No single system will dominate provision of health care in future, nor can any one model accommodate the huge pressure of technological development and patient demand.[8] Collaboration between public and private healthcare sectors, where it is sensible to do so, would serve the country better than continued isolation.

Competing interests: YD was director of medical policy for PPP Healthcare from June 1996 to March 1998.

1 *Laing's review of private healthcare 1997 and directory of independent hospitals, nursing and residential homes and related services*. London: Laing and Buisson Publications, 1997.
2 Williams BT, Nicholl JP. Patient characteristics and clinical caseload of short stay independent hospitals in England and Wales, 1992-3. *BMJ* 1994;308:1699-701.
3 Bull AR. Purchaser and provider relations in the UK: a perspective from the private sector. *J Management Med* 1996;10:4-11.
4 Department of Health. *Regulating private and voluntary care*. London: DoH, 1999.
5 Murray CJL, Govindaraj R, Musgrove P. National health expenditures: a global analysis. In: Murray CJL. Lopez AD, eds. *Global comparative assessments in the health sector*. Geneva: World Health Organization, 1994:141-55.
6 Maynard A. Evidence based medicine: an incomplete method for information treatment choices. *Lancet* 1997;349:126-8.
7 Normand C. Using social health insurance to meet policy goals. *Soc Sci Med* 1999;48:865-9.
8 Smith R. The NHS: possibilities for the endgame. *BMJ* 1999;318:209-10.

(Accepted 11 May 2000)

Commentary: Cooperation should be based on what the public wants and needs from its healthcare system

Justin Keen

King's Fund, London W1M 0AN
Justin Keen
fellow in health systems
j.keen@kehf.org.uk

Doyle and Bull argue that we need to devise new policies for managing the relation between the public and private healthcare sectors in the United Kingdom. The likelihood of such policies being developed seems to have been increased by the government's commitment to use private health care in certain circumstances.[1] This is not a simple matter as large increases in resources for the NHS might affect the demand for private hospital care, and the impact of one sector on the other will have to be considered.

Doyle and Bull do not set out a framework for thinking about the relation between the NHS and private health care, but they point to three issues that are critical in deciding how to frame policies. Firstly, should we be comfortable with the present arrangements whereby people using private services (and particularly hospital based services) can access them more quickly than NHS patients? The authors suggest that some people should make supplementary contributions but that these people and state funded patients would have similar access to care. Would this be preferable?

Secondly, the authors argue that private hospitals should take on a greater share of elective surgery. This raises many questions, but a central one concerns the supply of doctors and other clinical staff to do the work. The numbers of surgeons in orthopaedics and other specialties are closely controlled, and these surgeons already do substantial volumes of private work. It is difficult to see how more private surgery could be provided without affecting access to NHS elective and emergency services[2,3] unless the number of surgeons is increased. The argument here, therefore, is that both the private and the public systems should be larger. Do we as a society want this?

Thirdly, what are the objectives of a healthcare system? One answer is that health care should be available to all regardless of income or where we live—this is the equity principle that underpins the NHS. Doyle and Bull do not say what they think the objectives should be, but the article implies that one important objective is to promote consumer choice and hence, presumably, a mixed economy. One role of the NHS would therefore be to provide a safety net for people unable to take out insurance.

It is not necessary to agree with the authors about the way that policies should develop. For example, alternative arguments can be used to show that a tax financed NHS is sustainable for the foreseeable future.[4] Doyle and Bull do, however, point to the need for a serious debate about what people in the United Kingdom need from their healthcare system. The government is beginning to combine the NHS and private sectors in its thinking, and the Care Standards Bill is a start.[5] Now we all need to think about these three issues as we move forward in this most difficult of policy arenas.

Competing interests: None declared.

1 Department of Health. *The NHS plan: a plan for investment, a plan for reform*. London: Stationery Office, 2000. (www.nhs.uk/nhsplan)
2 Williams B. Utilisation of Nation Health Service hospitals in England by private patients 1989-95. *Health Trends* 1997;29:21-5.
3 Yates J. *Private eye, heart, and hip*. Edinburgh: Churchill Livingstone, 1995.
4 Hills J. *The future of welfare: a guide to the debate*. York: Joseph Rowntree Foundation, 1997.
5 *Care standards bill*. London: Stationery Office, 1999.

Corrections and clarifications

Decision making, evidence, audit, and education: case study of antibiotic prescribing in general practice
Some data were wrong in this paper by Toby Lipman and Dawn Price (22 April, pp 1114-8). In table 3, under the heading "Organism" the correct number (percentage) for the 7 day treatment for "No growth" should have been 16/43 (37) [not 16/74 (22)] and that for "Trimethoprim sensitive" should have been 25/43 (58) [not 25/74 (34)].

Risk of acquiring Creutzfeldt-Jakob disease from blood transfusions: systematic review of case-control studies
In this paper by Kumanan Wilson and colleagues (1 July, pp 17-9) we inadvertently deleted, just before going to press, a note drawing readers' attention to the fact that further information about the methods is available on the *BMJ*'s website.