REFORMING THE NATIONAL HEALTH SERVICE - SEVEN GOLDEN RULES

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Until recently, relatively few people seemed to think that the NHS required major change and even fewer put themselves forward as architects of such change. Now everyone is donning the mantle of radical reform. Despite this new-found enthusiasm for reform however, there is little agreement about how best to change the Service.

On one side, are those who believe that the basic framework is sound and that most of what is wrong could be set right by pumping in more resources. Supporters of this position often point to countries like Holland and Sweden as evidence that a fully funded NHS can deliver high quality care to all according to need.

On the other side are those who think that the NHS needs root and branch reform in both its finances and delivery systems if it is to make an efficient contribution to the health care of the population. Supporters of this view often point to countries like West Germany or the United States as evidence of the great benefits (and additional funding) that the harnessing of market forces and private enterprise can bring.

In this short article, our aim is not so much to enter the fray on either side as to promote seven general principles and to suggest that a relatively modest set of changes may

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accomplish more - and with greater certainty - than many of the grander visions.

Rule 1: There's no such thing as a free lunch. There is no one right way of financing and providing health services: there are only different ways of getting it wrong. In Sweden for example, the average citizen usually has better access to most health services than does the average UK citizen. To achieve this however, the Swedish government spends about twice as much of its gross national product on health care than the UK. Equally, while the United States provides about three quarters of its population with high quality, reasonably accessible, and often very efficient care, more than 30 million Americans have no health insurance of any kind and when serious illness strikes are wholly dependent on charity. Moreover, the United States is the home of health care cost inflation. Markets are themselves costly to set up and maintain. Equity of access, efficiency, effectiveness and consumer satisfaction are all goals to which most people aspire. Each however, comes with a price tag: to get more of any one of them requires giving up something. Sometimes what must be given up is actually one or more other health goals. Even change itself is costly. Reformers should be frank about their objectives, not implicit: they should be open about which ends their reforms are expected to promote and which ends, if any, they are willing to sacrifice.

Rule 2: Only the ends justify the means. Not all health systems are intended to serve the same objectives. The NHS is intended to be not merely an efficient system of providing

health care, but also a comprehensive health-promoting and sickness-preventing service. It is also intended to be egalitarian in accessibility. The NHS's record of achieving these ends is patchy. But if these still are relevant goals for Britain, then we must be wary about the import from elsewhere of systems that are not primarily intended to serve them. The danger is not only that the new means may be quite inappropriate to some of the ends to which we aspire, but also that they may give rise to new problems. We should be left in the worst of all possible worlds with the old problems left substantially unaddressed and compounded by the new. Reforms based on ideas imported from elsewhere should be explicit not only about the supposed advantages of such reforms, but also about how the problems experienced elsewhere will be avoided in the U.K.

Rule 3: Don't throw out the baby with the bathwater. Granted the imperfections in all countries' health services, the UK way of getting things wrong is extraordinarily inexpensive. At about £400 per head (public and private) the UK spends considerably less than almost any other country, given its income. The NHS is not costly. It also appears to be quite cost effective. For example, the health of the British - especially of those groups like the newborn and new mothers, where the impact of health care is fairly direct - stands reasonably well in comparison with other developed countries and better than some which spend a good deal more on health care. The unambiguous achievements of the NHS should not be lightly dismissed.

Rule 4: No expenditure is enough. There is no observed limit to the amount of resources that could be devoted to health care and which have some prospect of actually being beneficial. The crucial point here relates to the prospect. Total expenditure, public or private, is not capable of being judged "too much" or "too little" in its own right: only in relation to the prospective benefits it will buy. More can always be done. The appetite of health care providers for more resources is insatiable. The tough issue - as inescapable for those in the debate as for those who manage the NHS - is to ensure that extra funding goes into effective care, not into prestige but unproven technology, or the bureaucracy of private insurance, or fatter salaries for the professions. Performance is easier talked about than measured or delivered. There are some spectacular unmet needs in Britain - we need to be confident that reforms bringing in more resources will not be squandered.

Rule 5: In health care funding be an economic heretic. There is considerable evidence from around the world that private finance provided by competitive insurance agencies and out-of-pocket consumer payments is (a) highly costly in bureaucracy, (b) extremely given to cost inflation, (c) highly discriminatory against high risk groups - especially the elderly, the chronic sick and the poor - and, (d) apt to leave large segments of the population with no protection at all against ill health. Attempts to counter these disadvantages are themselves often costly in bureaucracy, ineffective at controlling cost inflation, discriminatory and exclusive. By contrast, financing schemes that are (a) monopolised by one

agency and (b) compulsory in membership, do not usually suffer from these problems. Traditional rules of good economic conduct are thus upturned in health care finance. The financial lessons from overseas are very clear: reforms that ignore them need to be scrutinised with particular care.

Rule 6: Public finance is not the same as public provision. Much mischief results from the common supposition that public finance of health care necessarily entails public provision. If radical change to the NHS is on the agenda, this distinction is crucial. There is still nothing as effective as competition between providers to act as a spur to efficiency, innovation and consumer responsiveness. Moreover, such competition depends neither on the existence of private insurance nor on prices or fees payable by patients. The powerful arguments against competitive insurance should not be allowed to obscure the fact that a competitive market with both public and private health care providers might well result in a more efficient and responsive health care system. Reforms which fail to distinguish between these two different roles for market forces misunderstand the nature of health care markets.

Rule 7: Let managers manage. Despite improvements in recent years, there is ample evidence to suggest that the NHS does not yet make the most efficient nor effective use of its resources. Wide variations in resource use still exist between different hospitals and health authorities throughout the UK. There is, moreover, a widespread belief in NHS management that - given sufficient local freedom and

incentives - better use could be made of existing resources. NHS managers who attempt to experiment and innovate to make better use of existing resources however, are often hamstrung by central rules and civil servants who are distant from the local opportunities for better resource use. Given sufficient local freedom, there is little reason why NHS management could not be as inventive and responsive as that which exists in the best private sector organisations. One can only speculate about how great an impact this single reform might have on the present financial crisis. Reformers who assume that it is the method of financing health care or the amount of finance available which matter most, may be overlooking the one reform whose impact could be really dramatic and which involves no traumatic reorganisation at all - better management. The NHS is blessed with some of the best management this country has at its disposal: they should be set free.

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