Under presumed consent[9] people are assumed to consent to be cadaveric organ donors unless they or their families explicitly refuse (opt out). Phil Berry, a leading advocate for organ donation in the US (and a liver transplant recipient), argues for presumed consent in this issue (p 1445).[10] European studies have shown significantly higher rates of organ donation in Belgium and Austria, which use presumed consent, than in the United Kingdom, Germany, and the Netherlands, where "opt in" systems are used.[11 12] The American Medical Association's council on ethical and judicial affairs believes that presumed consent raises serious ethical concerns unless effective mechanisms are in place for documenting and honouring refusals.[8] Belgium, Portugal, and France are attempting to meet those standards by maintaining national opt out registers; consultation of the database is mandatory before organ removal in Belgium.[13 14]

Doctors are frustrated that current approaches are not working. Both the American and the British medical associations are looking at ways of increasing organ donation, including presumed consent. While the ethics of presumed consent continue to be debated, policymakers can and should move forward with mandated choice, which has the potential to narrow, if not eliminate, the gap between organ supply and demand.

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Markets, politicians, and the NHS

Enthoven's analysis still illuminates the NHS

In 1985 Alain Enthoven, a visiting American professor, published a monograph that introduced the idea of "an internal market model" for the National Health Service,[1] a phrase that was to resonate over the coming years. He has now returned to report on what has happened to the idea, drawing on 120 interviews with people working in the NHS. In the 1999 Rock Carling lecture, commissioned and published last week by the Nuffield Trust,[2] he gives his conclusions. The result is a scholarly analysis of the implementation of the 1991 NHS reforms. On the one hand, it helps to make sense of the past: the reasons why the 1991 reforms disappointed both the hopes of their advocates and the prophecies of their critics. On the other, its arguments and insights feed into the continuing debate about the NHS's future.

One myth, however, first requires exploding. This is the view that the 1991 reforms represented a systematic attempt to translate an "internal market model" into practice. They did not. The phrase itself, as Enthoven notes, did not appear in *Working for Patients,*[3] the government paper that introduced the 1991 reforms. The whole enterprise was, like Enthoven's own 1985 monograph, much more pragmatic and less ideological than the outraged reactions to the reforms suggested. Some of the key innovations—notably the purchaser-provider split and the introduction of general practitioner fundholding—did not feature in Enthoven's model. If Enthoven's ideas were influential it was because they crystallised ways of thinking about healthcare policy rather than because they provided a blueprint: his central theme in 1985 was the need to devise "powerful incentives for NHS personnel to serve patients as efficiently as possible"—a theme which, his 1999 lecture reminds us, remains as important as ever.

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The balance sheet that Enthoven draws for the 1991 reforms of the NHS largely echoes that of the King's Fund review.[4] There appears to have been a marginal rise in the rate of increase in NHS productivity, to set against higher transaction costs. Fundholding tilted the balance of power from secondary to primary care. In some trusts a "culture of ownership, responsibility and enterpreneurship" developed. More instructive are the conclusions Enthoven draws from this limited success story. In effect, he argues, the conditions and incentives required for success were not in place. Information about costs and quality was inadequate. Incentives were often perverse: instead of money following patients, as intended, patients had to follow the money. Above all, the government was not willing to accept the logic of a competitive system—which is to allow failing institutions to close.

What implications can be drawn from this for the future? In 1985 Enthoven emphasised the need to test policies in pilot schemes before introducing them across the board: the failure to do so, he now argues, contributed to the problems of the 1990s. This is not entirely convincing. The conclusions to be drawn from

pilot schemes are not necessarily generalisable; pilot projects themselves get modified during implementation, so it is often not clear precisely what is being evaluated. Above all we tend to have far too short time horizons—as Enthoven himself emphasises. We rarely allow enough time to evaluate pilot, let alone national, policies. Maybe therefore the policy process that was actually followed in the 1990s—a policy of gradual adaptation—was the right one. After all it was this process that allowed Labour to build on Conservative achievements while denouncing them. Consider the widespread move from contracts to longer term agreements that took place in the mid-1990s, so preparing the way for Labour's "abolition" of the market; or the total purchasing pilots, which prepared the way for primary care groups—thereby universalising fundholding while repudiating the concept.

In turn, primary care groups and trusts could—in Enthoven's view—lead to a reinvention of the internal market under a suitably "third way" label. If this happens, however, he thinks it essential to learn the lessons of the past and create the right conditions. There would have to be incentives to primary care groups and trusts to ensure more responsive and patient friendly services. Abandoning his usual sensible reservations about performance indicators, Enthoven suggests rewarding groups and trusts which make the greatest improvements in their patient satisfaction scores. Provider mergers which reinforce local monopolies should be prevented. It might also be necessary to think hard about the appropriate size of primary care groups and trusts: fundholders could be entrepreneurial precisely because their purchasing power was limited and their decisions did not destabilise existing providers.

Enthoven leaves us with two big questions, however. Firstly, is it possible to create and sustain a culture of innovation, efficiency, and good customer service in a public sector monopoly where demand exceeds supply and where individual units do not get more resources for caring for more patients? Secondly, can Labour achieve its objectives of modernising the NHS and making it responsive to the public without introducing consumer choice, competition, and substantially more resources? Enthoven is sceptical on both points. It will be interesting to see whether Labour ministers can prove him wrong: the odds are surely against them.

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Healthy living centres

Deserve evaluation, even though evaluation is complex

The United Kingdom government has set aside £300m from the National Lottery to establish a network of "healthy living centres" around the country.[1] Its aim is to improve health through community action and particularly to reduce inequalities in health in deprived areas. The support for healthy living centres therefore complements other strategies such as health action zones and local health improvement programmes. The initiative involves a considerable commitment of money and energy. How can we tell if this investment is worthwhile? The criteria for assessing applications for lottery funding rightly emphasise the importance of evaluation,[1] but the difficulties should not be underestimated.

Healthy living centres will take various forms and may exist as partnerships and networks rather than as new buildings. They are based on a recognition that determinants of poor health in deprived areas include economic, social, and environmental factors which are outside the influence of conventional health services.[2] Any attempt to address these wider issues requires a coordinated approach from several agencies in the statutory and voluntary sectors. Most importantly, local communities must be involved in all aspects of developing and delivering projects.

The ideas behind this initiative can be traced back to the Peckham Pioneer Health Centre in 1935. This centre was organised by its members and provided services such as antenatal clinics, sports clubs, musical events, and legal advice which crossed traditional boundaries between health, social, and leisure facilities.[3] Several more recent projects have also been based on a holistic approach to health and a commitment to partnership with patients. For example, the Bromley by Bow Centre links health, education, arts, and the environment. Activities include a community education programme, a food cooperative, complementary therapies, and exercise classes.[4] In Bristol, Knowle West Health Park is planned to include a new health centre, family centre, dance studio, community café, jogging track, and community gardens.

Evaluation usually involves assessing progress towards objectives, based on a before and after study or comparison with another model of care. The objectives of healthy living centres are, however, often expressed in nebulous and idealistic terms: "ownership" and "empowerment" are not easily measured. Defining the intervention is problematic as the services included may vary over time. Assessing the impact of models of care on health is always difficult because of the long time lag between intervention and outcome, but the changes in local culture sought by healthy living centres may take generations to achieve. Even when outcomes can be measured (probably related to the process of care and intermediate outcomes such as healthy lifestyle behaviour) it will be difficult to

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