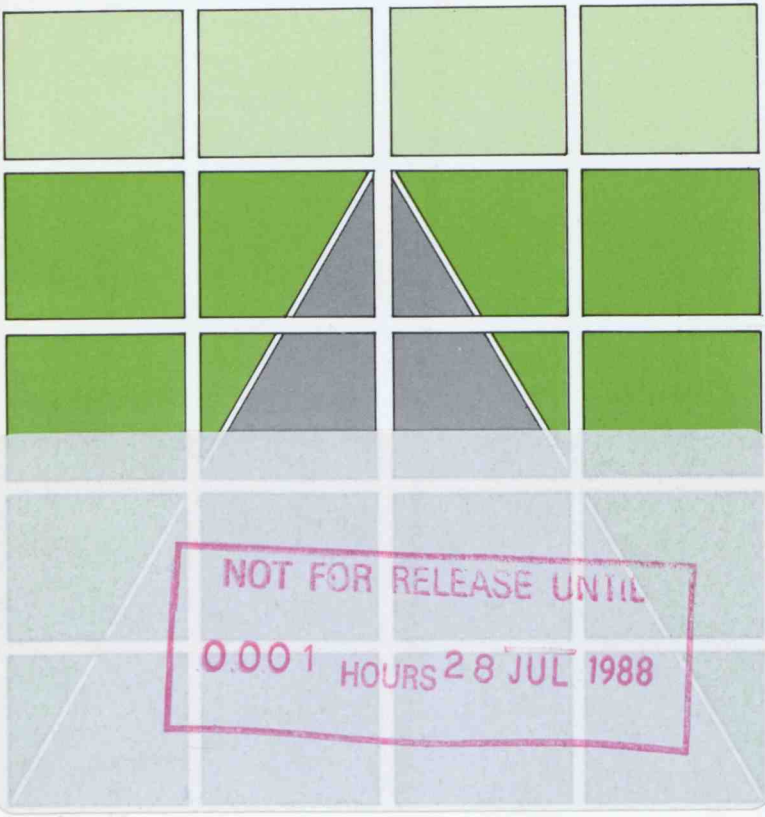
THE NHS

A suitable case for treatment

BY THE 'NO TURNING BACK' GROUP OF CONSERVATIVE MPs



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The background

THE GOVERNMENT HAS devised and introduced an educational strategy which involves greater independent control for the schools, more parental choice, and funds flowing to the schools which can best show their worth. The 'No Turning Back Group' played a part in that decision. Now health has become the next major social service in line for review.

The Government may have intended the reform of health services to wait for its fourth term of office. However, the education reforms have advanced with a speed which leaves legislative time available. Their relatively smooth passage creates an opportunity which the recent debate on the NHS has highlighted. There is now a widespread perception that radical reforms must be introduced into national health care without delay.

Proposals have already been announced to improve the efficiency of general practitioners. They will be allowed, for example, to undertake the cost-saving check-ups and preventive medicine which have been precluded thus far by their contracts, GMC rules, and official regulation. In dentistry, where there has been some incentive for practitioners to over-treat patients instead of trying to prevent the need for treatment, there are also changes.

The strains in public provision

Another factor has accelerated the debate. It is the recognition that, no matter how many resources we devote to a public health care system, there will still be shortages and closures that are bad for the patient and damaging to the government of the day.

Health Service spending averages over £400 per annum for every man, woman, and child. Standing at a record 6 per cent of the gross national product, the NHS budget has been expanded by nearly 40 per cent since 1979, even allowing for inflation. The NHS is Europe's largest employer outside the Red Army. It has 842,000 employees, including 24,000 general practitioners (a rise of 10 per cent since 1980). It treats 38 million out-patients

(up 11 per cent since 1978) and 6.5 million in-patients (up 19 per cent since 1978), and performs 2.36 million operations annually (up 17 per cent since 1978).

This Government has increased the number of nurses by 44,000 and improved their pay by 44 per cent. It has built 270 major new hospital facilities and 260 new X-ray rooms. Yet despite all this, wards are closed, patients wait for urgent treatment, and the Government gets roundly attacked for not doing enough.

Unlimited demand

Plainly the NHS has improved and is still improving in its finance, its personnel and its output. Despite all of these positive signs, however, it is the failings which seem to attract most attention. There are 660,000 people still waiting for operations, including more than 160,000 who have waited for over a year.

The Government's waiting list initiative directed extra resources towards this problem, and did achieve a reduction in waiting times, particularly in priority areas. Before long, however, the lists started to creep up again — indicating that more money, even when sharply focused in this way, does not eliminate the underlying pressures that cause the problems.

By now, the principle once understood only by a few economists has become a practical fact evident to all: that when a service is free at the point of consumption, the demand for it is literally infinite. Higher levels of spending have not satisfied the demand for health care; if anything, they have raised public expectations about what the Health Service can do, and consequently increased the demand.

Because the Health Service is free, consumers have no way of appreciating either the value, or the cost, of what is provided. They have no reason to limit their demand, nor any way of determining how they best might do so. Meanwhile, supply is not maximised because the providers of the service have no incentive to allocate their resources efficiently. So the dissatisfaction gap grows wider.

Rising costs

The advancement of medical science simply makes the allocation problem more difficult. Once a disease is overcome,

the service concentrates on solutions for the next. Having succeeded with the easy problems, we go on to tackle ones that are by nature more difficult and more time-consuming to solve, and the treatments for which are typically more expensive to put into practice. Yet because the treatments are feasible and are perceived as being free, every patient naturally demands them. Each new advance adds to the pressure.

Although the population of England and Wales has risen by only 1 per cent since 1980, there has been a 15 per cent increase in those aged 75 and over — a group which requires greater provision of health services. Moreover, medical technology has led to demands which did not even exist in previous decades.

It was not long ago that kidney failure meant certain death. As soon as dialysis by machine became a practical treatment, NHS decision-makers faced a new moral dilemma. Patients knew the treatment was possible, so all demanded it. To deny it meant letting people die. Nothing but a massive injection of funds into dialysis could satisfy that demand — but then a hundred other developments such as open-heart surgery, sophisticated operations on infants and even on children in the womb, cancer treatments, and transplant techniques, all cause the same problem.

Meanwhile, new procedures are developed in cosmetic surgery, invitro fertilisation, psychiatric and geriatric care. They may not be life-saving, but they are nevertheless in demand. To provide all these services requires an enormous diversion of resources from other urgent applications. As the range of new treatment possibilities expands, there is no end to the potential spending. It is possible to continue for ever, solving more and more difficult diseases, or just making sick people more and more comfortable. We could spend the entire national income on health and still leave demand unsatisfied.

Political manipulation

Inevitably, then, we face rationing problems, and the question is how to apply scarce resources so that the most urgent and important needs are met.

The most disturbing feature of the mechanism we use today is how quickly and brutally the allocation decisions have become politicised. The NHS sits firmly in the political arena. The political process decides its budget, its manning, and its direction. Not surprisingly, those within it, or who defend the

status quo on ideological grounds, use political methods to get their own way. Indeed, they are getting more accomplished at it, using patients and the media quite ruthlessly to put pressure on the political decision-makers.

Some consultants, for example, have advised patients to take legal action against the NHS, using it as a peg for publicity in a way which health professionals would have regarded as shameful only a few years ago.

The ideologues too use patients as pawns. During the last general election campaign, a boy awaiting surgery was paraded at Labour Party press conferences, in a deliberate attempt to embarrass the Government at a sensitive time.

Of course, these cases arouse concern in all of us; but our sympathy must be tempered with unease when we realise that our emotions are being manipulated with deliberate intent, by outsiders who want to embarrass the Government for political purposes, or insiders who seek the diversion of more staff and more funds for their own specialities and departments.

Let the people choose

Unfortunately, then, we have entered an era of hostage medicine, where patients are being used to hold the decision-makers to ransom and make political points. And the problem will continue just as long as health services are organised politically and patients have no power to change them.

In the economy at large, choice is everywhere. A walk down any high street reminds us of the sheer diversity of goods and services which the market can provide. Better technology has allowed us to transcend the era of mass production: today's economy is a custom-made economy, where people are demanding things more closely tailored to their individual needs and desires.

Many of our public services, however, were set up in the mass-production era and still give us all the same production-line service, whether it suits us or not. But people today **expect** choice — as Mrs Thatcher's administration has recognised. We now have choice in our pensions, we will soon have choice over who runs our schools. Why should we not choose the doctors and hospitals we prefer?

At present, only a few people can have choice in health services — the better-off families who can afford private insurance on top of their tax contribution to the NHS. We

really need to bring the power of choice down market, so that everyone can express their preferences between different health providers, and can go elsewhere if they feel they are getting a poor service.

Of course, some ideologues do not like this idea. They say that if we gave people choice, the articulate middle classes would desert the NHS, leaving nobody to defend it. They miss the point: we want choice **within** the state sector, so that people can support the parts of it they prefer, as well as choice between the public and private sectors. And everywhere else in the past, the stimulus of competition which that choice brings has the effect of improving the quality of services available to everyone, rich and poor. You do not have to hold people captive to improve public services: it is more effective to set them free.

Some people think that in health and education, people do not know what is best for them. Of course, that is exactly the view we would expect to come from the self-proclaimed experts who control such services. But the fact is that ordinary people are much more discerning than the experts think. And by giving patients the best possible information about the standards achieved by different doctors and hospitals, we can make that discernment even sharper.

Defining the problem

This is where the need for good information about service, quality and performance is so important.

At the moment, things can be very confusing for the public and politicians alike. We are told there is a chronic shortage of skilled nurses, although we employ nearly twice as many nurses per bed than most other advanced countries. Are they being used properly?

The media circus adds to the confusion. Closed and deserted wards, or patients being turned away from overstretched intensive-care units, are good television; but hospital staff naturally enough never direct the camera crews to the store-rooms groaning with unused equipment, over-ordered and forgotten until it becomes obsolete. There are few pictures to be had from the fact that half of the nation's operating theatre time is lost because the scheduling of admissions and the deployment of staff is so poor.

In fact, there are wide divergences in the relative efficiency with which different regions and health boards use personnel

and other valuable resources. In 1985/86, Huntingdon managed with only 10 ancillary staff for every 1000 in-patients; Macclesfield employed nearly 40. In 1986/87, North Hertfordshire needed less than 10 administrators for each 1000 in-patients, while Brent employed more than 25.

Other information is simply unavailable. The NHS does not even publish figures showing the relative success or failure of different types of procedure performed in different districts or hospitals. It is probably not a deliberate attempt to keep patients in the dark, rather a result of the fact that there is no mechanism for patients to express a choice even when they are given this information. Nevertheless, it seems quite reasonable to demand of the Health Service exactly what we demand of those schools which have deliberately withheld their examination results: we have a right to know what is being done with our money, and to be able to compare good and bad providers of the same service.

Given all this, the suspicion grows that many deficiencies are not contingent faults which can be swept away by a new cash injection, but rather that they are the result of flaws within the system itself. The National Health Service — centrally planned, funded and directed — has always lacked any serious appreciation of performance and cost, and patients have never had the power to do anything effective about it.

Without some means of feedback and a mechanism for allocating resources to where they are needed, waste will persist and rationing by queue will be the norm. If there are no price signals, and no effective data by which to compare performances, there can be no basis for decision. If we are unable to measure the effectiveness of doctors, consultants, nurses, hospitals, regions and districts, there is no way of knowing where resources should be directed to best effect.

Meeting the challenge

The first requirement, therefore, is information itself — cost and efficiency information communicated within the Health Service, and quality and performance measures communicated to patients. If we can establish relative performance levels and calculate needs, it might well be possible to set in motion forces within the NHS which can lead to its systematic improvement.

Improvements within the present system

Two strategies

There are, broadly speaking, two areas in which the NHS might be reformed, and on which many proposals have tended to focus their attention. The NHS might be improved in respect of its finance or with regard to its structure.

With 85 per cent of NHS resources coming presently from taxation, changes might be made to NHS funding by introducing alternative sources of cash, or by venturing towards health stamps, a voucher, an assignable health tax, or by promoting private health insurance.

Equally, changes might be made to its structure, its management and the way in which decisions are made and implemented. In place of the Regional and District Health Authorities and the Family Practitioner Committees in England and Wales, we might introduce other bodies to carry out, and take responsibility for, the NHS functions and duties.

Although most reforms cover one or other of the two areas, some proposals might be made which would change both the method of financing the NHS and its structure and organisation.

On a more modest level, there are clearly some improvements which could be made within the context of the present system, and which would raise the quality of the NHS regardless of the methods chosen to fund and organise it. Let us start by examining these options.

The present system

A policy of no change, even with more resources devoted to the Health Service, is not an acceptable option. The problem of over-demand would remain, however much was spent — and the lack of competition within health services would continue to stifle innovation and efficiency, to undermine cost control, to support administrative overmanning, and to preserve inefficient practices. Allocation decisions would become ever more politicised as those inside and outside the Health Service

learned the craft of media management. Patients would still have almost no choice.

Without administrative changes, more money would not immediately pull resources to where they are needed. The source of the problems in a recent Birmingham case, for example, was a shortage of personnel with skills in nursing children under intensive care. But we cannot expect such people to flock to Birmingham just because the general NHS budget has risen. It would require a mechanism for setting pay and conditions that is far more responsive to local surpluses and shortages. To avoid the problem recurring would require still more change: building on the recruitment, training, and career structure initiatives that the Government is putting into place.

Remember, also, that the present system is expensively organised, relying too much on costly hospital treatment. And within it, there is inadequate cost control. Doctors prescribe courses of treatment, unknowing and unconcerned about their cost; expensive items of equipment are used once and thrown away; attempts to reduce prescription costs are opposed.

Clinical services

A major problem with the present system is the difficulty of imposing sound management upon clinicians. When it was constructed in the 1940s, the consultants posed a major obstacle. The outcome was that paybeds continued in NHS hospitals, with the consultants in effective command of hospital organisation. While consultants may be very good medical staff, they are not necessarily good managers. Indeed, their incentive might be to spend more money on their own projects, rather than to economise for the benefit of other, more urgent, applications.

Managers know that the best consultants have five times the productivity of the worst. But they can do little to change the attitudes, or manage the performance, of a group of people who are used to autonomy, who are contracted at regional level, paid at district level, and work at the hospital level.

Similarly, there is no effective management mechanism to improve the efficiency of GPs in terms of drug prescription, referrals or patient satisfaction. With 24,000 general practitioners, each with about 2,000 patients and seeing, between them, some 750,000 patients each day, this is a large part of the Health Service which we have to get right. But costs

continue to rise — expenditure on Family Practitioner Services, for example, increased by over 30 per cent above the level of inflation between 1978/79 and 1985/86 — while performance indicators remain crude.

GPs, of course, refer patients for consultation or for hospital treatment, so larger spending on the primary sector tends to produce more referrals and therefore greater pressure on the secondary. Outside Scotland, the two sectors are separately controlled, meaning that GPs effectively have a blank cheque on managers who are powerless to manage them.

Hospital management data

The hospitals themselves have long lacked adequate data relating to costs, performance and effectiveness, although this is improving. With some 2,000 hospitals in the UK, it would seem essential for efficient management to have comprehensive and regularly updated data. This data should include figures on the costs of personnel time, overheads and capital; on staffing, staff skills, and hospital needs; on stores and stock control; on waiting lists and the availability of beds.

Better information is already being collected by hospital managers, of course, and small but systematic improvements in efficiency are resulting at the local level. Nevertheless, the Korner management information systems now up and running in the districts and the performance indicators now amassed by this Government (for the first time in the Health Service's forty-year history) are not being put to the best effect in terms of judging the relative efficiency and service quality of different elements within the NHS. The performance information data collected at the DHSS remains extremely complicated; and as one might expect from a first attempt, they do not properly get to grips with a number of important points. Politicians and the public find them indigestible. Can they really be used effectively for serious management purposes?

It is natural that questions should be asked about ward occupancy rates, and the variation of 70-90 per cent between different areas. Few authorities can tell what is the cost per hour of a fully equipped and staffed theatre, or give the relative costs for different types of operation and treatment between different hospitals and districts. The absences of some of these key figures at national and local level gives little basis for resources to be allocated or priorities determined.

Claims are made, for instance, that only 800 hospitals have computerised management systems. At present, an ordinary microcomputer plugged into the telephone network can tell a user in Macclesfield how many hotel vacancies there are in Manhattan; but there is no system to tell a doctor how many vacancies there are in British hospitals.

Contrast this to the record of a British company which operates hospitals all over the world: in one of their facilities in Jeddah the computer printouts alerted the managers to someone stealing coffee on one floor of one wing of the hospital — their stock-control information was that good. If a British company can do it, why not the British Health Service?

No systematic judgements

The fact that all treatment is free at the point of consumption, means that patients too, have no information on which to make decisions. It encourages patients to expect the benefits of new techniques that can be very expensive, in terms of the improvement to longevity and the quality of life they bring. If patients knew the costs involved, they might well conclude that the benefit they enjoyed from some procedures could not justify the expense, and that the money would be better spent on other people with more urgent needs.

In fact, it is difficult to perceive any point at which value judgements about the merit of expending funds on some types of treatment at the expense of others are made systematically. Should resources go on an open heart operation for an infant or on a kidney transplant for a pensioner, or on staff training? Not even a framework for choice has been thought out, because the costs of the inputs are largely unknown and the value of the outputs remains unassessed. What decisions ultimately arise are haphazard and unsystematic.

They can also be manifestly unfair. Those who argue for patient choice are often accused of wanting a 'two-tier' systems consisting of a luxury service for the rich, and a substandard service for the poor. In fact, the present system is a two-tier one. Those who are educated are more aware of the potential procedures available, and more self-confident about demanding better service from doctors; those with professional or family connections can jump the queue by putting pressure on health administrators, or even getting an MP to intervene for them.

Immediate reforms

There are some reforms which can be made, without regard to the organisational system which prevails overall. Simple tests and treatments could be done in local clinics, for example. A one-stop clinic makes much more sense than the present system, where the patient sees a GP, the GP refers him for a test to a hospital, the hospital does the test, the patient waits, and the hospital sends the test results to the GP. The patient returns to the GP, the GP assesses the needs, and the patient goes back to the hospital for the treatment.

In other countries, X-rays and other tests, and even simple treatments like cataract operations, are done in the doctor's surgery, cutting down duplication and error, and curbing the use of expensive hospital staff and facilities, as well as avoiding the waste of patients' time.

New incentives could encourage GPs to take on more of this sort of care. Ultimately, however, the artificial separation between the family doctor and the hospital sector needs to be broken down. Intermediate care facilities such as nursing homes or the old cottage hospitals might lack the high-tech facilities of a district general hospital: but they are perfectly adequate for convalescence and for simpler procedures. Not only are they likely to be less expensive to run, but they can be nearer to home and therefore more convenient for patients and their families.

The agglomeration of facilities into large district units, another example of 1970s giantism at work, is now recognised to be deficient. The bolstering of intermediate care facilities would benefit the NHS patient. And it would encourage the private hospital operators — presently scared off by the fact that everyone expects even the smallest hospital to have all the sophisticated equipment of the district general — to enter this market niche, to the benefit of all.

Incentives for more preventive medicine can also be built into many systems, although they are difficult to manage. They could nevertheless reduce the demand for hospital facilities later on. Family doctors are obviously the most important part of such a process.

Better managers

Also needed are greater incentives to attract good managers into the system and to enforce new systems of cost control. Managers in comparably large organisations outside the health service are paid considerably better, and it is distressing that even some of the new wave of managers recruited from the private sector are now drifting back out again. Furthermore, there is no sense in an allocation system which rewards the efficient manager only by paring his budget even more in the next annual round.

Managers need to be able to manage. One way is to revise the contractual arrangements of GPs and consultants, so that their time and skill can be deployed more effectively within the overall context of patient care. Another is to depoliticise the health authorities, so that ideological posturing and the appeals of vested interests from inside the Health Service, cannot undermine sound, but sometimes tough, management decisions, nor prevent the formation of rational priorities by perpetual bickering.

Asset rules

Assets as well as human resources must be managed, and here the national rules do not always help. Today, capital schemes include 500 projects of £1m. and over, at a total of nearly £3bn. at various stages of planning, design and construction. The NHS owns property on about 46,000 acres. Plainly it is important to see that these assets are working as hard for the patient and the taxpayer as they possible can.

Capital goods depreciate: at the end of a certain period of time, they have outlived their usefulness, and must be renewed. The standard accounting practice is to put down an annual figure to reflect the rate at which capital is being used up, so that sensible provision can be made for its eventual replacement. But in the NHS accounts, there is no depreciation. On a wing and a prayer, health managers just live in hope that the politicians who control the budget will grant them the huge one-off payments needed to build a new hospital or replace obsolete equipment.

Because of this curiously trusting approach, the NHS tends to regard capital as resulting from the happy whim of a benefactor rather than as something which can be built up

through sensible planning, management, and budgeting. Thus, Victorian hospitals creak on without those running them expecting to make provision for their replacement, not being given the latitude to propose any solution (such as selling the site for offices and building a more cost-effective new hospital nearby). Likewise, insufficient maintenance budgets are put aside for the cracks and leaks of the 1960s generation of hospitals, because capital maintenance, like replacement, is seen as someone else's problem. Until there is proper capital budgeting depreciation, and amortisation, however, these problems will persist.

In capital management, bad attitudes are reinforced by bad rules. Local authorities tend to be huge land hoarders, and some of this attitude has spilt over into the health authorities. There are still too many buildings and too much land that is not used effectively. One solution would be the straightforward sale of underused land and buildings, with the proceeds being reinvested in new plant and equipment. Unfortunately, the structure of district authorities makes them reluctant to embark on such a strategy; and even if they did, there is a rule preventing them from keeping the proceeds of any sale.

Transactions other than outright sale could also help rationalise NHS asset portfolios and improve patient services if the rules allowed. Sale and leaseback arrangements can bring much-needed capital and prevent ward closures. Unfortunately, local authorities regularly interfere in such decisions, or block them completely. This means that they have to go up to the DHSS, which causes unnecessary delay. A more direct central commitment to this kind of novel financing arrangement, as well as to raising loans or local equity to help the system, is long overdue.

With the success of public-private partnerships in other public services and industries, growing numbers of entrepreneurs are coming forward to propose joint ventures with the NHS, in which new facilities will be jointly financed and operated. Adding to the other disincentive against district participation in such ideas, however, are the Ryrie rules affecting public sector capital investments in public sector activities. Intended to prevent the public underwriting of activities that should properly be risk taking, the rules conspire to outlaw much experimentation with joint ventures that could pay handsome rewards over future years.

This is a great misfortune, because the private sector can

often add considerably to the value and quality of services presently being provided, if such co-operative ventures are allowed. The private health sector, for example, tends to be better capitalised, and able to embark upon new investment projects more quickly and decisively than the public sector. The matching of private-sector resources with public-sector personnel is something which asset rules should encourage, not deter.

The use of contractors in ancillary services is saving money and bringing downward pressure on in-house costs. There is also room for greater partnership between the public and private sectors in estate management and financing.

Better hospitals

A more radical approach would examine the opportunity for contract management of hospitals. As an alternative to closing hospitals, tenders might be invited for their management, with preference given to those who demonstrate they can manage the facility better and cheaper than at present.

This system is quite common in the United States and in Canada: the staff in the hospital stay the same, but the managers change, unless they perform well enough to win a new lease of tenure. Of course, those coming forward as potential contract managers might come from the private sector. They might come from existing management, from those presently in the service and conversant with it and who feel that they could manage it better if they were given the freedom to do so.

Standards must be laid down and monitored in any such contractual arrangement. The cost of treating each diagonistically related group is obviously one measure. Quality assurance programmes, management targets, staff satisfaction, the number of complaints and the response to them, the introduction of new facilities within the unit, and many other indicators will all be watched. And improvements in them can be demanded more readily of contract operators than they can of today's in-house staff.

Setting hospitals free

A route which might lead to this in time, but which would produce instant benefits now, would be to make NHS hospitals better able to run their own affairs outside the district decision-making structure. Constituting them as independent trusts, with a strong management element but some sprinkling of local business and community interests would not be a difficult change. It would give hospitals more of the identity they need to attract further local support, and more of the independence they need to seek other private sources of capital — although the Treasury rules on this might need some relaxation if the full potential is to be reaped.

The existing management would form the nucleus of each trust, which would make it easy to go on to the next step, a contractual arrangement between the trusts and the district authority, whereby the hospitals were paid largely on the basis of what they did and their cost-effectiveness in doing it. The district authority would 'bulk buy' procedures and services, comparing the cost and quality of the different hospitals within its area or even nearby. At last, this would produce the beginnings of diversity in service provision, and would start the process of introducing the stimulus of competition into the NHS.

Competition within the NHS

UNDER THE CURRENT mechanisms of NHS organisation, patients have little or no choice. They find it hard to switch to GPs they prefer, and they are still largely dependent on the facilities, priorities, and waiting lists which their district or health board maintains.

The competitive stimulus

Because they lack the power of choice, patients are regarded merely as patients, when they should be seen as valued customers. Human nature being what it is, there can be no chance of such a Health Service becoming more efficient unless it is subjected to competition. Public services generally have never responded to politicians' exhortations to do better: only competition or the threat of privatisation has led to systematic improvements.

This is partly because, in the absence of competition, there is no reason to do better. Inefficiency is the privilege enjoyed by the monopolist. Because the service is publicly funded, it is too easy to blame politicians for the shortcomings of the system. There is little point even in collecting cost information, quite apart from seeking to reduce costs, if there is no incentive to do so.

Competition is the effective way of providing that incentive. Managers can be urged to collect more information and to act upon it, but these exhortations will not be effective unless their livelihood is at risk, or unless rewards follow success.

The mechanism

This is why it is important to introduce more competition into the NHS itself. Particular hospitals and particular areas should be able to specialise, with patients being referred to whichever can provide the best or cheapest service. Excess capacity should be traded across district boundaries instead of having empty places in one location accompanied by shortages in another.

There is no intrinsic reason why there should be high boundaries to separate each of the regions, districts, or health boards, or why patients and resources should not move across them. Ideally a patient with specialist or hospital requirements should have access to the best available facility nationally, and enjoy the benefit of the most efficient source of treatment.

This is dependent on up-to-date information being available on where there are consultant and hospital facilities ready to use on a national basis. And it also requires full cost information from each hospital, so that managers can compare different health-care providers and make an informed choice on behalf of their patients.

Unfortunately, the present DHSS allocation structure prevents it. There is no direct mechanism of cross-charging between hospitals and districts. But this seems to be a relatively simple administrative change which could bring disproportionately large benefits in terms of the speed, quality, and cost-effectiveness of patient care.

Not just managers, but GPs have a key role to play. The incentive system must be constructed to give GPs an interest in selecting the best-managed and most cost-effective source of treatment. They need more cost and quality information from the hospitals, and more incentives to perform diagnostics and straightforward procedures in their own surgeries, when those things would be more costly to provide in hospital.

Hospital independence

Some hospitals have started to make *ad hoc* charges, marketing to other parts of the Health Service the things they do best, or the excess capacity they have lying idle. But generally, the law forbids this. Others have refused to take any cross-boundary movements at all because the existing cumbersome reimbursement mechanism makes it not worthwhile; so potential benefits are lost. High priority should be given to the setting up of a system of direct payment.

At present, many hospitals have only the vaguest idea of the true costs of the treatments they administer. There is simply no incentive to find out. An efficient system to encourage cross-boundary transfers would certainly give them that interest.

The proposal to reconstitute NHS hospitals as more-independent trusts would undoubtedly help in this regard. Their relationship to the district authority would be a

contractual one, and it would be plain that along with the boons of independence and greater individuality of management, NHS hospitals would face the challenge that the districts could buy-in services from elsewhere if they thought they could get a better service at lower cost.

Moving to more-independent NHS hospitals, which charge the districts for what they do, might require transitional rules to ease the immediate burden of plant costs. Some Victorian hospitals are not designed for today's health-care needs; or have archaic heating systems that load their costs significantly; or will soon face enormous replacement costs. Their charges to the district would be much higher than those of a newer hospital, and if districts shopped around, such units would have problems.

Being more independent, the trustees of an old and costly hospital could certainly opt to raise new capital to replace their building or relocate nearby and redevelop the site; and a robust free-marketeer would welcome the pressure on them to do so when their performance decides their budget. However, we would not want all hospitals to be going through such changes simultaneously, and the best solution might be to phase in the reform gradually or temporarily meet some overhead expenses through block grant arrangements.

Partnership with the private sector

PARTICULARLY IMPORTANT for extending competition and co-operation is that the spur should come not just from within the NHS, but with the private sector as well.

Of course, it is most important that the basis of the cost comparisons should be similar in each case. Clearer guidelines, drawn up by the DHSS or preferably by the Institute of Health Services Management, could form the new standard, where today the basis of cost calculations in the two sectors is incompatible.

For example, the NHS has a tendency to regard capital assets as 'given', which is one reason why they are often so badly managed, while in the private sector they are an essential part of cost calculation. Or again, when contracting for ancillary services in the NHS was introduced, contractors had to add 15 per cent VAT to their bills, and were sometimes rejected by the health authorities as more expensive, despite the fact that the tax went straight back into the same Exchequer. This was resolved: but other differences remain. Pension rights should be included, for example, as should the opportuity cost of buildings and facilities presently used for in-house staff.

Existing partnership

As well as tendering for ancillary services, which has so far saved the NHS over £100 m.; partnership with the private sector has grown far beyond this. Hospital waiting rooms are being made more like airport lounges, for example, with comfortable seating, cafes, and shops selling flowers, fruit, and all sorts of goods.

Not just these services, but clinical procedures are now being seen as sound areas for partnership. Hospitals have used private facilities to clear their waiting-list backlogs or when their own operating theatres were infected. Private and public health managers have embarked on the shared use of costly equipment, and even the sharing of staff and facilities for the development of new procedures.

Private hospitals already undertake a significant proportion of elective surgery, and can be very cost-effective at it. The NHS manager can frequently make cost savings by shopping around: there is a lower demand for private admissions at weekends or in holiday periods, for example, and NHS backlogs can be contracted out cheaply at these times.

There are other advantages that the private sector can sometimes bring into partnership. The acquisition of expensive technology is usually easier and quicker; and if up-to-date facilities are necessary, it is worth bearing in mind that half the UK's independent hospitals are less than ten years old (whereas around 70 per cent of NHS hospitals are older than the Health Service itself). Long stay geriatric, disabled, and mentally handicapped patients are increasingly cared for in the independent and voluntary sector.

What is needed is a diversity in supply, so that health managers can buy in the services they need from the highest-quality and most cost-effective sources.

Some services, such as pathology or pharmacy, could work well as functions that were independently managed by those presently working within them — a process roughly equivalent to a worker buy-out in the commercial sector. There are now 170 pathology laboratories in the UK which can tender for the NHS work, many with very high-tech equipment. This new boost would help the Health Service to avoid the large capital costs involved in modern pathology, while stimulating NHS pathologists to develop new methods and to market their skills more widely.

Whole treatments, such as dialysis, can be contracted out. Some NHS hospitals bring in a regular income by contracting out paybed facilities to private firms which overhaul them and pay well for the privilege. Even more adventurously, hospital builders such as Tarmac Construction suggest that they could build and operate entire hospitals more efficiently and more cheaply than the public sector.

There is, however, a reluctance for health managers to consider such partnerships. This stems from the current lack of incentive to reduce costs through contracting, the political objections and subsequent delays managers face when recommending such change, and the absence of sound cost comparisons. Some health authorities block the injection of private sector money and profitable partnerships for political reasons alone.

Boosting the partnership

Innovative partnerships with the private sector will bring more and more benefits as experience is gained. From the government side there must be a financial incentive structure which encourages such experimentation and development.

There should also be structural reform of NHS decision-making in order to take advantage of the best of both private and public sectors — drawing up sound cost and quality comparisons, allowing private bodies to offer their services to the NHS, and enabling NHS managers to buy from the private sector or from other parts of the Health Service wherever it is efficient to do so. It is time to lower the political drawbridge between private and public health care.

The introduction of internal markets within the NHS, as a first step, would get managers used to buying and selling services between themselves, and to both knowing and controlling the costs of everything they do. In adopting this more businesslike approach, they would be drawn naturally to greater partnership with private suppliers as the comparative strengths of each sector became evident.

The finance

IN THE SEARCH FOR more radical alternatives to the present public health system, some extension of private medical insurance might be one possible model. There are several ways in which private cover could be enlarged from the nearly ten per cent of the population presently enrolled. Private medical cover has the advantage that it takes away some of the demand for scarce NHS resources. It brings more money into the health-care sector as a whole, and allows state resources to be concentrated more precisely on those who need help.

Universal insurance?

In the complete form of this model, everyone would be required to have private medical insurance of an approved standard, just as everyone who drives has to have motor insurance provided by companies authorised by the Department of Trade and Industry. Those who were too poor to pay for their medical insurance premiums would have them paid on their behalf through the social security system, perhaps through a voucher that they could take to any insurer.

The effect would be to ensure that everyone received treatment when they needed it, and those on the poverty line would not have to pay. People who could afford more and thought it worth paying for a more luxury service would be free to take more expensive insurance if they wanted to.

There has already been a large growth in private medical insurance since 1979. The rise in economic prosperity has brought private cover within reach of many more people. Even the recent media hype of alleged NHS shortcomings has made private alternatives seem more attractive — although this can hardly have been the intention of those behind the campaign.

Sir Geoffrey Howe, when Chancellor, gave the private medical insurance sector a boost by restoring the tax concessions for group schemes of employees earnings less than £8500 per annum. The rise in group enrolments, many from

trade union branches, since that time indicated its effectiveness. Although coverage under some kind of private scheme now extends to a tenth of the population, the main obstacle to further growth remains that of double payment. With no tax concession except for low earners, private medicine is now limited to those who can afford to pay twice: once for the NHS which they do not use, and once for the private service which they do.

At present we have a Treasury which is not fond of tax relief and concessions. Indeed, they are easy to abuse, hard to police, and difficult to end (witness mortgage interest relief). They mean the general level of taxation must be higher than would otherwise be necessary, generating demand for yet more exemptions and allowances.

However, they are also a powerful political weapon: and health services could certainly benefit from a more robust private sector accessible to greater numbers of people, providing a real alternative, and putting a stronger competitive pressure on the NHS.

There is also the point that the income distribution is a bell-shaped curve. Those under the thin wedge at the wealthy end are already in private medicine; if private insurance is made less expensive, much larger numbers can be drawn into it. As it is brought more and more down-market, very rapid increases in the number of those demanding it can be expected. Thus a small tax concession can have a disproportionately large effect. This can syphon at least some of the excess demand away from the NHS.

The need for caution

There must be caution, however. Overseas experience suggests that an unrestrained system of private insurance can produce serious cost escalation. Insurers have little way of challenging the decisions of the doctors, whose interests may lie in the performance of ever more tests, longer hospital admissions, and costlier treatments. Workers, meanwhile, demand more and more comprehensive health care packages as part of their wage settlements, bidding up the premiums for everyone.

In the United States, insurers have begun to exercise more control, and large firms are starting up their own employee health schemes in which costs can be better managed. While it might be possible to give private insurance a necessary boost

through tax concessions, the American experience suggests that we should not move to a completely unregulated universal health insurance system.

Another worry about tax concessions is the so-called 'deadweight' effect. The reliefs will not only go to those newly tempted into the private sector, but to those already there; so part of the concession is wasted. However, against this effect must be set the savings made possible from those who are drawn off: and market research should reveal what levels of concession will be likely to leave the balance positive.

Tax relief for the elderly

The area in which tax reliefs would bring the greatest benefit, and so could be offered immediately without any of these qualms, is for private medical insurance for elderly people.

Health insurance premiums rise dramatically as people become older, just at the time when their incomes generally drop. This combination causes many of them to allow their private health insurance to lapse. Tax help for this group would give them help just when they needed it. And because so few would normally be able to afford insurance, that help goes overwhelmingly towards stimulating renewals and new participants. Very little is wasted on any 'deadweight' of those who would have stayed insured even without the help.

As far as the NHS is concerned, the elderly as a group form a major part of demand for health services and are costly to look after. Average NHS spending on a person of 75 years of age or more is nearly £1500 per annum, compared to the £200 per annum it costs for the average young person. Each elderly patient who is prompted to transfer his or her demand to the private sector therefore represents a potential release of considerable resources that can be saved or spent on acute services elsewhere.

Thus, tax concessions which might at first seem large, e.g. of the order of £1000 or so, can still bring major savings to the Exchequer and the Health Service.

There would be benefits too, in terms of the size and shape of the market for private health insurance and health care. At present, the insurance market for the elderly is very small. Insurers, of course, prefer large numbers of people on their books, because then the risks balance out and the costs of meeting claims can be more closely predicted. Health insurance

for the elderly, however, is expensive, and because it is expensive it is self-selecting: those who think they will need most care are first to renew. By encouraging the spread of health insurance for the elderly, making it a mass market instead of a rarity, we begin to reap the gains of large numbers. Having broken the number barrier, self-selection becomes less significant a factor, and insurance becomes cheaper for all.

Insurers, of course, like the variety of providers they can call on when their clients need care. Again, although growing, there is no major insurance boost available to the private care sector. With insurance more generally available, however, we can expect that independently managed care facilities for the elderly will experience a similar boost, to everyone's benefit.

Because the number of elderly people living in the UK is growing significantly, we need that help from the private sector. On present trends it will cost at least £1000m. to provide places for the expected increase in the number of over-75s in the next five years. It would certainly help the health authorities if that burden could be spread more widely.

We need a diversity of providers to allow a diversity of new ideas to come forward, so that we can choose the styles of care that will be best and most cost-effective for this growing group. We need a diversity of solutions so that we maximise the opportunities for the best solutions to emerge and develop.

It should be a priority, therefore, in any reform of the NHS system of finance, to offer generous tax reliefs or rebates to those over 60 or 65 who opt to pay for private health insurance. Once the full results of this have been seen and understood, the use of tax reliefs for private health insurance can be extended systematically.

Public finance strategies

In addition to tax concessions designed to get more private money into the health system, and to promote the use of private insurance at the points where it can improve facilities and take pressure from public funds, we need to steer public money toward areas of greater efficiency.

That means giving financial incentives to doctors, managers, and hospital staff who provide a cost-effective service.

A system characterised by competition and choice has the advantage that funds can be allocated to follow the choices that are made. Just as in the present Government's education

reforms, the money will be able to follow the child so in the Health Service it should follow the patient.

The NHS as presently constituted does not allow this. GPs have an incentive to have large lists but to provide little attention, although the White Paper proposals on primary care may help to change this. But right now it is largely to their professional dedication that we owe the quality of our family doctors, not to any incentives given to them. Changes to the allocation mechanism should reward the good and penalise the bad more effectively.

The role of the GP as gatekeeper and monitor of hospitals and consultants can also be strengthened. GPs can help keep expenditure down if they have the right information about costs and performance. Training that gives them an appreciation of resource management and the relative costs of different styles of care, and an obligation to seek cost-effective strategies or justify the use of others, would all help.

There is an urgent imperative not only to promote wider use of private health insurance, with emphasis on phasing in incentives to target groups, but also to a reorganisation of the public supply itself so that resources are routed more effectively within it.

A new management approach

THERE ARE LESSONS for the UK from the sort of management structures which operate successfully abroad. As an answer to the cost escalation problem of their fee-for-service private insurance system, for example, Americans have turned in astonishing numbers to the principle of the health maintenance organisation (HMO).

The problems we face in the UK, of course, are quite different: but out of the development of HMOs have emerged some interesting management approaches which could well bring enormous benefits if applied carefully and sympathetically within the context of the National Health Service.

The HMO principle

Millions of Americans are currently covered by HMOs of various descriptions. They are often locally based, and provide a complete medical care package to employee groups, rather like miniature, competing NHS systems.

The essential mechanism is that the HMO managers work on a fixed per capita budget for the membership they take on. If they can provide a full service for the group within budget, they share in the surplus; if not, they lose. That gives them the incentive to keep the members fit and away from the surgery, or to make sure they are treated as quickly as possible and in the most cost-effective way. Thus, there is a great emphasis on preventive techniques, with some HMOs offering health education in the workplace and undertaking routine screening of the members of each new group they take on.

Some HMOs tie up with their own hospitals, others buy in the treatment they need from the most competitive provider. In any event, the treatment given is monitored closely by the managers of the HMO, with daily reviews of whether a patient still needs to be kept in hospital, for example. The managers also encourage GPs to do routine tests and treatments in their own surgeries rather than buy in expensive hospital time.

As a result of all this, studies have shown that the HMO

system produces a less costly type of care, with 40 per cent fewer hospital admissions and 40 per cent shorter stays for those admitted. But any tendency for an HMO to contain costs by supplying insufficient care is countered by the fact that patients can vote with their feet. People can simply go to another HMO or back into private insurance if they think they are not getting a good service.

There are other benefits. Naturally, the managers demand very full cost information from the hospitals and doctors who look after their patients. The HMO managers also provide much more information to the GPs, such as information about what prescribed drugs and equipment cost, what drugs their colleagues are prescribing for the same cases, what new and less costly treatments have become available. Managers even check to make sure that the doctors are readily available to patients on the telephone, and make regular surveys of users' opinions of the treatment they receive (not something that NHS managers are known to do).

Of course, Health Maintenance Organisations were designed for the health market in the United States, a market dominated by private sector supply (or even oversupply) and facing problems entirely different from our own. While private-sector HMOs could be promoted by tax concessions in the UK, therefore, their major point of interest lies elsewhere. The question is whether the successful management techniques pioneered by the HMO sector have some relevance to any future reform of the NHS management structure.

Applying the lessons

The use of these techniques could, in fact, make major improvements to the NHS without putting at risk any of its achievements.

The key to the reform is to separate those who control the budget from those who actually provide medical services. This allows diversity and competition in supply to emerge; meanwhile, the budget holders can look around, more independently than at present, for the most cost-effective strategies and sources of health-care delivery.

Such a reform is not as difficult as it sounds at first. A good starting point, for example, would be the existing district health authorities (merged with the family practitioner committees), and in Scotland, the health boards.

The existing managers would have to be divided into those who manage hospitals and those who manage the overall budget. The state would provide annual funding on the basis of patient numbers (perhaps weighted by local age and morbidity statistics), and the financial managers would be obliged to provide health care for their patients within that sum, commissioning the necessary services from the GPs, consultants, and hospitals.

From the point of view of the Government, the reformed management structure is simply another way of disbursing NHS funds, although it is a way which makes for more responsive and more cost-effective treatment. The funding would go to the managers in the form of an annual grant, based on an annual per-capita figure, weighted by age, local morbidity and perhaps other statisticss to reflect the burdens imposed by potentially more expensive patients. The financing principles already set out by the Resource Allocation Working Party (RAWP) could provide the foundation for such grant allocations.

Patients, for their part, should be given as much opportunity as possible to change their GPs, and to express a choice if they have one about consultants and hospitals they prefer. The information which managers can derive from such choices is a good indicator of service quality and user satisfaction. But otherwise, patients continue to receive the services of GPs and hospitals as before, free at the point of consumption.

Patients should receive an annual report from their districts, giving details of costs, service quality, and performance achievements. This would encourage a more questioning attitude toward NHS providers, and would prompt hospital and district managers to consider customer attitudes more closely. It would also persuade private health-care providers to show what they could do if judged by the same standards, and sharpen the managers' awareness of patient needs even further.

For service providers, there will be greater changes. In place of central direction and resource allocation, the system becomes based on competition and the need to satisfy customers. Thus doctors and hospitals will acquire an interest in monitoring costs and selecting the most cost-effective methods, so that they remain attractive to the financial managers. Meanwhile they will want to provide high-quality services that are attractive to patients, because the state funding will follow the patient. And they will know that the better they

perform, the more funds they will have to work with; no longer need able and enthusiastic people remain stymied through lack of funds.

Those managing the budget would be free to buy in medical and non-medical services from the private sector, or even from other parts of the NHS outside the district or health board boundary. Value for money and security of service supply would be their main criteria for choice. The existing regional health authorities in England and Wales, perhaps diminished in size and reconstituted in scope, could form an effective monitoring body to scrutinise these choices and to help managers and service providers make future planning decisions.

The mechanics of the reform

The principles of this reform are very like those of the 'Health Management Units' first proposed by the Adam Smith Institute and later taken up under various names by others. A comprehensive health-care service is commissioned from a per-capita budget by specialised management teams. Hospitals and other service providers, meanwhile, become independently managed, increasing choice and variety.

Starting at the district or health board level, most of the benefits of this approach can be enjoyed, without the need for a radical restructuring of the Health Service. Competition in supply would exist, but it must be admitted that patient choice would be somewhat restricted if people had to accept the management team that existed within their own locality, and could not transfer to others.

Nevertheless, the foundations for greater patient choice can be laid right away. There could be immediate choice at the boundaries of each district, for example, with GPs taking their patients under the wing of a neighbouring management team if they thought it would improve patient care. When the new system and the new attitudes have become more established, it might well be possible to split the management units into two or even three per district, so that patients begin to get a real choice about who should organise the delivery of health-care services on their behalf.

Merits of the system

Whatever future adjustments are made, certain essential features and benefits would remain the same.

The existing administrative division between primary and secondary care would be ended, for example, with GPs' and consultants' contracts all being held at the same management level. Managers would undoubtedly introduce incentives to encourage the provision of routine check-ups and other preventive medicine which in the long term would reduce treatment costs.

There is also likely to be much more mutual understanding between doctors and managers. Protocols for the admission and discharge of hospital patients, peer review of prescribing practices and referral rates, increased training to keep doctors aware of new and more cost-effective strategies of patient care, would all be encouraged.

Hospitals, likewise, will be better managed. Because the budget managers can commission health care from whichever source they wish, hospitals have to stay cost-effective. The hospitals, being independently managed under these reforms, and paid for each service they provide, will experience a tendency to specialise and to expand whatever they do best. This alone promises to bring huge benefits to the NHS.

More independent hospitals, each able to build on its own identity and no longer just a small cog in a large machine, will find it easier to rally local support. Opportunities for local sponsorship, fund-raising, and in-kind contributions should be enhanced.

Another likely consequence will be the spread of facilities intermediate between GPs and hospitals, with group diagnostic and day-care centres or one-stop health clinics offering a variety of treatments presently done at great expense and less efficiently in hospitals. Hospital managers will make greater use of recuperation wards or nursing homes, where patient recovery can take place without pre-empting the use of expensive treatment facilities.

Probably, the managers would buy services in bulk, based on actuarial calculation of the likely needs of their patients. This gives the advantages of competition without the uncertainty of finance which could result from a system of one-off purchases. Since there would be no obligation for the budget holders to buy their services solely from NHS providers if they could get a

better deal from shopping around, the competitive element would stimulate both public and private sectors.

A patients' charter

A key element in this new system is that patients must know more about what the NHS providers locally are doing for them and what they have a right to expect. Because district managers are given the power to shop around, their customers' views will be important to them: patients will have some influence over the performance of hospitals and doctors for the first time, even if it is only indirect.

NHS health-care providers should be required to publish performance figures so that comparisons can be made by the public as well as by budget managers. The annual report will help patients make informed criticisms, instead of being brushed off by insider experts.

Perhaps the first question they will ask is exactly what the NHS entitles them to. At present, NHS doctors make daily decisions about how resources should be allocated, and who should get what courses of treatment: yet still they feel obliged to maintain the pretence that everyone has equal rights to the same level of health care.

Patients, however, have a right to know what they are genuinely entitled to and can expect. This probably requires redefining the types of procedure which are a priority and to be provided free of demand to all comers. Doctors are always interested in new technology and experimental medicine, but they or the district managers would be required to express more caution about the availability of items that are costly to provide or where the skills needed are too new and in too short supply to allow the free provision of the service to everyone who demands it.

The separation of treatments into various priority levels is not an easy task; it would require clinical and budgetary decisions at the national and local level, and would require continual updating as new procedures became possible. Some boundaries would be indistinct, and local managers and doctors would need to retain a fair amount of flexibility to decide whether a patient fell into one priority category or another.

Accident and emergency care would obviously have the most urgent priority status. The patient would have to be treated

immediately, at the nearest hospital, without charge (although that hospital, if outside the patient's health district, would recover the cost of that care in due course). Next on the priority scale would come a range of treatments for acute problems, contagious diseases, and so on, for which no waiting times or very short waits only are acceptable. Further down are problems that are presently not life-threatening but which could become so later on; and then, problems which are not life-threatening at all but which cause physical discomfort or curb the patient's activity.

There may be many other categories; but last on the list would be certain forms of elective procedure (much cosmetic surgery, and perhaps procedures such as in-vitro fertilisation), which might not even be available as a free service at all.

The priorities, implicit in the present system but not clearly chosen, will be much more explicit, and so will waiting times. This latter point is important, because once patients are aware of the waiting times that prevail in different parts of the Health Service, and can pressure budget managers to do something about it, the internal market will be automatically strengthened.

Firstly, with better patient information, hospitals with surplus capacity will experience an active demand from people in other districts who are prepared to travel in order to avoid longer waiting lists at home. The home districts are empowered to buy in services from anywhere, and would happily do so if the supplier were cost effective, if facilities nearer to home were overbooked, and if the patient did not mind travelling.

Secondly, the publication of a maximum permissible waiting time means that the district managers have to buy in the service at least before the time is up; otherwise the patients must have some remedy (such as seeking private treatment and billing the authority). Consequently, there will be a pressure on managers to make the best use of pockets of excess capacity within both public and private systems, in order to ensure that they stay well within the explicit time allowances.

A development of a list of entitlements, showing the priority ranking of different procedures and maximum permissible waiting times, might well be the spread of insurance cover the private treatment of conditions which the NHS regards as having a low priority. This can do nothing but good, taking pressure off NHS resources, while increasing the total budget expended on health care.

Conclusion

THE NHS HAS major achievements to its credit which need to be preserved and extended. It also has failings which need to be corrected. Reforms are needed to its structure and to its finance, but they should not put at risk the basic security which the NHS has brought to most people in its forty-year history.

New sources of funds

The finance of the NHS can be improved by bringing extra spending into health from several sources.

Firstly, additional funds can be brought in from charities and private donors, stimulated through tax concessions and public-private matching fund initiatives. Public support will also be enhanced by making hospitals into independent self-governing trusts, which will foster their local identity.

Self-government for hospitals will also extend to the management of capital assets and co-operation with the private sector on innovative capital financing packages. To work, hospitals must be able to apply the proceeds of sales or financing schemes as they deem appropriate, which might require changes in the existing Treasury rules.

A two-way partnership between public and private sectors will release still more funds for patient care. Independently run NHS hospitals will be able to market their services widely and so generate new sources of revenue. Similarly, the purchase of health services from private hospitals can enable the savings to be spent more effectively elsewhere in the NHS.

The use of private insurance should be extended by tax reliefs. This should start with rebates, to encourage those aged over 60 or 65 to take out, or retain, private health cover. This is especially important, in the light of new private schemes about to emerge, tailored specifically for this section of the population.

The tax funds which go toward health should be made more visible, so that the cost of the NHS is more widely known, and so that the relationship between service and cost is better understood. One way would be to have an annual health allocation set for each age group of the population, and paid on behalf of patients to secure health care for them.

The confusion of administrative tiers in England and Wales, in particular the excessively sharp division between primary and secondary care, could be eased by merging the main management functions and contractual arrangements at the district level.

The management of the budget in each district or health board should be separated from the actual provision of services, allowing budget managers to buy in services more independently, from whichever are the most cost-effective and high-quality sources of supply in either the NHS or private sectors.

The budget managers would be responsible for providing a total health care package for patients, paying GPs and consultants on the basis of work done at agreed rates, and buying in hospital treatment from independently managed hospitals.

In time, it might be possible to split the budget management teams into two or even three units per district, giving patients the opportunity to go to other NHS managers if they are dissatisfied with the standards of service they receive.

A Patients' Charter priority system should be set out at national level, giving the treatments which patients were entitled to expect, and the maximum waiting times which were permissible. The management bodies would be inspected and would have to achieve these norms as a minimum standard. The inspectorate would also consider complaints and appeals.

The results

The effect of these changes will be to set in motion changes within the NHS, which will make it more suitable to the needs of the coming century than to the conditions of the 1940s, when it was established. Internal markets, full cost pricing and, above all, competition and choice, will make their beneficial influence felt. The results will be better value for what we spend, improved service quality, and greater public satisfaction.

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