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PRIME MINISTER

NEW WORLD IN HEALTH

Mr Moore's paper on independent hospitals - and my previous note upon it - may have insufficiently stressed the radical potentialities of separating the buying of medical care from its provision. It changes everything (by degrees).

Apartheid in Health

Consider the status quo. It is a sort of medical apartheid between a national system offering comprehensive health care on the one side and a small-scale private sector offering a restricted range of treatments on the other. In this world, it is simply not possible for someone to "opt out" of the Health Service completely; the private sector could not cope with all his likely medical needs.

Similarly, under the present structure, private health insurance cannot cover for accident/emergencies. If anyone who had opted out of the NHS were to be injured, either he would be shuttled around in an ambulance looking for a suitable private hospital or (more realistically) the NHS hospital would treat him anyway despite his persona non grata status here.

That is why the Health Review has devoted such ingenuity to constructing schemes of contracting out that are confined to the "elective surgery" services that the present private sector does not provide. The snag is that, as the Treasury paper demonstrates, such schemes tend to be bureaucratically complicated and politically unappealing.

Mixing the Health Economy

All this changes when buying and providing health care become different functions. Buyers, both public and private, buy medical treatment undiscriminately from providers, both

public and private, not at first perhaps, but gradually and with increasing significance. The old apartheid shatters. Public and private organisations become indistinguishable.

At that point, it is perfectly possible for a private health insurance "buyer" to offer a comprehensive range of medical treatments. They merely have to contract with a mixture of "independent NHS" and private hospitals to purchase a full range of services for their clients. They are no longer restricted to the Wellington in London and BUPA cottage hospitals in the country.

Accidents and emergencies similarly cease to be an insuperable problem. Private "buyers" would simply contract with the two or (at most) three District General Hospitals with A/E units in their client's vicinity to provide such treatment at certain rates (if it should ever be needed). That would leave only a statistically insignificant number of cases where the patient is knocked down while on a work's outing to the seaside and is taken to a hospital where he has no cover. But every "buyer", public or private, would have a small contingency fund to cover such cases.

From the hospital's point of view, the matter is simple. Every patient wheeled in is covered by someone - by a "private" buyer if he has opted out, by an NHS buyer if he has not. Both sets of buyers will receive a bill in due course. There is no need to demand proof of insurance cover before admitting a sick person. [That should indeed be made illegal, as it now is in the USA.]

A crowning advantage of this structure is that it would not mean "two standards of care". NHS patients would be treated in both "private" and "NHS" hospitals; so would private patients. In medical terms, they would receive identical care. In the 50 per cent of hospital cases covered by accidents and emergencies, their treatment would probably be identical in all respects (privacy, food, etc). "Private" patients would, as now, be buying avoidance of the waiting

list in "elective surgery", and some luxuries and convenience in convalescence. There would be one standard of care in theory: as many standards of care as there are hospitals in fact.

None of this happens overnight. It will be a series of gradual developments. Two related changes would, however, speed the process along.

First, introducing a measure of competition between the public "buyers" by allowing patients and/or GPs to move between them. Wihout that pressure, there is a risk that "buyers" and "providers", though separate in theory and on bureaucratic wall-charts, would continue to act like the united District Health Authority they currently are.

Second, reducing the cliff-edge of the cost of private health insurance. All the methods proposed have drawbacks. But the simplest would be to allow a patient to transfer a part of his "capitation fee" from the public to a private buyer. That transferrable portion might be equal to his capitation fee (which itself would be related to age) less the redistributive element in NHS spending. Or it might be a slightly lower amount in order to soothe Treasury anxieties about the financial consequences of private sector growth.

The first step should be an early stage of the prepared reform. But making capitation fees partly transferrable could wait until the structure of competing public buyers had been established and was working reasonably effectively.

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