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CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

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- *All letters must be typed with double spacing and signed by all authors.*
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Financing health care

SIR,—In October 1982 you published a letter in which I expressed gloom about the future of the NHS[1]; unhappily my fears were well founded. Clinical services have had to be reduced and wards have been closed; this makes one wonder whether the government's record of underfunding indicates a plan for partial run down of the hospital services, a considerable expansion of the private sector, and consequently the development of a two tier service.

The alternative strategies for funding the NHS have been elegantly discussed by Professor Rudolf Klein (12 March, p 734), but our present redistributive system of taxation, in which all receive the same quality of service but each pays according to income, does seem to be a proper method for a civilised society.

There has been no lack of ideas for reorganisation,[2,3] some originating from the American experience with health maintenance organisations (HMOs) and nearly all assuming an increase in private practice. The introduction of competition using variations on the HMO idea is unlikely to be acceptable since the Americans have found that HMOs have not been able to provide an adequate choice for the patient and have failed to control costs. In addition the HMO relies for its financial survival on enrolling the young, the healthy, and the employed, and none of the numerous schemes so far put forward have given adequate consideration to the care of the chronic sick (geriatric patients, the young disabled, the mentally handicapped, and the mentally ill). In 1987 the available beds for these patients constituted about half the total beds in England and Wales.[4] The exclusion of the chronic sick from any reorganisation would allow their care to sink back into the Dickensian state from which it has only recently emerged.

An expanded private sector would have many drawbacks, but these are rarely discussed openly. The articulate upper income groups, having chosen private care, would no longer have a stake in the quality of the state service and, with tax exemptions for insurance, would leave the NHS to be funded by increased tax contributions from the less well off. Alternatively the NHS would be funded at a lower level as a second class service. Consultants would have less time available for their NHS commitments to patients and hospital committees and for the training and support of their junior staff; they would have little incentive, and perhaps a disincentive, to improve the standard of care for their NHS patients. By its very nature, private practice demands more medical and nursing time per patient than does the state service. The buying and selling of services between hospitals (the "internal market")[5] has a superficially attractive logic but would do nothing to improve the finances of the less well equipped hospitals; such a scheme could mark the beginning of restrictions on the freedom of the general practitioner to refer his patient to the consultant of his choice, irrespective of administrative boundaries.

I am not saying that there are no good ideas in the present flurry of comment, but much more information is required about what needs to be done, how it should be done, and the possible results. The infinite demand (or "bottomless pit") theory is in vogue, with its corollary of a service limited by inadequate supply, except for the rich. There has been no survey (as far as I know) which has examined the amount of unmet need in a defined area or community. Equally important, we do not know how much of the met and unmet need could be reduced by measures designed to lessen the amount of avoidable illness and disability (in this context, for example, a planned programme for hip replacements could be regarded as a form of preventive medicine). What is needed is not another management upheaval but planned evolution from where we are at present, with experimental schemes in a few areas. Consumer interests should be better represented at management and clinical levels. All groups working in the NHS should combine to put forward constructive and comprehensive suggestions for improvement, rather than indulging in piecemeal approaches and demonstrations in favour of different sectional interests. If there is no united front each section of workers will be bought off with financial bribes or picked off by political manoeuvres. We must preserve the principles on which the NHS was founded before it is downgraded by the epitaphs of the economists or destroyed by the prejudices of the politicians.

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1 Black J. Monetarism and health. *Br Med J* 1982;285:1272-3.
2 Butler E, Pirie M. *The health of nations.* London: Adam Smith Institute, 1988.
3 Goldsmith M, Willetts D. *Managed health care: a new system for a better health service.* London: Centre for Policy Studies, 1988.
4 Chaplin NW, ed. *Hospitals and health services year book 1987.* London: Institute of Health Services Management, 1987: 390-1.
5 Timmins N. NHS region may test internal market plan. *Independent* 1988 Mar 14:2.

Private nursing home care

SIR,—Professor W J MacLennan discusses some of the difficulties of quality assurance in private nursing homes (12 March, p 732).