Nat Health

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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From the Secretary of State for Social Services

6 May 1981

BF. 15/5

WH 8/5

Mike Pattison Esq
Private Secretary
10 Downing Street
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Dear Mike

I am sorry not to have responded more promptly to your letter of 6 April about the report of the Health Services Group of the Centre for Policy Studies.

As you may be aware the report follows a series of meetings over the past 18 months - usually attended by the Secretary of State and Dr Vaughan - and the group have received, in confidence, copies of working papers produced by officials here on the options and problems to be overcome. Both Ministers attended a meeting on the report last month - I attach a note produced by our officials which summarises some of the issues yet to be resolved.

The Secretary of State now intends to circulate a paper to colleagues on progress achieved so far and the work which remains to be done, and will propose an official study group led by officials here to take the work forward. The Health Services Group have nominated two of their members to the study group - Mr Hugh Elwell and Mr Michael Lee. I will keep you informed of progress.

Yours ever
D

D Brereton
Private Secretary

ENC.

SM

NOTES ON HEALTH SERVICES STUDY GROUP REPORT AND SUBMISSION - SPRING 1981

Points that might be clarified

Paragraph 2.4 -

appears to be suggesting an item of service basis payment. Is this really regarded as essential and if so why? If the approach is a pluralist one why should this not be left to providers to negotiate with the insurance carriers?

Do they intend payment to be made direct to the doctor/hospital? Is it really the case, as the last sentence of 2.3 suggests, that individual payment is necessary for a proper service?

What does the reference to providers of treatment having "control over their revenues" mean? Deciding what should be paid without control or being free to negotiate with individuals or "communities"? How would "communities" get involved?

Paragraph 3.1.3

The option of compulsory health insurance of some specified kind is favoured, but who would be compelled to make insurance payments to whom? Do they envisage a basic national scheme from which people would be able to opt out if they have equivalent cover? Would contributions be proportionate to income or flat rate? For whom would "credits" be paid - the old, the unemployed, people below a given income level? How would the patient have "responsibility for payment" if the insurance is paying?

More understandably the paper does not come to grips with the UK Government financial convention that compulsory contributions are regarded as taxation and the expenditure met from them is public expenditure. Controlling public expenditure is not merely a matter of limiting the subsidy from general taxation, but would also be a matter of controlling expenditure met from compulsory contributions.

Paragraphs 3.5 and 4.2

These suggest that new arrangements should be allowed to emerge in a free market. There is a case for this if one adopts the opting out and contracting out approaches. But the Group's favoured approach of compulsory social insurance could not just emerge. Though it is not necessary to have fully worked out details, possible models will have to be set out even to encourage a debate.

Paragraph 4.5

The relevance of this quotation to the preferred social insurance model is not clear. The European social insurance systems have in fact financed rising costs from higher rates of compulsory levy.

The notion that the onus of contrary proof must lie with those who want to maintain the present system is all right as a piece of polemic, but does not make much sense as advice to Ministers. The costs of change will certainly be substantial and Ministers will have to present a positive case to show that the benefits are likely to justify the cost.

Appendix 1

The growth in the private sector is common ground. The extrapolation of recent growth rates to 1984 is of course more dubious. In so far as the growth takes place, criticisms of the NHS 'monopoly' become less convincing.

The comparisons of administration costs between the private sector do not compare like with like. On the private sector side they take the insurer's costs in collecting money and paying out benefits and compare these with the health service costs of planning and managing services. A true comparison would need to take into account both types of cost in both sectors. The point is touched on in footnote 2 on page 2, but commenting only on the information missing on the NHS side of the equation and not on the information missing on the private sector side. The marginal cost of raising additional revenue for health purposes through the general tax system or social security contributions is in fact very small.

Appendix 2 -

fits oddly with the rest of the Report, which is arguing for greater spending on health through a social insurance scheme. European social insurance schemes appear to have larger per capita expenditure than the NHS (though we are looking into this in more detail at present). The Appendix purports to show that health cover can be provided for a good deal less.

6 April 1981

The Prime Minister has seen the Centre for Policy Studies' discussion document, produced by its Health Services Group.

She would like to know how your Ministers propose to respond to the issued raised in the paper.

MAP

Don Brereton, Esq.,
Department of Health and Social Security.

FILE

VLB

2 April 1981

Thank you for forwarding to the Prime Minister a copy of your Health Services Group Report. Mrs. Thatcher will see this over the coming weekend.

M A PATTISON

Alfred Sherman, Esq.

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10 DOWNING STREET

PRIME MINISTER

The Centre for Policy Studies have sent this discussion document to DHSS.

Do you want us to enquire about Mr. Jenkin's proposed response?

M/F

Yes please

2 April 1981

Centre for Policy Studies

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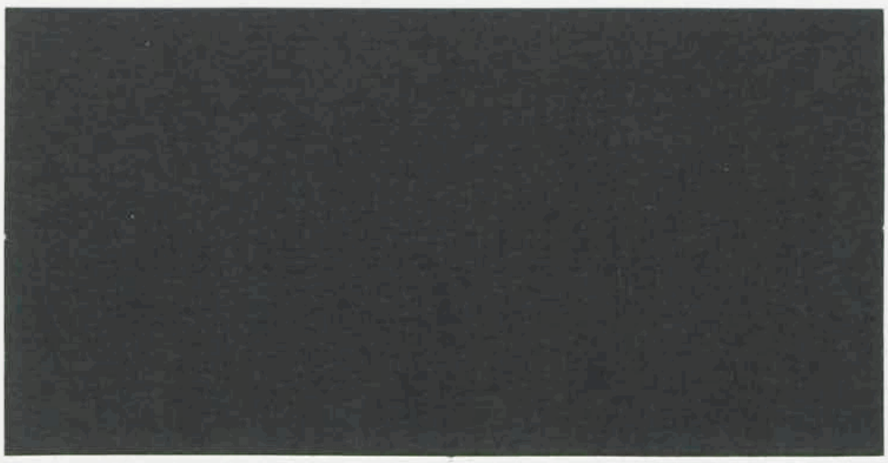
27 March 1981

I enclose a courtesy copy of a document which our Health Services Group produced for discussion by our Health Ministry at Sir Keith Joseph's request.

Yours sincerely

Alfred Sherman

The Rt Hon Margaret Thatcher MP
Prime Minister
10 Downing Street



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Confidential

HEALTH SERVICES STUDY GROUP:

REPORT AND SUBMISSION, SPRING 1981

Published by the CPS and Health Services Study Group

HEALTH SERVICES STUDY GROUP

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George Teeling-Smith BA FPS(Hon) M Pharm

Nigel Morgan (Secretary)

In attendance

Christopher Mockler

Alfred Sherman

1.1 In the introduction to our first report in 1979 we said that no document about the NHS, written at the present time, could be composed without a sense of sadness at having witnessed over a 30 year span, the inevitable decline of a service born into a post-war era of hope and expectation. Since then it has become clear that there is some growing willingness to consider reform but there are still some entrenched attitudes and ways of thinking which we had expected might prove difficult to alter - not least in the DHSS.

The NHS, having been cast into its mould in 1948, has solidified into a pattern which successive governments and hence the public, have found impossible to change, except by minor alterations in organisation, which have done little to modify its basic financing and structure.

It is not therefore unwillingness, but sheer inability to give serious thought to the implications of fundamental change in the financing and therefore the organisation and administration of health services. Reform is not only long overdue but would clearly be of benefit to both the people and the state. As Christian Morganstern put it:

> And thus, in his considered view,
> What did not suit - could not be true.

The ideal enshrined in the NHS is that we, as a community, ensure that the sick are adequately treated irrespective of their means. This ideal remains but we contend that the NHS has failed to fulfil it, and those who still champion the Service and who would oppose any thought of change must be prepared to prove to us:

1 That the NHS has in fact done what it was set up to do in the interests of the poor, the needy, the under-priveleged, the stupid and the feckless - all those in real need of care.

2 That is <u>really is</u> egalitarian, when there is evidence of gross discrepancy in available standards of care. [1]

3 That central financing <u>is not</u> more wasteful and expensive than peripheral financing. [2]

4 That political motivation and expediency <u>are not</u> involved in policy decisions at both central and local government level, nor involved in the distribution of resources.

5 That the terms and conditions of service for doctors, nurses and other staff <u>are not</u> divisive, morale-sapping and the cause of industrial conflict, frustration and the practice of bad medicine.

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1 see Working Group on Inequalities in Health ("The Black Report") DHSS April 1980

2 In official comparisons of costs between the NHS, on the one hand, and private or institutional provision on the other, the real costs of NHS financing - that is cost to Government, taxpayer and the economy of raising the revenue - is ignored. Whereas the cost to private and institutional health schemes of raising revenue is always fully measured.

2.1 As a service free at the time of use, the NHS is centrally financed. The administration is therefore inward looking and does not respond effectively to the patient's needs or demands at personal level, in total spending or in allocation of resources. The challenge is to explore ways in which treatment of the sick may be improved and made more responsive to individual need. The objective must be to ensure that the sick are treated compassionately and promptly by a service which is shaped more closely around their needs whether rich or poor.

We are particularly concerned about this last point. It was in the name of the poor that the NHS was conceived and yet it is the poor who are now suffering most from its defects and inadequacies.

2.2 There is no reason to confine medical care to the resources that the State can finance from taxation. Whatever can be done to use resources more efficiently there is no need to shut off other sources of money or to finance health services only by taxing when they could be paid for in other ways.

2.3 A variety of methods such as direct payment, insurance or other collective financing arrangements, are flexible and could raise more money than a centralised state system because they are tailored to the needs, circumstances and preferences of the individual. No impersonal service can satisfactorily replace the direct link between individual payment and service.

2.4 We propose a system in which each item is costed and paid for, and under which the providers of treatment, either individual or institutional, have control over their revenues. They would then be responsible in a direct manner to the individuals or communities which they serve, who would in turn know the cost and be prepared to pay for the services they want.

2.5 It is essential that resources are so organised and managed that they are used efficiently and directed effectively. However much more money and improved resources are provided, there will never be enough to satisfy every demand for treatment that may arise.

2.6 We are of the opinion that the present National Health Service should be eventually replaced by a comprehensive range of health services, both public and private, which will give choice to the patient and adequate financial resources to meet his expectation of good medical care and at the same time enhance professional status and responsibility.

3.1 There appear to be three courses open to us.

1 The maintenance of a system of opting out which presumes the persistence of the present structure of the NHS and private medical treatment. The private sector is currently growing at a substantial rate. If maintained it will mean that a significant proportion of the population will have made financial provision of their own for treatment by the mid 1980's (approximately 12 million). They have made provision to opt out of the NHS as medical episodes arise, but still maintain the right to be treated as NHS patients at will. The major drawback to this course is that apart from a competitive challenge, it does little or nothing to reform the NHS.

2 This may be described as contracting out, under which various sectors of the community, eg employment groups etc - can contract out of the NHS in return for tax relief, to provide a comprehensive private insurance system such as exists in a number of other countries.

3 The third course is to replace the centrally financed monopolist NHS by a system of financing from the periphery. This would allow a variety of providers, both public and private to compete in meeting the needs of the patient. They would be paid by a variety of insurance agencies - again both public and private.

Health insurance of some specified kind would be compulsory, inadequacy of income being met by a system of credits of varying sorts. This fundamentally changes the nature of financing health services so that at the point of use the patient, advised by the doctor, has choice and the responsibility for payment for the type of medical care provided. Treatment should be available within institutions now provided by the NHS or within the growing sector of independent hospitals. The minimum level of cover must

be fixed to ensure that people can obtain no less than they do at present; health services must be costed and described, and this assumes that services currently available in the NHS will be included.

3.2 We believe this last option to be the best and what we describe provides the same universality as the NHS and will not descriminate against lower socio-economic groups. The objective being to provide choice between kinds of health services and methods of paying for them. It will then allow the State to concentrate its efforts to help those who cannot make adequate provision for themselves.

3.3 We believe that insurance as the method of financing health services carries with it inherent advantages in costs and their control, auditing and review, particularly as competing services and financing systems seek to minimise costs in order to widen their markets.

3.4 In measuring efficiency the insurer, the provider and the insured have common interest. The insurer wishes to be involved in the least payment and therefore it is in his interest to see that treatment is prompt, efficient and leads to the least possible disability. Therefore he is interested in making sure that medical skills available are of the highest order. The provider has the onus of providing as good a service as possible otherwise he will not succeed. The insured is interested in getting the best return for the least premium. This is in direct contrast to a state monopoly which interposes political decisions and a self-interested bureaucracy between doctor and patient. Politicans and civil servants have perfectly understandable but nonetheless independent interests that do not necessarily coincide with the patients' or doctors' interests and may even conflict with them.

3.5 While it might be apparently simple to propose an "Insurance" scheme in detail, this approach is too elementary. A study of systems in other countries shows that a number of financial and administrative arrangements exist which can provide treatment better than the NHS. But a prepared solution in detail takes no account of how a free market might develop. Different arrangements will appeal to different people and all we can predict is that the more advantageous systems will displace the less advantageous. Indeed there may emerge better alternatives not yet considered, since technical development, higher incomes, more sophisticated information and social policy techniques have developed since 1948.

3.6 What is clear, as shown in the Appendices, is firstly that the search for better health care outside the NHS is gathering momentum and now includes Trades Union members. Secondly that the administrative costs of insurance-based systems are not necessarily greater than in a centralised service and thirdly that insurance premiums can be as comprehensive as the NHS.

4.1 After thirty years experience - and experiment - we do not believe there has ever been a decisive case for a permanent all embracing monopolistic Health Service. It has rested on two hypotheses that are not plausible. That individuals put public spirit before personal interest sufficiently to husband allegedly "free" services, and that resources would be plentiful enough to permit the best medical services to be universal. These expectations have been encouraged by all political parties and have caused increasing dissatisfaction, not only with the NHS but with the democratic processes that had promised them.

4.2 Government must turn from running a National Health Service to creating an environment favourable to the development of health services based on alternative theories of financing and organisation. It must allow as much space as possible for a combination of government and independent organisations financed by taxes and rates, social insurance and private insurance, compulsory and voluntary insurance, fees and charges that would emerge from the efficiency of competing suppliers and the preference of patients.

4.3 Government policy is easier to apply in a closed than in an open society, but if it tries to achieve its purpose of efficiency and equality by exclusion or coercion it demands too high a price and is unacceptable. The NHS confronts intensifying coercion or eventual collapse. If the centralised NHS is not replaced by a multiple choice system it will solidify still further until it is incapable of reform except by convulsion, in which both patients and providers will suffer even more than in the gradual changes that are still possible.

4.4 The lesson of all health systems - from the NHS and the state-controlled systems in Eastern Europe to the decentralised systems of Western Europe, is that finance ultimately determines the power, structure, organisation and administration, the political influence on policy and the capacity of occupational vested interests to resist reform, and the ability of the patient to exert his sovereignty. No system that could be devised is perfect - but it is much more difficult to remove the faults of a National Health Service than those of market orientated health services. We maintain that experience round the world supports our view.

4.5 In conclusion, we cannot improve on what was written 10 years ago by Ivor Jones:-

> " So long as the present financial structure of the National Health Service is maintained the Government must either impose further considerable increases in taxation or face a deterioration in the standard of medical care which it provides for the British people. The alternative is to accept that it has become impossible to finance the rising cost of universal provision of <u>all</u> the health services from compulsory levies and taxation if the rising standards which the legitimate expectations of our people demand are to be achieved.
>
> The restraints on personal consumption necessary to combat inflation as a basic aim of political policy are easier to achieve if they are buttressed by an outlet for voluntary spending on the health services. There is a limit to the level of taxation which is either acceptable to the people or compatible with a sound economy."

We believe that acceptance of these facts must inevitably lead to acceptance of the principles upon which the system of financing health services outlined here is based - and that the onus of contrary proof must lie with those who would obstruct any thinking that change might be either desirable or necessary.

4.6 If this acceptance is forthcoming then Blue Prints and transition arrangements will need to be prepared.

Appendix 1

During 1980 the number covered by private health schemes rose by 812,000. This increase was by far the highest ever recorded. On average over 15,600 people were recruited each week to the major Provident Associations, making provision to opt out of the NHS.

At the end of December 1980, the three major schemes had 1,647,000 subscribers, covering a total insured "provident population" of 3,577,000. This represents some 6.4% of the total national population, or about one person in fifteen.

The most notable feature is the increasing rate of growth. During 1980, subscriber numbers increased by 27.5%. This compares to 15.6% growth in 1979 and 5.8% growth for 1978. The Provident Associations saw no growth in 1977, and slight declines during the two previous years.

If the 1980 annual growth rate persists till 1985, the provident population will exceed 12 million persons or over 20% of the national population.

Table 1

Provident Associations Administration Costs. 1976 to 1979

Year	Administration costs (BUPA, PPP & WPA)			
	Total £m	Per cent subscriptions earned	Provident Population Numbers million	Provident Population £ costs per head
1976	8.270	11.7	2.28	3.62
1977	9.781	10.8	2.25	4.34
1978	12.335	11.7	2.32	5.31
1979	17.286	14.2	2.54	6.79

Notes

1 Data are derived form Annual Reports and Accounts for BUPA, PPP and WPA - Consolidated Revenue or Consolidated Income and Expenditure Accounts.

2 The figures cover items described as Administration and development, plus Special Contribution to staff pension funds (BUPA); Administration, Development Special contribution to pension fund (PPP); Administrative expenses, Development (WPA).

3 Data for subscriptions earned are derived from Table 3 Lee Donaldson Associates, Provident Scheme Statistics 1979. The total Provident Population is a mid year estimate for 1976 to 1978 from Table 2 (LDA Report) with actual figures for June 1979.

The NHS now costs 12,000 million or £220 per annum for each person in this country. Thus a family of four is paying out £880 per annum; almost £17 a week.

Data have been gathered on costs of the administrative systems in the existing private sector and the NHS. These are confined to costs of those controlling bodies who administer rather than directly provide patient care.

In the private sector these are the Provident Associations (BUPA, PPP, WPA).

In the NHS they can be defined as the Regional, Area and District administrations plus Boards of Governors and Community Health Councils.

The Department of Health's central administrative costs are excluded, though DHSS statistics give a figure of £43 million for central administration for 1977/78 (Royal Commission, Table E9).

Table 1 sets out the costs of administration of the three main provident associations for the years 1976-79. The costs are expressed as a percentage of subscriptions earned and as costs per head of the population insured.

Table 2

NHS Administration costs 1977/78 England

Health Authority	NHS Administration Costs £m
Regional & Area	135.8
District	79.1
B'd Governors	2.4
Community H.C.	3.1
Total	220.4
Percent NHS Revenue exp.	4.4%
Per head population	£4.75

Notes

1 Data are derived from NHS Summary Accounts for 1977/78 for Regional and Area Administration and for Community Health Council. DHSS abstract for District and Boards of Governors administration.

2 The total £220.4 million is expressed as a percentage of £5,041 million Net Revenue Expenditure NHS England 1977/78 (NHS Accounts) and estimated mid year Home population 46.352 million (OPCS).

3 Data for DHSS on central administration are difficult to interprete in terms of NHS costs. The Health Department's Statistics give a figure of £43 million for Central Administration for 1977/78 (Royal Commission Table E9).

In 1976 the administrative costs amounted to £8.270 million. By 1979 the figure had risen to £17.286 million. In 1976 to 1978 the costs amounted to between 10% and 12% of subscription income. 1979 was a year of rapid growth when administrative costs came to 14% of subscription income. If we consider costs in terms of the service provided and express them as costs per head of the population insured:-

The cost for 1976 was 3.62 per cap. rising to 6.79 by 1979. The rise is 87% or 32% if expressed in terms of constant retail prices.

The cost for 1977 was £4.34 per cap.

Table 2 summarises data for the NHS in England for the financial year 1977/78. It shows costs published in summarised accounts for administration of the Regional, Area and District health authorities and for the Boards of Governors and Community Health Councils.

Total administrative costs for the year amounted to £220.4 million, this amounting to 4.4% of the NHS net revenue expenditure. The cost for the national population averaged £4.75 per cap.

The differences in the proportion of total income and expenditure spent on administration reflect the different characters of the health services constituted by the NHS and private medicine in the UK. The data however argue that the total administrative costs per capita for a system of insurance payment is not necessarily greater than for a system which controls and distributes central funds.

Appendix 2

It is possible to provide a model of the approximate cost of insuring the national population by considering two actuarially typical lives - male and female - calculating the cost of insuring them from birth to death, and adjusting the premiums to cover all medical services. This is intended purely as an example of the possibilities and as an exercise dealing with basic insurance principles.

Table 3 follows a typical male life from birth to his independence at 19, through a marriage during which he supports two children to their independence, and on to his death at age 70, his actuarial life expectancy. The premiums are those quoted by a leading health insurance group for a scale of benefits which covers the cost of more than 80% of the country's hospitals; and the 'experience' on which the premiums are based arises (almost equally) from the use of private NHS facilities and of independent private hospitals and nursing homes.

It is assumed that throughout the man's life the bread-winner is covered by a company scheme as a result of which a discount of 40% is obtained against published scales (this appears to be in line with current practice and should be viewed in the context of a 20% discount being obtainable on company schemes covering as few as twenty or even a dozen people). The total cost over 70 years is £3,334.11 and the average annual premium is £47,63.

The table for the female life is similar except that it is assumed that she is a second child, marries a year younger and lives to age 76, giving an average annual premium of £52.71. Averaging these two figures brings us to £50.18 as the per capital premium for a large, actuarially typical population, which is less than one quarter of the average NHS cost per head of the population. Of course the private

insurance does not cover the same population or services as the NHS. Some of the differences between them are considered in the following paragraphs.

Private insurance does not cover General Medical, dental, opthalmic or drugs expenditure which account for about 24% of NHS costs.

Table 3

Actuarially Typical Male Life

Age	Status	Number in family	Age of oldest member of family	Annual Premium (discount of 40% off standard published scale)	Annual Premium per head	Number of years	Cost (premium per head) x number of years
1-2	Child	3	18-29	£111.60	£37.20	2	£ 74.40
3-5	Child	4	18-29	£111.60	£27.90	3	£ 83.70
6-18	Child	4	30-49	£123.98	£31.00	13	£403.00
19-21	Single	1	18-29	£ 44.64	£44.64	3	£133.92
22-23	Married	2	18-29	£ 89.28	£44.64	2	£ 89.28
24-26	Father	3	18-29	£111.60	£37.20	3	£111.60
27-29	Father	4	18-29	£111.60	£27.90	3	£ 83.70
30-44	Father	4	30-49	£123.98	£31.00	15	£465.00
45-47	Father	3	30-39	£123.98	£41.33	3	£124.00
48-49	Married	2	30-49	£ 99.22	£49.61	2	£ 99.22
50-64	Married	2	50-64	£138.82	£69.41	15	£1,041.15
65-70	Married	2	65+	£208.37	£104.19	6	£625.14
1-70	TOTAL LIFETIME COST FOR A TYPICAL MALE					70	£3,334.11

Average annual insurance cost over a typical male life £47.63

The insurer from which the figures are taken was able to set 25% of his income aside for capital expenditure and to reserves. (The previous year it was almost 30%). The NHS costs contain no provision for reserves or capital expenditure and to get a strict comparison the private sector premium should be reduced by 25%. In practice however some provision for reserves should always be expected in a privately funded system, probably of the order of 10% of income. Capital investment does not present any difficulty in these comparisons. To the extent that physical facilities already exist the only problem is the practical one of ensuring that they are available to be used by those who need them when they need them. Transfer of resources would need to be studied carefully at a practical and operational level but in principle it should provide the insurance sector with the necessary facilities and the government with a source of cash to finance the transitional costs of the change-over.

The private cover contains certain exclusions which limit liability and these fall into two categories:-

(i) Geriatric

14% of the population are over 65. In the actuarial model considered above 25% of the premiums are paid by people over 65, but the over 65's account for 36% of the costs of the NHS.

Associated with this discrepancy is the the fact that many of the NHS costs (especially for the over 65's) are really welfare rather than medical costs and result from the failure of other branches of the welfare system. It could be argued that these extra welfare services undertaken by the NHS need not and would not be carried by private medical insurance.

(ii) Medical catastrophe

The enormous costs associated with medical catastrophe are often quoted as a reason why insurance is impractical; but this is equivalent to saying that all third party accident risks must be covered by the government. The individual cost may be high but because of its rare occurrence it can be insured for a small premium over a large population - far from being uninsurable, it is a classic example of an insurable risk. This is only valid however if the insured population is both large and typical whereas that covered by private health insurance is at present exactly the opposite and it is largely for this reason that the private insurers have chosen to limit their liability, knowing of course that the NHS provides a safety net.

If the total insured population were large enough and sufficiently representative of the population as a whole the cost of medical catastrophe could be calculated, covered and financed and the overall cost would be small relative to the total. Most of the large company schemes now being negotiated have no upper limit to benefits and the indications are that in a large private market the limit could be removed with an increase in premiums of no more that 10%.

No comment can be made about maternity or psychiatric care because no accurate figures have been found for them.

The cost of private health care would also be affected by various other influences which should be mentioned. About three-quarters of the cost of the NHS is absorbed by the hospital service and there is no doubt that the private insurers could make substantial savings compared with the costs now built into their premium scales. In order to compete with a 'free' service the private sector sells privacy, colour television, a more personal service etc. and it charges accordingly. In an open market those who can afford it would

still pay extra for their privacy and convenience but the general service could be considerably cheaper. A simple awareness of economics should also lead to significant savings through, for example, greater use of para-medical facilities, particularly nursing and convalescent homes, protected housing for the elderly, or cash subsidies for those convalescents able to make their own arrangements in the total community or within their own families.

On the other hand General Practice would be more expensive in a private system since the GP would be spending more time with each patient and might make more home visits. Some of this extra cost would be recouped by an easing of pressure on the hospitals, particularly urban casualty departments.

A decline in the monopoly purchasing power of the state might increase the price of drugs but a more personal service from GP's might reduce the volume of drugs prescribed.

A significant and at present unqualified factor is the extent to which the private sector costs are distorted by the fact that the sample is "self-selected" and therefore unrepresentative of a cross-section of the national population. The population covered by the Provident Associations is predominantly middle-aged and made up of middle and upper income groups. There are indications that these figures may seriously under-estimate the medical costs of a typical cross-section of the overall population. There is insufficent evidence at present to determine whether this is so and if so then to what extent the figures are distorted.

The actuarial model indicated about £50 per head as an insurance premium based on current scales and experience. The differences and adjustments which can be approximately quantified suggest a premium level very roughly of the order of £75 but still subject to adjustments and uncertainties some of which have been touched on above and many of which can only be guessed

at in the light of our existing knowledge. However, if it turns out that this last figure must be doubled, or even trebled, to cover a comprehensive national population, it would still not compare unfavourably with present NHS costs of over £200 per head per year.

At the very least these figures raise some fundamental questions for those proponents of an NHS monopoly to justify their position and show why experiments with alternative systems should not be tried.