Private pensions have enjoyed a boom, and account for most of the income of an overwhelming majority of those retiring. These are rightly held to be worthy of international comparison, and are widely regarded as examples of what a pension system can achieve. They are funded, secure, and they deliver good returns. They mean that most people who retire will not depend on the goodwill of future taxpayers, or on the flimsy promises of long-departed politicians.

By contrast, Britain's state pensions have given poor returns. Since they are not funded, their level depends upon what politicians think taxpayers will bear. Their benefits can be expanded only as far as taxes can be raised, rather than the much superior levels that have been achieved by private pension companies from investing in world markets. And the old trick of persuading people to accept increased contributions by the promise of spectacular returns in the future no longer works. People do not believe government will deliver, and they may be wise to think so.

One of the government's dilemmas is that if it tries to make the basic state pension meet an adequate and acceptable standard of living in retirement, it sends a signal to discourage people from taking out or contributing to private pensions. If it awards increases on a means-tested basis, it makes fools of those who have looked ahead and saved for their own future needs. Those who simply squandered their money are helped at the expense of those who saved.

The public's lack of confidence

Such is the lack of public confidence in state services that most people in Britain are pessimistic about whether those services will survive. An ASI poll conducted by MORI (*Facing the Future*, 2000) revealed that people's expectations for the next 50 years are very low for public services.

37 percent think that most or nearly everyone will pay for private schools

56 percent think that most or nearly everyone will pay for private health

59 percent think that most or nearly everyone will pay for private welfare insurance

66 percent think that most or nearly everyone will pay for private pensions

This is not exactly a ringing vote of confidence in state provision of services. People simply do not expect that services of this standard will survive. In a Consumers' Association survey, 40% of the public said that in the face of NHS

delays, they were willing to pay for private treatment, even if they had no health insurance and had to pay for treatment out of pocket.

Glib talk about adequate funding overlooks the fact that any new money is likely to be as mis-spent as the old money, unless fundamental changes are put in place. The amount spent has been increased before without solving the problem. The new “massive injection” of cash by Gordon Brown will not solve the problem either, unless the services are restructured so that they spend it more effectively.

A further ASI poll (*The Wrong Package*, 2001), also conducted by MORI, found that in general the public services do not spend their money on those things that the public values. In other words there is a *producer agenda* which government and the services feel able to deliver, but one which differs markedly from the *consumer agenda* which the public would like to see holding the priorities.

Producers versus customers

Market economists, including those associated with the Adam Smith Institute, argue that although each public service in Britain faces its unique and distinctive problems, these problems are all symptoms of a systemic weakness in the nature of the public sector itself. It is that it cannot be market-led because the payment is indirect. This means that because members of the public do not go along with cash in hand to buy health, education or police services, like they buy vacuum cleaners or digital recorders, the services do not feel the demand pressure of a discriminating public, a demand pressure which causes constant improvement in the private sector.

It is because the public services do not have to please their end users to survive that they pursue other goals. Ironically, although the non-profit ethos lies at the core of public service, it is the very fact that they do *not* make profits which makes it easy for the service to deteriorate. For a private firm, falling profits are a warning light telling it that it is no longer producing what its customers want and that it must change what it does. The public services, having no profits, receive no such signals. They are denied the essential feedback which comes direct to them from the daily purchasing decisions of sovereign consumers in the market.

This not only makes these services unresponsive; it makes them inefficient. Falling sales and profits tell private firms that their approach is wrong. Watching their customers shop elsewhere tells them that their quality and prices are not right. These market disciplines force private firms to cut costs, to change their product or service offerings, to copy best practices, to streamline their production, and to operate in more efficient ways. All this allows for keener prices, a more customer-focussed way of working, and outputs more attuned to the needs of the public. But the public services, having no such daily exposure to the pressure of the public, can become very inefficient, and have outputs which cost far more than their private sector equivalents.

New approaches

This does not necessarily mean that public services are doomed. What it does mean is that they can probably be improved if ways can be found to expose them more to demand pressures, and let them feel the beneficial influences that market principles can work. The internal market which (despite the official

rhetoric) operates in the NHS via the Primary Care Groups, is one way of doing this. The use of private sector firms to undertake the delivery of at least part of the public service's output is another. The Labour Manifesto for the June 2001 General Election put it succinctly:

"Where private sector providers can support public endeavour, we should use them. A 'spirit of enterprise' should apply as much to public service as to business."

Precisely so. Although there is by no means agreement on how public services should be funded, or indeed on the level of funds which they might require, there is beginning to emerge a consensus around the attitude expressed in that manifesto extract. With few exceptions, the Conservative Party would not disagree from the official view of the Labour Party. Both agree that more private sector methods are needed, more private sector expertise, and more *actual* private firms need to be involved in the production of public services.

This represents a break with public service tradition. The old model saw the state own all of the land and buildings, employ all the staff, buy such equipment as it needed, and set about trying to provide whatever it thought it could manage, even if this was sometimes by no means clear.

Efficiency targets versus user wants

The introduction of the Citizen's Charter brought several innovations into public service, not least of which was the requirement for public services to set targets. In some cases they had never previously had to think about what it was they were trying to do, much less to write it down and publish it. The Charter introduced the idea of targets — routine for private sector firms — but a novelty for some of the public services.

The problem with the Charter, and indeed with other methods which seek to have the public sector copy private sector behaviour, is that the *direct pressure from the public* is not there in the state services. The demands of the public are mediated through politicians, and are often expressed only infrequently, at elections and in opinion polls, so their response to changing public needs can be slow and confused. They do not face bankruptcy (not yet, at least); they do not see more sales translate into higher profits and salaries. The incentives and fears which motivate people in private firms are simply not there. True, there are other motives, including the desire to serve, but they do not supply the same force or induce the same behaviour as market pressures do in the private sector.

It has been remarked of efficiency drives in the public services that they tend to run out of steam after about six months. Campaigns to promote savings, efficiencies and better quality cannot be sustained as they can in private firms because there is nothing to sustain them. No market pressures equals no market behaviour. No demand pressure equals no consumer orientation.

If the public services had to bid for each customer, as private firms do, and if their finance came only as a result of satisfying that customer, the public services would be utterly transformed. The fact that they do not operate like this means that their under-performance is not an accidental feature of their output; it is inherent in their structure.

Capital inadequacy

The fact that public services are chronically under-capitalized is again, no accident. It does not happen because some wicked government has neglected them and starved them of money. It happens because they do not have to attract investment on the basis of their likely performance. They receive it instead from a government which always has more claims on public finances than it can meet, and which allocates its funds on the basis of political pressures, not necessarily from any long-term, considered, objective assessment of each service's need for capital and likely success in using it.

Facing demands for money to be spent on children, old people, roads, hospitals, tax cuts, housing and the environment (to name but a tiny few), governments of all parties have tended to satisfy as many of the raucous voices as they can by shaving money off the capital account. Investment denied or delayed does not show in the same way that lack of current spending does. The buildings may get a little more dilapidated, new facilities are put off another year, but at least there are no staff cuts. It is politically the easiest option. It is for this eminently political reason that many of the public services seem out of date and under-resourced. They never received quite enough to keep up-to-date with the latest technology and innovations. They never had customers who would leave them if they did not do so.

Today's opportunity

There is currently in Britain a unique opportunity. The public services are receiving an increase in funding (although not on the scale which is put about, where three year funding is presented as if it were one year, is not inflation corrected, and is announced many times over). Even so, there is a real increase. It is accompanied in informed circles by the knowledge that this money by itself will not work. At the end of it there will still be inadequate, under-performing public services which fail to meet public expectations of them or demands upon them.

Failure to achieve the promised improvements will therefore leave the new government highly vulnerable when it faces the next election four years or so from now. There is thus an acceptance that radical reform of the structure of public services is needed, combined with the determination that this must happen, a mandate from the electorate to do it, a sufficient surplus in the public budget to finance the restructuring, and a broad, cross-spectrum agreement about how real user-focussed reform might be achieved.

This creates, perhaps for the first time, a chance to modernize the public services in the same way that the state industries, and then the utilities, were transformed under the impact of policies influenced by market ideas. If this opportunity is not seized, it will leave Britain with low quality and declining public services which will wither away, even as they continue to consume vast quantities of public money to no good effect. The opportunity is here, and the time is now.

2. The NHS

“The NHS employs one million dedicated people. But it needs far-reaching reform to redesign its services around the needs of patients.”

Labour Party Manifesto, May 2001

If a privatized health service had made many of its patients wait 18 months for their operations, put them on trolleys in corridors when they arrived, given more than a quarter of them an illness which they did not have when they arrived, and confiscated the organs of their dead babies without bothering to seek their permission, or even to tell them, people would have blamed privatization. For that matter, if one of its practitioners had murdered 150 of his patients, or one of its surgeons had removed healthy kidneys instead of diseased ones, or one of its teams had conducted smear tests so incompetently that operable disease was not treated, while healthy women were unnecessarily subjected to distressing operations, all this would somehow have been put down to the reckless pursuit of profits, or to putting shareholders ahead of patients.

Of course, there has been no privatization to take the blame. Some people have adventurously attempted to blame under-funding and lack of resources as the causes of all problems, but to more detached observers, these occurrences might seem to indicate that the system itself, together with the attitudes it engenders, are at fault.

Many of the above horror stories are symptomatic of an institution which has an inadequate relationship with its customers. As with all state-run bodies, there is a tendency for producer concerns (often dressed up as “professional judgement”) to dominate over responsiveness to customers. Since such bodies usually receive their funding regardless of how well they treat their customers, the incentive to treat them with courtesy, respect and consideration is somewhat diminished.

The government itself has recognized that the health service falls down in the way it treats its patients. The Labour manifesto for the June 2001 election says, “We will redesign the system around the needs of patients.”

Existing collaboration with independents

Part of the problem is under-capacity. There are more demands on the health service than it can meet. Extra money could indeed secure more doctors, more nurses, more facilities and more equipment, but it takes time for all of this to come on line. Meanwhile, there is surplus capacity in the private sector which could be put to immediate use.

Furthermore, the private sector generally has a better record at bringing new facilities on line more rapidly, with better quality and better cost controls than the public sector can manage. If new health facilities have to be provided, they

will be brought on line more rapidly, with better results, than has traditionally been the case in public-sector-led projects.

One recurrent problem for health services in Britain has been the apartheid between public and private sectors. Many in the NHS and in government, both Tory and Labour governments, have felt the private sector to be an irrelevance, nothing to do with the NHS and its problems, except perhaps for making them worse.

The truth has been that the independent sector has already taken pressure off the NHS by treating many thousands of people who would otherwise have been added to NHS waiting lists. It plays a significant role in total health care, much of it in providing “Cinderella” services that are often forgotten in the heat of the political debate. For example, the independent sector provides more than 3,000 acute psychiatric and substance-misuse beds (and the majority of the country’s country’s substance misuse treatment and care). It provides more than 55% of the NHS’s medium secure mental health care, in 900 of these beds, and 87% of the UK’s acquired brain injury rehabilitation beds.

Similarly, the independent sector has 420,000 long-term care beds and employs 660,000 workers, making it one of the top UK employers, delivering more than 85% of residential community care. It now provides the majority (56%) of the care that is given to people in their own homes.

There is, in other words, a very strong and beneficial working relationship between the NHS (and social services) and the independent sector in a number of areas of healthcare. That collaboration can be built on and extended. The apartheid has already started to break down.

Phase One reforms

The first phase of reform, to build on this collaboration, should consist in immediate and extensive use of private facilities to supplement those already available within the NHS itself, in a range of healthcare areas much wider than those already cited. Polls by MORI show that 82 percent of people do not care what the status is of where they are treated, so long as it is free, and so long as it is good.

The facilities of the private sector should be opened up to NHS patients, paid for by government, to receive the immediate and high quality treatment they need. This single action could achieve more to reduce waiting times than any extra cash pumped into the existing NHS structure, or any amount of procedural reorganizations,

More than 1 million surgical treatments are delivered by the independent sector’s 211 hospitals each year. Most, 70%, are funded by private medical Insurance, though 20% are people simply paying directly, out of their savings or income. The remaining 10% are paid for by overseas customers or the NHS.

Indeed, the independent sector treated more than 25,000 NHS-funded patients in the first quarter of this year alone. At that rate, it could be treating 100,000 NHS patients over the lifetime of this parliament.

Nevertheless, the independent sector has spare capacity. Dr Tim Evans of the Independent Healthcare Association suggests that by working to capacity it

could handle 200,000 NHS patients per year — a million over the lifetime of the parliament. This would be a huge and worthwhile gain. It represents, however, a small part of what the private sector could contribute.

Based on the concordat between the Department of Health and the private healthcare providers, long term contracts should be signed for the types of operations, the numbers required, and the prices to be paid. These contracts should ideally be constructed at the regional level. What the private sector needs is predictability. They need to know what work they will be required to perform. What the NHS wants is availability. They will want to know that they have booked a certain number of places for a certain number of operations, and that they can rely absolutely on the private operators to deliver the goods. The work must be of high quality, and available on an utterly reliable basis. This will enable the NHS to make long term plans to fit increased numbers of patients onto its treatment schedule.

New facilities

In addition to the current spare capacity of 200,000 patients per year, the private sector could efficiently provide new facilities. The assured income from long-term contracts with the NHS could, within a very short length of time, enable the private providers to create up to 30 new facilities. These will be the so-called 'fast track' surgical centres. They will specialize in the very areas of cold surgery (and some other specialisms) where the need in the NHS is most urgent, and where the log-jams occur to cause delays.

These new centres are likely specialize in four main areas where the pressure on the NHS is very severe, namely:

- hip replacements
- hernia repair
- cataract removal
- cardiac cases

The concept here is that specialist units can and will become centres of excellence in treating a single condition or a closely-related group of conditions, generating higher quality and better outcomes, with surgeons and staff performing more of the same procedures many times a month or a year. This reduces the risk of error, focuses the efforts of expert staff on continuing quality improvement, and keeps costs down through efficiency and economies of scale. Patients may need to travel further to receive this socialist care, but they will be reassured that the quality and safety of the work is likely to be higher than it could be at a general hospital where the risks are higher because staff do fewer such procedures each year.

These centres of excellence will perform on a routine and systematic basis the very work which can do most to relieve pressure on the NHS lists, bringing with them all the expertise and management skills of the private sector into providing operations for NHS patients.

To capture the biggest gains from that private-sector management skill, it is important that these new centres should be designed, funded, built and operated by the independent sector. They must also be free from day-to-day interference and political pressure, which means that they must operate under *long-term* contracts with the NHS to guarantee their independence and their future income

stream. To work, this concept needs to create long-term relationships between the private sector and the NHS; no private consortium will confidently invest in building and staffing an expensive new facility if the future flow of work is not clear and the relationship with the customer is not cordial and likely to last.

It is equally important that the government does not impose, for political reasons, any arbitrary limits on the non-NHS work undertaken by these centres. What should be important to the NHS is the quality and cost of the output — the services provided for NHS patients — not how these private facilities choose to marshal and use their inputs. Thus, they must be allowed to perform work for wholly private paying patients, for example, as well as for NHS patients who will receive free treatment. That will increase the throughput of these centres, raising quality and reducing risks even further. And it allows them to cover their setting-up and overhead costs more quickly, resulting in a better, lower-cost service for the NHS. They must similarly have access to global staffing markets, and not have arbitrary limits put on their recruitment.

Estimates suggest that the private suppliers could have the first of these centres on line after two years, with others coming into use after that. The calculation is that, aided by these new facilities, the private sector could treat first 1,000,000 NHS patients, and within four years, up to 2,000,000, who are presently stuck on the waiting list. In other words, this new partnership between public and private sectors would make the most dramatic improvement to the capacity of the NHS in its entire history. It would truly give people the assurance that they could expect to be treated promptly, expertly, and with the personal respect and consideration which the private sector brings to bear.

There is no reason for NHS purchasers to stop at Dover. Some UK citizens seeking private treatment already go to countries like Spain, where there are shorter waiting times for cold surgery such as hip replacements, service quality is good, and the out-of-pocket cost to the patient is less than in some independent hospitals at home. Similarly, there is no reason why the NHS should not purchase treatment for NHS patients from independent hospitals in Europe, provided that the patients themselves are willing to travel in order to get a better or speedier service.

GP surgeries

Additional improvements in the health service can be made with respect to general practitioner surgeries. This has already started in a few places, but could easily be rolled out on a large scale. Many GP surgeries are old-fashioned and under-equipped, sometimes located in converted old Victorian houses with little space and few amenities. There is often insufficient space to bring together enough GPs to create an efficient practice with a good spread of medical expertise, nursing support, and administrative capability.

However, private consortia are already starting to work with GPs to upgrade and expand their practice facilities, enabling them to do more work, of higher quality, for more patients.

This principle should be encouraged and extended. Private-sector consortia should be called upon to assess the practicality of upgrading all practices, or forming more efficient groups of practices with new facilities. They would plan and execute the work in collaboration with the GPs, taking some of their return

from the expanded work and rental income which the practice will be able to secure in the future.

The injection of up-front private capital, committed on the basis of a secure future income stream, could lead to the upgrading of several thousand GP surgeries, and would produce many visible benefits. For example:

- GP practices, presently constrained by the cramped space within premises that were not purpose-built, could expand. This removes the risks associated with solitary GP practices, and allows the individual GPs within the practice to specialize more, increasing the depth of expertise that is available to patients.
- Practices could afford to staff and maintain a small number of beds for patients requiring overnight observation, or even those recovering from surgery performed on-site.
- The flow of a considerable amount of work from general hospitals down to the primary-care level, adding to the convenience (and reducing the apprehension) of patients. Indeed, some estimates suggest that around 40% of the work presently undertaken in general hospitals could safely be done at the primary level.
- Larger premises may incorporate higher-specification diagnostics (such as radiology), minor surgical facilities, or pharmacy services on-site, reducing the need for patients to travel to other centres. Travel, particularly for the elderly, can also be made easier by the incorporation of transport facilities within the refurbishment package.

If done systematically, this would be a revolution in primary-care services, allowing the government easily to surpass its goal of 3,000 modernizations by 2004. This will not only improve life for the GPs and their patients; it will also take yet more pressure off the hospitals and their waiting lists.

At present, GPs tend to work as partnerships; they might own their building (in which rests much of the value of the practice) but otherwise it is difficult for them to raise fresh capital or to expand much beyond the original partnership.

However, there is no reason in principle why some GP practices should not become independent businesses like any other. Some are quite large enough to become quoted on Ofex, or AIM, or even the Stock Exchange as PLCs; though it may require some new and forward thinking in the nature of the contract between the NHS and such new-style practices — perhaps not before time. This new form of corporate identity would in turn give GP practices access to fresh new sources of capital, and therefore make it easier for successful practices to expand and develop further the range of services they offer to patients.

One could imagine the most go-ahead and successful PLC-practices acquiring others and forming national chains of GPs, and spreading their successful management and clinical strategies from one to the next. Such newly-created chains might well offer branded service packages so that people choosing a GP (say, when they move to a new area) would have a better idea of the standard of care they are likely to receive than if they (as now) took pot luck by going to the nearest or picking a practice out of the *Yellow Pages*. Instead of an NHS contract which rewarded good and mediocre GPs much the same, those GPs which offered a quality and range of services that the public truly appreciated would find the value of their businesses increasing, and would be able to reap the rewards of that success much more easily than they could at present.

Private management

Although the private sector is associated in the minds of anti-capitalist protesters with profits, what it brings in reality are superior management skills, and the ability to present its potential customers with a range of choices, and treat them as individuals rather than statistics.

It is in its superior management skills that the private healthcare sector has most to offer to the really sub-standard NHS trusts. Where hospitals have such a demonstrably low quality and poor outcomes that they are deemed to be failing ('red light') NHS trusts, private consortia should be employed under contract to take over the complete management and turn them around. Part of their reward would be earned on the basis of results achieved. This is one of the quickest and most successful ways to covert bad practice to good, and to take a grip in places where the NHS control has fallen apart.

Given a choice, private healthcare operators would prefer to start afresh on greenfield sites. They would, in an ideal world, not start with hospitals that were perhaps poorly built for modern work, under-equipped, out of date, or plagued by bad practices, low morale, a failing culture and sloppy management. However, in this less than perfect world, some of them believe they can effect an immediate improvement. They cite examples, notably in the USA and Canada, where outside firms have come in to oversee poorly performing hospitals under contract, and have utterly transformed them.

Private-sector management could do the same for the NHS, and should be encouraged to do so. As stated already, the public does not care who runs the hospital, or even who own it, so long as the treatment is free, and so long as it is good.

NHS Direct

There is also scope to extend the collaboration between the NHS and the independent sector into other value-added services currently provided, or often not provided or not fully provided, by the NHS. Chiropody (particularly for elderly or disabled patients) might be one example; and the NHS Direct service is another.

NHS Direct is proving its value in providing another entry point to the NHS for patients, no doubt reducing unnecessary visits to the doctor and, on the other hand, ensuring that patients do seek medical advice when it is really necessary, instead of leaving things until it is too late.

As a logical matter, however, there is no reason why the NHS Direct service has to be provided by government employees, and staffed by NHS nurses (who are already in short supply in front-line ward work). The questions asked of patients when they call NHS Direct inevitably have to proceed by way of a set of standard algorithms, since the caller is unknown to the NHS Direct nurse and his or her medical records (tellingly) are not available. So the questioning is designed to elicit the patient's true condition accurately and with no significant risk of serious, health-compromising error. Many of the lines of questioning simply end with the recommendation to seek medical advice.

These are the same sorts of algorithms used by call-centre operators the world over. And it seems likely that the commercial firms which run call-centre

systems probably employ state-of-the-art management and control techniques, not to mention technology, that could help to produce a marked improvement in the efficiency of NHS Direct. Independent healthcare providers, in collaboration with insurers, banks, or other high-volume call-centre systems designers, should be asked to analyze the performance of NHS Direct and perhaps even take over its management.

Medical records

Certainly, any independent-sector providers of a service such as NHS Direct would want to link into the medical records of its callers as quickly as possible. Once again, however, the NHS has managed to achieve very little movement towards more readily-accessible patient records.

The cost of today's paper-based records system is large — not just in terms of the cost of storing large amounts of paper, but in terms of the dislocation that results. When a patient takes a prescription to the local pharmacist, for example, there is no quick way for the pharmacist to check whether it is incompatible with some prescribed or over-the-counter medicine that the patient is already taking. When a patient is admitted to hospital, there is no accessible record of what medicines he or she has been prescribed by general practitioners in the past. Often, these problems can have harmful, even fatal, consequences.

It is questionable whether the amount of money committed to getting medical records in accessible, electronic form, is likely to be enough to do the job. Instead of trying to fund the whole exercise out of the NHS budget, which is tightly stretched as it is (and therefore likely to produce an inadequate and underfunded records system), a better strategy would be to get the necessary upfront capital and design from the private sector. That would require designing in a stream of future income — say, a tiny fee to the capital providers every time a medical professional accessed the system. But it would produce a joined-up records system much more quickly. And if the actual management of the service were divided between a number of operators, with doctors having a choice of whose service they used to access patient records, there would be a competitive pressure to keep the speed and quality of the service high, and low cost to the users.

Personnel and training

When the private sector provided mainly stand-alone services such as hernia treatment and varicose veins, it did not have the facilities to play a full role in training. It is a fallacy, common even in government, to suppose that the private sector benefits by having people trained in the NHS leave their state jobs to take up private sector appointments. In fact, of the many nurses who leave the NHS each year, only about 4 percent go to work in private healthcare. Most just leave the profession altogether.

However, private healthcare has extended its reach into some of the most advance and complex areas of modern medicine, and now does perform the full range of activities required as part of training. If the private sector is to play an expanded role in making the NHS an efficient, high quality, patient-centred organization, it has a responsibility to contribute more to training. It already helps in the post-qualification training of nurses.

In fact training in the future can consist of three varieties. There will be those trained wholly within the NHS, those trained privately, and those trained in both private and NHS situations. The last group could be the largest one.

Large sections of the training programme should be handed over for private healthcare providers to supply under contract. Private firms should be invited to tender for training work, setting out the standards they will meet and the levels to which students will be taken. This provides the government with a source of reaching the required NHS staffing levels more rapidly than it could otherwise accomplish.

A number of nurses leave the NHS not so much because the pay is poor (though it is), but because the NHS is unable to offer them the flexibility they need in terms of when they work. Many ex-NHS nurses are women with family commitments that place difficult and often unpredictable demands on their time. Private nursing agencies, though able to offer higher wages than the NHS, claim that it is their superior ability to manage time flexibly that makes them most attractive to such nurses. Instead of trying to copy such human-resource techniques, it must certainly be better to use the resource and management that already exists in the independent and agency sectors, and pass over the actual management of NHS personnel departments to them.

Purchasing and procurement

The NHS spends about £25 billion annually on goods and services procured from third parties, about half its annual budget — from essential equipment and supplies down to postage and fuel. Clearly, the outsourcing initiatives described above would increase this procurement figure.

Today, however, this purchasing is fragmented between some 350 Trusts and around 5,000 Primary Care Groups. The creation of NHS Supplies (and its successors, PASA and NHS Estates) was an attempt to reduce costs and waste by purchasing more centrally, but professionals within the Service complain that the bureaucracy of this centralized system outweighs its cost.

On the basis of procurement systems reform in other organizations, there seems no doubt that savings in the order of £2b–£4b could be made within NHS procurement. Indeed, some service industries such as banks and independent healthcare have achieved savings up to 20% of budget by focusing clearly on their purchasing systems.

Other benefits would include ensuring that the goods and services procured are accurately specified according to the NHS's needs, eliminating waste. Vendors can be managed more effectively: as professional 'sellers', they often have much more expertise in selling than purchasers (for whom purchasing is not their main purpose or activity), and can take advantage of that fact. Information and logistics can be improved: specifications can be changed, for example, on the basis of the outcomes that the purchased item or service actually achieves.

Again, there is no reason to re-create such expertise bureaucratically in the NHS. The supplies and procurement function can be outsourced to professional private-sector providers, with savings and efficiency that can be re-directed back into patient care.

Managing the estate

The land and buildings owned by the NHS have a book value of around £25 billion and would cost some £75 billion to replace. The Service owns and uses some 535,000 buildings, but over 90% of them are over 30 years old — which for medical purposes, often makes them highly inefficient, even useless, because they cannot accommodate the high-tech equipment needed for modern medicine, or are not laid out in ways that make it possible to focus different specialist teams effectively.

The Private Finance Initiative has made a feeble impact on the urgent need to upgrade existing facilities and create new ones, partly because of the inevitable bureaucracy involved in the public side of the partnership. Instead of trying to create long-term partnerships, PFI has worked through contracts, which may extend for 25 years, but which are often absurdly inflexible, given the enormous changes that could happen in medicine over such a time. While PFI has certainly produced some benefits, the inflexibility it encourages is a grave mistake.

Even when the current wave of building is complete, the NHS estate will still be a mixture of the good, the very bad, and the downright ugly.

The DSS has derived some benefits by packaging its estate and selling it off in return for a cash sum and a stream of facilities-management services, such as repairs and upgrades, in the future, under the Prime initiative. However, it would be optimistic to expect the capital and service markets to be able to digest a single £25b conversion of the NHS estate under similar principles.

Rather than the small-focus PFI route (which is usually focused on providing buildings and services for a single hospital), or the overblown idea of an NHS-wide Prime initiative, a more productive way of bringing fresh capital and management into NHS facilities would be to focus on a scale somewhere between, and to make it a genuine partnership between the sectors. Thus, NHS Trusts or groups of trusts to join in partnership with private-sector partners to jointly own and manage the estate. Joint equity stakes would help to deliver a flexibility that does not exist in PFI. And such a partnership would deliver the prospect of being able to upgrade the estate as and when necessary in the future, to integrate facilities management across the estate, and bring in joined-up ICT, transport and equipment services.

Why not extend the partnership principle beyond the individual hospital, perhaps to cover all the NHS facilities within a particular region, in order to deliver economies of scale? It is impossible to predict intellectually what the most efficient scale might be, and of course it might be different for different services. It is time that the NHS opened up a dialogue with private-sector consortia to establish how far there are economies of scale from integrating facilities management, ICT, equipment, logistics, catering, cleaning, and other estate-related services, across larger geographical areas that might comprise health authorities or groups of health authorities near to each other.

Indeed, the partnership approach could be extended to the provision of other back-office services that are closer to the idea of clinical care, such as diagnostics, pharmacy, pathology, radiology and so on.

Phase Two

If Phase One of the reforms will involve making full use for NHS patients of private healthcare facilities currently available, together with the introduction of new ones, Phase Two should involve the restructuring of the NHS itself, so that it becomes patient-led, instead of being centrally driven by bureaucratic instruction.

The key is local autonomy and independence, and the introduction of choices throughout the system. Management responsibility must be devolved downward, so that local communities feel that their NHS institutions are indeed part of the local fabric, rather than the representations of some remote central apparatus.

The driving force should be the Primary Care Groups. As presently constituted, these are probably too large to be effective units, and certainly too large for any cohesion or sense of belonging. Their procedures are also too bureaucratic, committee driven, and appointments to them are too narrowly set, and too many.

The former 'budget holding doctors' entered the health reforms taking shape in 1988 and 1989 almost as an afterthought. The main emphasis was on the split, recommended by Prof. Alain Enthoven, between purchasers of healthcare and providers of it. In fact the budget-holding doctors, introduced as alternative purchasers of secondary care, were the most innovative and imaginative, and were soon effectively driving the system forward.

The number of patients required for a viable budget-holding group kept being revised downwards, until even 10,000 was thought to be sufficient. They finished up covering 60 percent of patients. The budget-holding principle was extended into the new Primary Care Groups, but these have been made too unwieldy, too bureaucratic, and too remote to retain the vitality of the original budget holders.

The Primary Care Groups should be recast so they can become smaller and more local. 100,000 patients is too large. Perhaps a more appropriate figure, based on the budget-holding experience, might be 25,000 patients, or roughly 3 practices. They should be more local, and relieved of much of the burden of directives from Richmond House which weigh down their decision-making processes, and inhibit the vitality which could make them so much more energetic on behalf of their patients.

The providers of care

In tandem with reforms to the structure of Primary Care Groups, NHS provider units should be given their independence. As part of Phase Two of the reforms, hospitals should become free-standing, self-owned, with the status of charitable trusts. They should be run by governing boards which represent the hospital management and medical staff, the local communities in which they are located, and local business people prepared to donate time energy and goodwill to helping them.

The units themselves will decide their policy and priorities, instead of having these decided and directed from central government. They will offer their patient services to the reconstituted Primary Care Groups and other purchasers

of healthcare, and balance their budgets by producing sufficient work to bring in revenue to cover their costs. They will not be profit-making, but will plough back any surplus into improving facilities for their patients.

It is important that any Primary Care Group should be able to obtain clinical services from any of these providers, regardless of geographical location or past history, if they believe that is right for their patients. This introduces the elements of choice and competition which drive both quality improvement and greater efficiency. Because they have to sell their work, they have to achieve good results at costs which are attractive to the GPs who buy on behalf of their patients.

These self-managing NHS trust units will not be subject to detailed bureaucratic management from the central ministry or the local authority. They will be free to determine their staffing levels and the remuneration. It will be up to them, driven by the demand from GPs, if they choose to concentrate on particular groups of medical specialties or provide more general services. It is this independence which will unleash the creative vitality which can do so much to improve the NHS.

As a further part of Phase Two, the concordat will be extended so that Primary Care Groups will be free to purchase whatever procedures they wish from *any* provider, including those wholly in the private sector. This will open up to NHS patients a further range of quality treatments to supplement those produced in the newly reorganized Trust Hospitals.

A corollary to this breakdown of the artificial barrier between public and private sectors will be that the self-managing NHS trust units will be permitted to sell services to private sector patients, in addition to those funded by the NHS. These 'pay beds' will be an important source of additional funding.

The result of Phases One and Two of these changes will be to transform the NHS. The pattern will be of free healthcare, paid out of taxation, but performed in a variety of institutions. The newly independent, non-profit Trust Hospitals will stand alongside non-profit private hospitals, and alongside profit-making private hospitals. All will offer medical services to NHS patients.

In summary, the production of healthcare will be local and independent, and free from government controls and restrictions. The purchase of that care will be made principally by Primary Care Groups, who will have complete freedom to do so, from any of the sources. The NHS patients will have their treatment paid for by their Primary Care Group from NHS funds.

What will be new will be the additional capacity this will bring on line, the variety of different types and sources of treatment, and the vitality which choice and competition will bring into the system. The NHS will indeed become patient-centred.

3. Education

“We will abolish the rule that stops successful schools from expanding to take more pupils.”

Conservative Manifesto, May 2001

If a private school took children for 7 hours a day for 40 weeks a year for 11 years of their lives, and turned them out without any meaningful qualifications, and in some cases unable to read and write at a functional level, parents would withdraw their children and refuse to pay its fees. There are no private schools like that, for they would not survive the wrath of their customers. But there are state schools like that, and not only are parents forced by law to send their children there, they are forced by law to pay their fees through the tax system.

As with the NHS, part of the problem stems from an inappropriate relationship between some of the schools and their customers, and in this case, between the education service as a whole and its customers. Independent schools face a different situation. They do not receive money from captive taxpayers; they have to attract it each time, individually, from the parents of each child. They have to make their product such that the parents will freely choose to buy it. They have to compete with rival alternative schools. They have to keep up to the quality standards of a demanding and discriminating clientele.

Furthermore, the service they offer has to be attractive to the student as well as to the parents, or they will face demands for a transfer to a competitor. The general estimation of fee-paying schools is high, even for those living in the most disadvantaged communities — a staggering 70% of the poorest people in England report to MORI that they would aspire to private schooling, if only they could afford it.

It is true that private schools have access to more resources, and can give more attention to each child. It is also true that resources alone are not the answer. There are examples throughout Britain of state schools which achieve outstanding results on the same, or even less, resources than a school not more than a mile away. The difference, in cases such as these, lies in a difference not in resources, but in leadership.

The evidence comes back repeatedly that good leadership can turn the worst of schools around, and that bad leadership can set the best of schools into decline. One of the problems is that incompetent or failing schools, those with bad leadership, the ones which would be forced to close if parents were able to exercise any choice, are kept going simply because parents are unable to move their children elsewhere. In a market situation characterized by competition and choice, the bad schools would close simply because no-one wanted their product, and new, more successful schools would spring up to replace them.

The Education Reform Act of 1988, piloted through by Kenneth (now Lord) Baker introduced many elements of choice and competition. Parents could choose the state school they preferred, instead of being assigned a place at one. Schools could elect to have a greater degree of control over their budgets, and exercise somewhat more independence in policy decisions. In much the same way the Act broke the logjam of central controls, and started in modest ways, the movement to local autonomy.

The Baker Act of course faced a lot of opposition in practice. The debate on opt-out status became highly politicized, and local education authorities fought strongly to prevent opt-outs and protect their own position within the status quo, concentrating their resources on one ballot after another.

However, the biggest single impediment to the successful operation of the Baker Act remains the insidious “surplus places” rule. This prevents expansion of successful schools and, more importantly, the starting up of new schools in areas where there are “surplus places” in existing schools.

What this means is that because there are unfilled places in failing schools, new quality places cannot be established in the area to offer parents alternative choices. It is as if an entrepreneur were prevented from opening a vegetarian restaurant in some town because there were already plenty of hamburger joints. The whole point of a market is that the upward pressure on quality and efficiency comes from choice and competition.

The problem is that there is not enough competition and not enough choices to enable parental pressure to force improvements onto the system by simple supply and demand forces. The former Education Secretary, David Blunkett, did a great deal to reflect parental concerns by his insistence on standards. For the first time a Labour government began to critique the provision of education quality on the basis of outputs, rather than inputs. Where previously the emphasis had been on amount spent, number of teachers with degrees, salary levels and the like, now the questions asked include whether the children can read, write and pass examinations.

Phase One

An urgent requirement, recognized by both major parties, is to increase diversity in the provision of education. It must become easier for schools to offer different approaches for parents to choose between, and for new schools and new types of school to emerge. This means an end to the philosophy of central control.

Elizabeth Phillips, headteacher of St Marylebone Comprehensive School in Westminster, the most improved inner city school in Britain, said in May 2001 that “Headteachers are over-burdened with bureaucracy, teachers are demoralized, and schools are coping with one initiative after another.” Her complaint is that the creative talents of teachers are being confined by the attempt to micro-manage education from the top.

The Conservative proposal is for local independence, the so-called “free schools.” For Labour it is Specialist Schools, City Academies and Foundation Schools. These are ways to introduce variety, and with it, choice. In practice the first phase of education reform cannot be achieved merely by the creation of specific types of alternative school. Rather it must be a move to ensure that

many different types of school can emerge. The pressure and the initiative must come from below.

All state schools should become locally self-controlled and independent of local education authorities. It will be the school's decision about who it admits or excludes, and how it teaches them. Its performance will be measured, of course, to ensure that the aims of education are being achieved. But each school will basically set its own policy. This will include the hiring of staff, and the decision to take on more staff in special areas of need. It will be for the school to make decisions about school uniform, homework and sport.

The need to comply with the minutiae of bureaucratic management will be replaced by local initiative and responsibility. The stream of government directives and initiatives will dry up, and it will be the job of teachers to decide how they set about their task. Their creative imagination and talent will not be repressed by remote control.

Government may well choose to set helpful guidelines for schools which feel they need such help and advice, but it will not be forced upon schools. Provided the school maintains an adequate standard of achievement, it will be for the school to decide how it proceeds.

Parallel to the granting of self-government to the schools must come a complete overhaul of the way in which schools can expand, or new schools started. The "surplus places" rule will go, as will an excessive burden of planning compliance which thwarts new school start-ups. The proposed governing body should present its plan for a new school, and be given the go-ahead without regard to unfilled places in sink schools nearby.

The Charter School model

A good model is afforded by the Charter Schools in the United States and, on a smaller scale, in New Zealand. These are growing rapidly in numbers and popularity, find huge favour with parents and students, and achieve very impressive results. A group of parents, teachers and perhaps business people apply to the state for a charter to open and run their school for state pupils. The grant of such a charter leaves the school largely free to determine its policy, methods and conditions, but it receives state funding on behalf of each student.

Denmark's long tradition of independent schools that receive public funding is not, in principle, dissimilar. The Danish educational system developed from the belief that parental authority over education should be paramount, and that a truly democratic system of government-run education would be impossible without a range of independent, publicly funded, alternatives.

Roughly 75 percent of the Danish education budget supports pupils at non-state schools. The Ministry of Education pays a per capita sum to each independent school, the exact amount varying depending upon the size of the school and the age of the students.

Denmark has plenty of state-run schools, but they are not regarded as being inferior to independent schools, as they often are in countries without school choice. Parents do not choose an independent school for the usual, British reasons — so that their children associate with a more affluent peer group, or because of better facilities or a more rigorously academic approach. They select their school for its pedagogical approach, for its principal and teachers, or

because they feel their child would benefit more from an alternative educational environment. Danish municipal schools are successful because, if they are not, they face the threat of a mass exodus. The number of parents choosing independent schools grew by 50 percent in the course of a few years during the 1980s. The municipal schools responded when it became clear that they were losing students.

This is how the new schools will work in Britain. Each child enrolled will bring with them the average expenditure which the state earmarks for students of that age, just as will happen with the existing state schools. Each school will have full control of its own budget, and decide how many teachers to hire, and what to pay them. US experience testifies volubly to the fact that, the greater the independence granted to the new Charter Schools, the more innovative and superior is their performance.

As with the Charter schools in the United States, performance will be monitored and measured, and the continuation of the charter will depend on a satisfactory outcome. Charter schools faced much opposition when they first began, including from those who feared they would 'cherry pick' the ablest students from comfortable middle class backgrounds. In fact the reverse has been true. It is with people from disadvantaged backgrounds who have had a poor education hitherto that the schools have done best. Indeed, many of the schools practice a reverse selection, preferring to concentrate on such students.

A wave of new schools

The aim of the reform should be to unleash large numbers of new and different types of school. Some will concentrate on basics; others might prefer specialize in mathematics, perhaps, or music. Some will undoubtedly emphasize vocational skills; others might try to establish reputations as sports academies, training the champions of the future, while equipping them with a thorough grounding in the educational basics at the same time.

In Denmark, a group of parents or educators needs only to gather a few willing families and establish a board of governors. Smaller schools receive an allocation per pupil that is greater than that of larger schools. Schools are free to determine their own student enrolment; and they may select or expel students on whatever grounds they choose, reflecting a belief that such freedom is necessary both to attract innovative and visionary educators and to provide schools that can cater to diverse student bodies.

The same sort of ease of starting new schools will call forth more innovation and variety in education in the UK too. A wave of new schools is the best way to raise standards because it will force the closure of most of the bad schools. Government has two weapons in its arsenal, and will need to use both. In the first instance a failing school can be handed over to private management to turn it around. If this fails, the school will simply be closed.

The second weapon is parent choice. If parents desert the sink schools for the new ones springing up under the enabling legislation, the failing schools will not attract enough students to remain economically viable, and will, in effect, have been closed down by the parents.

The emphasis should be on variety and choice, not on conformity. The schools, be they the existing ones with their newly-acquired independence, or the new schools started up, can be selective if they choose. They can be grammar schools if they wish. They can expel unruly pupils if they want to. They can open at staggered hours, run an extra term in the summer, or require every student to pass an end-of-year exam before they can move up the school. The point is that the decisions will be their own, as will the choice of parents whether or not to send children there.

Education and scale

It is not clear whether education would demonstrate the same economies-of-scale benefits that might be found in, say, healthcare. The core of education is, fundamentally, the relationship between the individual student and the individual teacher, and the leadership role of the individual head within the individual school.

Nevertheless, there are a number of back-office services that can efficiently be shared — services such as personnel management, equipment and supply, planning, estate management, ICT, logistics, course materials (including high-tech presentation materials), testing, and much else.

There may well be scope for ‘formula’ or ‘branded’ education strategies, as there has been in other countries, rich and poor alike. Why should parents who are disappointed in the education offered by today’s schools, and who want to set up their own alternatives on the back of per-student public funding, have to learn afresh what management and pedagogical techniques are cost effective? Good models abound, not just in the UK, but from around the world. So rather than re-invent the wheel, they may chose to adopt the systems of a national or international education ‘brand’ — systems such as timetabling the school day and school year, arranging safe transport for students, choosing and rewarding teachers, ICT systems, and much else. Both they as providers, and parents as customers, would have a clearer idea of what kind of education their children would get, and scale economies would be maximized.

Much of the pedagogy might have few gains from scale, resting as it does on the personal relationship between teachers and students. But it seems fair to suppose that other parts of the provision of education services are capable of squeezing efficiencies out of larger-scale operations. Schools themselves might remain local, led by parents and teachers with a clear idea of what they want for the locality, while many of the inputs used by those schools are provided across many schools, or even across many towns and counties, by dedicated specialist supply companies. Thinking on this larger scale might allow the provision of integrated services, privately providing such back-office functions as supplies, equipment, human-resource management, school trips, school transport (providing parents with a reassuring and environmentally sensitive door-to-door service)...and much else.

Phase Two

When Phase One of the reform begins to bring in different types of school, including many new schools, Phase Two will separate the production of education from the finance, as with the proposed reforms to the NHS. The school place will be free, but once the schools become independent, they become self-owned. Their premises will no longer be the property of national or local

government, but of the school trust, administered by its governing board. The teachers, including the headteacher, will be employees of the school, rather than of the government.

The dividing line between private and public will be blurred because the schools will all have similar status as independent bodies. The finance of state education will still be public because the education will be 'free' to the parents at the point of consumption. The school will receive the tax funds from government for each child it enrolls.

Under Phase Two of the reforms, the free choice which parents have over schools will be extended to cover all schools which reach the required standard. This means that whatever school parents choose for their children will be the one which receives their child's funding. Private schools will be no different in this respect from the newly-liberated state schools or the new schools which have been started. The rule will be *open choice, open access*. No school which reaches the appropriate standard will be ruled out.

As Tony Blair said during the election campaign, the question is not whether the school is publicly run or privately run. The question is whether it is a *good* school. In practice a policy of *open choice, open access* will open up places in quality schools to children from deprived backgrounds who have not hitherto had such opportunities. With the state's annual funding behind them, their parents will face a variety of choices, including admission to prestigious schools backed by a supplementary bursary to meet the balance of the fees.

This division of education into separate tracks of finance, done largely by the state, and production, done by self-governing schools, corresponds in many respects to the system used in Denmark, and generally admired by both parents and analysts for its high quality. The key in Denmark, as it will be in Britain, is the ability to start up new schools rapidly with help, rather than obstruction, from the authorities.

Universities

"Over the next three years we will continue to expand student numbers, taking us towards our 50 percent target."

Labour Manifesto, May 2001

"Conservatives want our universities to be free to shape their own character and specialisms, competing with the world's best."

Conservative Manifesto, May 2001

The era of state control of the universities is drawing to a close. Many of the universities, and many in Parliament, have already recognized this. Institutions and systems established to take 5 percent of the age group through higher education were bursting at the seams when that figure rose to 35 percent. The current 50 percent target is commendable, but will emphasize even more the need for a restructuring of the system.

When the product was given to one in twenty, it could be luxurious. Those admitted received their university education free, and a maintenance grant which varied with the parent's financial circumstances. Welcome as this was to

the lucky recipients, it always seemed remarkable that working class taxpayers were expected to meet not only the fees, but three years of board and lodging for the largely middle class beneficiaries. A product now provided for one in three cannot be as luxurious, even less so when it is received by one in two.

Students now receive loans, rather than grants, for their maintenance, and are expected to contribute £1,000 towards their fees. Universities receive most of their funding from the state, and have to provide the appropriate number of places for students on approved courses. The official view, until quite recently, was that one university education was equivalent to another, and that the standard across the country was more or less even. The admission of the polytechnics to university status, and the publication of league tables, have changed that. The obvious fact is now admitted, that some universities are better than others.

A further fact is that many universities have expanded their intake, to cope with the increased targets, without expanding their facilities proportionately. This means that life is less comfortable for both students and teachers. The same buildings and classrooms have to cope with much larger numbers, while some lecturers and professors find their workload expanded by increased class sizes.

Universities themselves complain that they cannot continue to dilute the value of what they offer, simply to make it available to greater numbers. Some of their spokesmen complain that, as servants of the government, they have to meet *its* needs rather than their own. The Russell Group has been particularly active in setting out an agenda which its members consider to be consistent with a viable future.

It is one thing for government to finance people through university, or to help those who might otherwise be unable to take the opportunity. But government's involvement in the *production* of that education is quite another. Government should be allowing the universities to offer what they wish to, competing with each other in quality, as well as to attract both staff and students. Its role should be one of providing the financial support to those who would not otherwise be effective bidders.

The new model is essentially that which will represent the reformed NHS and the new school system. It is one of competing producers, putting a variety of products on offer, with choice by customers determining where government money is to be directed. Selection of a school by parents sends the costs of the education to that school. Selection of a hospital by a Primary Care Group sends the costs of treatment with it. Similarly, selection of a university will send the costs of the course to the institution chosen.

Universities should be given their independence from government, and compete with each other to attract students. Those students will bring with them not only their own contribution to fees (presently £1,000), but also the government's contribution. Universities will be free to set their own policy and follow their own priorities. They will decide themselves which departments to expand, which to create, and which to close down. They will decide how many students to admit, and what their admissions standards should be.

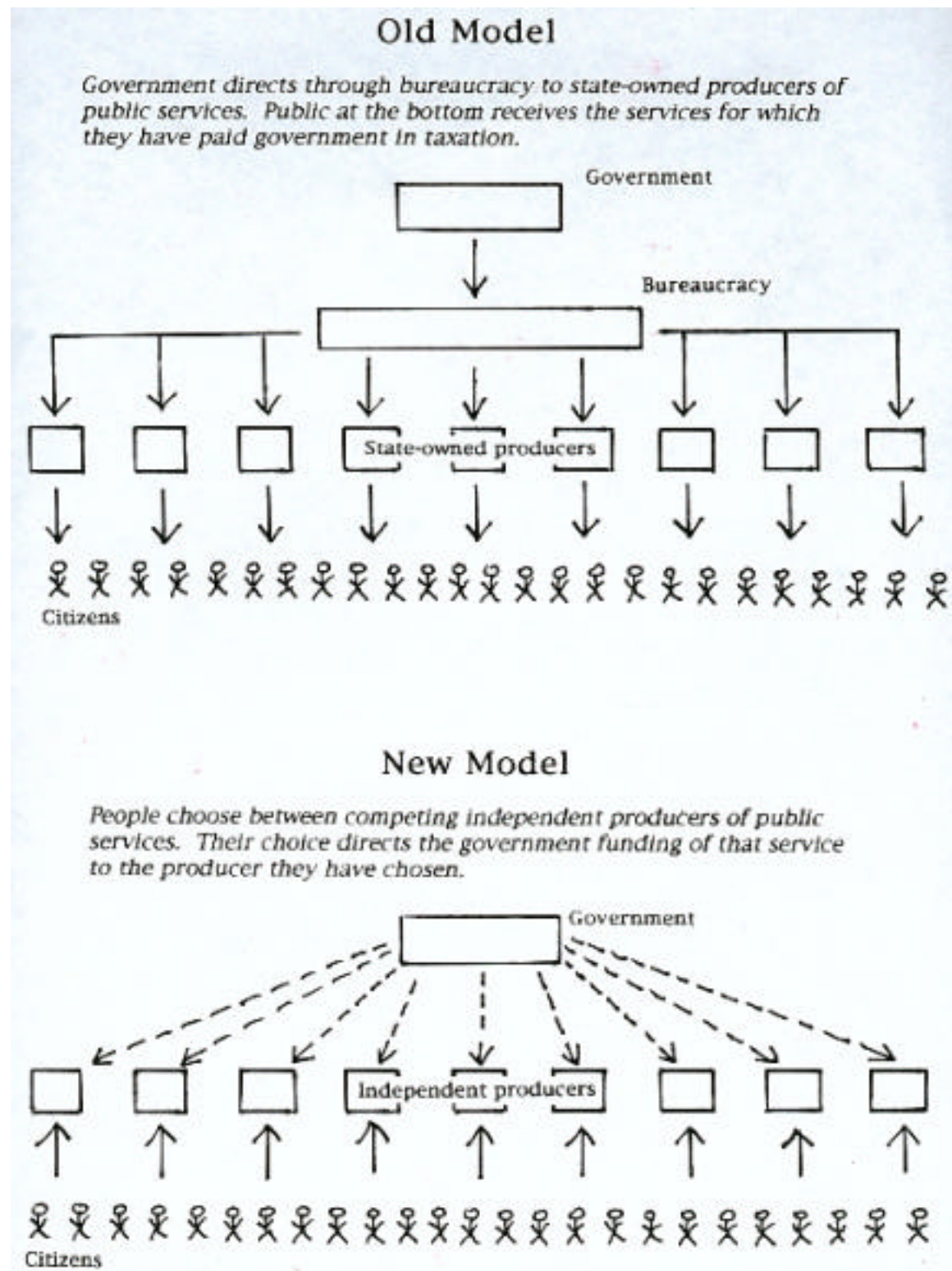
Universities will also decide what pay and conditions to offer their staff. They will be competing against each other, and against overseas countries, to attract them. They will, in Phase Two, be allowed to set their own fees, in the

knowledge that any increases will be paid for by the students from loans, and might make them less attractive to potential applicants.

Research will continue to receive special government funding. Universities will be helped to build up endowment funds to make them less and less dependent on government for their revenues. Governments will assist from time to time in the build-up of these funds.

The final model is that of free-standing, independent universities which have to make themselves attractive to potential students, and which have to keep to an acceptable quality if they are to continue receiving tax-funded fee payments for their students.

4. Model Diagram



5. Conclusion

“Where the quality is not improving quickly enough, alternative providers should be brought in.”

Labour manifesto, May 2001

Refinancing the public services is not enough. The problem is that their funds are not spent in the right way, and that their output is not up to the standard which people would wish. The way to spend the funds wisely and to improve the quality of their output is to reshape them so that different incentives come into play. The input of extra finance into the public services provides an opportunity to reshape those services at the same time, so that a lasting improvement is achieved.

Choice is the key. If people can choose, they will choose the best. In the case of public services, this means the one which comes closest to meeting their expectations. Where people are able to make choices, the choices will be between continually improving alternatives. The desire to be chosen makes producers keep up to date with the latest techniques and innovations, and has them constantly striving to improve their product so that it will attract more people to choose it.

It is for this reason that the public services have to be restructured so that choice is incorporated. A corollary of choice is variety; there must be something to choose between. Producers must be allowed to offer different ways of achieving the public service objectives. There are different approaches to education and health care, many of them equally valid in different ways. In that people have different standards, tastes and preferences, they may opt for different ways of achieving the same goals. Provided the education is good, and the student attains the required levels of proficiency, it can be left to the school to decide which approach it chooses to take. The same is true for doctors and hospitals.

The way to secure additional output from the public services is to encourage production from different sources. The state schools and hospitals should be supplemented by new ones, some with charitable, non-profit status, and some profit-making. It should be a matter of indifference to the state which choices people make, as long as the service they receive is of an acceptable standard.

If circumstances are created under which talented people are seeking to set up new schools, and new types of school, and perhaps new hospitals and new types of hospital, it can bring huge gains for the quality of public service provision. The more that is on offer, the more meaningful is the choice available to the citizen, and the more likely it is that quality will improve.

On the other side of the coin, those parts of the public service which fail to attain acceptable standards must be turned around or closed. The private sector has different management skills in this respect, and is quite used to the problem.

There is scope for the failing parts of the public service to be turned over en bloc to private firms, under contract to achieve improvements, or with the alternative of closure.

The new model

The old model of the public services was top down. Authority, decisions, and money flowed downwards, from government, through its bureaucracy to state-owned producers. The public, at the bottom, received whatever output could be achieved.

The new model has power flowing upwards. Citizens make choices between competing independent producers. The producers respond to their wishes, rather than to orders from on high. The funding for each school place, each hospital procedure, is directed by these choices. Each one tells the government where to send the funding for that particular piece of public service work.

Government still acts as guarantor of the public services, and still funds them through the tax system. What is changed is the idea that government must be producer, employer, owner and director of those services.

The public still receive their public services free at the point of consumption, and are still guaranteed them. The difference is that they obtain them from independent producers, and can choose between different ones.

The new model puts different incentives into the system. The funding secured depends upon the work done, which in turn depends upon how many of the public can be attracted to make one particular choice rather than another. Each producer, be it a school or a hospital, has a direct incentive to achieve the highest quality they can, and to operate as efficiently as they can manage.

A major feature of the new model is that it is decentralized. In place of central, soviet-style controls is a spontaneous, inter-acting system which responds rapidly to the decisions and choices made by its participants. It is more flexible than the central system, and contains more information, even though this is not held in one place.

The programme

- NHS hospitals should become free-standing, self-owned, and given full autonomy.
- There should be immediate and extensive use for NHS patients of surplus capacity within the private sector.
- Government should negotiate for the private sector to build and operate 30 fast track surgical centres, under long-term contracts with the NHS.
- Private sector finance should be used to upgrade thousands of GP surgeries.
- Parts of the NHS which persistently fail to achieve adequate performance targets should be contracted out en bloc to be taken over and run by private firms.

- The Primary Care Groups should be streamlined into smaller, more manageable groups representing an average of 25,000 patients each, and should become less bureaucratic, losing some of their appointed officials.
- Primary Care Groups should be able to obtain treatment for their patients from any healthcare producer. Their choices will direct public funds from their budgets to meet the costs of the procedure.
- A programme should be devised which has the private health institutions playing a full part in medical training.
- Every state school should become free-standing, self-owned. Its policy should be determined by its governing board. Its staff become employees of the school, not of the government.
- Parents will have free choice of schools, and their choices will direct public funds to the institution they have selected.
- Schools which fail to achieve acceptable standards should be contracted out to be taken over and run by private firms.
- Barriers to the starting up of new schools should be removed. New schools should be accepted on a probationary basis, so that any parents who choose them will thereby direct state funds to them to pay for their children's education.
- Universities should become fully independent of government. By their choice of university, students will direct part of their fees from government to the institution they have selected.