Summary points

Current UK health reforms could end up with patients paying privately for more of their care

A managed care approach is unlikely to increase NHS efficiency without explicit recognition of cash limits and selective adoption of models for specific diseases

An integrated system of care with a focus on general practice based commissioning would prevent too much emphasis on acute care

To make competition work the national tariff needs to be scrapped

Patient choice should be shifted from secondary care organisations to new community based integrated care organisations which provide or commission all services for their patients

encouraged to exercise choice and consumer power by moving between these integrated care organisations, rather than through their choice of secondary or tertiary care providers.

To prevent superpractices creaming off low risk, low cost patients, the NHS would need to develop a more sophisticated risk adjusted resource allocation formula. This could use the data now routinely collected at practice level by the new quality outcomes framework—for example, smoking status, body mass index, and blood pressure. National bodies will still be required to assess performance and conduct other monitoring, and both national and regional bodies would provide the technical and infrastructure support for assessing needs and setting priorities. Methods and criteria for managing scarcity and improving services could also be developed at this level but adapted locally with community and partnership agencies.[17]

Conclusion

Current government policy and US managed care have many good points. Building on these, our proposed model of integrated care, rooted in genuine practice based commissioning, would make it much easier to control overall NHS costs and manage scarcity without compromising clinical standards or equity. If foundation trusts take over and develop these roles, more emphasis is likely to be placed on acute care and demand would be supply rather than patient and primary care led. Our proposals bring the counterbalance that is needed, while recognising cash limits. They would safeguard the founding principles of the NHS and guarantee its continuation as an asset for the twin goals of economic efficiency and social justice in Britain.

Contributors and sources: CD has written for several years on incentives in health care. DR has several years of experience in academic and NHS public health. The thoughts expressed in this paper stem from recent writings of CD for a recent book entitled *Economics of Health Care Financing: the Visible Hand* and the experiences of DR. The article was jointly written, and CD is the guarantor.

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Corrections and clarifications

The parents' journey: continuing a pregnancy after a diagnosis of Patau's syndrome
An editorial oversight led to the names of two authors being left out of this clinical review by Locock (*BMJ* 2005;331:1186-9, 19 Nov). Jane Crawford and Jon Crawford should have appeared as coauthors under the article title. We apologise to all three authors.

Self management of oral coagulation: randomised trial
A observant rapid respondent spotted that the abstract of this paper by Fitzmaurice and colleagues (*BMJ* 2005;331:1057-9, 5 Nov) should say that intervention patients used a point of care device to measure international normalised ratio every two weeks, rather than twice a week.

Height and mortality from cancer among men: prospective observational study
When preparing an update to this analysis by Davey Smith and colleagues (*BMJ* 1998;317: 1351-2), the authors realised that a computer program miscoding had occurred for cancers related or unrelated to smoking. They had originally reported that greater height was associated with increased risk of cancers unrelated to smoking, but not cancers related to smoking. They have now found that, although the overall association between height and cancer mortality remains, there is no material difference in the strength of the association with cancers related to smoking or those unrelated to smoking. Full details of the reanalysis are available in the report of the updated analysis (Batty GD, Shipley MJ, Langenberg C, Marmot MG, Davey Smith G. Adult height in relation to mortality from 14 cancer sites in men in London (UK): evidence from the original Whitehall study. *Ann Oncol* 2005 Oct 25 [epub ahead of print]).