well provide incentives that act against the interests of some non-remunerative local services. To avoid this danger monitoring should extend beyond clinical outcomes and incorporate more general data on the comprehensiveness of services and access to them.

Conclusion

Self governing hospitals will represent an untried form of organisation operating within an untested market environment. It is impossible to say with any certainty how they or the market will perform. This will become clear only if and when the new style NHS gets under way. Recognition of the uncertainty surrounding these and other proposals led to widespread calls for experiments in the period of debate leading up to the publication of the white paper. But ministers have rejected this option. The white paper is about implementation not experimentation. Fortunately, however, the conditions that the government has specified as a prerequisite for attaining self governing status will mean that the pace of implementation can be only gradual. Indeed, after much initial enthusiasm many hospitals now seem more cautious about applying for self governing status as the pitfalls become more apparent. Present indications suggest that there is unlikely to be a rush of volunteers. All of this should mean that the process of implementation will at least provide the opportunity to learn by doing and to adjust the model of a hospital trust as its strengths and weaknesses become apparent.

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2 Barr N, Glennester H, Le Grand J. *Working for patients? The right approach?* London: London School of Economics, 1989.
3 Robinson R. New health care market. *Br Med J* 1989;**298**:437-9.
4 Pauly M. Efficiency, equity and costs in the US health care system. In: *American health care: what are the lessons for Britain?* London: Institute of Economic Affairs, 1989.
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The white paper and the independent sector: scope for growth and restructuring

William Laing

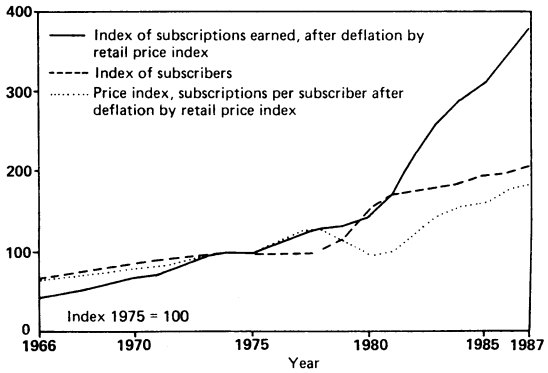
Working for Patients[1] has been enthusiastically received by independent sector interests. The NHS is to remain tax funded and this will be a disappointment to some diehards—though not an unexpected one. But any disappointment on this score is overshadowed by far by the prospect of private health care providers gaining access to what has hitherto been a largely closed NHS market. The white paper for the first time raises the real prospect of a single market for the delivery of publicly funded health care services, with public, charitable, and private suppliers competing on equal terms.

Exactly where the reforms will lead is hard to predict, since what is proposed is not so much a blueprint, like previous appointed day reforms, but rather a new framework for competition with all the uncertainty that entails. I can envisage greatly expanded private supply in some sectors. But equally there are real threats to the independent sector as currently constituted. I shall look at what the white paper might mean for the acute independent sector, firstly, in its traditional market—that is, privately paid or insurance funded services—and, secondly, in the new market that seems to be opening up, the NHS itself. In the absence of any white paper proposals on long stay and community care this important aspect of private sector activity is not covered.

Privately funded short stay health care

Medical insurance has been the engine of independent sector growth since 1948, accounting for 70% of the independent hospital revenue. The white paper proposes tax relief on medical insurance for people over 60. This is the measure that seems to carry least conviction among ministers at the Department of Health. Put in at the insistence of the Prime Minister, it has been dismissed in private as incidental to the main thrust of the NHS reforms. But what will its impact be? My own view is not very much. I base this on analysis of past trends. The figure shows that rates of medical insurance growth are only moderately responsive to price. People over 60 who pay tax, or family members buying insurance for them, will normally find their medical insurance premiums reduced by 25% and coverage can be expected to rise by somewhat less than 25%. Since people over 60 now make up a fairly small proportion of the medically insured population the new tax incentives are unlikely to make a substantial difference to the overall size of the medical insurance market. If, however, tax relief were to be extended to other age groups as well the impact would be that much greater. But as things stand those who dismiss tax relief for elderly people as a minor aspect of the white paper are probably right.

Tax relief will give an immediate if small fillip to medical insurance. But what will happen to the market in the longer term if the government's programme of NHS reform actually works? It would be wrong to characterise the growth of medical insurance cover as simply a manifestation of disillusionment with the NHS. Nevertheless, the most potent reason for taking out medical insurance is to avoid queues for NHS treatment. The state of the NHS waiting list at the time of the next election will be one of the key tests of success and there can be no doubt that the Department of Health will be trying its hardest to get this right. The NHS hospital trusts are going to play a crucial role



Medical insurance trends at constant prices after deflation by the retail price index, British United Provident Association, Private Patients Plan, and Western Provident Association data, 1966-87

London NW5 3ED
William Laing, BSC(ECON), *partner, Laing and Buisson*

Correspondence to:
1 Perren Street, London NW5 3ED.

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here. They will have no incentive to keep large waiting lists, since money will move with the patient. Moreover, as the white paper says, maximum waiting times will be an important feature of contracts. It would be unrealistic to expect waiting lists to vanish, but if they were to come down sharply what effect would that have on public perceptions of the need to take out private cover? It is not impossible that medical insurers might see the attractiveness of their product undermined sufficiently to reverse the rising trend in medical insurance that has been with us since 1948.

Independent sector providers and the NHS

Despite the hype that has surrounded recent NHS contracts for private hospital surgery they still represent an insignificant part of the independent sector market. Taking acute medical and surgical treatment alone, independent hospitals earned only an estimated £18m out of their £542m revenue in 1987 from the NHS.[2]

In the post-review NHS health authorities will be free to buy services from private hospitals. That in itself marks no change. What will be different is that

. . . once the traditional pattern has been breached . . . competition could lead to a major restructuring of private practice.

the whole system will gradually be geared to buying and selling services. Here again the NHS hospital trusts will play a crucial role as catalyst. The fact that health authorities will routinely be buying services from NHS hospital trusts will give them the skills and the information to seek possibly more attractive terms from other suppliers, including private hospitals. Moreover, the proposal for capital charging, whereby health authorities will pay for the cost of the assets they use, will put competition between NHS hospital trusts, other NHS hospitals, and independent hospitals on a more equal footing. As well as health authorities, general practitioner budget holders will be able to contract direct with independent hospitals on behalf of their patients, though since only 9% of the population belongs to those practices of 11 000 or more which will have the option of running their own budgets, this proposal will not in itself lead to a substantial shift to supply by independent hospitals. Taken together, however, the reforms could in time turn the independent sector's present trickle of NHS short stay care contracts into—if not a deluge—at least a respectable stream.

Competition

The down side for independent health care operators is that health authorities and NHS hospital trusts will be encouraged to compete to provide services for paying customers. The process has already been set in motion with the Health and Medicines Act which has given NHS units flexibility to develop and sell services at whatever prices they choose. There are already new NHS pay bed units—for example, in Bloomsbury and Hertfordshire—offering standards of amenity equal to private hospitals, and many more health authorities are attracted to their revenue generating potential. One of the big questions for independent health care operators, and here we are mainly talking about profit oriented organisations rather than the charitable and religious bodies that used to dominate independent health care, is how to face up to the challenge of dynamically managed NHS units.

The independents might pursue one of two strategies, or indeed both at the same time, to head off the threat.

- To engage in straightforward competition with the NHS for the limited number of private patients
- To get into bed with the National Health Service.

As to the first strategy, such competition as has taken place to date has gone almost entirely the way of independent hospitals. In 1982 the overall revenue of NHS pay beds was about level pegging with independent hospitals. But by 1987 it had dropped to about one eighth of independent sector earnings. The question now is whether the new type of NHS pay bed unit, run as a business rather than an underused convenience for local consultants, can halt and reverse this decline. NHS pay bed units will have many advantages, including convenience for consultants. But my guess is that the conflict inherent in running public and private services in parallel will weigh heavily against them. NHS managers and health authority members will remain vulnerable to the charge that private services are receiving resources to the detriment of public services.

NHS managers will also be placed in a difficult position with consultant staff. The white paper proposes fuller job descriptions for consultants than is commonly the case at present to enable district management to monitor whether consultants are fulfilling their contractual obligations. As providers of public services NHS managers will be under increasing pressure to monitor consultants' activity more rigorously and not to be slow in pointing out deficiencies. But as providers of private patient services, dependent on consultants to bring in business, they will have to develop entirely different relationships. Health authorities may find it difficult to cultivate consultants as effectively as independent hospitals and this may be a critical factor limiting their ability to compete effectively against independent hospitals, assuming consultants remain the principal source of private referral (see below).

Collaboration

The other strategy open to independent sector interests is to get into bed with the NHS by convincing health authorities or NHS hospital trusts that their objectives can best be met not by direct competition but by joint ventures of one sort or another, including privately financed or managed pay bed units. In time this might lead to the emergence of a new type of NHS and private management company as a major force in private acute health care and even the transformation of the independent sector as we know it.

There has been a surge of interest in joint ventures and partnership proposals in the past two years relating to a whole range of health care services aside from pay beds. Some collaborative arrangements for ordinary district services have already been set up. These include a novel scheme in Coventry where Bioplan Holdings plc has provided the capital for a new private patient ward, a day surgery unit, and an endoscopy unit at Walsgrave Hospital, to be managed by the health authority, which will in turn sell capacity back to Bioplan for private patients' use. There is hardly a major independent health care group that does not have a dozen or more collaborative ventures at some stage of the pipeline from discussions in principle to heads of agreement. The white paper states the government's determination to encourage these schemes where they are consistent with value for money and proper control of public expenditure, and

clearly the NHS environment will become more supportive as the white paper proposals begin to take effect. The proposed freedom for NHS hospital trusts to borrow from the private sector will create new opportunities for joint ventures while capital charging will further encourage health authorities fully to utilise their land assets. Spare NHS land is frequently the basis for mutually beneficial collaborative schemes.

Restructuring private specialist services

There is another way in which the white paper's proposals might bring a restructuring of private health care. So far, when talking of the independent sector, this has referred to hospitals and clinics only, which earned an estimated £542m in 1987. But an additional £302m went on surgeons', anaesthetistis', and physicians' fees. Whereas private hospital costs are usually comparable with, and often lower than, NHS hospitals, private medical and surgical fees are much higher than equivalent medical and surgical labour costs in the NHS. In part this reflects the bargaining power of the medical profession in their dealings with private insurers and in part it represents a tacit understanding that the NHS can offer fairly low pay rates on the understanding that many of those hospital doctors who become consultants will then be able to benefit from the much higher unit pay for private practice. No one has yet seriously challenged the private fee structure for specialists though there is an increasing awareness that substantial savings could be made for private patients if, say, hospitals were to employ their own specialists to undertake operations on a sessional basis. This would involve a major change in the traditional route of patient referral, which is through consultants who then choose the hospital. And it would clearly meet with strong resistance from privately practising consultants.

The establishment of NHS hospital trusts could well be the catalyst that destabilises the present structure. These trusts will be free to set pay and terms for their consultants—and other staff—as they wish. The first ones to be set up are also likely to include some of the most prestigious hospitals in the country. It is not hard to imagine the sort of arrangement that might emerge, possibly in association with an innovative insurance company seeking a preferred provider relationship, whereby the hospital itself would become the key focus of the referral chain and the full time consultants working for the NHS hospital trust would be compensated sufficiently to exchange that for the traditional pattern of private practice. Once the traditional pattern has been breached it is then not hard to see how the forces of competition could lead to a major restructuring of private practice in Britain.

1 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients*. London: HMSO, 1989. (Cmnd 555.)
2 Laing W. *Laing's review of private healthcare 1988/89*. London: Laing and Buisson, 1988.

Update box for *Oxford Handbook of Clinical Specialties*, p 281

Blood pressure in childhood

Hypertension in children aged 0-18 years. Values are mm Hg*

Age (years)	Significant†		Severe	
	Systolic	Diastolic	Systolic	Diastolic
0 (at birth)‡	≥96		≥106	
≤2	≥112	≥74§	≥118	≥82§
3-5	≥116	≥76§	≥124	≥84§
6-9	≥122	≥78§	≥130	≥86§
10-12	≥126	≥82§	≥134	≥90§
13-15	≥136	≥86‖	≥144	≥92‖
16-18	≥142	≥92‖	≥150	≥98‖

*Three or more readings should be taken (with snugly fitting cuff whose bladder width is ≥75% of upper arm length) before hypertension is diagnosed.
†>95th Centile.
‡Measurement requires use of Doppler devices; it is often possible to record only systolic pressure.
§Fourth Korotkoff sound as fifth sound often not heard in children until adolescence.
‖Fifth Korotkoff sound.

Differential diagnosis of hypertension

Newborn infants: Renal artery stenosis (or thrombosis), congenital renal malformations, coarctation of the aorta, bronchopulmonary dysplasia.
Infants: Renal parenchymal diseases, coarctation of the aorta, renal artery stenosis.
Children aged 6-10: Renal artery stenosis, renal parenchymal diseases, primary hypertension.
Adolescents: Primary hypertension, renal parenchymal diseases.

Clinical assessment Ask about family history (for example, phaeochromocytoma), genitourinary symptoms. Examine for abdominal masses, endocrine diseases, coarctation, and Turner's syndrome (p 758).

Drug treatment Indications: severe hypertension (as defined above), end organ damage. The following is a suggested sequence: move down the sequence (using drugs in combination, as required) if blood pressure remains raised, the previous drug is being taken in a suitable dose, and compliance is assured. Enlist expert advice.

Diuretics—eg, chlorthalidone 0·5-2 mg/kg/day by mouth

β *Adrenergic antagonists*—eg, atenolol 1-2 mg/kg/day by mouth

Vasodilators—eg, hydralazine, 200 µg/kg/6 h by mouth

Angiotensin converting enzyme inhibitors—eg, captopril 0·5 mg/kg/8 h by mouth if >6 months old.[1]

Hypertensive emergencies—eg, in glomerulonephritis, haemolytic uraemic syndrome, or head injury. Sodium nitroprusside 1-8 µg/kg/min intravenous infusion by pump to allow precise control. Monitor blood pressure continuously, increasing the dose slowly to the required amount.
Contraindications: Severe hepatic impairment. Withdraw over more than 10-30 minutes to prevent rebound hypertension. In prolonged use (more than one day) monitor whole blood *and* plasma cyanide concentrations (keep to <38 µmol/l and <3 µmol/l, respectively).
Note: labetalol is an easier to use alternative, but the manufacturers do not (yet) recommend it for use in children.—J M LONGMORE

1 Task Force on Blood Pressure Control in Children. Report of the Second Task Force on Blood Pressure Control in Children. *Pediatrics* 1987;79: 1-5.