The Final Report of the Health Policy Consensus Group

A New Consensus for NHS Reform – Summary

May 2003

The Health Policy Consensus Group came together to explore whether or not people drawn from across the political spectrum could agree about the best way to reform the NHS. Comprising senior NHS consultants as well as prominent Labour party members, it set out to preserve the access for rich and poor alike that we all support, whilst increasing consumer choice and personal responsibility for health care expenditure. This factsheet summarises our findings.[1*]

Hospitals: Main Recommendations

In order to ensure adequate supply of health services, and to allow a genuine ethos of local public service, independent of politics, to emerge, we recommend:

- The Government should not own hospitals and all such institutions currently in the public sector should become independent at the earliest possible date. The simplest method would be to make them all foundation hospitals, whilst ensuring that their assets must be permanently used to provide health care. Existing NHS hospitals should not be transferred to the ownership of for-profit institutions.
- However, foundation hospitals as currently proposed are only a small step in the right direction. Hospitals should have complete autonomy from Whitehall. In particular, there should be no specific restrictions (beyond those that apply to all workplaces) on the ability of hospitals to recruit staff or on the conditions of their employment.
- The Government has an important role in ensuring that hospital accident and emergency infrastructure is universally available. In the rare event of a hospital being in financial difficulty, the Government must be able to take appropriate action.
- There should be no restrictions on the establishment of new hospitals, whether they are for-profit or not, as at present.
- Foundation hospitals should be free to raise funds in capital markets which are not counted as part of public borrowing, but to avoid the perception that the taxpayer is the ultimate guarantor of loans, anyone making such loans must legally renounce any future claim on public funds.

Funding: Main Features of An Ideal System

In our first publication, *Options for Funding*[2], we examined the features of eleven different healthcare funding systems. As a result, we have identified six characteristics of an ideal health system and a number of options for policy makers:

- The primary role of government should be to create the legal and regulatory framework, to ensure that access to a high standard of care is guaranteed to all, and to ensure the supply of essential public health services.
- Patients should have a choice among a range of competing healthcare providers.
- Health insurance should be compulsory.
- Patients should be free to choose from among a range of third party payers so that the allocation of resources follows from patient preferences.
- There should be no compulsory user charges.
- Politicians must not override the professional duty of clinicians to act in the interests of patients.

---

[*] The Group's findings are published by Civitas.

The Underlying Conundrum[3]

The provision of health care is a thorny issue because of the dual character of medical demand. On the one hand, severe pain or dysfunction may prevent people from leading a normal life and in extreme cases life or death may be at stake. On the other hand, some demands for medical services are a matter of personal preference. No less important, some ill health is a matter of sheer misfortune and some a consequence of a self-destructive lifestyle.

Public policy makers continue to struggle with these conundrums in all countries, but some have devised solutions which have proved more effective than others. It is our conclusion that countries with social insurance systems (Germany, France, the Netherlands and Switzerland) have the most to teach us.

Where We Are Now

The UK government has a near monopoly over the funding and provision of health care. After decades of political control, our healthcare spending is comparatively low, but is set to rise to levels approaching the EU average over the next few years. Our healthcare outcomes are comparatively poor, and we need to put the NHS on a more sound ethical footing.

How to Get There: Evolution Not Revolution

It will not be easy to move from a public sector monopoly funding system like the NHS to an alternative. We consider funding first. Here are four possible solutions:

1. *Evolutionary reform of primary care trusts*
2. *A tax-funded core-service with treatment vouchers and top-up insurance*
3. *Social insurance with individual payment*
4. *Social insurance with consumer health purchasing co-operatives*

Evolutionary Reform of Primary Care Trusts

Scheduled to have control over 75% of the NHS budget by 2003/4, the 304 primary care trusts may lend themselves to change. Each person receives care from his or her local PCT, which is partially a local monopoly fundholder, partly a direct provider of primary care, and partly a purchaser of hospital and outpatient services managed by separate organisations.

We consider three possible routes for reform of PCTs: Offer choice of PCT; Convert PCTs to consumer mutuals; Convert PCTs to producer-led healthcare maintenance organisations.

Choice of PCT

The simplest reform would be to introduce free consumer choice of PCT. The income of a PCT is based on a weighted capitation formula, and it would be administratively simple to transfer funds between PCTs according to the preferences of patients. Such a reform would effectively enable individuals to choose from a wider range of GPs and hospitals.

Convert PCTs to consumer mutuals

Another possibility would be to convert PCTs to mutual organisations owned by their members. At the minimum this would require direct representation of patients on the controlling body of the PCT, but it would be better to go a step further to create real ownership by giving members control of their share of the Treasury allocation to the PCT. Members would be allowed to take this amount with them to another PCT to give trusts an incentive to provide a good standard of care. However, PCTs would still have cash-limited budgets set by central government. To overcome this problem, people need to be free to add to the funding available to their PCT, but how can such freedom be made compatible with social solidarity?

One method would be to let PCTs establish separate mutual funds for service development. Members could pay into the fund just as they pay into any savings account. Interest would be free of tax and payable so long as the capital were tied up for long enough to allow its use for investment in health facilities – perhaps until retirement age. Once the members reached the age of 65 the capital could be withdrawn or left to gather further interest. An arrangement based on mutually-owned PCTs would be voluntary and potentially create a sense of genuine social solidarity – always promised by the NHS but never achieved.

Convert PCTs to producer-run health maintenance organisations

It might be more realistic to convert PCTs into health maintenance organisations run by doctors.

Patients should be free to switch to another PCT if dissatisfied, but ownership and control of the PCT would lie with the doctors who work in it.

Treatment Vouchers and Top-up Insurance

A voucher scheme could enable people to spend more of their own cash on health care, in return for much greater choice.[4]

Funding the Voucher
According to the 'NHS passport' scheme, all individuals would have a health voucher which would entitle them to a universal and free basket of 'core' services which would be funded by general taxation, as today.

If patients wished to use current NHS Trust facilities to receive 'core' services, their treatment would be free. Those patients wishing to use other, private sector, facilities for 'core' services, to obtain higher quality treatment or greater comfort, would be given a 'credit note' (i.e. a voucher) to the value of their NHS treatment and would pay the marginal cost or 'top up' charge – between the national Health Resource Group (HRG) price and the actual price charged by the alter-native provider. The government would set the price it will pay – the value of the voucher – by defining the cost of each of the core service procedures, using existing Health Resource Groups. For example, a cataract operation may be priced at £2,000. Thus, the portable cataract operation voucher would be worth £2,000.

Patients wishing to be treated for 'non-core' services would be responsible for the whole cost. Competing insurers would offer individuals and groups (perhaps based on employers, unions, or churches) a range of top-up policies that would include coverage for many such 'non-core' services and would cover extra payments required when the voucher fails to meet the full cost of treatment.

Determining the 'Core' in a Voucher System
'Core' services would be strictly defined by the Government, following the recommendations of an independent advisory medical committee, and would concentrate on serious and long term illness and care for certain specified groups (such as the elderly, disabled, babies, children, pregnant women and so forth). Some procedures will remain outside the scope of the core package.

Ruth Lea argues that maximising economic 'health gain' should be central to what should or should not be in the core services. Those treatments that are unsatisfactory on economic grounds should be excluded. Recommendations on priorities for health care should be made by a politically independent committee of experts (clinicians, epidemiologists, statisticians and economists), on a sound medical and economic basis.

Provision of Health Services
Supply-side reform would have to go hand in hand with the introduction of vouchers that allow money clearly to follow patients. An important element of this scheme would be the break-up of the existing monopoly of provision, and the likely outcome would be a mixed-economy provider market. The subsequent encouragement of provider competition would enable the system to become sensitive and responsive to patients' preferences. All providers would be obliged to provide a high standard of care.

Advantages and Disadvantages
Proponents of voucher schemes emphasise two advantages. First, there would be improved choice of provider. And second, there would be an increase in private expenditure. Critics rightly point out that any such proposed voucher scheme will be to the advantage of the better off members of society who can afford to pay extra. However, its proponents counter that we already have a system in the UK, whereby only the rich, effectively paying twice, can afford full private sector costs of treatment or private insurance. In contrast, a voucher scheme would enable the benefits of choice and competition between public and private sectors, and the stimulating effects of increases in private contributions to overall healthcare expenditure, to trickle down the income scale to a greater number of people.

Patient Pathways
All UK residents would be entitled to the same 'core' services, funded from taxation, and free of charge. Patients would use GP services as they do now; top-up cover would not cover GP services. Likely differences in patient pathways become apparent when we consider the use of more expensive treatment facilities, and those

seeking ‘non-core’ treatment services. Let’s see how a typical married couple (Mr. and Mrs. Brown), with dependent children and elderly parents would be affected.

When they married, Mr. and Mrs. Brown decided to purchase top-up insurance, in order to obtain faster treatment. They pay slightly less per person than unmarried individuals, the average being roughly £80 rather than £100 per couple per month. Insurers also offer significant reductions for households with children, so for example the Browns, with two young children, pay around £110 per month (£80 per couple and £15 per child) for a typical non-profit community rated top-up policy. This policy entitles all family members to seek diagnosis and treatment for a wide variety of ‘core’ conditions in private hospitals and clinics, without paying extra fees above the voucher. However, the insurance policy requires the Browns to seek prior permission from the insurer before agreeing to pay top-up fees and that they pay excess fees up front and subsequently seek reimbursement from the insurer. With two children, significant sums of money can be outstanding at times.

Mr. Brown fractured his fifth metatarsal. Because of the pain involved and potential for long-term serious damage, fracture treatment is classified as a ‘core’ service. Following preliminary diagnosis, Mr. Brown decided where to be treated by consulting the lists of local providers published by the local strategic health authority and his insurer. These lists include details of services available, treatment prices, waiting times, and a number of other performance indicators. If Mr. Brown had chosen to be treated at one of the newly independent former NHS hospitals, neither he nor his insurer would have paid any top-up fees.

As the price of NHS treatment was £1,000, he was entitled to a treatment voucher worth £1,000. Treatment at one of the local non-profit private hospitals cost £1,500. However, this extra £500 entitled him to guaranteed appointment times of his choice, greater privacy, the use of more advanced technology (a removable aircast rather than a fiberglass cast), and intensive physiotherapy, all leading to a faster cure. The insurance company covered the whole of the £500 extra as Mr. Brown had chosen a policy with no excess for expensive hospital treatment – he simply asked the provider to send the bill for treatment directly to the insurer. Mrs. Brown’s widowed mother Mrs. Bishop, aged 65, relies on the state pension and has no other income. She expects to require medical care regularly but cannot afford top-up cover. However, her daughter buys her a comprehensive top-up insurance policy, costing £70 per month. After suffering from arthritis for years, Mrs. Bishop has been told by her specialist that she requires a hip replacement (a ‘core’ service).
Let us imagine that the price of an NHS hip replacement with rehabilitation costs is £3,000. If Mrs. Bishop chose to be treated at one of the newly independent former NHS hospitals, neither she nor her insurer would have to pay any top-up fees. However, having compared the performance of local providers through her insurer, it is likely that the much shorter waiting list, greater privacy, and the use of slightly more advanced technology at one local non-profit hospital would attract Mrs. Bishop, despite the fact that the operation would cost £4,000, and the voucher available would only be worth £3,000.

The insurance company would not cover the whole of the £1,000 extra, as, in order to obtain lower premiums, Mrs. Bishop chose a policy with an excess of £300 for all hospital treatment. She cannot afford the £300, but her daughter and son-in-law offer to pay. She decides to go ahead with the operation, because paying £300 out of pocket and receiving treatment almost immediately is preferable to waiting 6 months for treatment and paying nothing, or to paying taxes and spending £4,000 of her savings out of pocket and being treated almost immediately.

Social Insurance with Individual Payment

We rule out employer payment. We already have a NI scheme with employers and employees making payroll deductions, and so it would be administratively simple to introduce a strictly earmarked employment-based health insurance premium. However, there is no serious constituency in the UK for employment-based social insurance. The burden on employers, likely effects on employment levels, and the potential for coverage problems when people move between jobs, all conspire to make this option difficult in the UK. Swiss social health insurance is not reliant on employer contributions

and the scheme is considered to be successful and equitable.

How does the Swiss system work? First, the Federal government agrees the standard of care that everyone should receive, following advice from a number of committees. This 'basic' package has been likened to a luxury policy in the US or Germany. It covers the cost of medical treatment in the canton of residency, and includes inpatient and outpatient services, care for the elderly and physically and mentally handicapped, and unlimited stays in nursing homes and hospitals. Non-profit insurers price the same basic package and offer their products to the public. Prices vary and individuals can opt for different levels of cost-sharing, within statutory limits. Insurers must register with and are monitored by the Federal Social Insurance Office. They are obliged to accept all applicants, regardless of medical history. Customers may change insurer twice per year.

An individually contracted social insurance system could be introduced in the UK. Of course, switching everyone over on an appointed day would be complex. The burden on individuals could not be increased abruptly and so income tax (or other taxes) would need to be cut to adjust for the additional costs falling on individuals

In order to ensure that the economic burden does not fall disproportionately on the sick, old and poor, premiums must be community rated. Moreover, there should be open enrolment and an obligation to accept any customer. The result of such regulation is that certain high-cost individuals become 'bad risks' for insurers. Insurers may then engage in 'risk selection', commonly known as 'cream-skimming'. Therefore, a system of risk adjustment among insurers would also be essential.

In time, premiums may vary considerably, and we would expect insurers to offer a variety of deductibles, co-payment options, and no-claims bonuses, all serving to increase price consciousness. Practical concerns are advanced against moving to Swiss-style insurance; its reliance upon flat rate premiums and out-of pocket payments means that Swiss health insurance would weigh more heavily on the poor. At face value this argument seems plausible; however, it ignores the range of exemptions and transfer payments that may be made to spread the burden of contributions. The Swiss system explicitly aims to guarantee that the economic burden does not fall disproportionately on the sick, old and poor. One-third of the Swiss receive premium subsidies. We would do the same if individual payer insurance were introduced in the UK; one approach might be to cap both premiums and co-payments if they exceed 8% of taxable income.

Patient Pathways

How might such a scheme affect our hypothetical married couple with dependent children and elderly parents? Using current expenditure on the NHS as a guide (£1,000 per individual per year), we assume the cost of an average insurance policy will be £100 per adult per month – that is £1,200 per year. We also assume that the premium subsidy threshold is set at 8% of monthly household income.

The Brown family's annual household income is £35,000. Mr. and Mrs. Brown have separate insurance policies and also must purchase insurance policies for their two children. They are a risk-averse family, who regularly attend a family doctor, and therefore opt for policies with the lowest possible deductible. Their policies cost £100 per month each, while their children's, through the same insurer, cost £30 per month. Thus the monthly total household premium is £260. With a pre-tax monthly income of £2917, they are entitled to a small premium subsidy of £27 per month – a fraction over 10% of the total premium (£2917 x 8% = £233 (their maximum household premium)).

As a retired widower on a pension with no earned income and little in savings, Mr. Brown's father benefits from the minimum income guarantee, which gives him a monthly income of about £425. The premium-subsidy rule is that the government will pay the portion of the health insurance premium above 8% of his monthly pension income. With a pension income of £425 per month, he pays £34 per month (8% of x £425) to the insurer of his choice while the government pays a maximum of £66 per month to the same insurer. As a pensioner, Mr. Brown also feels that he benefits from the fact that health insurance premiums are community-rated and therefore do not rise with age.

Social Insurance with Purchasing Co-ops

Widespread reluctance to pay higher taxes combined with demands for better standards of care, is seen by paternalistic politicians as a sign of voter inconsistency. But it is more reasonable to see it as the inevitable consequence of concealing from taxpayers the amount they pay for the NHS. To move gradually to a system based on more mature democratic principles we propose to create a new choice: people will be able to become 'mutual members' of the NHS or remain as 'ordinary members'. Mutual members would gain more choice and control over their own cover but as part of the bargain they would directly bear the cost of covering the poorer members of society. Middle-income people bear this cost in any event, and a system of purchasing co-ops would make it more visible. This new transparency will overcome the chief conundrum faced by supporters of tax finance, that most people are reluctant to pay more in taxes because they cannot tell what they get in return. Without being able to tell whether they are getting good value for money, it is hardly surprising.

The system of healthcare purchasing co-operatives would let people choose to take personal responsibility for their healthcare costs in return for a tax credit representing part of the tax they have paid for the NHS. They would then be free to purchase insurance to cover the cost of their own care. This would relieve pressure on the NHS and, by creating a more predictable flow of income, give providers a better basis for increasing capacity.

40 Years Experience: The idea is based on a scheme which has been in operation for about 40 years, the Federal Employees Health Benefits Plan, the scheme provided by the US Government for its own employees. Every autumn all staff choose their insurer for the next 12 months. They can choose any insurer on an approved list, which has the advantage of weeding out the worst insurers and ensuring that good quality information is made available to allow individuals to make the best choice.

The US Federal Government pays about 70% of the cost of an agreed insurance plan. Individuals pay the difference between the government contribution and the cost of their chosen plan.

Would it work in England?: Here is one way it could be done. In each of the 28 strategic health authorities a separate health purchasing co-operative could be established.

To begin with, not everyone will want to change their current arrangements, and so there would be much to gain from allowing individuals to contract-in, that is, to become 'mutual members' of the new NHS system one at a time.

The purchasing co-op would make available to its members a range of insurance policies offered by competing private insurers. It would aid consumer choice by checking the insurers out and giving independent advice about them – for instance, pointing out which ones have a lot of small-print exclusions. Most important, it would ask all insurers to price the same package of services, so that consumers could easily compare like with like.

The Government could define the cover to be provided by the standard insurance plan, but a better alternative would be to allow the price of a standard plan to emerge as a result of consumer choice and to pay a percentage of it.

The decision to contract-in to the co-op would be a decision to take personal responsibility for purchasing insurance for all health care needs. Taxes will be paid as at present and the government will need to make a payment to the co-op representing part of the tax paid. 'Mutual members' of the NHS would then be able to choose their insurer and pay any additional cost out of pocket, not direct to the insurer but to the co-op which would make a collective payment to each insurer. This would both reduce administrative costs and increase the bargaining power of individuals.

People in Work: Let us assume that the market price of an insurance policy will be higher than the cost of the NHS. At present the average cost per annum is about £1,000 per individual. In our scheme there is a price per adult, with a separate price per child up to 18 (or up to 25, if in full-time education). As in Switzerland, the price of insuring a child is 26% of the adult price.

We assume that the insurance policy for an individual will cost about 25% above the average cost of the NHS, producing a figure of £1,250 and a cost per child of £325. It would be

advisable to cap the premium, so that the price is the same for two or more children.

People on Benefits: The main danger is that such a system could operate disproportionately to the advantage of the most well off in society. However, this risk could be avoided by guaranteeing a right to contract out to everyone on equal terms, regardless of income. What would happen to people receiving welfare benefits who would be unable to pay the additional premium? The simplest solution would be for taxpayers to make up the difference. This would mean that everyone would be covered, whether they had just lost their job or were in well-paid work, and whether they were fully fit or frail and elderly.

However, the Treasury would not want any additional costs to fall on the public sector. How could budget limits be met? One approach would be to reduce the percentage rebate paid to self-supporting members of the co-op so that the total cost to the Treasury did not increase. How many people are likely to contract-in to the co-op without being able to pay the additional premium? Let's assume a high take-up rate and that about 10 million people on benefits contract-in to the co-op. If they do not join the co-op they will cost the Treasury on average £1,000 each. If an individual policy costs £1,250 then there is an extra £250 to be found. This sum could be deducted from the Treasury budget allocation for other co-op members who contract-in and pay the personal contribution out of pocket.

For example, if ten million self-sufficient individuals in paid employment contracted-in and bought insurance for £1,250 each, the Treasury would refund £1,000 per person, a total cost of £10 billion. If ten million others on benefits contracted-in, the Treasury would have to find the difference of £250 each, a total of £2.5 billion. This amount could be deducted from the budget allocation (£10 billion) for the self-paying group, leaving a balance of £7.5 billion.

This would produce a percentage tax credit of about 60% of the insurance premium (£1,250) or 75% of the average cost of the NHS per person. Thus, an individual in paid work and living alone would receive a tax credit of £750, and a couple with two children would receive a tax credit of £1,890 (60% of £3,150).

Low income: In practice, there are varying degrees of self sufficiency and any cash transfer from the Treasury to the co-op would need to be paid on a sliding scale, according to income, with an upper limit – perhaps based on a formula applied in parts of Switzerland, namely that no one should have to spend more than 8% of taxable income on health insurance.

Conclusions: It is of fundamental importance that the majority of people should pay the market price for health insurance, to provide a measure of what can be afforded for the poor and to permit demand and supply to come into balance.

In the long term, we expect that everyone will want to join the co-operative system. Therefore it is likely that the NHS as we understand it today will cease to exist. But such a result would come about because of consumer pressure rather than a political decision.

The overall advantages of the scheme are:

1. People content with the current system need to take no action.
2. Equity would be satisfied, not by reducing everyone to the status of a claimant, but by empowering every person to be a private patient.
3. Individuals would buy insurance in groups to increase their bargaining power.
4. The purchasing co-op would be able to supply useful information to enable members to choose the best providers and thus encourage standards to be raised.
5. Heightened competition among insurers would encourage them to seek good value for money from providers (perhaps by integrating provision and finance).

Patient Pathways

How might a healthcare purchasing co-operative system affect our hypothetical married couple with dependent children and elderly parents? We assume that the average premium for the standard package is £1,250 per adult and £325 per child per year.

Mr. and Mrs. Brown decided to contract into the co-op system and take personal responsibility for purchasing insurance for all their family's health care needs. Every autumn they must choose their health insurance policy for the following year. The local healthcare purchasing co-op sends a

document to every household in September. This document details the range of insurance policies offered by competing private insurers that meet the co-op's standards.

The Brown family's annual household income is £35,000 (£2,916 per month). They pay taxes on this amount just as they did before the new health insurance system was introduced. With two children, the household health insurance costs £3,150. They receive a tax credit of about 60% of the insurance premium (£1,250) or 75% of the average cost of the NHS per person; their tax credit would amount to £1,890, which the government transfers to the co-op. That leaves an extra £1,260 per year (£105 per month) to pay out of pocket, not direct to the insurer but to the co-op, which in turn makes a payment to the insurer. The Browns know that by paying this £1,260 they will both empower themselves and subsidise those on low incomes. If their income fell below £15,750 and a rule limiting their contribution to 8% of their income applied, they would receive a subsidy; if it fell to £12,000 a year, they would have to pay only £960 and if it fell to £10,000, only £800.

Mrs. Brown's mother, Mrs. Bishop, a retired widow on a pension and with no earned income, chooses her health insurance policy for the following year every autumn. Just like her daughter, Mrs. Bishop often uses the co-op's telephone helpline to gain independent advice. As a single person on benefits, the government pays the co-op the full cost of £1,250. Mrs. Bishop has the same opportunity to choose an insurer or a provider as her daughter's wealthier and totally self-sufficient family.

The Supply Side: Public Service Not Public Sector

Options for Hospitals

We do not think the government should be involved in the provision of acute care, and so the first step should be to allow the transfer of hospitals to not-for-profit community trusts. Community trusts should be entirely independent of the government and free to serve consumers as they believe best. They should be obliged to preserve their non-commercial status, although there should be no restrictions on the freedom of new hospitals to emerge as commercial enterprises.

Locks on asset distribution and on asset use.

When NHS Trusts become community trusts, it is desirable that those assets cannot be transferred to private persons or profit making companies and thus permanently lost to the public good. To this we may need to have a lock on public asset distribution. Locks on *asset use* would be an even more stringent controlling factor; it is important to draw the distinction between privatising the asset and privatising the service. So long as we protect consumers by guaranteeing an adequate supply of readily accessible diagnostic and healthcare treatment services to all, the ownership of a hospital is irrelevant. Providers' use of assets would be subject to scrutiny by the independent regulator.

Do we need a new legal form?

What legal form should community trusts take? We consider that there are four viable solutions that would allow locks on assets and or asset use, and that would not require the creation of a new legal form: the royal charter model; the mutual model; for profit privatisation; and the lease model.

Royal Charter model

Hospitals could be given royal charters, like many voluntary hospitals before nationalisation. Universities have the powers given them by the royal charter and cannot change their constitution without the approval of the Privy Council. Like a charity, the assets cannot be privatised and must permanently be used for the public purpose stipulated in the charter – thereby protecting asset use.

Mutual model (+ asset use lock)

Alternatively there could either be a free transfer or sale of assets to newly founded mutual organisations. Mutuals are not explicitly defined in UK statute; rather, the Industrial and Provident Societies Acts and Companies Act regulate them. Though in theory the assets of an industrial and provident society (I&PS) must be transferred to a body with a similar purpose on dissolution, an I&PS can always convert to a company, be sold and distribute the assets to its members, as happened to the Halifax and Northern Rock to

name but two.[5] To avoid a repetition, a lock on assets would be essential.

For profit privatisation
Companies limited by shares are clearly not appropriate for community trust hospitals, as those organisations (or at least their managers) have a fiduciary duty to private and external shareholders who are the owners of the company and have a right to all profits. It is (at least politically) unthinkable that public hospitals would be converted into companies limited by shares.

Lease model
Though possible in theory to sell NHS Trust assets to private for profit companies, it would be a massive ideological Rubicon to cross. We think it might be better to rent hospitals to private (for-profit and not-for-profit) organisations – perhaps by establishing a government property agency to handle letting. Organisations could buy a 99-year lease, with the government remaining as the asset owner.

We expect that hospitals will be in the main transferred to mutuals, but in some cases the government may allow the transfer of the management of assets to private organisations that will make profits from their public service activities, as occurs in many German public hospitals.

Of course the legal framework for providers is only that – a framework. It does not determine how organisations are run.

Hospital Management

Hospital Board
Management boards play vital role in ensuring that public and non-profit organisations are publicly accountable and perform well.[6]

Board Membership and Appointment
The selection of board members is a potential stumbling block, the main problem being who should decide. The secretary of state for health should not appoint board members; doing so does not guarantee local public accountability. It may be better to have a mutual board whereby a genuine balance of interests (patients, medical staff, local health professionals, local politicians), is represented. But there would be a danger of factional stalemate in such a board.

Operation of the boards
The board must function as a board and must act in the best interest of patients. With many interests represented there is a potential problem of lack of agreement, in which case boards might be rendered very weak.

Autonomy of Financial Management
Ability to access a range of appropriate finance
Financial management freedom or otherwise will be the acid test of community trusts; without 'full financial management powers, the management of the health system operates within a straight jacket.'[7] The Government's current plan is that Foundation Hospital Trusts will be public organisations with freedom to borrow, subject to some constraints by a regulatory body.

Community trusts may also be able to attract more revenue by increasing throughput. A third element of financial management independence is the ability to set work conditions and pay levels. These elements have formed an important part of hospital reforms in Spain, Denmark and Sweden.

Freedom to set employment terms and conditions
Employment terms, conditions and pay should be outside national control. We are against uniformity and do not believe there should be artificial restrictions on the labour market. The spectre of a two-tier health system, with one hospital poaching another's staff is frequently raised; indeed, the same arguments have been rehearsed in Spain and Sweden. While it is not possible to guarantee that some hospitals will not lose valued staff to competitors, the benefits of local pay setting will surely outweigh the disbenefits.

Options for Reform of Accident and Emergency

If all acute care hospitals were de-politicised, what would happen to the accident and emergency services – those services that fall most clearly into the category of public goods? Many people accept that it is a legitimate function of government to ensure that there is an

accident and emergency service throughout the country, but the government does not need to own or run hospitals to do so. Nor does it need to pay for accident and emergency services from taxation – insurance policies can provide cover as they do elsewhere. However, there may be a role for the government in providing investment in the infrastructure in less densely populated areas.

Options for Reform of Primary Care

In most countries GPs work either single-handed or in small groups. In Switzerland, they have also established physician-led health maintenance organisations. They are paid on a fee-for-service basis, by capitation or a combination of the two. They may function solely as generalists or offer additional specialist services. Some offer diagnostic services and minor treatment; others do not. GPs may or may not act as gatekeepers to specialist and hospital services. GPs may be free to set up and practice wherever they wish; alternatively they may be subject to a variety of restrictions. It is very difficult to point to the ideal model and, perhaps, the best policy would be to have no policy at all, so that general practice can evolve as events unfold. But unless patients can inflict economic pain on their doctors, the service will continue to be unresponsive and inferior to continental Europe.

The government has already started to introduce some flexibility into primary services; a GP flexible working contracts scheme 'PMS pilots' is a key element in the modernisation programme of the NHS, improving patient access to the NHS by opening up new, more flexible ways of offering primary care services.

The New GP Contract: further flexibility.
We welcome extra investment in general medical services, and the practice-based nature of the contract, but are wary of the effects of tying extra resources to extra regulation through quality indicators and performance targets.

Ownership and Control
Primary care trusts could be mutualised. Many recommend that Foundation, or community trust status, subject to governance by a board of multiple stakeholders, should also apply to Primary Care Trusts. This would enable PCTs to be more accountable to the local community. Although NHS Trust hospitals tend to have a higher profile in a community, the very nature of primary care, being lower-tech and usually involving longer-term relationships, is in many respects better suited to active and meaningful patient involvement.[8]

Notes

[1] Our two interim reports are also available on the web: *Step by Step Reform,* (http://www.civitas.org.uk/pdf/hpcgMain.pdf); *The Supply Side* (http://www.civitas.org.uk/pdf/hpcgHospitals.pdf)
[2] *Options for Funding* is available on the web: (http://www.civitas.org.uk/pdf/hpcgSystems.pdf)
[3] The research on which this report draws was carried out by Civitas, which acknowledges support given by Reform
[4] This section is largely based on Lea, R., *Health Care in the UK: The Need for Reform.* Institute of Directors, 2000
[5] Mayo, E. and Lea, R., *The Mutual Health Service,* New Economics Foundation, 2002 [pp20-22]
[6] Cornforth, C., *The Governance of Public and Non-Profit Organisations: What do boards do?,* Routledge, 2002.
[7] Mayo and Lea, 2002. [p24]
[8] Mayo and Lea, 2002. [p11]