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BUYING BUREAUCRACY

Mr Moore's latest paper, "Self-governing Hospitals: Key Aspects", develops the idea of separating buying from provision in health care. This is a simple idea with great potential for achieving greater efficiency and patient choice without losing control of costs. Just how revolutionary it could be over time is outlined more fully in the attached "New World in Health" which you have seen before but which I attach FYI.

As developed by the DHSS in this paper, however, it has become overlaid with unnecessary and damaging bureaucratic controls. Not only does this destroy the simplicity of the original scheme - a major "selling point" since the simplicity of the NHS is an important part of its appeal. But, in addition, the "buyers" (or local health agencies in the paper) end up looking very similar to the District Health Authorities which they are supposed to replace.

The danger is, therefore, that we will labour mightily to effect real reform only to find that we have produced a mere reorganisation of bureaucratic responsibiities. The obvious remedy for this is to introduce a modest measure of competition between buyers - allowing the GP and/or the patient to choose between them. This is perfectly practicable and it offers a real extension of patient choice.

The fact that the DHSS resolutely resists the idea, relegating it to the annex where it is seen as something that might evolve "in due course", is a sign that the Old Bureaucratic Adam is reasserting itself in Richmond Terrace.

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It will require a very firm lead from you to get the discussion back on the rails and to rescue Mr Moore's original idea from the embellishments of the DHSS.

Who Will Buy?

Confusion starts early in the DHSS paper. It sees the buyng authorities as large bodies, covering a population of 500,000 or thereabouts, allocated as at present to them on a geographical basis; "identifying present and future health needs", negotiating contracts with the providers (ie independent hospitals); monitoring the performance of the providers and ensuring that patients and public are informed; and receiving payment from the central Government on a complicated RAWP formula which would include special provision for the different capital requirements of the hospitals in their districts.

Already, the simplicity of "buyers" financed by a simple age-related capitation fee has been lost. We have a resurrected District Health Authority which has lost some control of the hospitals but gained greater influence over the allocation of GPs. If you feel this to be too harsh, consider:

a. Capital costs. Why should the buyer be concerned about the different capital costs of the various hospitals available to him? His task is to purchase the best medical care at the best price, not to juggle the prices paid in accordance with the capital requirements of the providers. Indeed, if payments to LHAs were to reflect the differing capital needs of different providers, this would constitute an incentive to use some hospitals rather than others (with those in the private sector losing out).

There is, of course, a capital problem in that some NHS hospitals are Victorian relics with greater capital needs. But that should be dealt with by grants, either initial or transitional, direct to the providers. (I outline a possible solution in Appendix 1 from an earlier paper.) The DHSS formula is one of several instances of its confusion over the roles of buyer and providers.

b. Monitoring. This is another. LHAs will, of course, be aware of the performance of providers in their 'catchment area'. Their contract negotiations will make them so. But monitoring and accreditation for the purpose of public information should be in other hands - eg an NHS Inspectorate. To allow the "buyers" to monitor the "providers" would risk restoring the existing relationships under DHAs. Districts have used such supervisory powers to harass and restrict private hospitals -- and we cannot rule out the possibility that they would do so again.

c. "Identifying Future Health Needs". This too is a provider role rather than a buyer's responsibility. It runs into the same objections as b.

d. Size. An LHA covering 500,000 people would have 250 GPs on its books. It would be less able to negotiate "bespoke" contracts with its GPs for their patient's hospital care; it would be less responsive to local community feeling; it would be large enough to sustain mass union pay bargaining; and it could probably not take on responsibility for community care since its range of responsibilities, both organisationally and geographically, would lead to bureaucratic overload.

If the "buyer" is confined to buying, however, then the authority could be quite small and genuinely local - with all sorts of useful spin-offs in terms of better labour relations and community support.

Choice for the Bureaucrats

The central flaw of the DHSS system is its view of the GPs freedom to refer. Here the paper is particularly confused. For it attempts to reconcile what cannot be reconciled - namely, the GPs freedom of referral and the buyer's control of costs.

If the buying agency is to control costs, it must have two rights:

i. to insist that the GP refers only for the hospitals with which it has contracts;

ii. to specify the exceptions to this general rule.

If the GP retains his freedom to refer to any consultant, then the buying agency loses its control of costs since it is not negotiating a price in advance.

This plain dilemma is fudged in the DHSS paper. It proposes to solve the problem by "a cash limited back pocket .... supported (!) by a process of peer review". This bureaucratic complexity would lead to constant disputes between the buyers and the medical profession which in turn would lead either to a breaching of the cash limit or to serious restraints on GP and patient choice. It would also lead to great waste of time.

This problem is especially acute because the DHSS has ruled out competition among the buyers. GPs are bound to object if their freedom to refer is removed by a system which

has already allocated them to a buying authority on the basis of geography. What redress have they if they judge the buyers to be incompetent or even corrupt? None.

But this objection loses much of its force if the GP can choose between competing buyers in the first place. For he will have chosen them in the light, among other things, of their referral policies. He will have exercised choice at that stage in the negotiations (just as the patient will have exercised choice when he chose his GP).

Competition among buyers is essential if patient choice is to be constrained at the point of referral in order to control costs. A system in which the buyers choose hospitals but in which neither the GP or the patient chooses the buyer is one which has increased choice mainly for bureaucrats.

Competing Authorities

But how is competition among buyers to be achieved? Would it not be unfamiliar, administratively complicated, unsettling, too great a change, too big a bang? The DHSS will certainly argue so, for they seem to see their interest as requiring continued central control of health care which competition would threaten. However, there are a number of steps which might introduce competition without administrative upheaval. For instance, you might:

i. Allow GPs to register themselves, their patients and their capitation fees with a neigbouring LHA. This would be easier if there were a large number of small LHAs rather than the reverse.

ii. Follow the suggestion of the "No Turning Back" group of MPs and establish two buyers in each existing district. For the first year GPs and their patients would be

simply allocated to one of these bodies. After that initial period, however, they could register with the other.

iii. Permit GPs, either individually or in group practices, to apply to the DHSS to opt out of any buying authority and to be the budget holders and buyers for their list of patients. They would then negotiate directly with the hospital sector. This scheme would, of course, preserve the GPs full right of referral, but he would have to exercise it within the financial limits of his total capitation fees.

iv. Reconstitute Family Practitioner Committees as buying authorities in competition with the LHAs (with which they would overlap).

v. Enable patients to transfer part of their capitation fee from a public to a private buyer. That transferrable portion might be equal to his capitation fee (itself related to age) less the redistributive element in NHS spending. Or it might be a slightly lower amount in order to reassure the Treasury about the financial risks of private sector growth.

Recommendations

I suggest, therefore, that at Tuesday's meeting you insist that the distinction between health buyers and providers be rescued from the bureaucratic embrace of the DHSS. This would mean:

1. Restricting the functions of buyers to negotiating health contracts with health providers.

2. Distributing other functions to the providers (eg making capital provision for future health needs) or to central

bodies like an NHS Inspectorate (eg monitoring the performance of providers).

3. Keeping the size of buyers as small as possible in order to establish good local links between them, the community and the GPs.

4. Introducing competition between buyers by some or all of the methods proposed above.

Without such changes we will have gone to a great deal of trouble to reinvent not the wheel, but the rack.

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