PRIME MINISTER 11 August 1987

NHS - THE WAY FORWARD

What the last election showed was that it is possible to increase NHS spending massively and still suffer political unpopularity for poor services and "cuts". Despite the Government's efforts to improve the efficiency of the NHS and the significant increase in resources it received, the voters remained unconvinced that the Government had a genuine commitment to a first class health service.

Given the growing demands on the health service - from new treatments, more sophisticated medical technology and a longer living elderly population - unrestrained by prices charged to the customer, simply adding more money in pursuit of the same policies is unlikely to produce any better public reaction by 1991. As Sir Bryan Thwaites argues in his lecture "The NHS: the End of the Rainbow?":"It is unrealistic to suppose that society as a whole will be willing to subscribe, year on year through its taxes, the additional sums necessary to keep resources in sight of expectations."

We need therefore to find new ways of tackling the key issues. These are:

1 How can we get a better return out of the huge level of resources already invested in the NHS?

2 How can we reconcile rising expectations of health care provision with affordable public funding?

3 How can we improve the Government's political credit for its record in health care?

This paper is a preliminary examination of the NHS in the

light of these questions. It raises the major problems and offers some tentative suggestions as to how they might be tackled politically. It does no more than that -- and we shall return to the thornier and more fundamental points in a later paper.

THE NHS FRAMEWORK

Before considering policy options, however, we should reflect on the basic principles of the NHS. For it is these - not some particular administrative structure - which the public regards as vital and/or threatened by this Government's philosophy.

Yet there has been remarkably little research into public opinion - a gap well worth filling. In the meantime, our assumption is that the key attributes so far as the public are concerned are:

a comprehensive service primarily for accident/illness treatment (rather than preventative or community care);

this to be achieved through both primary and secondary care;

with high quality medical treatment available on need on an equal basis to all - regardless of income.

If we are right, quite far-reaching changes in structure and funding can be considered so long as the electorate can be reassured that those key principles are maintained. But any changes which threaten those principles would be much more difficult to sustain politically.

AN EVOLUTIONARY APPROACH

Some writers on health care argue that the only solution is to shift the NHS onto the US model of a combination of private health insurance and private hospital management groups. They base their argument on:

-- The need to raise increasing resources for the NHS, which are unlikely to be met by the taxpayer, to bring Britain's share of GNP taken by health spending from its present 6 per cent to the 9 per cent more typical of advanced industrial countries.

-- The need to balance supply and demand in health by some form of pricing.

-- And the benefits in efficiency and service from customer-based competition.

There are, however, a number of difficulties with this approach. To begin with, it is not clear that the higher level of health spending elsewhere necessarily provides more health care as opposed to higher cost health provision -- resulting from higher input costs and less severe cost control. Nor that there is a general shortfall of health provision in the UK currently -- except in the sense, described by Bryan Thwaites, that provision is always likely to fall below ever-growing expectations.

Over and above these theoretical objections, we do not consider it to be practical at this stage to consider reforms which would require the wholesale abandonment of traditional NHS principles. Our own proposals here are based on a more gradualist approach that would capture many of the benefits

of markets while leaving open the long-term structure of health funding. We would compare them to our present educational policy.

IMPROVING EFFICIENCY

Getting better value out of the resources committed to the NHS is crucial. Although the Government has maintained pressure for efficiency, the available evidence (mostly anecdotal) suggests there are wide variations in cost within the NHS and less efficient management in the NHS than in comparable private sector hospitals. To tackle this, we recommend:

1 Increase Competition

Whatever management structure or systems are imposed, a non-competitive health care system is unlikely to have the unremitting stimulus required for improved efficiency and lower costs. Once accounting systems can provide information about relative costs, we should look for ways of introducing competition between different public sector hospitals and, ultimately, between public and private sector hospitals.

How can this be done? Well, already patients can be directed by their GPs to hospitals and consultants outside their own district health authority. This doesn't happen often and it is actively discouraged by most DHA's and, still more, by RHA's. Furthermore, information on the performance of particular hospitals and individual consultants, which GPs and patients need to make such choices, is not available (although the DHSS is gathering such information to enable DHAs to improve their performance). Above all, because resources within the NHS are distributed by a central bureaucracy in accordance

with RAWP principles of geographical egalitarianism, there is an obvious limit to the ability of patients to move for treatment to "popular" hospitals and consultants.

There is an obvious next step if an effective, competitive market is to be encouraged. District health authorities can simply be reimbursed for each out of area patient they treat, at an appropriate rate. They would then be free to seek to attract additional patients where they were able to provide the treatment within the standard cost. To preserve control of the total NHS budget, the health authority covering the area where the patient lives - which would otherwise have born the cost directly - would then transfer payment from its budget to the other district. To avoid too large a transitional dislocation, the expansion in any district may need to be limited to - say - 10 per cent increase in any one year. Ultimately, however, popular facilities would be able to expand at the expense of less popular facilities. As in the current education proposals, this would make a practical reality of customer choice - with patients able to shop around to get the best service or shortest waiting time.

Such a system could be "management-driven" as well as "patient-driven." Where the local hospital could not provide the treatment cost effectively - or where a neighbouring district could provide it at much lower cost - there would also be an incentive for the district to either improve their own cost or "buy" treatments from the neighbouring district. Similarly, they could choose to contract out certain operations to private hospitals where these were able to provide a cheaper option - in fact the more enterprising districts already do this. This would be difficult to combine with the current practice of RAWP, but it is fully consistent with its underlying principle. Namely, it would equalise resources available to spend on

the people rather than on the facilities in different districts.

If this also resulted in more NHS patients using private sector facilities, it might over time become politically feasible to consider handing over the management of existing NHS hospitals to private management (although with the patients still funded by the NHS). Ultimately, the NHS could change to being purely a funding organisation, with provision of treatment to NHS patients provided by any number of competing health care providers -- again, on similar lines to our policy on education.

Such a model has considerable attractions. It would provide direct incentives for improved efficiency, allow greater customer (and GP) choice and accommodate a gradual shift towards private sector health management.

From the patient's standpoint, however, a possible barrier is the problem of creating long travel times for relatives and post-operative care if patients are treated at hospitals some distance away from their home. This may be a problem in some cases. But many treatments require a relatively short stay, where this should not be a serious inconvenience. The average length of stay is declining. And where patients have themselves chosen early treatment away from home (as opposed to being sent away by the DHA), they are unlikely to feel any sense of grievance.

Furthermore, there is some evidence that the historic trend to consolidate hospital facilities in a few, large and geographically distant hospitals may have been overdone. Due to managerial inefficiencies, the optimum hospital size may be reached at only 2-300 beds, and we could therefore get more competition by allowing a network of smaller hospitals to develop. In addition, if a large group of patients from one area were treated in a

neighbouring district, it would then be possible to lay on special, low cost coach/minicab transport for both patients and relatives.

Another objection might be that an ultimate separation of the "insurance fund" from health care provision could lead to an escalation of costs, as in the US. However, the US experience reflects the fact that only a few insurance companies conducted their relationship with health care providers in order to control the costs. What we are proposing is a much more active bargaining process, more similar to the new US "HMO" model.

2 Tackle producer power directly

To reduce costs in NHS facilities will ultimately require bringing the producer interests, particularly doctors, under control. Although district managers now have nominal responsibility for cost, in reality almost all the important decisions are under the control of consultants. They decide on medical grounds how long patients should stay and what equipment, supplies, medicines should be supplied. At present, these consultants have very little information about their costs, and no incentives to keep them under control. What incentives there are can often be perverse. For instance, a long waiting list creates a demand for a consultant's services by private patients. And a consultant's lifetime tenure makes it very difficult for district managers to exert much influence where he is unsympathetic to the manager's problems.

To remedy these problems, we need, first, financial information that would provide detailed cost performance by a doctor for specific treatments and allow cost comparisons with the same treatment by other doctors. Next, we must create the right incentives. Even though moves in this direction are likely to provoke a major

campaign by the medical profession, a consultant's lifetime tenure must be replaced by a fixed-term contract linked to performance. It would, however, be difficult to place this contract under the control of non-medical district management. District managers simply do not possess the necessary authority in relation to consultants. Instead, we might consider instituting a mixed medical/administrative review board to which the district manager could make a report. Unlike existing reviews by the medical organisations, which focus purely on medical standards, this would also look at efficiency performance measures.

In these circumstamces, the manager would then have greater influence over doctors in discussing how costs - e.g. treatment, equipment, or number of staff in the operating theatre - might be reduced without medical risk. Management would also have more influence over priorities - providing a balance to the consultant's inclination to pursue medically interesting cases at the expense of mundane priorities (which nonetheless can greatly improve the quality of life enjoyed by ordinary patients) .

We should also consider bringing local GPs under the same management as consultants, with fixed term, renewable contracts. GP performance - particularly in the rate of referrals to hospital consultants and the casualty department - can have a major impact on overall costs and waiting lists. Between 1978 and 1986, the increase in FPC expenditure, unplanned and fortuitous, was nearly double that of the hospital and community services. And GPs' performances can vary alarmingly. Local management needs the mechanism to remove rogue elephants.

Equally, we need to confront the nursing interests which are pushing for ever more qualified and higher paid nursing staff. Nursing is not one job, but several jobs.

Many jobs currently performed by highly-trained nurses could be transferred to less qualified auxiliary staff. We need to re-examine the whole question of task specialisation, to use expensive nurses more effectively and to reduce hospital staffing shortages and costs.

3 Slim the management hierarchy

While we should shy away from any further, disruptive major re-organisation of the NHS, we need to increase the opportunity for local management initiative and enterprise. That means slimming down the bureaucracy at the top and clarifying its role. If the district is to be the front line management unit, regional staff should be only a fraction of those required at district level - with a minimal performance review and policy making group at national level. The current structure seems at first sight to be top heavy at regional and national level, resulting in far too much detailed interference in local decisions - with a consequent loss of speed and sharpness in decision making.

What we now need is to remove the clutter from the current structure - cutting down the size and power of regional boards. To help implement this and to restore authority at district level, we should consider reconstituting Regional Boards to include the Chairman of the District Health Authorities in the region.

4 Extend best practice

Given the wide variation in performance between one district and another, we need to accelerate the transfer of best practice. We propose establishing a small review/audit team - comprising both medical and management representatives - which would examine the performance of

individual districts and present management with a set of recommendations for upgrading performance. Pilot schemes for trying out reforms should also be attempted more often.

Since in many districts the key factor blocking efficiency improvements appear to be the conduct of 'rogue' consultants, such an external review would strengthen management's hand in bringing difficult consultants into line. Reviews of medical performance are at present conducted by the relevant group - consultants are reviewed by consultants, nurses by nurses, etc. It might shine a brighter light in dark corners if the professional bodies were to cooperate in sending joint teams to review into a particular hospital.

In addition we should encourage districts to take advantage of the distilled best practice available through "off the shelf" systems and management packages from US service companies - which have developed to help US hospitals to bring their costs under control. Companies such as Service Master and American Hospital Supplies have shown that they can often dramatically reduce costs when given a subcontract opportunity.

MATCHING EXPECTATIONS AND RESOURCES

We need to consider ways of both bringing new resources into health care, and setting reasonable expectations for what the NHS can deliver.

1 Encourage private funding for non-core activities

While we believe the public regards the NHS as primarily providing treatment in case of sickness or accident, an increasing part of the NHS budget now goes on preventive care and care for the elderly. Both of these are areas

where we could increase private provision to reduce the call on NHS resources.

Preventative health screening might thus be provided through employer schemes - which a number of companies already run. It is clearly in the interests of both companies and their employees to develop such schemes and unions should have no difficulty in accepting - indeed demanding - such benefits for their members. We should review whether more generous tax treatment could encourage their development. At first glance, tax relief for employers' preventive health schemes are less likely to provoke political resistance than other forms of fiscal incentive for private health. And, once widely and successfully operating, such relief could be extended - both to those not in work via individual tax relief and to cover other forms of private health provision.

Residential care for the elderly is also a growing NHS cost. We could encourage private provision for such care by introducing a charging system, offset through the benefit system for those without resources to pay. The measures taken to increase the proportion of pensioners with personal and occupational pensions schemes should raise pensioner income and make it increasingly feasible for many to provide for themselves through savings and pension income if they need residential care.

2 Identifying NHS tax contributions

If health care is regarded as a consumer good, it is perfectly healthy for individuals to wish to spend more on the health service as their incomes rise. Most, however, have relatively little idea how much of their income does currently go on health care support.

At present, the income from national insurance

contributions provides only 13% of NHS resources. We should consider separating this out from NICS to have a clear "health insurance contribution" charge on every pay slip. This would emphasise the contribution principle and also make it possible to raise expenditure on health care - where there was popular demand to do so - without raising the basic rate of income tax. (Indeed, there might be political advantages in raising the NIC contribution at some point in the next 2-3 years explicitly to pay for the increasing NHS budget, at the same time as holding or reducing income tax.)

Ultimately we might look for some way of restructuring taxation to show the whole of the individual's NHS contribution as a single item (ie both tax and NICS). Separately identifying the health insurance charge in this way would then make it feasible to allow people the option of taking out alternative insurance (ie opting out of the NHS and the health insurance charge). Alternative insurance schemes would be able to negotiate their own terms directly with public and privately NHS hospitals - but would have to be prepared to pick up the investment of costs that might be incurred in the provision of emergency treatment at an NHS or other hospital to which the patient was delivered.

3 Charging for treatment

NHS charges - notably prescription charges - currently raise quite substantial sums. There has long been a good case for a "hotel" charge to cover the food and accommodation costs of hospital treatment with the charge tapering off the longer the patient remained in hospital. Now that most hospital stays are of short duration, the case is even stronger.

This has normally been considered too hot to handle politically. But the recent poll conducted on behalf of the

Public Finance Foundation suggests that there is now a small majority in favour of such charges.

IMPROVING POLITICAL CREDIT

1 Waiting Lists

Waiting lists are clearly the most obvious aspect of the health service where any Government's record can be attacked through the use of selective examples. So long as we do not have widespread payment at point of treatment, waiting lists are bound to form a rationing mechanism - and even the most efficient hospital would need some minimum waiting list under any circumstances in order to operate an efficient throughput of patients. It is, among other things, a primitive appointments system.

Furthermore, waiting lists statistics are currently distorted by many factors. They include individuals who have been offered a bed but chose not to take the appointment. They also include patients whom consultants add to their list without any intention of treating in the near term. And the size of the queue in itself is no indication of the speed of throughput.

The waiting list political problem could be deflated, however, by:

- classifying treatments into three or four priority categories - ranging from the painful/life threatening to the purely cosmetic;

- publicising both a target performance (eg 80% offered a bed within one month) and a guaranteed maximum waiting time to be offered a bed for each class of priority;

- patients who reach the maximum waiting time would then

be offered treatment by another consultant, another district or - if necessary - in private facilities if they could not be accommodated by the consultant on whose list they were waiting. NHS use of the private sector for the purpose of cutting down the waiting list would be positively popular.

Since waiting lists are currently the property of consultants, district management has only limited ability to influence the lists in their district. The existence of a guarantee would, however, give them the ability to intervene to offer the patient alternative options - and the political problem of waiting lists could be completely defused if it could be guaranteed that no-one need wait longer than the specified time for an urgent operation.

2 Tackling nursing shortages

The problem caused by nursing shortages are another area where the Government can be easily criticised. Sub-dividing the nurse's job as proposed above would be one way of getting round the growing difficulty of nurse recruitment. In addition, we will have to bite the bullet on providing much greater differentials to attract nurses into areas where there are currently shortages - notably inner London and certain specialties.

3 Improving customer handling

Customer contact is a key part of the image for any consumer organisation. Yet NHS reception areas are typically atrocious, and run on the principle of keeping the patient waiting as long as necessary to ensure that the doctor is efficiently used.

It would be a worthwhile investment to simply smarten up reception areas, and both train receptionists and provide

them with modern systems that would allow them to handle appointments more efficiently and courteously.

In addition we could improve the comfort and friendliness of NHS hospitals by allowing much greater opportunity for commercial services to be provided on site - ranging from fruit/drink stalls, books and newspapers, tapes and cassette players for hire, hairdressers and a range of other facilities that one would normally expect to find in hotels. Equally one could provide premium items on menus for those who preferred to pay for a greater choice in meals.

4 Provide an annual report

Given the amount of money that the average taxpayer is spending on the NHS, we should provide a regular vehicle for the NHS to report back on its successs story. This could take the form of both a written report in advertisements/leaflets, and a more exciting, popular version presented through an annual series of TV commercials. (This could also have an important effect on raising staff morale)

5 Clarify role of private sector

Finally, to avoid being accused of lack of commitment to the NHS because of its support for the private health sector, the Government needs to take steps to explain more fully the role of the private health sector. In particular, the fact that the maintenance of a privately funded health sector makes available to the NHS the services of many top class consultants and facilities which might otherwise not be available in this country. Expanding use of private sector facilities in a sub-contract role to the NHS would be another way of diffusing antagonism to private health by giving more and

more people contact with the use of privately funded facilities.

Conclusion

This paper offers some ideas for reforming the NHS in ways that will improve the service without undermining public confidence in the Government's intentions. We will explore some of them in greater detail in a later paper. It would be useful to have a general idea of which reforms are thought practicable and worth pursuing -- and which not.

J. O'S.
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John O'Sullivan.

NAT HEALTH: Expenditure PT8

10 DOWNING STREET

Prime Minister

Thanks for the work forward to the next paper on

Unless you wish to take this Policy Unit paper on the NHS on holiday I suggest I put it in a weekend box when you get back.

PLB 11/8.

Yes please AT

CF.

I'll put in weekend box after return

PLB 12/8

MR. BLACKWELL

NHS - THE WAY FORWARD

The Prime Minister has seen your paper of 11 August. She has read this carefully, and was grateful for it, though she has not made any specific comments upon it. She is, however, looking forward to the later paper promised in the final paragraph.

MARK ADDISON

24 August 1987

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