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23 March 1988

The Rt Hon Mrs Margaret Thatcher MP
The Prime Minister
10 Downing Street
London SW1

Dear Prime Minister

As promised, I enclose a paper suggesting a possible reform programme for the NHS.

The paper is intended solely as a confidential contribution to the internal Whitehall discussions which you are leading. It will not be published either in its original or a revised version without your explicit agreement.

As I mentioned to you, we have been pursuing research on the health sector for some six months; this is not long as these things go but some results and preliminary papers of possible interest are available even though the research is by no means complete. I would be very happy to present the ideas here and some of our results at an informal seminar if that would be helpful.

I have copied the paper to Bryan Griffiths and to Michael Grylls (together with the other associates mentioned in the opening footnote).

Yours sincerely

Patrick Minford

Patrick Minford

Copy No 1

SUMMARY OF PROPOSALS

(1) Health insurance contract to be drawn up and costed (the 'NHS premium') for a basic curative service. Maximum waiting times to be scheduled initially for different services, but expected to drop off sharply as the market works.

(2) NHS costs in National Insurance to be earmarked; one part as the NHS premium, the other as the 'NHS tax' supporting the poor and those not insurable at the normal premium.

(3) Basic contract to be compulsory. Contracting out permitted to wider contract (if so, NHS premium rebated but access to NHS services only at full cost).

(4) Privatisation of supply of medical care; possibly on a regional basis, with each regional company forced to divest one major hospital or district.

(5) Privatisation of insurance, again possibly by region. NHS premiums rebated. Private companies quote directly to consumers.

(6) Income support (approximating to a voucher) implemented by existing Family credit and income support system.

(7) Those not normally insurable to have premiums topped up by government to whatever necessary for basic contract.

(8) Government left in role of regulator (for contents of basic contract, for competitive process and for consumer standards); and provider of income support to poor and of topping-up premiums to those not normally insurable.

(9) Exchequer cost self-financing if no efficiency gains; but these are likely to be considerable because of competition in supply and insurance and free consumer choice.

(10) Waiting times likely to fall dramatically because the gap between the cost of NHS treatment and privately-insured treatment will fall to the true difference
so that more people will opt for enhanced insurance.

(11) Increased resources will flow into health care,for the same reason that the extra cost of enhanced insurance will fall to its true cost.

A POLICY PROGRAMME FOR THE HEALTH SECTOR

by Patrick Minford (University of Liverpool)*

The NHS is in crisis. Yet those who call for more resources for it without reform carry little credibility. In 1947 the NHS boldly attempted to sever the connection between access to health care and the ability to pay. But even some sympathetic academics (eg. Le Grand and Titmuss) have documented its failure in this attempt. Unfortunately it has failed expensively and is prone to chronic problems which cannot be solved simply by more funding.

The problems were inherent in the removal of health care from the market place. If a commodity is offered free at the point of consumption, there will be excess demand; some rationing device must be found. The NHS uses several; some patients are not treated, some join waiting lists or go private, and more urgent cases are treated according to informal and often arbitrary

* This is a personal paper; no responsibility attaches to other individuals or to institutions providing financial or research assistance to me. I would however like to thank my colleague Richard Stevenson for excellent comments and Paul Ashton for diligent research assistance; and last but by no means least Sterling Winthrop PLC, together with George Margetts, Dennis Boyles and Michael Grylls, for funding research in this area and providing most useful advice.

priority schemes. Not only does this cause inefficiency in the allocation of resources, but it is also a cause of constant political embarassment; the government is blamed for waiting lists and for particular failures of treatment, as recently we have seen with children in intensive care and constant claims by doctors of resource inadequacy.

On the supply side, there is monopoly power and politicisation of management, whose main object must be seen as coercing government and taxpayer to provide extra resources. Monitoring of costs by ministers is handicapped by lack of power over management, who will have an interest in denying proper information for control and can engineer a headline-grabbing scandal of closed wards and so on to frighten off too enthusiastic a search for economies.

Economic efficiency and political considerations both point to a greater role for the market, with government intervention reserved to ensure effective protection of the weak, the poor and the unfortunate. This paper argues that this can best be achieved within a privately organised insurance system.

In 1984 ('State expenditure: A study in Waste' - Economic Affairs, 1984), I argued for privatisation of supply, charging for health care supplies, compulsory basic health insurance, and direct cash help for those unable to afford this insurance. Individuals would then choose freely to spend extra private resources either directly on health care supplies or indirectly through more expensive insurance. This solution still I believe offers the best prospect.

The practical questions are how precisely to arrange this eventual solution in detail and what steps are politically viable to achieve it.

Background: the health industry

Health expenditure falls into three main categories. There is spending to maintain or promote good health; this is a wide spectrum covering diet, exercise, constructive leisure activities, preventative medicine, and anything else that forms part of a healthy regime of living. While much ink has been spilt on the government's duty to spend on preventative health measures, beyond obvious things like free inoculations and public information campaigns, there is no case for intervention. Nevertheless, in a reformed NHS public health, hygiene and information on health issues would remain a key area of government activity.

The second category is care for those who are old or disabled or in some other way unable to look after themselves, but who do not require active medical assistance. There is already an important private sector and there is no good reason why the rest should not be privatised subject to safeguards against fraud and exploitation.

The idea of giving vouchers or cash help to those in need is also quite natural here; the gain would be that clients can shop around, and that they will find the most appropriate solution for their needs. Their own families may be in some cases the best source of home and help; the cash or voucher would not discriminate against this.

The last category is the NHS core - curative medicine dispensed by GPs and hospitals, both in the NHS and the private sector. This is the difficult part to reform. In the appendix I list the traps awaiting the unwary reformer. The most dangerous is the morally charged nature of curative medicine; many feel it is wrong that an ill person should be denied treatment because he or she cannot afford it.

There is misunderstanding and confusion about the nature of most sorts of medical care. Some is urgent and unpredictable - such as accident medicine. But much of NHS work is elective. Most therapies are a complex bundle of skilled medical inputs, care and hotel conditions. This allows considerable flexibility and choice. Many people, and not only the rich, may wish to exercise choice over qualities of treatment. This would not mean, as some opponents of reform have argued, variation in *medical* standards, with poorer people getting inferior treatment; rather the non-essential elements in the package including its timing would naturally be tailored to individual choice.

The moral charge does not extend to waiting for certain periods or to being denied non-essential treatment, such as much cosmetic surgery, or to hotel conditions in hospital. This limitation on the universality principle gives some flexibility, fortunately.

Politically, a major problem is the length of waiting times and waiting lists. As we shall see, the efficient economic solution will dramatically reduce if not totally eliminate this as a problem.

From a purely economic viewpoint, there are three main sets of problems. Efficient insurance and effective consumer choice require good information on claimant patients, on rival medical services, and control on the costs of satisfying insurance claims. Competition, efficient resource allocation and minimising the burden of taxation on incentives point to privatisation and charging. But finally, if direct help is given to those who cannot afford to pay directly or through insurance, it should not worsen the poverty trap.

A reform proposal

What follows describes first the eventual structure being aimed at; later we look at possible phasing.

To satisfy the universality principle as seen by the typical taxpayer, a basic insurance contract should be devised, which provides essential curative medicine. It should define clearly what is expected to be paid for in different contingencies; presumably, from nothing for routine doctor's visits to all of bills for serious operations, but this aspect, the degree of coinsurance, would need to be carefully thought out, especially initially in the transition period. The contract would also specify maximum waiting times in these contingencies; again from long to short depending on the essential urgency of the treatment. In fact, as argued further below, we would expect these waiting times to disappear as the industry organised itself to meet demand efficiently; waiting is essentially a feature of a planned and rationed health care industry. However, writing in maximum times would be a reassuring feature for a transitional period.

This contract should then be priced, on the assumption that it is compulsory for the whole population (some will add to it, as we shall see). Compulsion is necessary to enable a fair actuarial premium to be charged (this requires a large pool of insured persons). It also ensures proper personal cover; health insurance can be compared to having third party motor insurance, in that it is a 'public good' that people should be obliged to purchase.

Payment of this insurance premium should replace one part of National Insurance contributions currently devoted to the NHS; the other part represents the implicit tax being paid to support the poor and those not insurable on normal terms. The precise way in which this support would be given, essentially as now, is dealt with later.

Some will wish to take out bigger policies and will pay accordingly as they do now; only they will be able to contract out of, or convert, their basic policy and so pay only the extra cost of the policy enhancement, whereas at present they pay to some degree twice.

So far the proposal mirrors a number that are circulating. But more radical action is needed to make the new framework work much better than the old. Merely relabelling N.I. and allowing partial contracting-out of the NHS could mean that the NHS would be left with the poor and the less cheaply insured cases so raising the average cost per case in the public sector. There would be improvement of some aspects, notably waiting times, and resources would flow into medicine through the private sector; less total resources would be needed in the NHS because of the lower number of cases.

But there could be difficulties politically in having the NHS seen as a lower class service. Also, the service would still be bureaucratic and politicised, without competition either in the insurance process or the supply of the medical service. These problems are confronted by the move to full private supply and insurance, to which we now turn. Besides competition, this will ensure that no one part of the insured population is concentrated with one company or in one part of the industry.

We now accordingly hand over to the private sector the operation of the basic insurance contracts, as well as the bigger contracts which are already private. A competitive insurance industry would keep costs and premiums down by shopping around the medical sector and by competing on the premiums offered to the public. Premiums would be paid directly to these companies.

The government's role would be limited to that of policing the compulsory insurance and vetting policies for compliance with the compulsory minimum contract; this would include regulating competition between companies to ensure no creaming off merely of good risks from a rival company's market. It could be argued that the state itself should remain as the provider of the basic insurance contract, since regulation would be complex in practice. However, it should be possible to design rules of fair competitive practice for this area, much as is done in other areas raising complex issues; for example, takeovers and insider dealing, Lloyds underwriting, and the investment industry generally.

The precise details of design require careful attention and are not gone into in this paper. Essentially, the basic contract implies not a single normal premium but a lifetime premium structure rising with age, with designated renewal dates corresponding to these age points; companies would compete by offering a complete schedule of premiums for each age group, and would have to accept anyone who applied. Those falling outside normal risk categories must also be covered on the schedules with a relevant price; as discussed later, the government will top up their premiums (just as now it pays for them directly) according to politically agreed criteria of social support. Regulation would in this way ensure that companies competed across the whole population, offering a complete service.

We now turn to the structure of the medical industry itself. This has no need of public intervention, since the insurance contract has done all the necessary work. GP services are already private partnerships, but hospitals would need to be sold off to private organisations (including charities) in combinations that gave no group a monopoly in any region.

It is tempting to think of selling whole regions off as they stand. This would avoid breaking up current administrative units, with all their local expertise and data-bases. The disadvantage would be the lack of competition within regions, which could be serious. Nevertheless, competition could be ensured by divesting each regional group of at least one major hospital (or possibly of one whole centrally placed district); the divested units would be sold separately to one or two major private firms operating across the country, no doubt already in the business of private sector medicine.

It is hard to predict what final structure would emerge from this sell-off. But probably, as in the US, links would be formed between GP practices, hospitals and insurance companies to minimise administrative and monitoring costs. These links need not be ownership however, they could be merely contractual. Probably, too, Health Maintenance Organisations would grow as in the US, offering as they do to the consumer the advantage of paying his or her GP a fee for health maintenance and not for treatment. In any case, subject to the control of regional monopoly, this restructuring is best left to the private sector to work out through market forces.

The break-up of the industry should ensure that firms negotiate with their own doctors, nurses and ancillaries as in a competitive labour market. Attempts might be made by some unions to exert monopoly labour power. But the existing and new labour laws should be sufficient to break any such attempts; there is an international market in doctors, ancillaries are easily recruited from the unemployed, and there is a large potential supply of trainee nurses among non-working women. Below, I argue for the opening up of the medical schools to competition, to ensure free entry into the medical profession; ultimately the only way to break its monopoly power. Firms will also have strong incentives in the competitive environment to resist labour power, as the alternative is to go out of business.

Very likely however the new arrangements would benefit workers in the industry without any monopoly exertions, as the health care business will undoubtedly expand rapidly once privatised. This is, contrary to what is often implied, clearly a good thing provided the labour market is not protected from competition by union laws or restricted entry. The health

industry is a potentially dynamic part of the economy (as in the USA) and it is not allowed currently to realise this potential for jobs and wealth.

Income Support and the Exchequer implications

The last element in this reform is the system of support for the poor upon whom the extra costs of the compulsory insurance contract would fall as an extra burden compared with their current NHS-related National Insurance payments (including those made on their behalf by their employers); also they would now have to pay for those elements of health care not paid for by the insurance contract- for example doctor's visits and medicines up to some modest level.

In my 1984 article, I argued that amounts should be added to supplementary benefit and to family credits to offset these extra payments; the extra costs in respect of children should be added to child benefit. This is still I believe the only practicable way. In that article I showed that it would not seriously worsen the poverty trap; the extra child benefit element involves no worsening at all, while the adult element does cause a modest worsening offset there by large rises in tax thresholds. Even this worsening can be avoided if the extra family credit and supplementary benefit payments and N.I.rebates are structured carefully to approximate to a voucher system; this involves subjecting the extra NHS-related supplement to the poor to withdrawal only when they qualify for the full NHS N.I. rebate - see illustration in figure 1.

However, the reforms should yield a significant fiscal surplus which can be distributed in tax cuts or rising tax thresholds to achieve a positive improvement in incentives generally.

While it is not possible to be precise about the arithmetic because there has not yet been a serious attempt to price the basic insurance contract or to assess the privatisation revenue, one can make up a schedule of public finance gains and losses as follows:

Gains: Recurrent saving of NHS budget

Privatisation sale revenues implying a recurrent saving of debt interest resulting from liquidating government stocks.

Losses: Reduction of National Insurance contributions by an amount equal to the cost of the basic insurance contract for the whole population (rebate of the NHS premium).

Cost of income support for poor (defined as those currently receiving supplementary benefit and family credit) = difference between cost of basic insurance contract and the reduction in their N.I. contributions.

Funding of those not covered by new basic insurance contract - because already ill or too old to be normally insurable - can be thought of as paying an extra premium on top of the basic premium cost above. Much of this is transitional so the recurrent cost is mainly the extra interest on the public debt needed to fund these transitional costs, plus an amount for ongoing topping-up. This ongoing element will cover those who even when insured privately from birth begin with or develop above-normal risks; at each renewal date the state will top up premiums for those who move out of the

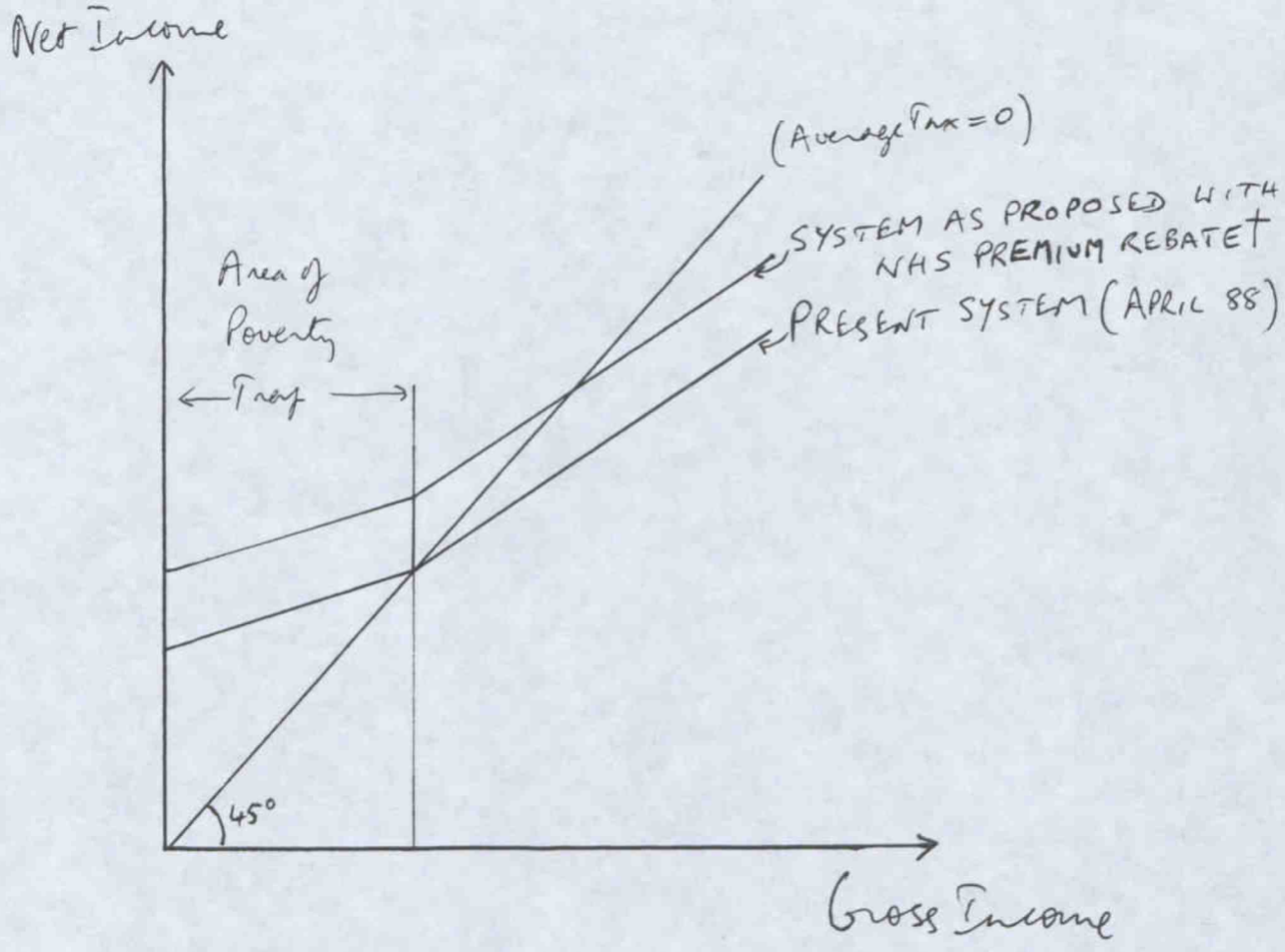


Figure 1 : Income Support for Health Illustrated

† Equivalent to Health Voucher.

normal risk category, with topping-up being regulated by agreed criteria (much along the lines of current sickness and disability benefits). Thus the proposal comprehensively covers the population as now.

This whole operation can be thought of as basically self-financing if the new set-up makes *no* efficiency gains; this is because one is simply then re-arranging things - giving people back the money they are currently paying so that they can pay for the same service privately, ensuring that the poor still get the service they are now getting at the same cost, and transferring operations and assets to the private sector who will presumably set the price of the insurance contract so as to cover recurrent costs plus the cost of servicing the capital costs of buying the assets (the privatisation revenue). The only element that costs new money is the NI rebate to those already with private insurance, in so far as this insurance duplicates what is offered in the NHS; however, this element of duplication is likely to be quite small as existing private insurance tends to provide a supplementary service for the most part, leaving the acute and the expensive treatments to the NHS.

Furthermore, the whole point is to change the system of incentives so as to achieve greater efficiency. By introducing competition in supply and insurance, by allowing consumer choice,and not least by depoliticising management (so that it can take decisions free from media pressure on politicians to intervene), the efficiency gains may well be rather large. This has been the experience so far in the privatisation programme which has covered many varied situations in the public sector. There are certainly good reasons for believing the NHS to be inefficient in supply and its obvious failure to satisfy consumers is unlikely to be entirely due to the fact that it is

free at the point of delivery. There are obvious parallels on the supply side with the large (de-) nationalised industries like British Airways, British Steel, and Austin Rover. On the demand side, the less close parallels are with education and local authority services (increasingly being charged for especially with the community charge coming up). The essence of the market case is that we do not really know until the market has done its work in a way that no central planner can second-guess.

In short, there is likely to be a significant fiscal surplus, available to raise tax thresholds and improve the poverty trap, or increase incentives generally through tax cuts.

How to get there

The ideas set out above have been designed for maximum flexibility in the phasing and details of implementation. In intellectual structure it is a privatisation-cum-insurance-voucher scheme. By using the N.I. and income support system, however, greater flexibility is possible than with explicit vouchers (though these can still be used if politically their simplicity and explicitness seems desirable). With such a sensitive area, a step-by-step approach seems inevitable.

From the public finance viewpoint, the privatisation revenue and the phasing of N.I. rebates both create a transitional source of financing to meet the largely transitional costs of those who will not be normally insurable.

Privatisation of hospitals can occur independently of the switch to private in place of state insurance. Privatisation could take place by region, starting perhaps with the prosperous Southern regions with large Conservative majorities.

Preparation for privatisation could begin at once with 'internal markets' whereby hospitals within the NHS become profit-centres competing with one another for the custom of Regional Health Authorities and RHAs can spend their resources in hospitals outside their region. Restrictions on competition between GPs should be lifted.

Preparation would include proper accounting procedures in hospitals so that costs can be allocated across activities and patients. All patients should be charged for on a shadow basis, making it possible then to charge other RHAs on a real basis.

Turning next to insurance, the estimated total costs of the NHS should be charged explicitly against the N.I.fund. A part of N.I. contributions should be earmarked as an NHS charge. Conceptually, this charge is to be thought of in two parts, the NHS premium and the NHS tax, and it would be helpful to make this clear so that people should not expect eventual rebates of the whole amount.

It would then be possible to proceed region by region. An RHA which had prepared full accounts and costings would be in a position to make actuarial calculations of insurance premiums for normal and high risk categories of patient in its region. It would invite quotations from competing private

insurance companies for its entire population in the first instance. It would then hand over its population to the successful company. People in that region would then be rebated their earmarked NHS premium; for those in high risk categories the government would also credit them with the extra premium over normal. Those in the region on Family credit and supplementary benefit would be topped up as discussed earlier.

One could imagine this as a regional second stage after the region had successfully privatised its supply side. The RHA would then be left as private hospital-service company, with whatever commercial links it desired to GP partnerships.

The ultimate scheme leaves no room for tax relief, because there does not seem to be a case for subsidising health-care expenditure relative to other goods and services. Indeed if anything the opposite is the case; we want people to remain healthy, so they should spend their money on prevention including healthy living, and the curing process should reflect its true expense to discourage careless illness.

Nor does tax relief play a transitional role, for the same reason. It might seem attractive to give tax relief to private medical care in order to encourage people to increase their insurance and relieve the NHS of caring for them. But this would not in practice relieve the NHS of its core caring role for such people; the private sector is basically unable to cope in acute operative surgery or expensive treatments. Private insurance as it now is provides fast service for elective treatments, relying on the NHS for the rest. It is an add-on symbiotic service. People already are taking out this service

precisely to speed up such operations for which there are long NHS waiting times.

Giving tax relief would reduce waiting times for such operations. But it is a blunt instrument, not designed to mirror accurately the relative cost of private versus NHS care. It could develop into an unnecessarily large charge on the Exchequer, and would prove politically difficult ever to remove, besides the basic economic inefficiency of subsidising curative as against preventative medicine.

An alternative proposal is to allow contracting-out of the NHS premium in return for joining a full private scheme. This is quite different, because the assumption is that the private scheme would offer a *complete* service outside the NHS; the contracted-out insuree would forfeit entirely rights to NHS treatment, except at full cost. Since in our scheme here it is envisaged that the basic insurance contract would be competitively priced, the person who pays privately will get no advantage. There is no objection to allowing this sort of contracting-out early on. The contract will not undermine the capacity of an RHA to offer a large viable population to insurers, since they will already have people who have contracted-out on their policies, and can put them into the insurable pool.

Transitional movement towards the final structure can therefore be envisaged on a variety of fronts. As the ideas and experience spread, the pace of change is likely to speed up naturally. The programme enables constructive action to be taken now without political storms and yet goes in an appropriate long term direction.

Political issues and government's role

Once this system is in place, government will have two main residual roles. It will regulate the content of the basic insurance contract (not its price which will be determined by competition) and will wish to ensure that information from medical research flows freely and effectively through the population. Other information - about the effectiveness of individual doctors and hospitals, for example - is best left to the market, though in its existing role of regulator of consumer standards generally it will obviously take an interest in professional incompetence and fraud.

The role of medical education will need to be considered in the context of university reforms. It would make sense for the medical schools to be privatised and to charge fees, with the government acting solely as a provider of scholarships to worthy students. These schools would negotiate contracts with private hospitals to collaborate much as now occurs in the NHS. By introducing competition in the schools the restriction of entry into the medical profession, giving it its monopoly power, would be frustrated.

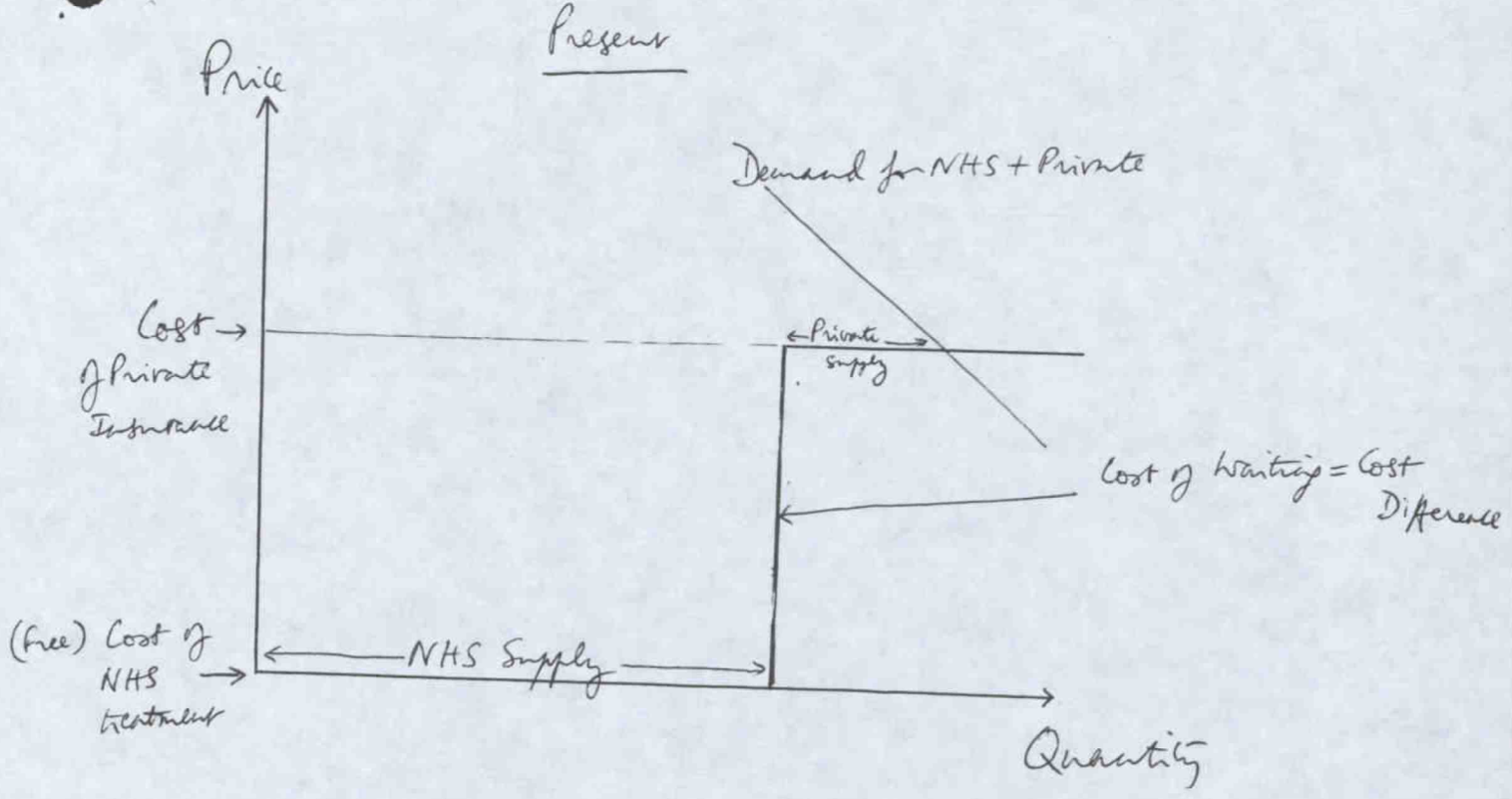
The basic insurance contract was to specify all aspects of medical services to be made available and the refund structure for them. One aspect of great political significance is waiting times. Maximum waiting times are to be specified in this contract for different categories of illness. The NHS currently operates a policy of urgency ratings to regulate waiting times; however practices vary widely around the regions and even within them. These disparities cause political embarassment; indeed there is the suspicion

that waiting times are manipulated to cause such embarassment in order to get resources.

The private sector gets its business currently from treatments that are not too expensive where patients would rather pay than wait the specified NHS period. Thus for such treatments NHS waiting time is determined by the marginal cost to patients of waiting relative to the cost of the private operation. For example if a treatment costs £500 and the cost of waiting an extra week is £100 then the average waiting time will be 5 weeks.

However, under the proposed new system people will opt for extra insurance on a much larger scale because its extra cost will reflect only the extra resources needed to give a faster or better service. In the previous example, it might cost only £100 more to have the operation in 1 week rather than 5; then the extra insurance will reflect that, so that waiting time will drop to 1 week. Another way of putting this is that if you go private now you pay up to twice whereas in the new system you will not pay the basic premium if you opt out of the basic contract. In other words, the cost of waiting will now fall to equality with the true cost of *reducing* waiting, with a gain in consumer welfare and a probably sharp reduction in waiting time. Figure 2 illustrates.

It is likely that waiting lists as we now know them will be entirely eliminated. They are virtually unknown in the USA for example. The extra cost of providing a service essentially on demand subject to normal operational delays is probably quite small and waiting time would



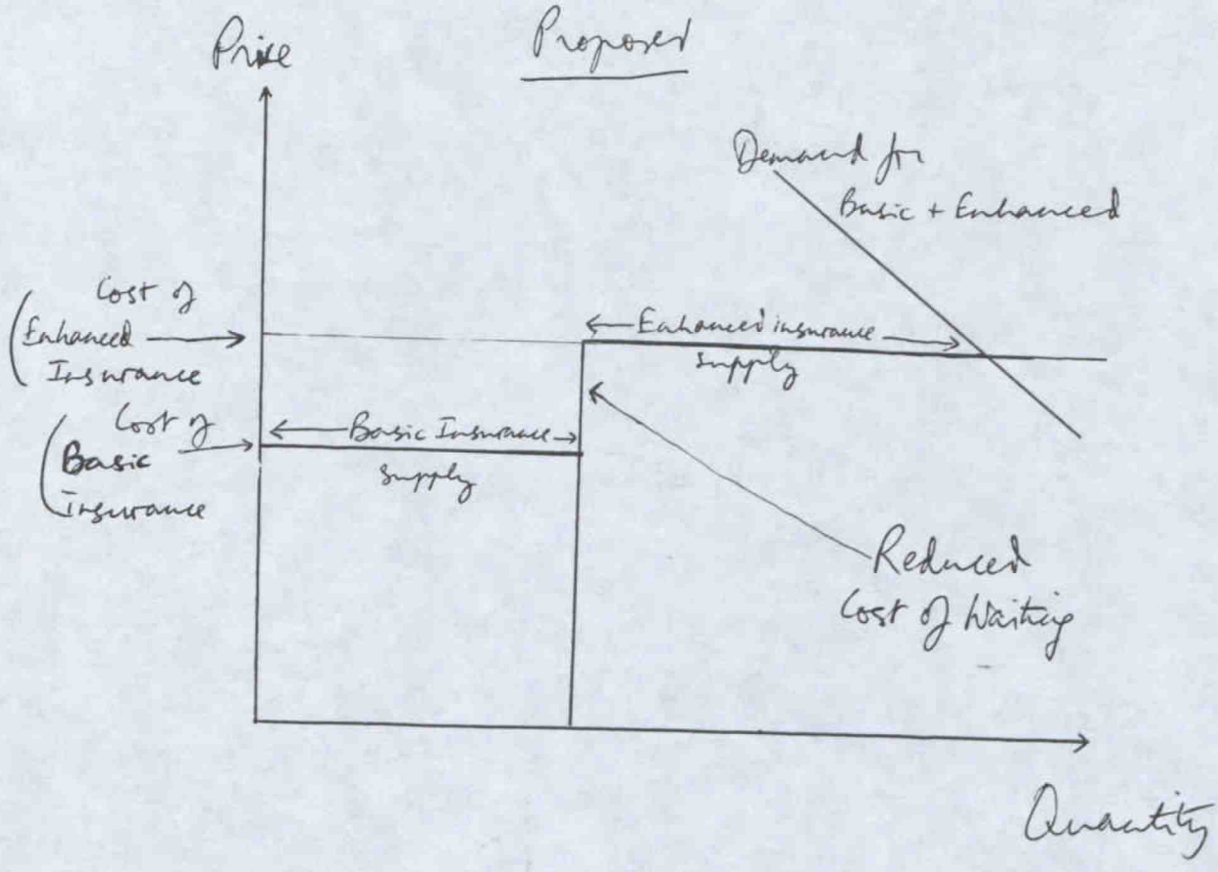


Figure 2: The Demand for Enhanced Insurance under current and proposed systems

correspondingly be small too; the NHS operates with large queues not because it saves much money but because it is a necessary rationing device.

In setting the terms of the basic contract, waiting times will initially however be set as a reassuring safeguard to reflect the average voter's trade-off between waiting for specified treatments and the cost to be paid, in the form of the minimum insurance fee plus the NHS support tax. Presumably, it will come out much like the average in the NHS today; non-urgent treatment will also be largely covered by more expensive policies that buy speed, leaving the basic policy to provide such treatment to those who prefer to wait. The gain politically is that the maximum waiting times would be known and contracted for, so that any delinquent hospital would be actionable. Furthermore, politicians would no longer be involved in policing such delinquency; they would merely reflect popular feelings about the basic contract, pointing out the cost to those who want it expanded. Finally, the average voter would - as shown above - take out more enhanced insurance than now, have a much lower waiting time, and be more satisfied.

Thus a private system might not entirely abolish waiting time but it would efficiently price and regulate it. Average waiting times would fall sharply as a result of efficient pricing; while all including the poor would be guaranteed *maximum* waiting times by the explicit terms of the basic contract. Waiting would be depoliticised as an issue.

A major aim of reform is to ensure that resources move into health care in response to people's demands. Again, just as with waiting time, the new system will, by bringing down the extra cost of buying enhanced service to

the true extra cost,increase the demand for enhanced insurance for this purpose too - for example, to pay for more nursing care or better hotel services. The argument is exactly parallel to that above; at present the buyer of these extra services pays up to twice for them, a considerable disincentive. Thus here too we would see a closer correspondence between consumer's demands and health supplies.

APPENDIX

Traps in health reform

The free market arguments for privatisation rest on the monopoly power and resulting inefficiency of public production, the denial of free choice to the consumer with bureaucratic choice inefficiently second-guessing consumer needs and creating queues, and the added burden of inefficiency from having to raise incentive-reducing taxation to pay the cost of publicly provided health services.

Against this line of attack are ranged two main sets of arguments, which are the traps of this appendix.

First, it is argued that health care is a service that morally should be available on an equal basis. Waiting lists, with first-come first-served, not price should be used to ration scarce resources. Political difficulties arise, reflecting these moral attitudes, if waiting times become excessively long for essential treatments.

These attitudes are a powerful fact. Any reform must not confront them or it will risk political destruction. However, the attitudes are subject to qualifications, and it is these qualifications that allow elements of a free market solution as sketched in the paper.

The paper advocates the definition of a basic health care insurance policy, to be afforded by all if necessary with income support. Essential, high cost, and emergency services would be insured differently from low cost and inessential services. Acceptable waiting times will be defined in the light of essentiality and cost. To ensure equality in this essential health protection, the policy is compulsory with the poor therefore covered, paid for but unable to switch the money received into other forms of spending.

By definition any spending voluntarily above this contract will be politically acceptable, since the voters will decide - if necessary they could do so by some form of direct consultation - on just what the basic contract should be; more they would not wish to pay for, but of course would not stop someone paying for on his or her own account.

The second set of arguments relate to the possible inefficiency of the free market in health. It is said information is inadequate for consumers to exercise proper choice; doctors have the information and must be regulated to prevent them abusing their powerful position.

Further, in private health insurance two main problems arise. First people who are a poor risk conceal their true riskiness and to protect themselves against this insurance companies have to charge higher than normal premiums; this discourages the normal risk people so that a vicious cirle develops, of excessive premiums being charged for the worst risks only. This 'adverse selection' problem can be solved by regulation, forcing a wide population to insure so that premiums can be kept down.

Secondly, private insurance companies have trouble controlling the costs of claims, because doctors have an interest in inflating bills via over-prescribing or over-testing for example, and the insured have no interest in limiting them and may have an interest in inflating them in certain ways too. This is 'moral hazard' in health insurance in its particularly dangerous form of 'third party effects'; doctors are difficult for insurance companies to control because of their information advantage.

These arguments have been deployed over the years by health economists eager to preserve the NHS and hostile to free markets. However, they neglect the ability of free markets to come up with market solutions. Doctors are hired by companies to check applicants; if doctors have better information they may well be able to deploy it effectively in this sort of screening, so limiting adverse selection. Consumers do not have professional information about the qualities of different doctors or hospitals but they can consult independent experts who make a living from such comparisons. Reputations for good treatment will become an important market force - just as for airline or drug safety. Third party moral hazard can be contained by insurance companies sending insurees to their own hospitals or by paying only according to their own competitively priced scale of charges.

Competition is a potential force here in both the supply of health care and of insurance. Hospitals that are inadequate will eventually go out of business as will insurance companies that do not ensure minimum cost in satisfying claims. Much has been made of the explosion of health care costs in the USA; but this has come about largely because of the growth of Medicare and Medicaid, both state programmes where cost control by the state insurer has

not been subject to the disciplines of competition. The private sector in the US has come up with a variety of competitive innovations, including the Health Maintenance Organisations designed to protect people against doctors' over-treatment in fee-for-service, and the vertical integration of insurance, doctors and hospitals in particular companies such as Humana. The power of the American Medical Association has been broken not by government but by these private developments. The US health system is no model but it does exhibit interesting and copiable aspects, that a free market here would certainly explore. (The issue of malpractice suits is a US problem which is as potentially important here, NHS or no; its resolution requires the courts to take into account the full social costs of their settlements. Too high awards act as a tax on the whole health care sector, because they induce clinicians to over-test and over-prescribe to protect themselves and of course the cost of malpractice insurance soars as well.)

These problems should by no means be dismissed. But they can be responded to by market means for the most part. Regulation may also have a role to play as a last resort. We have seen in any case that compulsory basic insurance, put in our proposal for other reasons, does take care automatically of any adverse selection for basic care. No doubt too the government will continue to exercise powers of consumer standard inspection in the medical as in other areas. A little regulation to allow markets to work over a bigger area is preferable to a totally controlled and centralised operation like the NHS.

To conclude, there are indeed traps for the unwary health reformer but they can be skirted with a little care.