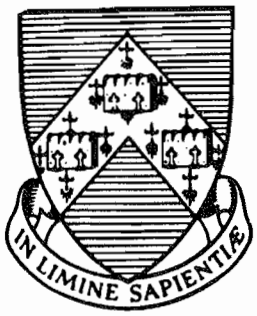

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Reforming the UK Health Care System

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DISCUSSION PAPER 47

REFORMING THE UK HEALTH CARE SYSTEM

A Framework for Analysis and a Review of Some Recent Proposals

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SEPTEMBER 1988

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ACKNOWLEDGEMENT

We gratefully acknowledge the assistance of our colleagues, Professors Alan Maynard, Alan Williams and Tony Culyer, Chris Godfrey, Nick Bosanquet and Liz Currie, who provided helpful comments. We would also like to thank the secretaries, Gil Woodruff, Lucy Allen and Paula Meadows, for typing the manuscripts from a variety of styles of handwriting at such short notice. The editors accept full responsibility for the views expressed in this paper and any remaining errors it contains.

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ABSTRACT

As a contribution to the current debate on the future of the NHS this paper sets out a framework with which proposals for reform can be analysed. Eight different proposals are classified according to their dominant methods of finance and provision of health care. Criteria are then developed by which the proposals can be evaluated covering issues of efficiency, equity and consumer choice.

A checklist of questions is addressed to each option (the detailed results of which are attached in Appendix 1) to determine the mechanisms by which beneficial change is to be brought about, and to identify the evidence available as to whether these mechanisms would be successful.

The conclusion is that there is very little hard evidence to support the claims in the various proposals. More experimentation and evaluation is required to produce this before major change is contemplated. What the approach does demonstrate is the difference in ideological perspective behind the proposals and the need for clear statement of objectives by the proposers of reform before its full implications can be assessed.

INTRODUCTION

Our aim in this paper is not to put forward another proposal for reforming the NHS, but to address the more fundamental issue of how to determine whether proposals for reform will lead to improvement. There is no shortage of proposals, but there is a distinct lack of detailed explanation of which perceived problems of the current system they are designed to tackle, and exactly how any improvements would come about. We hope to advance the current debate by putting forward a framework within which the current proposals can be assessed on the consistent basis.

The current review of the NHS began by concentrating on finance, but most proposals for change have devoted as much attention to the provision of health care. Although in some circumstances the same system of health service provision could be funded by different methods, the mechanism by which the finance is transferred from consumers to suppliers will usually influence their behaviour. This will in turn influence the quantity, quality and type of health services demanded and supplied. This mechanism of financial allocation is the link between raising finance and managing provision, making the simultaneous consideration of finance and provision essential.

We therefore present a method for classifying reform proposals on the basis of method of finance and organisation of

provision. In section II we review the criteria by which any proposed scheme can be assessed. A check list of questions which must be addressed in applying these criteria is suggested. The results of applying this to the eight proposals are reviewed in section III. The more detailed assessments of each proposal are attached at Appendix I.

SECTION 1

To assist in classifying the proposals we have identified a series of broad categories based on methods of raising finance and types of organisation of provision. Table 1 (page 17) shows the possible combinations of financing method and type of provision. It must be remembered that all systems are pluralistic to some degree, and that the current debate is not so much about exchanging one monolithic system for another, as changing the relative mix of financing and provision methods. For example, the NHS is primarily funded from general taxation, but also has elements of co-payment for dental services and prescriptions, and the use of vouchers for opticians services. A private health sector financed by insurance and direct out-of-pocket payment also exists in the UK. Several of the proposals advocate increasing the proportion of private finance, whilst retaining publicly raised funding as the dominant method of finance. Similar diversity is to be found in the provision of services. Consequently, the proposals are classified by what are judged to be the dominant method of finance and the main form of organisation of provision.

METHODS OF FINANCE

Uncertainty over future needs for health care, and over the cost and effectiveness of different treatments, leads individuals to prefer some form of insurance against the cost

of health services either through guaranteed free provision or re-imbursement of costs incurred. Direct out-of-pocket payment for health care is not the dominant method of finance in any system and has therefore been excluded from the categorisation. However, this method is present to some degree in all the proposals under review and may have a key role in specific services. The four main methods of financing are taxation, social insurance, private insurance, and service entitlement fees paid directly by the consumer. (For a more detailed discussion see Culyer et al, 1988 c & d).

a) Taxation

Health care finance can be raised through general taxation or through specific taxes, earmarked to provide for health services. The taxes can be raised centrally, as in the UK, or locally as in some Scandinavian countries. Budgets are allocated by the government to health service providers and care is provided free at the point of use to consumers. Contribution to funding is not directly linked to use of services for any individual.

b) Social Insurance

Social insurance exists in a variety of forms in many countries (McLachlan and Maynard, 1982). It can be administered by a regional government, national government or a

quango, and enrolment may be compulsory or provide for opting-out by those with private insurance. The premium is often deducted directly from employees' incomes, and collected from employers in the form of a payroll tax. If funds collected in this way are used to provide health services free at the point of use then there is little difference between social insurance and taxation - in effect the only difference is the tax-base. However, if the provision is organised so that consumers must pay for services and claim reimbursement, then the implications are rather different.

c) Private Insurance

Insurance companies charge a premium in return for a guarantee to cover an individual (or family) for the costs of treatment in the event of illness. Premiums may be averaged across a large group, eg a firm's workforce, or "experience-rated", that is actuarially based on the estimated risk of each person requiring treatment in the future. There is therefore the possibility of some link between utilisation of services and payments by individuals through alterations of premiums. The extent of insurance cover is related to premium levels so individuals can choose the level of cover they wish, provided they can

afford it. The poor and the elderly are usually offered subsidies in some form to bring their level of cover up to minimum acceptable standards.

d) Service Entitlement Fee

This method of private finance is usually associated with Health Maintenance Organisations. It involves the consumer voluntarily enrolling with an organisation and paying a fixed annual fee, like a premium. In return the providers accept the risks of covering their health care needs. This in effect cuts out the third party intermediary between consumer and provider, and combines finance with provision within a single organisation (eg HMOs). For a pre-determined fee the provider will guarantee to supply a certain level of services. Thus the consumer is offered services free at the point of use, as in a tax financed system, but chooses his provider and pays an annual sum, not directly related to the cost of services actually used, as in an insurance system.

TYPES OF ORGANISATION PROVISION

Classifying ways of organising the provision of health services is even more complicated than categorising financing systems. The plurality of systems, referred to above, and the mass of minor variations, mean that our four broad categories cannot be

comprehensive, nor can they include every important detail. (These aspects are discussed in Culyer et al 1988 a & b).

We examine the following four types: the NHS in 1988; prospective payment per item of service; provider markets; and provider markets with consumer choice.

The key feature of each type are:

(i) whether purchasing agencies are separate from the provider of health care;

(ii) how purchasing agents receive their finance (eg fixed budgets, per capita payments or fee for services);

(iii) who provides services and whether they are public or private sector, and

(iv) how providers are paid (eg fixed salary, per capita fee or fee for service).

The link between finance and provision often involves a third party, defined here as the "purchaser of health services". Many of the proposals concentrate on this aspect of the system rather than the actual delivery of care or the raising of general finance.

1. The NHS 1988

The NHS is not, of course, a static and unchanging system. For example, its last major re-organisation as the direct result of the Griffiths Management Inquiry is still being felt in the NHS. Any comparison between the NHS and other types of organisation should take account of ongoing changes initiated within the NHS.

For comparative purposes the NHS as it is in 1988 will be used. The essential features remain: a hospital sector with the purchasing and provision of services carried out by DHA's with fixed budgets determined by capitation and activity levels; and a primary care sector, administered by Family Practitioner Committees (FPC's) with services provided by self-employed general practitioners, dentists, opticians and pharmacists. Any proposal for significant alterations in these basic feature will be regarded as a separate proposal for reform.

2. Prospective Payment for Item of Service

Prospective payment per item of service (PPS) relates payment to the type of case treated, with a fee schedule for all cases determined in advance. The fee is related to the average cost of actual service provided. The difference between PPS and traditional fee for service

systems is that the payment in PPS is based on a complete episode of care for the patient, not an aggregation of fees for individual medical services. The system has been developed and applied in the USA using diagnosis - related groups (DRGs) to classify cases for the calculation of the payments schedule.

3. Provider Markets

Provider markets involve the separation of responsibility for ensuring that patients receive care from the responsibility for the direct provision of that care. A purchasing agent with statutory responsibility for ensuring that care is available to those resident within the area, will provide it by a combination of contracting with other agencies and direct provision. For example under this system a health authority might use its budget to buy-in services from other health authorities, private hospitals, general practitioners, private nursing homes, and local authority social service departments. A version of this approach restricted to contracts between the NHS authorities is often referred to as an NHS "internal market".

4. Provider Markets with Consumer Choice

This is a development of the provider market approach which allows more freedom to the individual to select his purchasing agent. The purchasing agents would not be like districts, which are statutory bodies with responsibility for all individual residents in their area. This allows more flexibility both for the consumer and the purchasing agent. The purchasing agent contracts to supply the full health care requirements of consumers, and must buy-in from outside any specialist services, which cannot be provided directly. Where local competition exists there is greater pressure on purchasing agents to keep consumers satisfied with their services. This type of organisation can be funded from general taxation (in a voucher system) or by a direct out-of-pocket payment of the annual fee by consumers.

SUMMARY OF PROPOSALS TO BE REVIEWED

Our selection of proposals for review is not intended to be exhaustive and is necessarily restricted to those schemes which have been sufficiently well formulated to stand a degree of comparative analysis. Eight proposals are described briefly below and placed within our classification system (Table 1). All eight have been published and received some critical attention during the current NHS debate and, as a set,

represent a broad range of opinion on potential reform. The classification of proposals in Table 1 clearly illustrates how proposals have concentrated on the reform of provision with only limited discussion about changing the dominant method of financing.

Funding the NHS: Which Way Forward? (NAHA, 1988)

In spite of the title, the National Association of Health Authorities' proposal favours reforming the organisation of provision, rather than the method of finance. To this end they propose a form of payment per item of service for hospital and community health services (HCHS). District budgets would no longer be cash limited, but 'flexed' to the actual level of throughput each year at an agreed cost per activity, probably categorised by diagnosis related group (DRG). Which elements of the HCHS budget would become flexed is not specified although it is suggested long stay services could remain cash limited.

To prevent an uncontrolled expansion of spending, they recommend using capital RAWP and retaining control over consultant appointments. In addition, there would be a more detailed short term planning process with greater regional scrutiny of district plans.

Reflections on the Management of the NHS (Enthoven, 1985)

Enthoven's proposals are based around the concept of an 'internal' market for the NHS, with finance continuing to come from general taxation. District health authorities would be given budgets to meet the health care needs of their residents through the purchase of services either in-house, from other districts, other pubic sector agencies, or the private sector. The flow of patients thus becomes the result of formally negotiated contracts between districts and would be paid for at negotiated prices (note emergency cases are left outside the negotiating framework). The 'Internal' market model extends dramatically ideas already implemented in contracting out of ancillary services to areas of clinical activity.

The detail of Enthoven's plan includes negotiating wages and salaries locally and allowing districts to borrow at government long term interest rates (up to some prudent level). Consultants would contract with districts who would be free to enter all sorts of contractual arrangements, including short term contracts and links with performance. Family practitioners would also contract directly with districts.

"Provider Markets" (Culyer, 1988)

Culyer describes the characteristics of what he claims to be a workable form of provider markets. GPs would continue in their

role as 'gatekeepers' to the health care system and would be paid on a two stage capitation basis plus fee-per service to promote specific services. The first stage of capitation together with expected income from fee-per service would enable GP's to reach a target income. The second stage would be an allowance per patient (age and sex adjusted) from which GP's would purchase drugs from pharmacists and various services from hospital and community health services, eg pathology tests, domestic support services etc.

Local Health Boards (LHBs) would replace RHAs and DHAs as being responsible for ensuring the provision of hospital and community services but the Boards would not provide care directly. Local providers (public or private) would compete for contracts with the LHB to provide care. LHBs would be funded centrally, from taxation, at a level determined by broad cost effectiveness comparisons, judgements about national specialities, teaching, and equity (RAWP may be continued). The system could involve each locality having the option of a local health premium. As well as allocating funds to LHBs, DHSS would monitor their performance and develop information systems on costs, inputs and outcomes for use by management and consumers.

Health Management Units (Pirie and Butler 1988))

In this system individuals choose their GPs, as at present,

but GPs enroll with a Health Management Unit (HMU), which replaces RHAs and DHAs as being responsible for ensuring the provision of total health care for the patients enrolled with them through GPs. The HMU receives a capitation payment from DHSS for each enrolled patient, which may vary with the age of the individual and the local health services costs. From this budget the HMU pays GPs, on a fee-for-service basis, for every consultation and course of treatment they provide, and purchases services from hospitals, who act as independent management centres. Since the HMU holds the budget from which care is purchased for each patient, when a GP refers a patient to hospital the HMU selects the hospital which will provide the treatment.

The HMU must accept all the patients registering with a GP who is enrolled with the HMU except when the optimum size of the HMU (not defined) has been reached.

Managed Health Care Organisations (Goldsmith and Willets, 1988)

This proposal makes a clear distinction between finance and provision. A new tax-funded organisation, the Managed Health Care Organisation (MHCO), would combine the purchasing functions of DHA's and FPC's. A new financing-administration would be responsible for allocating funds to MHCO's on a variable capitation basis (RAWP) dependent upon the custom each MHCO can attract.

Independent providers, including managers of existing NHS facilities, would compete for contracts to supply services to the MHCOs. Consumers are free to change MHCOs and top-up their basic publically-financed package for extra amenities.

A New Deal for Health Care (Brittan, 1988)

Brittan sees merit in many of the proposals put forward for securing the better use of resources within the NHS including competitive tendering, the rationalisation of support services to secure economies of scale and the introduction of provider markets. He would also consider the limited extension of charges (cost sharing) to hotel services and a fee per visit for consulting general practitioners.

While supporting these changes, Brittan does not view them as adequate for solving the basic problem of how to produce a substantial increase in total resources devoted to health care. He rejects a large increase in public spending on macro-economic grounds and proposes an increase in private spending providing it leads to an increase in total provision (both public and private); the principle of adequate health care being available to everybody irrespective of their means is preserved; and the public sector is not relegated to a lower tier service.

Brittan's main proposal is a fundamental change in the method of financing based on the premise that people will be willing to pay for more health care if they know what they are getting for their money and paying is partly voluntary. The NHS will be fully funded by contributions to a National Health Insurance Scheme. However, individuals would have the option to replace all or part of their contributions to the national scheme with equivalent or greater private insurance cover.

National Health Crisis - a Modern Solution (Whitney, 1988)

Whitney proposes a basic social insurance scheme with facility for private topping-up. Each insured person would receive a voucher with which to arrange "satisfactory medical cover" with an approved provider. The voucher would be funded out of a general taxation with a commitment to maintain its value at current levels.

Independent providers of health services would compete for custom and therefore the precise nature of provision would depend on the outcome of market forces. Whitney advocates HMO's but PPO's (see Culyer et al, 1988 a & b), or GP managed HMO's are possible alternatives.

Everyone a Private Patient (Green 1988)

Green concludes, from a review of the available evidence, that government's role should be limited to ensuring that everyone has the power to buy health care; regulating competitive markets to serve the interests of all consumers; and providing information to facilitate more effective consumer choices. The NHS would be retained as a provider of health care in a more competitive provider market. However, everyone would have the right to opt out of the NHS, relinquish their right to free health care and receive an appropriate voucher to finance health care through 'health purchase unions'. These would be responsible for making available several choices of insurance company. For most people the health purchase union role would be played by their employer or a private association, though independent, statutory health purchase unions would also be established. All those privately insured in this way could continue to receive care from the NHS as paying customers. In placing Green's proposal within the classification system (Table 1, 4C) it has been assumed that private insurance would become the dominant method of finance.

TABLE 1: A CLASSIFICATION OF PROPOSED SCHEMES FOR THE UK HEALTH CARE SYSTEM

ORGANISATION OF HEALTH SERVICE PROVISION	DOMINANT METHOD OF FINANCE: PUBLIC FINANCE		PRIVATE FINANCE	
	A. TAXATION	B. SOCIAL INSURANCE	C. PRIVATE INSURANCE	D. SERVICE ENTITLEMENT FEE
1. NHS WITH INTERNAL CHANGE				
2. PROSPECTIVE PAYMENT SYSTEM	Flexed budgets - NAHA (1988)			
3. PROVIDER MARKETS	Internal markets - Enthoven (1985a) Provider markets - Culyer (1988)			
4. PROVIDER MARKETS WITH CONSUMER CHOICE	HMUs - Pirie and Butler (1988) MHCOs - Willets and Goldsmith (1988)	Whitney (1988) Brittan (1988)	Green (1988)	

SECTION II

EVALUATION CRITERIA

To determine whether any of the proposals for change will lead to improvements over the current NHS, it is necessary to specify the objectives of the system. Most of the proposals are concerned with improving efficiency and equity, and increasing the scope for consumer choice. However, closer examination reveals that the authors often mean different things when they use the term "efficiency", and have very different conceptions of what an "equitable" system is. Furthermore, even when there is agreement on the definition of objectives there may be disagreement over the relative importance of each one. The pre-requisite of a comparison of the proposals for reform is a set of criteria, by which each can be appraised, which explicitly recognises these differences, as well as the more obvious differences in institutional arrangements.

Efficiency

In general terms most people accept that efficiency relates to how well inputs are used to produce desired outputs. In the case of health service provision there are three levels at which the efficiency of a system can be measured.

i) Technical Efficiency

This is where a given activity is carried out without waste. For example once a particular drug has been prescribed it should be obtained from the cheapest sources, or if a surgical procedure can be performed as a day case it should not involve an overnight hospital stay. Technical efficiency implies an activity is performed at a minimum cost to a desired standard of quality.

ii) Cost Effectiveness

The second level of efficiency is concerned, not so much with whether activities are being carried out without waste, but whether the correct mix of activities is being undertaken. For many health problems there are a number of effective treatments which differ according to their probability of success, their net effect on the health status of patients and their cost. A cost-effective treatment is one which maximises the beneficial impact on the patient for a given level of cost, or minimises the cost of obtaining a given level of benefit. The cheapest treatment may not be the most cost-effective because the more expensive options may also be much more effective. Cost-effectiveness comparisons require the technically

efficient method of delivery of each treatment to be identified first.

The key issue is the way in which effectiveness is measured. One approach is to assume that individual patients do not have the technical knowledge to judge the relative merits of different treatments and therefore require an agent, usually a doctor, to advise them on what choice to make. This expert advise should be based on objective assessment of the likely impact of various treatments on the patient's health. In this way the relative benefit of different treatments for the same patient can be compared, and also the relative benefits from attempting to treat different patient groups. (See Williams, 1985).

An alternative approach is to assume that the patient is the best judge of the benefit of different treatments, and that the benefit enjoyed will be indicated by the patients' willingness to pay for different services. Research to identify the health benefits of different procedures is rendered unnecessary, and cost-effectiveness is judged by the relationship of income to cost.

iii) Social Efficiency

Cost-effectiveness analysis assists choices between predetermined alternative uses of resources in health care, but gives no indication of what overall level of health care expenditure is worthwhile. To decide this requires information on all other possible uses of the resources involved, and a social judgement as to whether the correct balance has been struck between health services and, for example, education, leisure, transport or housing. Social efficiency (also known as global, allocative or high level efficiency) is achieved when the benefit to people from further expenditure on health services is no greater than that from alternative uses of resources. This raises an important question as to whether the benefits from health care should be valued by an agency on behalf of consumers or by individuals themselves in the market place.

In a tax-financed system, such as the present NHS, a political decision is made on the appropriate size of the health care budget. For example as new techniques and procedures are developed, decisions must be taken as to whether they are to be made available to all patients under the NHS. In systems involving private finance new procedures will be introduced, and will result in an

expansion of the system, if patients are willing to pay for them without reducing demand for other health services. (This is more likely to happen in a system financed through insurance rather than direct patient payment). Advocates of private finance assume social efficiency to be automatically achieved in these circumstances as consumers are free to obtain the level of services they desire.

Equity

The notion of equity in the provision of health services has many ideological interpretations. The aspect of equity most often discussed is that concerning access to services; for example, the principle behind the NHS is that individuals should have equal access to services solely on the basis of clinical need (ie irrespective of willingness or ability to pay). Equality of access does not guarantee equality of use; or benefit from services, or, ultimately of health status; all of which have been put forward as alternative bases for defining equity in consumption of health services. Equality of access is generally considered in geographical terms, but the willingness of different social groups to make use of services, ostensibly equally accessible, will also vary. Hence the need to consider utilisation as well as physical accessibility.

An alternative definition of equality of access is that individuals who themselves perceive a need for health services should have access to the system. This would be reflected in a system which generated equal treatment to those willing to pay an equal amount.

As important as equity in the distribution of benefits is equity in the distribution of the burden of financing the health sector. One view of equity is that contribution to the cost of the system should be related to the individuals' ability to pay, rather that the amount of services consumed. In this approach those disadvantaged by ill-health are not given an additional financial handicap. An alternative approach is to regard equal payment for equal consumption of services as equitable. Those worried about the potential cost of fees and charges for treatment, should cover the risk with health insurance. Clearly the method of distributing costs will affect the distribution of benefits, as it will influence consumers' readiness to make use of services.

Consumer Choice

The third objective is less tangible, but nevertheless it is a significant objective of many proposals for systems of health care provision and finance. Individuals may value for its own sake, the ability to make their own choices, regardless of whether the making of these choices gives them other benefits

such as improved treatment or reduced costs. This objective therefore relates to individual freedom as an end in itself and should not be confused with the advocacy of more consumer choice as a means of achieving greater efficiency.

CONFLICTING OBJECTIVES AND IDEOLOGIES

Where multiple objectives are being pursued there is always the possibility of conflict between them. In theory, the efficiency objectives are complementary. The principles which determine the best overall level of health care expenditure are also the principles which determine the best level of provision for each of its components. In practice, the drive to achieve cost effectiveness may also be stimulated by constraining the overall level of resources. Conversely, a system which is primarily concerned with ensuring that the total level of resources is sufficient to meet society's demands, is likely to find the achievement of technical efficiency or cost-effectiveness more difficult, at the hospital or clinic level.

A more commonly cited conflict is that between efficiency and equality of access. The most obvious dimension of this conflict is geographical but it also occurs between social classes and income groups. If economies of scale exist in the provision of services then some degree of centralisation is indicated to make efficient use of resources. If this takes

place then communities will have different types and levels of service immediately available to them, and will face different travel and time costs to reach the centralised services. The distance from appropriate facilities may also affect the health benefits ultimately achieved from the treatment.

On the other hand, there can be complementarity between equity and efficiency. If resources are devoted to those services giving the greatest improvement in health status to patients then there need be no conflict with the objective of giving access on the basis of clinical need. If the latter is defined in terms of potential to benefit from treatment then pursuit of equity or efficiency should lead to provision of the same level and mix of services to similar populations.

Similarly the relationship between efficiency and consumer choice is open to differing interpretations. Centralisation of services to achieve economies of scale will reduce consumer choice, by cutting down the number of hospitals offering a given treatment, for the sake of cutting down costs. Freedom of choice of treatment for consumers, in a system where access is determined by willingness-to-pay, may lead to demands for services which are less effective in producing improvements in health status. This can be because treatment is not given to those who could benefit most (because they are unwilling-to-pay) or less cost-effective treatments are given because they have other characteristics attractive to consumers. For

example, patients without the technical knowledge to judge the relative merits of the clinical services provided by different hospitals, may take account of factors they can judge, such as the quality of hospital environment and the "hotel" services offered.

There is also a conflict between freedom of choice and the financing of health services. The type of service in tax-financed systems is generally determined by the professional groups responsible for its provision. The quality of work is judged by the providers' professional peers. Such systems allow finance to be raised from those most able to pay (through progressive taxation) and provide equal opportunity of access to services to all income groups, without charge at the time of use. Although paying for the service through taxation, since the patient is not in a position to act like a consumer since any individual patient's satisfaction with the service has little influence on the behaviour or income of the providers. Such a situation generally prevails in the NHS and those people who wish to have greater control over the timing and nature of their treatment can choose to pay for private services (but cannot opt out of their tax contribution to the NHS). Several of the proposals reviewed have attempted to strengthen the position of the patient as consumer, without undermining the fundamental equality of access principle of the NHS. While those schemes advocating more direct charges, tax relief on insurance premiums, or "basic" public health services

with better facilities open to those willing to pay, are not consistent with that equity principle as increased freedom of choice in a market situation gives greater benefits to those with more money to spend.

The relative weight given to each objective, and the interpretation placed on its definition will be governed by ideological perspectives. To avoid argument at cross-purposes the different ideological perspectives behind the reform proposals must be made explicit. Two broad schools of thought can be identified. (Williams 1988). The mainstream public sector school lays emphasis on: the needs for equality of access on the basis of clinical need; finance through progressive taxation; benefits defined in terms of improvement in health status; and the use of cost-effectiveness analysis to identify the appropriate allocation of resources within the health sector. The overall size of the health sector should also be determined by rational analysis of the contribution of health care to improving health status, as opposed to the health benefits of, for instance, improved road safety or better housing. An underlying assumption is that individuals are not well informed about the likely effects of different treatments and therefore consumer choice has little role to play in resource allocation.

The alternative approach emphasises the need to link payment with consumption of services regarding equity as being achieved

if consumers pay for what they consume - redistribution of income is not regarded as a function of the health sector. Consumer preferences are the guiding principle of resource allocation, and therefore objective measures of health benefits are regarded as unnecessary. This approach is based on the idea that an individual is responsible for their own health and that direct payment for health services will provide a clear incentive for the adoption of more healthy life-styles. Many of the proposals for reform appear to mix aspects of the two broad approaches, making it necessary to identify whether the relative weighting of objectives is being changed from that of the current NHS, or whether reforms are being proposed to achieve existing objectives more effectively.

A CHECKLIST OF QUESTIONS

With these difficulties in mind, a checklist of key questions (see Table 2) is suggested as a means of establishing the differences between proposals for reform of the NHS, and examining their relative merits in the light of empirical evidence. For each of the first four criteria the questions address four main areas.

1. The definition of objectives in order to establish the ideological position of what the health sector should be doing and how its success should be judged.

2. How the system should work in terms of the (predominantly economic) theory underlying it.

3. Whether the system is likely to work in the light of results of published evaluations of similar schemes elsewhere.

4. Where appropriate, what might be required to overcome perceived difficulties with the scheme.

The questions about consumer choice seek to establish, in more detail, the schemes real potential in this area of interest.

TABLE 2: KEY QUESTIONS FOR THE EVALUATION OF PROPOSALS

Technical Efficiency

This is assumed to have a common definition regardless of ideological viewpoint.

1. What mechanisms exist for minimising the cost of each activity carried out?
2. What evidence exists that these mechanisms work?
3. What is the implication of these mechanisms for the cost of managing the system?
4. What adjustments to the scheme might improve its performance?

Cost Effectiveness

1. How is cost effectiveness defined in the proposal:
   a) by reference to an objective measure of gain in health status; or
   b) by reference to consumer satisfaction with services as indicated by willingness to pay?
2. What are the proposed mechanisms for achieving cost effectiveness?
3. What evidence exists that these mechanisms work?
4. What adjustments might be made to the scheme to improve its performance?

Social Efficiency

1. How is the socially desirable overall size of the health sector defined in the system:
   a) by reference to the relative valuation by the community of measured gains in health status, derived from all forms of health care and promotion, and benefits derived from other forms of public and private expenditure; or
   b) by reference to the relative valuation by individuals of the benefits derived from health services and the benefits from the purchase of other goods and services?
2. What are the proposed mechanisms for achieving the appropriate overall size for the health sector?
3. What evidence is there that these mechanisms will work?
4. What adjustments might be made to the scheme to improve its performance?

Equity

1. What aspects of equity in the finance and provision of health care concern the authors of this proposal?
2. What mechanisms are proposed to achieve such equity?
3. What evidence exists that these mechanisms will promote equity?

Consumer Choice

What effective opportunities will the system offer consumers to choose:

1. their method of payment for health services;
2. their level of expenditure on health services;
3. their providers of health services (eg. doctors, hospitals); or
4. the timing of their treatment?

SECTION III

REVIEW OF PROPOSALS

The results of applying the checklist of questions, described above, to each of the eight proposals for reform, and the status quo, are detailed in Appendix A. The classification of proposals in Table 1 indicated similarities between proposals in terms of dominant methods of finance and provision which are reflected in the comparative analysis of their performance against the criteria.

In the pursuit of technical efficiency there is broad agreement within the proposals that this requires greater use of competition between suppliers of services, and it is noticeable that no proposal advocates an increased role for planning as a means of improving efficiency. Purchasing agencies buy services on behalf of patients and can be quite seperate from the providers. They are motivated by being given specific obligations to be met within tightly constrained budgets, or by use of prospective payment systems of reimbursing for numbers of consumers served. There is little evidence of the potential benefits from this approach in the UK, but great weight appears to have been placed on the USA evidence of the impact of HMO's on health care costs, although there are dangers in translating these results to UK context. The UK already has a much lower rate of hospitalisation and

surgical intervention, the reduction of which was the main impact of HMO's in the USA. The extra management costs of operating competitive contracting are recognised in some proposals but no quantitive estimates are produced.

Cost-effectiveness, based on improvement in health status, is a prime concern of those authors recommending schemes which remain within the broad philosophy of the NHS. The need for monitoring the quality of care when contracts for services are competitively allocated is critical, since cost-effectiveness requires measurement of changes in effectiveness as well as cost. The lack of progress in the measurement of health outcomes in the NHS to date, casts doubt on the viability of proposals which have positive incentives to cut costs. Whether a significant increase in management and evaluation resources would be necessary for these proposals to improve on the current NHS is open to debate (Culyer 1988; NAHA, 1988). The proposals emphasising the need for an enhanced private sector, and less control over individual expenditure and consumption of services, are ambivalent about cost-effectiveness. It seems to be a requirement in controlling the state financed "safety-net system", but not necessary when "informed consumers" are making their own decisions (eg Green 1988; Whitney, 1988: and Brittan, 1988).

On the question of the overall size of the health sector, the issue which has sparked off the current debate on the NHS, most

proposals offer little change. Green, Whitney and Brittan propose an enhanced role for private insurance (and provision) to make it easier for those able to pay to obtain more health services and thus increase the total expenditure. This possibility exists at present, but, allegedly, is restricted to high income groups as taxpayers contribute to general exchequer funding in the NHS and get no tax relief on health insurance premiums. There is no evidence put forward to support the contention that a large increase in private insurance is being constrained by the current financial arrangements. It could be argued that consumers are currently making an informed choice based on the relative benefits from private and NHS health services.

The proposals for provider market and tax funding all, explicitly and implicitly, rely on the political process to determine the overall size of the health sector and the allocation of funds to the purchasing agents. However, Culyer proposes a mechanism for receiving additional funding from local taxation at the discretion of the individual boards. This could lead to an overall increase in resources in the health sector without an explicit political decision by central government. The NAHA schemes for payment of service providers by PPS also offers the possibility of increased funding, linked to increased productivity, without specific political intervention. Moves of this kind to allow more flexibility in the health sector would conflict with the governments' overall

financial objective of keeping firm control on all public expenditure.

Most of the proposals adhere to the current NHS principles of access to services on the basis of clinical need, and funding from general taxation (on the assumption that this is based on ability-to-pay). The proposals in column A of Table 1 all involve increased use of the competitive mechanism, but this is largely between suppliers contracting with informed purchasing agents - health authorities, MHO's or GP's. This use of competition is a means of achieving greater efficiency, not an end in itself, and may lead to more restricted choice by consumers, once they have selected their purchasing agent. These systems could lead to better operation of service provision on the basis of clinical need if improved information on the benefits from different procedures is obtained.

The schemes put forward by Green, Whitney and Brittan move away from the present arrangements by proposing to encourage the development of a two tier system - a basic level of state-supported services available to all, and further services available to those willing-to-pay through private insurance or directly to those out-of-pocket. Green and Brittan would allow those with private insurance to opt-out completely from funding the state-supported "safety net" service breaking the last link between ability-to-pay and contribution to costs. The Whitney

proposal would maintain the general tax - funding of the state-supported service, but would encourage "topping-up" from consumers' own resources. The move to an insurance basis for the service, requiring more explicit choices by the consumer of methods of payment, levels of expenditure and providers, is seen as an end in itself, not just as a means of stimulating more efficient behaviour. Green does recognise that the power of the individual consumer is limited, as long as the medical professions are able to control the registration of practitioners and determine what is considered appropriate medical practice in particular circumstances. Ultimately, these three proposals see more merit in allowing those consumers who are able, and willing, to pay more for health services, than in restricting the freedom of choice of individuals in the name of equity and clinical effectiveness.

CONCLUSION

The approach adopted in this paper has been to use a broad system of classification, and a consistent set of analytical questions, to expose the characteristics of the current proposals for reform of the NHS. This has served to highlight the differences and similarities between the proposals in terms of content and reveal the basis on which their respective claims are advanced.

The first point to emphasise is that although the options are concentrated in the "Public Finance" category in Table 1, the methods of financial allocation and organisation of provision advocated in the different proposals involve deep ideological divisions.

Once the ideological position of the authors has been clarified it is easier to interpret their arguments about efficiency. It is noticeable that much of the argument remains at a conceptual level, as there is very little evidence put forward to support the claims advanced in most of the proposals. This lack of information is crucial to the policy debate. Without better information it is not possible to evaluate the proposed changes to determine whether they would lead to the improvements claimed by their authors.

Closer examination of the proposals reveals a lack of comprehensiveness in their discussion of health services provision and the consequences of organisational change. Very few of them address the whole spectrum of health services but are primarily concerned with the acute sector. Culyer's proposal, which recognises the different approaches required for different aspects of the service, such as community care, is a notable exception. Some of the other schemes could be adapted to take on board these issues, but this has not been done by the authors.

On the fundamental question of the overall size of the health sector the proposals have little to say. Those retaining the fundamental NHS approach admit scope for more efficient service provision within current resources. Those proposing two-tier system argue that private individuals will determine the appropriate size of the health sector by their willingness to make additional contributions towards the cost of their own health care. This, however, is based on the assumption that the government will not simultaneously reduce spending on the public part of the health service as more people opt for private health care. This review has not included as a specific option the view taken by many commentators that the NHS is basically sound and merely requires an injection of extra finance (up to £2 billion per annum) to bring services up to the desired standard. It should be noted that the information is not yet available to produce a considered judgement on this issue, just as it is not available to support the immediate adoption of any of the schemes analysed in this paper.

To conclude a review of this nature with a call for more research is common and often regarded as unhelpful to those responsible for resource allocation decisions. In this case we feel that it is fully justified given the issues at stake. Even an apparently small change in the system of health care provision or finance, intended to improve efficiency, could have profound implications for the equity of the system. It is

vital that this is fully understood and that the objectives of any change are clearly identified. The information needed for evaluation can only be obtained from observation of the proposals in practice. Carefully planned and comprehensively evaluated experimentation of a range of proposed reforms should be the path to follow.

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APPPENDIX 1

TECHNICAL EFFICIENCY

1 What mechanisms exist for minimising the cost of each activity carried out?

Proposal	
1. Status Quo	Hospital and Community Health Services (HCHS) must keep total costs within an annual cash limited budget, but few direct incentives for professionals or hospitals to minimise costs per activity. Developments such as the Resource Management Initiative and medical audit are attempts to introduce a more cost conscious culture, but still at implementation stage. In Family Practitioner Services(FPS), most of GPs' income is fixed each year according to size of list and allowances with significant payments for specific activities (eg. Cervical Services).
2. Flexed HCHS Budgets	Financial incentives from funding acute HCHS by activity at an agreed cost per case possibly using diagnostic related groups (DRGs). FPS as now.
3. Internal Market Model	Competition amongst NHS hospitals and private sector, to win contracts from District Health Authorities (DHAs) who have a responsibility for their population's HCHS and FPS. DHAs will seek to minimise costs and maintain quality.
4. Provider Markets	As for internal markets in HCHS, but read Local Health Boards (LHBs) for DHAs. GPs are made aware of the cost of the drugs and services they prescribe for their patients since they must pay for these services from a budget determined by a fixed allocation per patient.
5. Health Management Units (HMU)	HMUs must provide total health care for their membership from a fixed annual budget. It is claimed they therefore have an incentive to minimise payments to hospital and GPs in order to maximise the service they can provide for their members. Providers must compete to supply services to the HMU.
6. Managed Health Care Organisations (MHCO)	Competition amongst purchasing agents for consumers and amongst independent providers to supply health care.
7. The Brittan Plan	Use of competition amongst public and private providers to supply health care and possibly between purchasing agents for consumers.
8. Whitney's Proposal	Competition amongst purchasing agents for consumers and amongst public and private providers to supply health care.
9. Green's Proposal	An increased role for competition among both providers (eg. hospitals and GPs) and purchasing agents (eg. private insurance and Health Maintenance Organisations (HMOs)), who will be selling their services to consumers and/or their employers. The author also favours some deregulation of restrictive practices in the medical profession.

TECHNICAL EFFICIENCY

2 What evidence exists that these mechanisms work?

Proposal	
1. Status Quo	There is a substantial body of evidence that the NHS, like other health care systems, is inefficient in terms of resource use per activity (for a review see Culyer et al, 1988a). For example, there are large variations in length of stay for the same procedure (eg. Morgan et al, 1987). NHS statistics suggest efficiency may be improving, since throughput in the acute sector has increased considerably over the last five years, but quality consequences have not been monitored.
2. Flexed HCHS Budgets	US evidence shows costs of inpatient cases can be reduced by a system of prospective payment per DRG (Guterman and Dobson, 1986), but this may have been achieved by shifting costs to other areas (Carroll and Erwin, 1987), by reclassifying cases into higher paying DRGs (known as "DRG Creep" - Ginsberg and Carter, 1986) or cutting the quality of care, about which there is little evidence.
3. Internal Market Model	There is no evidence on the consequences of this form of competition in the provision of patient care. Indirect evidence on the likely effects of competition may be obtained by static comparisons between different agencies providing health care. Comparisons of public and private providers of non-acute care have found the latter to be cheaper but without controlling for quality it is not possible to draw conclusions about efficiency (eg. Knapp, 1986; Knapp and Missiakoulis, 1982; and Judge et al, 1986). The weight of evidence from the US suggests privately owned hospitals do not operate at lower costs than non-profit making hospitals (Stoddart and Labelle, 1985). The only experience with genuine competition in the NHS has been in contracting out ancilliary services. This has been estimated to have saved around 10% of costs (Key, 1988), but the impact on quality has not been assessed.
4. Provider Markets	In HCHS, as for Internal Market Model. There is no evidence on the effects of giving GPs budgets for drugs or certain hospital services. Most research in clinical budgeting has been in hospitals, but to date there has not been an operational system (Wickings et al, 1985 and DHSS, 1986b).
5. Health Management Units	On competition amongst providers, see review of evidence under Internal Market Model. HMUs are similar to HMOs because they indirectly extend consumers' choice to the purchasing agent of hospital care. Research in the US has found that HMOs reduce total cost by 28% but most of this could be explained by reductions in hospital inpatient admission rates, rather than the cost per case (Manning et al, 1984). Evidence on the consequences of HMOs for cost per case, per outpatient visit, per test and so on, is less conclusive (Luft, 1981).
6. Managed Health Care Organisations	Evidence on the effect of competition amongst providers is reviewed under the Internal Market Model, and between purchasing agents under Health Management Units.
7. The Brittan Plan	As for Managed Health Care Organisations.
8. Whitney's Proposal	As for Managed Health Care Organisations.
9. Green's Proposal	As for Managed Health Care Organisations for competition between providers and purchasing agents. There has been a more general study of the consequences of increased competition in provision and financing on total costs. It claims to have found an associated once off decrease in cost escalation of around 15% in that country (Pauly, forthcoming). This evidence is difficult to interpret because it is not possible to prove causality and consequences for the quality of service were not monitored.

TECHNICAL EFFICIENCY

3 What is the implication of these mechanisms for the cost of managing the system?

Proposal	
1. Status Quo	A comparison of percentage spent on administration by the NHS with other countries found it has one of the lowest (Maynard, 1982). Though such comparisons are fraught with methodological difficulties, costs may increase with improvements in information systems and management.
2. Flexed HCHS Budgets	Additional administrative costs may arise since hospitals will be required to adopt a casemix classification system, such as DRGs, for reimbursement.
3. Internal Market Model	There are likely to be costs arising from the negotiation and monitoring of contracts. Hospitals will be required to collect more information in order to cost the services they provide.
4. Provider Markets	There are likely to be costs arising from the negotiation and monitoring of contracts. Hospitals will be required to collect more information in order to cost the services they provide. However, the author claims that a provider market would not necessitate a large increase in information costs since the market itself would correct mistakes.
5. Health Management Units	As for internal markets, with the additional costs of managing a fee-for-service payment system for GPs.
6. Managed Health Care Organisations	As for Health Management Units. There would also be costs from collecting premiums and administering financial agencies. Evidence from other countries suggest that private health care systems spend more on administration (Maynard, 1982, Evans, 1982).
7. The Brittan Plan	As for Managed Health Care Organisations.
8. Whitney's Proposal	As for Managed Health Care Organisations.
9. Green's Proposal	As for Managed Health Care Organisations.

TECHNICAL EFFICIENCY

4 What adjustments to the scheme might improve its performance?

Proposal	
1. Status Quo	Internal reforms including the continued development of the 'Resource Management Initiative', medical audit, and so on.
2. Flexed HCHS Budgets	Extend the item of service classification to all areas of care to counter cost shifting. Include an audit of the type and quality of care being provided to prevent any abuses of the system.
3. Internal Market Model	The author acknowledges that a weakness with this proposal is a lack of incentives to serve patients well. Quality would need to be specified in contracts and successful tenderers would have to provide effective quality assurance mechanisms for cost reductions not to be at the expense of outcome. May be limited competition in sparsely populated areas. One solution would be to franchise the supply of health care and retender at regular intervals (Culyer, 1988).
4. Provider Markets	As for Internal Market Model.
5. Health Management Units	As for Internal Market Model.
6. Managed Health Care Organisations	As for Internal Market Model.
7. The Brittan Plan	As for Internal Market Model.
8. Whitney's Proposal	As for Internal Market Model.
9. Green's Proposal	As for Internal Market Model.

COST EFFECTIVENESS

1 How is cost effectiveness defined in the proposal?

a) by reference to an objective measure of gain in health status; or

b) by reference to consumer satisfaction with services as indicated by willingness to pay?

and;

2 What are the proposed mechanisms for achieving cost effectiveness?

Proposal	Definition	
1. Status Quo	a	Strategic plans and DHSS targets are intended to determine the overall balance of resources between specialties and certain activities. In practice the pattern of activity is often the result of clinical decisions rather than formal planning. In FPS, it is through policies and paying extra for certain desirable services.
2. Flexed HCHS Budgets	a	A planning review system at a more detailed level than under Status Quo.
3. Internal Market Model	a	There would be "suitably trained" managers to make efficiency decisions on appropriate levels of activity based on their contracts. This would have implications for 'clinical freedom'. Presumably this would include examining outcome, as well as cost, to enable the purchasing agents (DHAs) to make choices which promote a).
4. Provider Markets	a	As for Internal Market Model. Furthermore, quality would be specified in contracts and successful tenderers would have to provide effective quality assurance mechanisms. Central funding of LHBs would be partly determined by broad cost effectiveness judgements.
5. Health Management Units	Predominantly a)	HMUs compete for members, through GPs, and, therefore have an incentive to provide cost effective, care, which will maximise health benefits.
6. Managed Health Care Organisations	a) and b)	Exercise of choice of MHCO by informed consumers and of providers by MHCOs.
7. The Brittan Plan	a) and b)	Though not specified by author, under a provider market it would be left to a management structure to make efficient choices, based on the costs and outcomes of different activities. In the private sector, cost effectiveness will be guaranteed by willingness to pay for services provided.
8. Whitney's Proposal	a) and b)	Exercise of choice over finance and provision by well informed consumers.
9. Green's Proposal	Predominantly b)	As for Whitney's Proposal.

COST EFFECTIVENESS

3 What evidence exists that these mechanisms work?

Proposal	
1. Status Quo	Evidence on two fold variations or more in procedure rates (see review in Culyer et al, 1988a), and large inequalities in the allocation of resources between health authorities (DHSS, 1986a) and FPCs (Birch and Maynard, 1986), suggest large inefficiencies in resource allocation exist.
2. Flexed HCHS Budgets	There is no direct evidence on the success of such a system. The UK experiments with resource management at the level of clinical firms (Wickings et al, 1985; DHSS, 1986b) suggest it is difficult to obtain agreement between managers and clinicians, and the experiments have as yet failed to address successfully the measurement of outcome.
3. Internal Market Model	As for Flexed HCHS Budgets.
4. Provider Markets	As for Flexed HCHs Budgets.
5. Health Management Units	Research by the Rand Corporation in the US found that HMOs reduced total costs with no apparent adverse effects on outcomes for the majority of members, the exceptions being low income individuals who were unhealthy when they first enrolled with the HMO (Manning et al, 1984). HMUs differ however, from the HMOs evaluated in this study. In particular, GPs were paid by salary rather than fee-for-service, in the HMOs studied. This evidence is contradicted by a more recent study which found a significantly higher mortality in populations with a greater proportion of HMO enrollees (Shortell and Hughes, 1988). In addition, US evidence is difficult to translate into the UK context. For example, the same cost per annum reductions achieved could not be expected in the UK where admission rates are already much lower than those of the US (McPherson et al, 1981).
6. Managed Health Care Organisations	For definition a) as under HMUs; for b) tautological - if consumers are willing to subscribe to MHCO it must be cost-effective by definition though this raises the question of whether consumers are best able to judge the value of health care.
7. The Brittan Plan	In the public sector under definition a) as for flexed HCHS budgets. In the private sector, if consumers are willing to subscribe, it must be cost effective by definition. This raises the question of whether consumers are best able to judge the value of health care.
8. Whitney's	Consumers are held to be the best judges of their own welfare. As for The Brittan Plan.
9. Green's Proposal	As for Whitney's Proposal.

COST-EFFECTIVENESS

4 What adjustments might be made to the scheme to improve its performance?

Proposal	
1. Status Quo	Increase planning and management of activity levels to reflect their relative cost effectiveness (Williams, 1985). This necessarily requires improvements in information on inputs and outputs of health care.
2. Flexed HCHS Budgets	Improvements in information on inputs and outputs of health.
3. Internal Market Model	Improvements in information on inputs and outputs of health. Proposal also fails to acknowledge the likely problems of controlling GP referral patterns and managing clinicians' activities in hospitals.
4. Provider Markets	Author argues that large increases in information on inputs and outputs are not required for a market to work, though some improvements undoubtedly are.
5. Health Management Units	As for Internal Market Model. For competition to be an effective mechanism for ensuring cost effective care, consumers and GPs would require detailed information on relative outcomes before choosing an HMU.
6. Managed Health Care Organisations	As for Health Management Units. Government may have a role in improving the information available to consumers to compare alternatives.
7. The Brittan Plan	As for Managed Health Care Organisations.
8. Whitney's Proposal	As for Managed Health Care Organisations.
9. Green's Proposal	As for Managed Health Care Organisations.

SOCIAL EFFICIENCY

1 How is the socially desirable overall size of the health sector defined in the system:

a) by reference to the relative valuation by the community of measured gains in health status, derived from all forms of health care and promotion, and benefits derived from other forms of public and private expenditure; or

b) by reference to the relative valuation by individuals of the benefits derived from health services and the benefits from the purchase of other goods and services?

2 What are the proposed mechanisms for achieving the appropriate overall size for the health sector?

Proposal	Definition	
1. Status Quo	a	A cash limited budget determined in advance by a political decision on the level of taxation and the share of tax revenue going to the NHS.
2. Flexed HCHS Budgets	a	Mainly determined in advance, as above, but with a degree of flexibility to respond to increases in productivity.
3. Internal Market Model	a	As for Status Quo.
4. Provider Markets	a	As for Status Quo. The budget may also be made more sensitive to local demands for health care through a local health premium.
5. Health Management Units	a) with some b)	As for Status Quo, with an increased role for the private sector through tax concessions for private insurance.
6. Managed Health Care Organisations	a) with some b)	As for Status Quo, with scope for individuals to top-up basic care according to willingness to pay.
7. The Brittan Plan	a) and b)	As for Status Quo for public sector and willingness to pay for private sector.
8. Whitney's Proposal	a) and b)	Current level of expenditure is assumed to be sufficient to provide basic package. Topping-up facility allows individuals to supplement basic package to obtain "amenities" and therefore decide appropriate level of funding.
9. Green's Proposal		As for Status Quo, but whether money goes to NHS depends on whether people choose to opt out. Individuals or their employer, can top-up their voucher to desired level.

SOCIAL EFFICIENCY

3 What evidence is there that these mechanisms will work?

Proposal	
1. Status Quo	None due to insufficient data on the relationship between inputs and outputs, though opinion polls suggest many of the population feel more should be spent on the NHS.
2. Flexed HCHS Budget	As for Status Quo. Though flexibility is supposed to allow a response to increased demand via productivity improvements.
3. Internal Market Model	As for Status Quo.
4. Provider Markets	As for Status Quo, though the 'local health premium' may make it more responsive to opinion.
5. Health Management Units	As for Status Quo in public sector. There is no evidence on the impact of tax concessions on the demand for private health insurance in the United Kingdom. However, the desirability or otherwise of changes are difficult to interpret. By definition, consumers will spend up to b), but whether consumers are in a position to judge the value of health care is open to question.
6. Managed Health Care Organisations	As for Health Management Units.
7. The Brittan Plan	As for Health Management Units.
8. Whitney's Proposal	As for Health Management Units.
9. Green's Proposal	As for Health Management Units. Experience from other countries with insurance-based schemes suggests there are problems with escalating expenditure (Evans, 1982). The author recognises this and suggests a number of solutions through competition and anti-trust regulation.

SOCIAL EFFICIENCY

4 What adjustments might be made to the scheme to improve its performance?

Proposal	
1. Status Quo	Improvements in data on costs and societies' valuation of health care outputs.
2. Flexed HCHS Budgets	As for Status Quo.
3. Internal Market Model	As for Status Quo.
4. Provider Markets	As for Status Quo.
5. Health Management Units	As for Status Quo. It is important to monitor whether tax concessions for private health care will be accompanied by changes in public expenditure.
6. Managed Health Care Organisations	As for Health Management Units, though the issue of appropriate level of public finance is not addressed. The position of community care is unclear.
7. The Brittan Plan	As for Managed Health Care Organisations. Government may have a role in providing consumers with information. The position of community care is unclear in this scheme.
8. Whitney's Proposal	As for The Brittan Plan.
9. Green's Proposal	Consumers will need to have better information and may benefit from combining to enhance their market power (eg. employer based schemes).

EQUITY

1 What aspects of equity in the finance and provision of health care concern the authors of this proposal?

Proposal	
1. Status Quo	Though there is no single, well defined statement of equity in operational terms (eg. see Mooney, 1985), various official documents have been concerned that the NHS offers 'equal opportunity' of access to health care for people at equal risk (eg. DHSS, 1976).
2. Flexed HCHS Budgets	Overall access to health care should depend on need rather than willingness and ability to pay. They specify equal access by geography, medical and social need, and by generation.
3. Internal Market Model	Enthoven accepts that a tax based system of finance for a service which is 'free' at the point of consumption receives popular support. Implicitly, in this model, the author is concerned with equity in geographical access to services.
4. Provider Markets	The author is concerned with maintaining a service which is 'free' at the point of consumption and is financed from progressive taxation. He supports the pursuit of equity in access to services and equity in the distribution of health benefits derived from the service.
5. Health Management Units	They appear to be concerned with maintaining a system of health care, access to which is independent of ability to pay. Though supplemented by topping-up.
6. Managed Health Care Organisations	As for Health Management Units.
7. The Brittan Plan	Treatment for all would be guaranteed, irrespective of means and paid by social insurance, though opting-out has implicit consequences for the distribution of health care benefits.
8. Whitney's Proposal	Equal access to a basic level of health care met from general taxation.
9. Green's Proposal	Equity is defined in terms of a minimum standard of health care (ie. a safety net for the poor). Beyond that, the principle of services for those willing to pay for them is considered equitable.

EQUITY

2 What mechanisms are proposed to achieve such equity?

Proposal	
1. Status Quo	A RAWP formula which distributes the HCHS budget between Regions according to an estimate of relative need (DHSS, 1976), and a similar 'needs' based approach for allocating down to Districts. These are in addition to Region's control of large capital projects and consultants' appointments. FPS are not 'RAWPed', but determined by the distribution of GPs and their activities (particularly drug prescribing).
2. Flexed HCHS Budgets	Solely through Region's control of large capital projects and consultants' appointments.
3. Internal Market Model	Equity in geographical access would be achieved by allocating resources to districts on the basis of RAWP adjusted per capita sums.
4. Provider Markets	Equity in access to health care by geographical area could be achieved by the DHSS allocating resources to LHBs by a RAWP formula. However, it is suggested that the allocation of resources to LHBs, be partly determined by broad cost effectiveness judgements about cost per unit of accomplishment. This mechanism would allow equity in the health benefits derived from the service to be pursued since those areas achieving the greatest marginal benefit would get more resources.
5. Health Management Units	A predominantly tax financed health care system with resources allocated to HMUs on a per capita basis. However, encouraging private insurance would conflict with the objective of ensuring access to health care independent of ability to pay.
6. Managed Health Care Units	Variable capitation allowance (based on RAWP-type factors) goes with individual to the MHCO of his or her choice.
7. The Brittan Plan	Adjustments to the tax system to achieve the desired distribution of finance. No comment on how equity is achieved within a health care budget.
8. Whitney's Proposal	Insured population have equal entitlement to voucher with which to purchase sufficient insurance coverage to secure basic level of health care. Non-insured (very elderly and/or chronically sick) would be covered by government. Regulatory body to arbitrate between consumers and insurers.
9. Green's Proposal	NHS retained to provide for poor.

EQUITY

3 What evidence exists that these mechanisms will promote equity?

Proposal	
1. Status Quo	The application of the RAWP formula appears to have had some success regionally, but at district level substantial inequalities remain (DHSS, 1986a). Measuring social class inequalities is more controversial, but there is evidence of inequalities in use remaining (Le Grand, 1982). In FPS large geographic inequalities have also been found (Birch and Maynard, 1986).
2. Flexed HCHS Budgets	The 1962 Hospital Plan for England and Wales (Ministry of Health, 1962) had only a limited effect in equalising the distribution of building stock (Allen, 1981). There has been no evaluation of redistribution through consultant appointments. No additional mechanism has been proposed for social group access.
3. Internal Market Model	No evidence available. Social group equity in the access and utilisation of health care may decrease if patients must travel large distances to receive care as a consequence of provider markets, since travel costs are greater for lower social classes (Le Grand, 1982).
4. Provider Markets	As for Internal Market Model. Also there is no evidence on the practicalities or consequences of allocating funding by comparisons of cost effectiveness.
5. Health Management Units	There are financial incentives for HMUs to only accept GPs with lists of comparatively healthy individuals of a given age. Some studies in the US have found that HMOs do 'cream skim' (Eggers, 1980 and Luft 1981) although other evidence suggests that this is not always the case (Berkie, Ashcraft, 1980, and Blumberg, 1980). The authors recognise this problem and suggest HMUs must accept all individuals registering with GPs, up to an 'optimum' size, (the 'optimum size' of each HMUs is not defined).
6. Managed Health Care Organisations	As for Health Management Units, although authors propose no solution (eg. by making enrolment by MHCO of prospective members compulsory). Deciding on the appropriate value of each person's voucher will be important (eg. will HIV positive individuals have a larger voucher?).
7. The Brittan Plan	As for Managed Health Care Organisations.
8. Whitney's Proposal	As for Managed Health Care Organisations.
9. Green's Proposal	As for Managed Health Care Organisations. Evidence from USA on the operation of Medicaid and Medicare programmes as safety nets for the poor and elderly indicates over 10% of the population slip through and are uninsured (Helms, forthcoming).

CONSUMER CHOICE

What effective opportunities will the system offer consumers to choose:

a) their method of payment for health services;

b) their level of expenditure on health services;

c) their providers of health services (eg. doctors, hospitals);

d) the timing of their treatment?

Proposal	(a)	(b)	(c)	(d)
1. Status Quo	Tax is compulsory, but apart from that, consumer (or their employer) chooses.	Public sector expenditure determined by Government while private spending by consumer or their employer.	Choice of GP, not hospital doctor, in NHS.	Patients usually fitted into an appointment system.
2. Flexed HCHS Budgets	No change.	No change.	No change.	No change.
3. Internal Market Model	No change.	No change.	Could be less than at present since the district, not an individual's GP will choose the hospital for treatment. Choice of GP restricted to District of residence.	No change.
4. Provider Markets	No change.	No change unless a local health premium is introduced.	Could be less since LHB, not the individual's GP will choose the hospital for treatment.	No change.
5. Health Management Units	Tax concessions offer choice on method of paying these resources.	Effective choice may be increased by being able to transfer NHS contributions, and, thereby reduce the real cost of private insurance.	Indirectly increased since individuals can choose their purchasing agent for HCHS.	No change in public sector.
6. Managed Health Organisations	Can choose method of top-up. Similar in principle to current situation.	As for Health Management Units. (HMUs)	As for Health HMUs	As for HMUs
7. The Brittan Plan	Given choice not to contribute to NHS funding.	As for HMUs	Provider markets may constrain choice for consumers who remain in NHS.	Only for those who take up private insurance.
8. Whitney's Proposal	Can choose method of top-up. Similar in principle to current situation.	As for HMUs	In private sector, depends on system of delivery chosen eg. HMOs may offer more limited choices.	In private sector, depends on system of delivery chosen, eg. HMOs may offer more limited choices.
9. Green's Proposal	As for Brittan's proposal	As for HMUs	As for Whitney's Proposal.	As for Whitney's Proposal.