

PO-CH / NL / 0102

PART A

Part A

**SECRET**

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Begins : 23/12/87.  
Ends : 7/3/88.



PO -CH /NL/0102



PART A

Chancellor's (Lawson) Papers:

THE NATIONAL HEALTH  
SERVICE REVIEW

PO -CH /NL/0102  
PART A

Disposal Directions: 25 years

D. Hillson  
9/8/95



10 DOWNING STREET  
LONDON SW1A 2AA

CH/EXCHEQUE	
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ACTION	CST
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23 December 1987

*Handwritten in red:*  
We must see the paper - if  
in fact from a paper.

*Handwritten:* prep.

From the Private Secretary

*Handwritten on green sticker:*  
Gray  
PODGER  
23/12

*Handwritten:* Ch - this is the letter to which  
to be aware of where this stands. PEM

*Handwritten:* MPW 4/1

Dear Geoffrey,

THE NHS

The Prime Minister plans to hold a meeting in January with your Secretary of State, the Minister for Health, Sir Roy Griffiths, Treasury Ministers and possibly one or two officials, to discuss the NHS.

The Prime Minister has herself reached no view on the scale of any changes which may be needed and she therefore also has an open mind on timetable, on whether there should be a Government statement (whether a Green Paper or in some other way) and whether legislation will be needed. But the Prime Minister does now wish to take stock of progress so far in improving the performance of the NHS, to review existing plans for future changes, and to consider what more might be done.

In considering options for the future, certain basic principles are already clear. They include the following:

- (i) a high standard of medical care must always be available to all, regardless of income;
- (ii) the arrangements must be such as to give the users of health services, whether in the private or the public sectors, the greatest possible choice;
- (iii) any changes must be made in such a way that higher health spending does not lead only to higher incomes for the suppliers of health care;
- (iv) responsibility, whether for medical decisions or for budgets, should be exercised at the lowest appropriate level. Skilled people should not be expected to do work which could be done by people with less skill.

You will no doubt have other criteria to suggest. But it will be important at an early stage to establish a clear framework of criteria for judging the desirability of change.

Against this background, I should be grateful if you could arrange for a paper to be prepared as the basis for the Prime Minister's meeting. This should describe the main changes made during the past eight years and assess how far achievement has matched expectations. It should include a discussion of the variation in performance between districts and the causes of these variations. It should set out plans for the future, for example for the development of management accounts and inter-district and inter-region charging and the extension of external purchasing of medical and non-medical services, and describe the timetable for achieving these changes in some detail. The paper should include annexes describing health care systems in other major countries and summarise the main proposals which have been made for reform of the NHS and draw on this material to set out models for the provision of health care, with a discussion of their advantages and disadvantages. These models are intended simply to help establish a framework for discussion and a common use of terms.

The Prime Minister does not at this stage intend formally to discuss these questions with people outside Government. But she continues to receive letters from supporters with proposals for change and she is likely to discuss them with those concerned from time to time. At a later stage a meeting with knowledgeable outsiders, invited not as representatives but as individuals, could well be useful.

I am copying this letter to Alex Allan (HM Treasury).

*Yours,  
David.*

DAVID NORRGROVE

Geoffrey Podger, Esq.,  
Department of Health and Social Security.



PWP

NOTE OF A MEETING HELD AT NO.11 DOWNING STREET  
AT 9.00 ON THURSDAY 28 JANUARY

Present: Chancellor  
Chief Secretary  
Sir T Burns  
Mr Anson  
Mr Kemp  
Mr Parsonage  
Mr Saunders  
Mr Call

WALLACE  
NOTE OF  
MEETING  
28-JAN

NHS

The Chancellor reported on the Prime Minister's meeting the day before. There were signs that the debate could be moved in a very useful direction, and he was anxious that the Treasury should capitalise on this. The meeting had accepted the Chancellor's insistence that debate should focus first on structure and cost controls within the NHS and only later address any questions of additional finance. The Chancellor had also made the point that, although the review would concentrate on the hospital service, it would also need to address the issue of prescription charges, which would have an impact on other parts of the health service. The Prime Minister seemed well seized of the need to look at the privileged position of doctors -this would be tackled anyway via the review of consultants' contracts. The next step was for DHSS and the Treasury to produce a joint paper charting the way forward. Formally, this would be a procedural paper, but would obviously have substantive implications: it was essential that the Treasury should have an early input in the drafting of this. The Prime Minister envisaged that the review could be completed before the House rose for the Summer, though no public commitment to this timetable would be made.



2. The Chief Secretary outlined the key points he felt the paper ought to cover. First, it ought to set out what a cost effective service would look like, and what the barriers were to getting there - lack of proper costings, separation of managerial and medical responsibility, lack of cross-fertilisation between public and private sectors, labour inflexibilities, high cost prescribing. The paper should then set out the pre-conditions for achieving the Government's objectives - notably satisfactory procedures for auditing costs and efficiency, and the establishment of information systems to link up those parts of the system which were under pressure with others where there was surplus capacity.

3. The Chancellor added that he felt the paper ought to spell out what was meant by the 'internal market' - and it might be helpful to rename the concept. Generally, it was important that the debate should be couched in sensitive language, however radical the ideas being discussed.

4. There was a general discussion of the obstacles that would be encountered. Mr Anson said that DHSS might argue that a system of 'patient-related funding' could not go ahead until the information systems to operate it had been put in place. The Prime Minister had made it quite clear that progress on this front would have to be faster in future. DHSS were bound to argue that radical proposals could not be implemented without a great deal more money. It had been agreed at the Prime Ministers meeting that this was a separate and subsequent question, and this line should be held. Mr Anson said that there was, however, obviously a need for proposals on structure to be consistent with the likely outcome of later decisions on finance - and they would be consistent, to the extent that they reduced the 'cliff edge' between the cost of public and private health care.

5. Mr Kemp asked how much urgency should be attached to the further work on options for introducing tax relief on private



health insurance. It was agreed that the Treasury would need to have thought through its position fairly soon, but that, in view of the other pressures on relevant officials' time it would effectively have to wait until after the Budget. The Chancellor mentioned that concern had been expressed at the Prime Minister's meeting that although private insurance was to be encouraged, experience in other countries did not necessarily suggest that it had an entirely positive effect on cost controls.

6. The Chancellor commented that the joint paper ought to bring out very clearly ways in which cost consciousness could be promoted amongst decision makers as well as amongst customers. DHSS seemed to be focusing mainly on customer awareness of the global cost of the NHS, for example, via their idea of a hypothecated health tax. But it was important to bring home the unit costs of different forms of treatment to decision-makers, not just in hospitals, but also in local authorities' social services departments, and, notably, amongst GPs. GP referrals seemed to be an increasing burden on hospital services: although it was perhaps unreasonable to expect GPs to operate within strict referral budgets, it would perhaps be possible to exert pressure on costs by publishing more information about relative referral cost in the way that information was now available about relative prescribing costs.

7. It was agreed that officials should ensure an early input to the joint paper, and that Mr Kemp should coordinate the exercise within the Treasury.

*Mpw.*

MOIRA WALLACE

1 February 1988

Circulation:

Those present  
Paymaster General  
Miss Peirson  
Mr Turnbull  
*Sir P Middleton*

**Mr. Kinnock:** Does the Prime Minister recall saying, just five weeks ago, on 21 December, that charges for patients in National Health Service hospitals:

"could not possibly come in during the lifetime of this Parliament because I remember very vividly during the election I confirmed we would rule it out. We have introduced extra charges which we think people can afford but we are not talking about extra charges beyond those which we have introduced."

Does the Prime Minister still stand by those words?

**The Prime Minister:** Yes, of course. I already made that clear when I was asked a similar question in the House but a short time ago.

**Mr. Kinnock:** Is the Prime Minister saying—it is important that she make a formal announcement about this—that there is no possibility in this Parliament of direct or indirect charges for visits to the doctor, for hospital visits, for family planning services or anything else? If she is—and it is what she said in the election—will she be good enough to make a formal announcement, instead of letting it seep out through Bernard Ingham?

**The Prime Minister:** I have been asked this question about board and lodging charges in this House, and I have answered it in this House. The statements made during the general election stand. I have said so before, and I say so again. They stand for the lifetime of this Parliament. By the time the next Parliament comes we shall have completed the internal review. We shall then make our promises, which will stand for the following Parliament.



SECRET

FROM: SIR T BURNS  
DATE: 5 FEBRUARY 1988

CHANCELLOR ✓

cc Chief Secretary  
Paymaster General  
Sir P Middleton  
Mr Anson  
Mr Kemp  
Miss Peirson  
Mr Turnbull  
Mr Parsonage  
Mr Saunders  
Mr Satchwell  
Mr Cropper  
Mr Tyrie  
Mr Call

### THE NHS

You asked for my comments on the Cabinet Office paper.

2. As far as the problems are concerned I am not sure that the absence of "consumer freedom of choice" (para 3a) is how most users see it. I see little prospect of giving a large proportion of the population much of a say in "when, where, how or by whom they are treated" without an enormous increase in resources going into health. My perception is that there is considerable satisfaction with the NHS as far as serious illness is concerned. The main problems relate to the speed or manner in which less urgent illnesses are dealt with; long waiting lists, long queues in outpatient departments, unfriendly staff and generally squalid conditions. Almost no concern is given to the convenience of the patient.

3. In a system that is largely financed from taxation I do not see much purpose to be served by informing patients what it costs to treat particular illnesses - as opposed to medical care in general (para 3b). The people who need to know the specific costs are the agents making the decisions, ie doctors or health authorities. It is also worth remembering that the number of 'cost' definitions is infinite and the relevant definition depends upon the decision under consideration.

BURNS  
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5 FEB

4. I would argue that the key objectives - broadly referred to in paras 3c and 3d - are to get maximum use out of existing resources and to ensure that the extra resources go where they can be used most efficiently.

5. I have little to add to the section on facts. When commissioning work on NHS inputs and outputs (para 6a) I hope we can look at trends through time as well as between countries. I would also like to see comparisons (again through time and between countries) of waiting times and periods in hospital for various types of treatment.

6. In terms of possible structures I would like to see most of the initial effort go into developing a new NHS structure based principally upon finance from taxation. Such a reform seems to be the best medium-term prospect and in the longer run should be consistent with increased charging, which I see as essential. Once a new NHS structure has been designed it will be easier to focus on the changes that could be made reasonably quickly to the existing structure that would be consistent with such a move.

7. I am attracted by the idea of making hospitals compete for custom and separating them from the District Health Authorities who would effectively do the purchasing on behalf of the patient; and similarly giving patients a choice between health authorities or HMOs.

8. Finally we should not lose sight of the claim by many defenders of the NHS that it delivers a good standard of health care (measured by outputs) for a very low cost in terms of percentage of GDP. There is scope for improvement but it is difficult to sustain the charge that the NHS is grossly inefficient. There is a general desire to increase resources going into health provided that it brings shorter waiting lists and better standards of service (mainly non-medical). We do not want an increase in the GDP percentage for the sake of it, even if it is partly privately financed; inevitably a large part of hospital care will remain publicly financed.

Indeed - not good to believe paying £30/week for an inefficient wasteful service.

page

Most people like to feel that if they suddenly fall ill help will be at hand, and the popularity of the NHS has been founded on this sense of security.

Recently, however, that security has begun to evaporate. Adverse publicity about waiting lists — dramatically brought to public attention by the Birmingham hole-in-the-heart babies — has led not only to demands for more taxpayers' money but also to serious debate about alternative methods of finance.

There are five main options for the reform of the NHS:

- Retain the existing structure and make it more cost-efficient.
- Retain the structure but increase revenue from other sources, such as charges for hospitalisation.
- Retain the allocation by government of a global budget, but privatise the hospitals to promote competition (the Canadian formula).
- Retain the NHS hospitals under present management but confine them to the delivery of services; finance health care from national insurance, as in Germany and France.
- Retain the NHS hospitals but introduce private insurance, using vouchers available either to all or selectively to the poor.

The principal disadvantage of the first option — promoting efficiency — is that the service would still be underfunded.

The second option — the introduction of hospital "hotel" charges — would produce additional revenue, but would not enhance competition. Pricing is only acceptable if people have alternatives available to them. Charging without choice hardly differs from taxation.

The third alternative recognises the importance of competition between the providers of health care. Most Canadian hospitals are run by local, non-profit boards which must compete for patients. The Canadian system, however, suffers from some significant disadvantages, not least that the government's close involvement in fixing professional fees gives rise to a high level of conflict, including strikes.

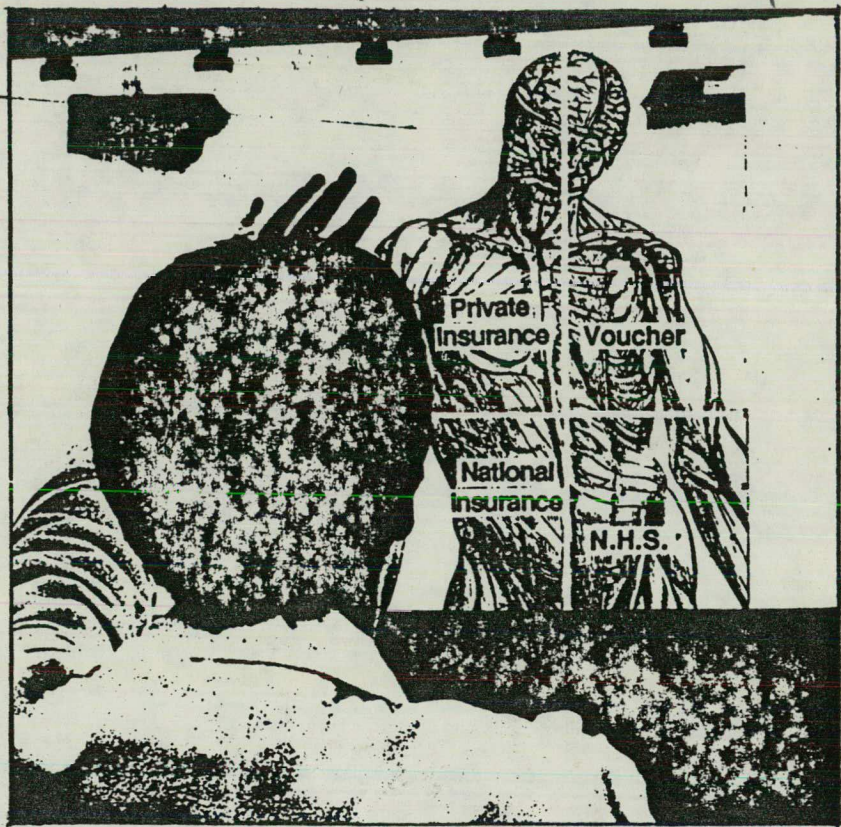
The fourth option, national insurance, operates in much of Europe. In Germany, individuals opt into one of about 1,200 non-profit sickness funds. Each fund charges its own premium, which is then deducted from pay packets, with the cost split 50-50 between employer and employee. Hospitals are under a variety of ownerships and compete for customers.

The main worry is that costs are out of control. There are two main reasons, neither an inherent defect of insurance as such. First, the tradition of German health insurance has been that everything should be free, an attitude which has encouraged profligacy typified by the right of patients who have undergone surgery to a period of recuperation in a spa.

Second, because of the corporatist nature of German government, producers have been allowed to dominate price fixing. The government requires that hospitals be reimbursed according to their allowable costs, a highly inflationary method. And doctors' fees are not paid by patients who then claim from their insurer; instead, the sickness funds pay local associations of doctors who pass on the fees to their members, a method which reinforces the ability of the organised medical profession to impede competition and raise prices.

Moreover, from the mid-1960s GPs began to be paid on a fee-for-service basis instead of by capitation payments: this too caused costs to escalate. High costs in Germany reflect inept and counter-productive efforts by government to regulate prices.

Option five, to finance health care



# The NHS: lessons from abroad

With the Government's review of health care now under way, David Green looks at the benefits and drawbacks of other countries' insurance-based systems

through private insurance, is the most radical alternative. America is the chief example, though 40 per cent of health spending is channelled through government hands and the insurance industry is subject to much clumsy government interference.

Two main criticisms are levelled at this approach: that it makes cost-control harder and that it is more expensive to administer than the NHS.

Until the mid-1970s, American health insurers had a poor record of cost-containment. But this had much to do with the restrictive practices enforced by the mighty American Medical Association, which has recently had its wings clipped by the Federal Trade Commission. This led to a renewal of competition and to the pursuit of cost-effectiveness in three ways.

First, insurers put providers under finan-

cial constraints. Health maintenance organisations (to which subscribers pay a fixed monthly premium in return for all the health services they require) penalise doctors who fail to be cost-effective.

Second, insurers share costs with patients, who might pay all bills up to a fixed sum before cover begins (similar to the car insurance excess) or pay perhaps 20 per cent of each doctor's bill.

Third, insurers apply checks and balances to clinical decisions. Second opinions to discourage unnecessary surgery are now common, and many insurers employ nurse reviewers to ensure that patients are not kept too long in hospital.

Are all health insurance schemes more costly to administer than the NHS? The true cost of the NHS is hidden, because the full cost of obtaining tax revenues is not included in published figures. And this is quite apart from the hidden cost of reduc-

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ing each person's disposable income and therefore his or her power to support alternatives which would bring about price competition. Moreover, the NHS is under-managed: its costs are unknown and its quality of service not appraised. To remedy these deficiencies would certainly require additional staff.

And administration costs depend significantly on customer choice. If a person wants 100 per cent cover for every expense, however small, the premiums will be high because many pieces of paper have to be handled and many cheques drawn. But if the patient pays a part of each medical bill the policy is cheaper to administer. Catastrophe insurance policies, which cover only very expensive serious illnesses, are particularly good value. If people choose to pay for costly policies, as in America they frequently do, that is their privilege, but the average cost of administering policies cannot be considered a flaw inherent in all health insurance schemes.

**T**he urgent task now is to devise a framework which will enable a competitive insurance market to work in Britain. Policy-makers should study three areas closely.

**Pro-competition law:** Until recently American doctors subverted the competitive process. Lest this happen in Britain, the medical profession should be prevented from enforcing advertising bans, fixing prices, interfering with cost-containment efforts by insurers, limiting the supply of doctors and obstructing the emergence of competing professions or occupational groups. This may require the ending of government-sponsored professional self-regulation, and changes in professional licensing laws.

**Risk selection:** A disadvantage of competitive insurance markets is that insurers tend to compete not only by promoting cost-effectiveness but also by selecting low-risk subscribers and excluding the chronically sick and frail elderly. Two rules will be necessary to prevent this. The first is open enrolment: a requirement that no one should be refused cover due to pre-existing ill health. This rule has worked well in Australia for many years. The second is modified experience rating: each insurer must charge subscribers in the same age-group the same premium. Premiums would differ from company to company but not for subscribers of the same age covered by the same insurer. The disadvantage of the latter proposal is that premiums cannot be adjusted to encourage a healthy lifestyle, for instance by offering non-smokers' discounts.

**Inclusion of the Poor:** Most people can pay their own way, but government will need to come to a view about the level of health care the majority feels should be provided for the poor, and to give them a voucher sufficient to buy an approved health insurance plan so that they are included in the insurance system on equal terms. The danger that a future government will allow the value of the voucher to erode could be avoided by linking its value to the actual average expenditure on health insurance of, say, the next 20 per cent of the population above the poverty line.

There are no perfect answers to the problems of the NHS. All the proffered alternatives have their drawbacks, and no single foreign nation can offer a ready-made blueprint, but an increased role for insurance in some form is unavoidable. The most urgent task is to create the legal framework necessary to direct the energies of a competitive insurance market to the service of all.

*The author is director of the health unit of the Institute of Economic Affairs.*

~~CONFIDENTIAL~~

FROM: E P KEMP  
18 February 1988

CHANCELLOR OF THE EXCHEQUER

*I agree with Mr K's conclusion on page 9. Poor also see that the students look @ some of the points we made. This is about 6 or 7 years of changes, you know as well as I do. Mr M. of health*

MR LEON BRITTAN - "NEW DEAL FOR HEALTH CARE"

You asked - Miss Wallace's minute of 11 February - for an assessment of the proposals in Mr Brittan's pamphlet on health, especially pages 10 to 15.

2. Generally speaking I felt that Mr Brittan's pamphlet was worthwhile and interesting, and a great deal better than some of the mass of material about the present state and future development of the Health Service which is currently washing around. In the early part of the pamphlet he says all the right things about the need for a continued drive for efficiency and value for money (though he does not seem to home in on an "Audit Commission" body to press this a bit harder), and he says the right things about contracting-out, some extension of charging, elimination of duplication of services (something we have not in fact yet really homed in on), and what I call the "cross pollination" between the public and private sector, which distinguishes public provision from public finance, and private provision from private finance, so that public finance could buy in care from private provision and private finance buy in care from public provision.

X |

3. Finally, and crucially to my mind, he seems to home in, although perhaps without knowing it, on a point about charging which is often overlooked; namely the question of who the charges are actually paid by, and in what form they are paid. My point here is that the question of increased and new charges is often bedevilled by images of patients actually having to fork out themselves at the point of service, so that old ladies who visit their doctor have to find say £5 or seriously ill people going to hospital have to find £500 a day, out of their own pockets

Y |

and there and then; in fact this does not have to be so, because within the charging concept one could imagine the bill actually being sent to someone other than the immediate patient (his insurance company, his employer, the local authority, or some other "sponsor"); and of course not necessarily sent there and then - all of which I think Mr Brittan gets near in his remark at the foot of page 10 about paying for services directly "(although not necessarily at the point of delivery)".

4. On the most fundamental issue Mr Brittan homes in on the dilemma, as he puts it, that there is a need substantially to increase spending on health care, and private spending at that, in a way which (a) leads to an increase in total provision both public and private, (b) does so in a way which does not destroy the central principle of proper health care for all irrespective of means and (c) does not relegate the public or private sector to a lower tier service; and he might have added, and this is perhaps a flaw in the argument here, that (d) we do not want to add to public expenditure as such - not wholly consistent with (a), and (e) even if private provision and private finance have both increased, the Government of the day would still probably have a view about the scale of this given first the knock-on effects which increases in the cost of private health care can have on the costs of public health care and second the arguable desirability in any society of not spending too much of one's wealth on any one product, especially perhaps health care, given the tendency of this to expand of its own accord and given the finite nature of national resources.

5. As is well known, Mr Brittan's recipe lies in developing the so-called "health stamp", which he sees as a way first of making people more aware of the cost of health, and second of encouraging private provision and reducing the so-called effect by providing more meaningful financial benefit from an "opting out" system, somewhat akin to the opting out from public pension provision. The argument, of course, is that at the moment people "pay twice" if they go private, since they have to pay the full cost (give or take any tax relief) for the private care while not being relieved of any part of their contribution to their public

entitlement, it not being possible to opt out of the tax system and it not being worthwhile to try to opt out of the relatively small health stamp we now have.

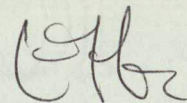
6. Put that way, there is a lot in Mr Brittan's approach (which is not, after all, all that original). It is certainly one which I think the second stage of the current review ought to look at carefully. But to my mind the specific way Mr Brittan sets about it will not quite do. To put it crudely, he over does it. He shifts all of the costs of the Health Service to the health stamp, giving on his figures a move from general taxation to the health stamp of some £9.4 billion. Mr Brittan suggests that this saving to general taxation could be used to increase income tax allowance thus taking many people at the lower end of income scales out of taxation all together; though he goes on to say, quite rightly, that "the full distributional consequences of the changes are, however, likely to be quite complex". This is very true indeed. It is not clear, for instance, how far this approach would have some of the same characteristics of the community charge, namely a flat ratedness regardless of means - not necessarily a bad thing, and even logical if one is dealing with basic health care for an individual, but difficult to defend, as we are seeing.

7. Lastly and from a Treasury point of view I think Mr Brittan overlooks the serious risk that hypothecated levies such as he proposes would constantly seem like an "easy" way to raise more money for public health finance, though it would still of course add to public expenditure as defined and would still add to the burden of taxation as we define it. And it would be difficult to control if all NHS spending was financed this way, in that any imbalance between the health stamp "take" and costs would always have to be met by Government, which risks a long term ratchetting up process.

8. It may be that the distributional considerations and risks to public expenditure and tax that arise (and indeed administrative costs which could be high), are such that you will want to continue to argue,

as you have argued up to now, against any tinkering with the "health stamp" apparatus at all. But I do not think one needs necessarily take that position. My view is that one could move down the charging path via the "sponsor" route, involving a degree of opting out coupled with some shift from NIC to health stamp (we need to run a lower NIF surplus anyway and this is an economical way to do it), and this, coupled perhaps with, some tax relief, would reduce the cliff edge, and could raise a great deal of private money for health care, all without altering the present proportionate sizes of the health stamp and the NIC too dangerously. I think that this is an avenue which should be explored.

9. To summarise, therefore, Mr Brittan has a lot of good ideas and his pamphlet is well worth reading. But in my view while usefully developing a sensible line of thought in relation to this charging/cliff edge/opting out nexus by way of increasing private finance for health care, he over does it and the distributional consequences and risks to expenditure involved in going as far as he suggests would not be acceptable. However, in a sense this is a matter of degree rather than kind and it certainly seems worth looking at his idea further.



E P KEMP



NEW HORIZONS

**A NEW  
DEAL FOR  
HEALTH  
CARE**

The Rt Hon Leon Brittan QC MP

Conservative Political Centre

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I AM greatly indebted to Graham Earles for his help in the preparation of this pamphlet.

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In common with other CPC publications this pamphlet is a contribution to discussion and not an official Party pronouncement.

CPC No. 0510-782

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ISBN 085070 775 7

Published by the Conservative Political Centre,  
32 Smith Square, London SW1P 3HH and printed by  
Conservative Central Office, 32 Smith Square,  
London SW1P 3HH.  
First published February 1988

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## A NEW DEAL FOR HEALTH CARE

IF A VISITOR from another planet were to arrive in Britain and listen to the current debate about the NHS he would wonder whether those putting forward the contending arguments were talking about the same country. On the one hand he would hear apparently accurate accounts of unmet needs, and on the other hand he would hear protestations about the ever increasing amount of money devoted to the NHS. In fact the same arguments could have been heard at any time for a number of years. But the recent accumulation of highly publicised incidents has brought the debate to the forefront of public attention and to the centre of the political arena.

This has had the effect of shattering the hitherto unspoken assumption that a combination of modest administrative reforms and increased funding can solve all our problems. It is now clear that to continue to go down that road is a recipe for ever growing dissatisfaction and is politically untenable. Up to now the huge popularity of the NHS has made even the boldest politicians reluctant to touch its essential structure or funding. Almost alone of our great institutions it has been allowed to continue substantially unaltered by the major reforms of the past nine years. It is only now that the intensity of the debate has at last put radical reform on the agenda.

What, then, is the essence of the problem, and what can we do about it? Put simply, the problem is that an inevitably limited supply of money is being required to finance a constantly growing and potentially infinite demand for medical services. Paradoxically, therefore, both the Government and its critics are correct in their assertions.

The Government is right to claim that spending on the NHS has increased in England by 26 per cent in real terms since 1978/9. It can also point to significant increases in services offered: for example, the increases in coronary artery by-pass grafts for the UK from 3,191 in 1978 to 10,500 in 1984, or the number of hip replacements from 28,000 in 1978 to 38,000 in 1984. Yet, these and the many other extra services offered, and the large number of modern new hospitals that have been built, create by their very existence increased running costs in the system as a whole. As a result, critics can point to examples of

what appears to be government underfunding and neglect: the closing down of wards or local accident units, poorly decorated hospitals, and appallingly high waiting lists. To them, this is all evidence of a health service in decline. Whilst they speak of unmet demands, Government apologists reply by highlighting the increased funds that have been made available and the inefficient use of resources that still frequently occurs.

How, then, can we move from a sterile argument that proceeds at cross-purposes to the reform that is needed to deal with the underlying problem?

Our first task is a political one. It is to reassure people that whatever changes we make, however radical they are, we yield to none in our absolute belief in the fundamental principle that adequate health care should be available to everybody in the land, irrespective of their means. The credibility of that commitment will depend not only on the frequency with which it is repeated, although the importance of that should itself not be underestimated. (For politicians should not assume that people have always heard them, or taken in what they say, when they say something for the first time).

At least as important is the general tone which we use when speaking about matters unrelated to the NHS. If we show that we understand that, vital as the enterprise culture is for our survival as a nation, there are values that we share that go beyond it, we shall be more likely to be believed when we reassert our commitment to proper medical care for all.

The 'umbrella concept' philosophy behind the foundation of the NHS is a vital one. Immense benefits are derived by having a service which is substantially free at the point of use. It is this feature of the NHS which gives the feeling of security that is so highly prized, the knowledge that at an inevitably stressful time, financial worries will not be added to concern about one's health and its implications for one's job and family.

The NHS in its present form is simply the administrative and financial structure set up to give effect to the principle of the availability of care for all, irrespective of means. There is nothing sacrosanct about that structure, but there is everything sacrosanct about the principle. The structure was set up after the Second World War and reflects the thinking and perceived needs of that time. It would be astonishing if after forty years it did not require radical change. There is no need to be afraid of such change provided we are loyal to the principle which the NHS, as originally founded, was designed to implement. When a patient seeks treatment today there is no reason why he

should have any special loyalty to the monolithic system of delivery that may have seemed right in 1948, provided he is sure of getting the treatment he needs, whether he can afford to pay for it or not. In fact, he may in the future be more likely to get that treatment if we have the courage to change the system. That is the essential case for reform.

### **Improving the NHS**

What changes should, then, be instituted? Some can clearly take place and produce benefits within the present structure. There should, for instance, be a continuation of the drive for efficiency and 'value for money' in the NHS through the encouragement of greater cost awareness. The changes recommended in the Griffiths Report of 1983 have largely been introduced. But there is still a long way to go before the new tools are used to the full. The use, for example, of option estimates and appraisals for capital projects, such as the building of hospitals, is now well established but the time scale for deriving benefits from a change of this kind is obviously a protracted one. Similarly, a computer-based package of about 420 Performance Indicators is published annually to help managers compare aspects of their services, such as the average length of a patient's stay in hospital, with that achieved in other authorities. From this, therefore, it should be possible to identify aspects of performance that could be improved. But it is bound to take time before managers fully appreciate how best to use these Indicators to effect real changes in the working methods of their own authorities.

Savings have also been made by the process of 'contracting-out' support services, such as laundry, to private providers. At present, the money saved stands at £73m. per annum, but there is still scope for further savings, with Government estimates that just under 50 per cent of these services by value have still to be put out to tender.

The whole process of contracting out and the delegation of financial control could, of course, be taken much further. It would be possible to contract out a whole hospital. The hospital would then continue to provide free treatment, but would charge the Health Authority directly for the work done.

There are further ways of extending cost awareness to the NHS, which have so far only been proposed, but not yet implemented. There is everything to be said for accelerating the pace of their introduction. One such proposal is that direct

control over budgets should be given to clinicians. If head teachers are being asked to control budgets, there seems no reason why the same concept should not be extended to doctors. The same idea is applicable in the case of primary health care as it is in the case of clinicians working in hospitals.

A far more controversial way of increasing resources for the NHS would be to make some extensions in the charges to patients for treatment. There is no doubt that it would be possible to go some way further down this road without undermining the fundamental principle of the NHS, so long as the charges are modest and defensible in their own right. Hospital 'hotel charges', for example, would certainly be defensible on the grounds that people have to pay for their own food if they are at home, and it is difficult to see why they should not do so when they are in hospital. Nonetheless, quite apart from their unpopularity, they would certainly be difficult to administer. On the other hand even a 10 per cent cut in the bill currently footed by the NHS for such services could provide 52,000 kidney machines or 490 body scanners.

A stronger case can perhaps be made for a small charge of, for instance £1, for a visit to a General Practitioner. Such a charge would certainly be easier to administer. Its importance would lie not so much in the money raised, as in the fact that it would be a gesture of understanding that a General Practitioner's time is valuable and costs money. It would not be too great a charge to deter the visit of a person who is in genuine need of medical advice, or genuinely anxious, but it has been estimated that there would be a substantial saving in GPs' time as a result of the reduction in the number of unnecessary visits. As a result, the quality of service for those seeing their doctor would noticeably improve.

In addition to measures to increase resources, attempts should be made, going far beyond the above mentioned efficiency savings within individual hospitals, to release resources that are currently used to provide duplicate services within Regional Health Authorities (RHAs), and sometimes even within District Health Authorities (DHAs). There needs to be a greater freedom for the co-ordination of resources between different DHAs within the NHS. As has been stated in a recent work\*: 'the NHS needs to dismiss the idea that all hospitals and health authorities must be able to provide all facilities themselves'. One example of where greater co-ordination is desperately needed should demonstrate the point.

\*Peet, *Healthy Competition*, 1987.

At present there is an enormous overlap of services offered by the Public Health Laboratories, the pathology laboratories, and hospital Microbiology Units. Rationalisation of laboratory services within RHAs would both cut administrative, technical and labour costs and also build up centres of expertise. The established benefits of economies of scale would apply without any loss in service. Hospitals could then 'buy in' laboratory services as they were needed - as indeed private hospitals do already, either from the NHS, or from specialist companies such as the Jean Shanks Pathology Services Group or Federal Express. It would be difficult to sustain the argument that laboratory services in the United States were in any significant manner inferior to British services. It is revealing, therefore, that in America the idea of every hospital having its own pathology laboratory, for instance, would be ridiculed as needlessly extravagant. Rationalisation of many other medical services at Regional level on these lines, with the consequential reduction in pointless duplication would release valuable resources which could then be used to provide real improvements in patient care.

#### **Links with the Private Sector**

Above all the concept of 'buying in services' both within the NHS, and between the NHS and the private sector, should be massively extended. If there is no waiting list for a particular type of operation in one place, and a substantial waiting list in another, there is absolutely no reason why a patient should not be entitled to have the operation performed where it can be done most quickly, irrespective of whether this is within the District or Region in which he happens to live. The proposal that there should be a national, computerised information bank to enable this to be done is one which should be implemented as rapidly as possible. There will of course be many people who are either unable or unwilling to travel the distance that may be required to have earlier treatment. But that is a decision that the patient and his family should make, as customers, not an option that should be denied to him because the NHS is not organised to provide it.

Even more important is the encouragement of much closer links between the NHS and the private sector. If the NHS cannot provide a particular service in a particular place, or cannot provide it in reasonable time, it may well be better and cheaper for the NHS to buy in that service from the private

sector, rather than to seek to duplicate it at great capital cost, and with substantial recurring current costs. This already happens to a limited extent. But instead of it being regarded as unusual, extraordinary and questionable in principle, it should be positively encouraged wherever it is the most effective and efficient way of providing patient care.

By the same token, the private sector should be fully entitled to buy services from the NHS, at the proper price, not only through the use of pay beds, but also by paying for specialised facilities of a wide variety of kinds, where the NHS is already incurring the running cost of providing them, and where the use of those facilities by the private sector would not deny or delay their use by any NHS patients. If buying in of services, in both directions, expanded substantially, the division between the two sectors of health care would become much less significant than is now the case. It would be more clearly recognised that both sectors are making a contribution towards meeting the same need: the provision of proper medical care for the country as a whole.

Nonetheless, even if all these measures or changes were implemented, the resources created or released would still almost certainly be insufficient to meet fully the rapidly rising demands for health care. In 1986 the Government acknowledged that health authority services needed to grow by 2 per cent per annum in real terms in order to meet the pressures they faced. (1 per cent to keep pace with the increasing numbers of elderly people, 0.5 per cent to allow the development of medical advances, and 0.5 per cent to make progress towards government objectives such as the improvement of renal services and regular cervical smear tests for women). Moreover, as the NHS becomes more efficient and treats more patients, it necessarily generates a greater and greater demand for resources. It is difficult to see how such expansion could be financed entirely from the savings resulting from the changes suggested earlier. It is estimated that just to meet the pressures identified by the Government in 1986, spending on the NHS for Great Britain would have to rise to £42bn. per annum by 1995, compared to £21.6bn. for 1986-7.

There can, therefore, be no escape from the conclusion that whatever else may be done, the real need of the health services in the UK is for substantially increased resources, although not simply by pumping more public money into the system as it is.

The history of the last twenty years has shown that resources for health care cannot be provided by taxation alone. Under

Labour governments the attempt to increase public spending across the board ultimately led to economic disaster and massive cutbacks, in the NHS as much as elsewhere. The Conservative government, by following a more prudent financial policy, has actually been able to provide more for the NHS, but still not enough for us to equal the share of national resources devoted to health care by many comparable Western countries. To attempt to increase provision simply by increasing state spending, financed by higher taxation or borrowing, may be tempting in the short run, but would soon involve reversing the economic policies which have brought us the steady growth without which we would become less competitive, poorer individually, and in the long run less able to pay for public services too.

The only answer to this dilemma is substantially to increase private spending on health provision, provided (a) that we can do so in a way that leads to an increase in the *total* provision, both public and private, and (b) that we can do so in a way that does not destroy the central principle of proper health care for all, irrespective of means, and (c) does not relegate the publicly provided sector to a lower tier service.

If, in addition, the substantial growth of private provision leads to genuine competition with the public sector, that is likely to achieve the further benefits associated with such competition elsewhere: increased choice, greater efficiency and lower costs.

### **A Fundamental Change**

All these objectives *can* be achieved. But they cannot be achieved while retaining the present system of financing the NHS. For the present system provides an effective barrier to an increase in provision on the scale necessary to achieve what is required. The reason for this is simple. At the moment anyone who wishes to pay for any form of private health provision has to pay twice over, as he has to pay his full share of the cost of the NHS as well.

The necessary reform is accordingly based on three fundamental premises:

(1) People are more likely to be prepared to pay for a service, whether publicly or privately provided, if it is absolutely clear what the cost of that service is, and if they pay for it directly (although not necessarily at the point of delivery).

(2) People are prepared to pay more for a service, if they are making a voluntary decision to do so, than if they are forced to pay through taxation.

(3) People are prepared to pay more in total for health care than they are currently paying, but only a minority are prepared to pay twice over for the same service.

It is on these bases that radical reform is essential if the extra resources needed for health care in this country are to be provided.

The reform proposed would centre around a fundamental change in the present method of financing the NHS.

In the last year for which figures are available, the NHS in Great Britain cost £21.6bn. £18.4bn. of that came from general taxation. Instead, the whole of the NHS should be financed by contributions to a new 'National Health Insurance Scheme'.

Insofar as existing social security benefits are paid for by employees' National Insurance contributions, that cost would be met out of general taxation instead. National Insurance contributions in their present form would be abolished for employees. Instead, they would pay the new National Health Insurance contributions, which would be set at a level to meet precisely the cost of the NHS (less charges).

The great advantage of this arrangement is that those paying the contributions would know that what they were paying was meeting the cost of the NHS, and nothing else. This transparency of funding would mean that if people asked for more money to be spent on the NHS, they would know immediately what the impact of that would be on their own National Health Insurance contributions. Whether this would lead to greater or lesser calls for increased spending, it is impossible to say, but at least the debate would be founded on a clear understanding of the financial implications of any proposal for spending that is put forward.

Just as in the case of the present National Insurance Scheme, what is proposed does not really involve the creation of a fund. It would be a pay-as-you-go scheme, but the similarities in the method of funding to the present National Insurance Scheme make it sensible to call the new scheme the National Health Insurance Scheme. This similarity of name will make it clear that the employees' contributions will now be exclusively financing the NHS, rather than social security, as is predominantly the case at present.

Perhaps of even greater importance, it is also proposed to

encourage extra resources to be provided for health care by voluntary private contributions. Individuals who belong to an approved private insurance scheme should be able to opt out of paying all or part of the new National Health Insurance contributions. They would, therefore, be able to secure health care from outside the NHS without paying twice for it. This would lead to an increase in the total volume of health care provided. For the most part those countries which spend a higher proportion of their national income on health care have a larger private sector, proportionately, than exists in the UK today.

These changes would, of course, completely alter the financing of social security as well as the financing of the NHS. Tables 1 and 2 set out how both would be funded before, and after, the establishment of the 'National Health Insurance Scheme'. As Table 2 makes clear, the employers' National Insurance contributions would remain an integral part of Social Services funding, thus allowing the present system of contributory benefits to continue. The major financial result of switching the chief source of NHS finance from taxation to insurance contributions would, other things being equal, be to increase the amount needed to be raised (above the old employees' NI contributions), from insurance contributions by a global total of £9.4bn., whilst conversely reducing general taxation requirements by £9.4bn.

The rise in insurance contributions needed to finance the NHS would be met by increasing present levels of payment pro rata. If such an increase in insurance contributions is regarded as regressive, the £9.4bn. corresponding reduction in the money needed to be raised by general taxation, could be used entirely to increase allowances, and thus take many people at the lower end of income scales out of taxation altogether.

The full distributional consequences of these changes are, however, likely to be quite complex. If a straightforward transfer of the financing arrangements in the way that I have described would lead to consequences that are not desired, there is absolutely no reason whatsoever why this should be an obstacle to the introduction of the scheme. It would be perfectly possible to make whatever adjustments are needed, either on the tax side or on the contribution side, or on both, in order to secure a distributional result broadly comparable to that at present existing, if that is what is desired. This could even, if necessary, include changes in the present regulations determining who pays National Insurance contributions, in order to ensure that payment is no longer tied to employment.

TABLE 1  
Sources of finance for NHS and Social Security, for the year 1986-7 (GB)

	<i>NHS</i>		<i>Social Security</i>	
		£bn.		£bn.
General Taxation	18.4		General Taxation	23.2
NI (employers and employees)	2.6		NI (employers and employees)	21.3
Charges	0.6			
<b>TOTAL</b>	<b>21.6</b>		<b>TOTAL</b>	<b>44.5</b>

TABLE 2  
Sources of finance for NHS and Security for 1986-7 (GB), if the 'National Health Insurance Scheme' had been in operation.

	<i>NHS</i>		<i>Social Security</i>	
		£bn.		£bn.
Nat. Health Ins.	21.0		General Taxation	32.2
Charges	0.6		NI Employers	12.3
<b>TOTAL</b>	<b>21.6</b>		<b>TOTAL</b>	<b>44.5</b>

SOURCES: The Government's Expenditure Plans 1987-90, HM Treasury 1987, Cm 56-II  
Autumn Statement, 1986, HM Treasury, Cm 14

For those who wish to opt out of the NHS, a public regulatory body would be established to ensure that they would be insuring themselves for a comparable standard of care. Proof of such cover would be required before an individual would be allowed exemption from payments towards the NHS.

An important part of the new arrangements, however, is that they would allow a considerable degree of flexibility in the pattern and choice of health care provision by permitting people to opt out of part of their National Health Insurance contributions, and be entitled to a correspondingly limited

proportion of the services provided by the NHS. They could only do so, of course, if they had bought the appropriate amount of private health insurance to give them cover for what they were no longer getting from the NHS.

For example, people could insure themselves privately for all services except emergency treatment and the use of a General Practitioner. In such cases appropriate payments would be made to both the NHS and private insurance companies. Clearly, however, it would be necessary for the NHS provision to be divided up into broad categories, with each one attracting an appropriate percentage of the total National Health Insurance contributions.

### **The Benefits of Reform**

The reform suggested is plainly a radical one, but if it were instituted the benefits to health provision in Britain would be substantial. Initially, most individuals would probably opt to remain in the NHS, with some perhaps partially contracting-out to private insurers. The necessary expansion of private health facilities, (needed to allow an increase in private money spent on health care), could then occur naturally as demand grew: groups such as BUPA or PPP could expand their services to compete effectively with the state for an individual's health insurance. Consequently, change would occur according to demand, without the previous top heavy re-organisations of health care in the NHS. As individuals would be free to spend what they wished on their health protection for the service they chose, the resources available for health care would be greatly enlarged. The problem of matching resources with needs will never be finally 'solved', but a major new injection of private funds would lead to a very substantial improvement on the present position.

The 'National Health Insurance Scheme' would also diffuse the more sophisticated arguments against encouraging the insertion of private finance into health care. First, the rightly sacrosanct principle behind the original creation of the NHS would remain. Treatment for all, irrespective of means, would be guaranteed.

Moreover, by the influx of private finance, and the creation of effective competition, the standard of health provision for all would increase, without increased unit costs (as has occurred in the United States, since effective competition was established there, after the US Supreme Court outlawed the American

Medical Association's ban on advertising for medical services i: 82.\*)

secondly, the new arrangements would not lead to the NHS being relegated to a second-class service, abandoned by all who can afford to do so. It is the fear of this which has up to now been the most potent argument brandished by those opposed to any growth in private health care. Under the proposals set out above there is no reason for this fear for the following reasons:

- (1) The introduction of new resources into the provision of health care by the growth of private provision will relieve the present pressure on the NHS. The extent to which this will happen, and the pace of development, is impossible to predict, but the NHS infrastructure should, over a period of time, need to accommodate fewer patients, until an equilibrium is achieved between the two sectors.
- (2) There will be a new direct relationship between the cost of the NHS and the National Health Insurance contributions that pay for it. Consequently, if there is demand for growth in the Service, that can genuinely be weighed against the extra cost to those who would benefit from that demand being met. The inevitably political decision about the level of funding would at last be made on a realistic trade off of the cost and benefits involved.
- (3) Another important factor militating against the NHS becoming a second class service is the fact that under the new system the contrast between the NHS and the private sector will no longer exist in its present sharp form. The much greater 'buying in' of services in both directions would blur the present sharp demarcations.
- (4) In addition, the ability of people to opt out partially, rather than make an all-or-nothing choice will produce a far more flexible pattern of health provision. The distinction between NHS patients and private patients will be blurred, and it is likely that most people at some stage of their life would use both the private and the public sector.
- (5) Finally, the benefit of competition both for the NHS and for the private sector will prevent a division between a first class and a second class service. At the moment there is no effective competition, because you cannot have competition when one of the products can only be bought if you have to buy the other one as well.

\*See Green, *Challenge to the NHS: A study of competition in American health care and the lessons for Britain*, IEA, 1986.



The developing competition would increase the efficiency of the NHS, which would for the first time be under pressure all itself. It would also ensure that what has been described as 'irrational and excessive desires for health care' would not be exploited by private doctors. Rather, doctors would have to offer cost effective treatment, for as the liberalised health market developed in Britain, consumers would increasingly be offered different options for insurance. (Indeed, many suspect that it is under the present system that some doctors are able to exploit the NHS — others are now investigating these claims; a good and recent summary of these can be found in *Why are we waiting?* by Jim Yates, OUP, 1987.)

One way in which this is likely to happen would be through the development of Health Maintenance Organisations (HMOs), as in the United States. HMOs are private companies, which in return for fixed monthly or yearly premiums, provide all the services and treatment a patient may need over the corresponding period of time. They differ from standard insurance in that the HMO is both the provider and the insurer — indeed, they are often centred around one hospital. The advantage to the consumer, therefore, is that provided the service is satisfactory, the administrative costs, and hence the premiums, are much lower. The HMO also has an interest in not allowing unnecessary treatment (being both the provider and the insurer), and, hence, the experience in the United States, (where there were 393 HMOs serving 18.9m. people in June 1985, with further growth of around 20 per cent expected for 1986), is that they place great significance on preventive medicine — which is being seen increasingly as the best way to improve general health standards. The benefits of HMOs are now widely recognised. They can, however, clearly only evolve in a system of health care, in which insurance based medical provision is well established.

Anybody who offers a complete 'cure' for the current ills of the NHS is either a fool or a knave. But this does not mean that we should throw our hands up in despair or carry on much as before. There is now both the scope and need for radical change. The proposed 'National Health Insurance Scheme', together with the management changes and efficiency savings suggested earlier in this paper, would create for Britain a richer, more efficient and expanding health service. It would give effect in today's conditions to the principle upon which the NHS was founded in 1948. We do no service to that principle by maintaining a structure which in its present form is outmoded.

British health care needs more resources; and, it is ironical that the NHS, originally formed to increase the provision of health care for all, is now seen as the major barrier to higher spending. The dialogue of the deaf that has characterised discussion of the health services must now be abandoned.

The present organisation of health care needs radical reform. The best way of bringing this about is to maintain the NHS for all who want it, but also to allow the free health market to flourish. This will enable individuals to deploy their health insurance how and to whom they decide.

Letting the consumer express his choice has been a principle widely followed by this Government in housing, and now in education as well. If it has been good enough for the Government elsewhere, why not in health care too?

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## THE AUTHOR

**The Rt Hon Leon Brittan QC** was MP for Cleveland and Whitby from 1974 to 1983, and has been MP for Richmond in Yorkshire since 1983. He has been Opposition Spokesman on Devolution and on Environment, and from 1979 to 1986 served in the Government as Minister of State at the Home Office, Chief Secretary to the Treasury, Home Secretary and Secretary of State for Trade and Industry. He is a former Chairman of the Bow Group and Editor of Crossbow and is currently Chairman of the Society of Conservative Lawyers.



*MW*  
FROM: MOIRA WALLACE  
DATE: 19 February 1988

MR KEMP

cc Chief Secretary  
Paymaster General  
Sir P Middleton  
Sir T Burns  
Mr Anson  
Miss Peirson  
Mr Turnbull  
Mr Parsonage  
Mr Saunders  
Mr Call

**MR LEON BRITTAN - "NEW DEAL FOR HEALTH CARE"**

The Chancellor was most grateful for your minute of 18 February giving your assessment of Mr Brittan's pamphlet "A New Deal for ... Health Care" (papers attached for copy recipients). The Chancellor agrees with your overall conclusion that the pamphlet contains many good ideas, even if some of them are slightly overdone. The Chancellor thinks the current studies ought to give some thought to elimination of service duplication, which, as you point out in your paragraph 2, we have not yet really homed in on. The Chancellor also takes your point that when we come to the question of charges we may also want to consider the question of who the charges are actually paid by, in what form, and when.

*MW*  
MOIRA WALLACE

CHANCELLOR OF THE EXCHEQUER

FROM: E P KEMP  
18 February 1988

MR LEON BRITTAN - "NEW DEAL FOR HEALTH CARE"

You asked - Miss Wallace's minute of 11 February - for an assessment of the proposals in Mr Brittan's pamphlet on health, especially pages 10 to 15.

2. Generally speaking I felt that Mr Brittan's pamphlet was worthwhile and interesting, and a great deal better than some of the mass of material about the present state and future development of the Health Service which is currently washing around. In the early part of the pamphlet he says all the right things about the need for a continued drive for efficiency and value for money (though he does not seem to home in on an "Audit Commission" body to press this a bit harder), and he says the right things about contracting-out, some extension of charging, elimination of duplication of services (something we have not in fact yet really homed in on), and what I call the "cross pollination" between the public and private sector, which distinguishes public provision from public finance, and private provision from private finance, so that public finance could buy in care from private provision and private finance buy in care from public provision.

3. Finally, and crucially to my mind, he seems to home in, although perhaps without knowing it, on a point about charging which is often overlooked; namely the question of who the charges are actually paid by, and in what form they are paid. My point here is that the question of increased and new charges is often bedevilled by images of patients actually having to fork out themselves at the point of service, so that old ladies who visit their doctor have to find say £5 or seriously ill people going to hospital have to find £500 a day, out of their own pockets

and there and then; in fact this does not have to be so, because within the charging concept one could imagine the bill actually being sent to someone other than the immediate patient (his insurance company, his employer, the local authority, or some other "sponsor"); and of course not necessarily sent there and then - all of which I think Mr Brittan gets near in his remark at the foot of page 10 about paying for services directly "(although not necessarily at the point of delivery)".

4. On the most fundamental issue Mr Brittan homes in on the dilemma, as he puts it, that there is a need substantially to increase spending on health care, and private spending at that, in a way which (a) leads to an increase in total provision both public and private, (b) does so in a way which does not destroy the central principle of proper health care for all irrespective of means and (c) does not relegate the public or private sector to a lower tier service; and he might have added, and this is perhaps a flaw in the argument here, that (d) we do not want to add to public expenditure as such - not wholly consistent with (a), and (e) even if private provision and private finance have both increased, the Government of the day would still probably have a view about the scale of this given first the knock-on effects which increases in the cost of private health care can have on the costs of public health care and second the arguable desirability in any society of not spending too much of one's wealth on any one product, especially perhaps health care, given the tendency of this to expand of its own accord and given the finite nature of national resources.

5. As is well known, Mr Brittan's recipe lies in developing the so-called "health stamp", which he sees as a way first of making people more aware of the cost of health, and second of encouraging private provision and reducing the so-called effect by providing more meaningful financial benefit from an "opting out" system, somewhat akin to the opting out from public pension provision. The argument, of course, is that at the moment people "pay twice" if they go private, since they have to pay the full cost (give or take any tax relief) for the private care while not being relieved of any part of their contribution to their public

entitlement, it not being possible to opt out of the tax system and it not being worthwhile to try to opt out of the relatively small health stamp we now have.

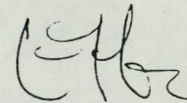
6. Put that way, there is a lot in Mr Brittan's approach (which is not, after all, all that original). It is certainly one which I think the second stage of the current review ought to look at carefully. But to my mind the specific way Mr Brittan sets about it will not quite do. To put it crudely, he over does it. He shifts all of the costs of the Health Service to the health stamp, giving on his figures a move from general taxation to the health stamp of some £9.4 billion. Mr Brittan suggests that this saving to general taxation could be used to increase income tax allowance thus taking many people at the lower end of income scales out of taxation all together; though he goes on to say, quite rightly, that "the full distributional consequences of the changes are, however, likely to be quite complex". This is very true indeed. It is not clear, for instance, how far this approach would have some of the same characteristics of the community charge, namely a flat ratedness regardless of means - not necessarily a bad thing, and even logical if one is dealing with basic health care for an individual, but difficult to defend, as we are seeing.

7. Lastly and from a Treasury point of view I think Mr Brittan overlooks the serious risk that hypothecated levies such as he proposes would constantly seem like an "easy" way to raise more money for public health finance, though it would still of course add to public expenditure as defined and would still add to the burden of taxation as we define it. And it would be difficult to control if all NHS spending was financed this way, in that any imbalance between the health stamp "take" and costs would always have to be met by Government, which risks a long term ratchetting up process.

8. It may be that the distributional considerations and risks to public expenditure and tax that arise (and indeed administrative costs which could be high), are such that you will want to continue to argue,

as you have argued up to now, against any tinkering with the "health stamp" apparatus at all. But I do not think one needs necessarily take that position. My view is that one could move down the charging path via the "sponsor" route, involving a degree of opting out coupled with some shift from NIC to health stamp (we need to run a lower NIF surplus anyway and this is an economical way to do it), and this, coupled perhaps with, some tax relief, would reduce the cliff edge, and could raise a great deal of private money for health care, all without altering the present proportionate sizes of the health stamp and the NIC too dangerously. I think that this is an avenue which should be explored.

9. To summarise, therefore, Mr Brittan has a lot of good ideas and his pamphlet is well worth reading. But in my view while usefully developing a sensible line of thought in relation to this charging/cliff edge/opting out nexus by way of increasing private finance for health care, he over does it and the distributional consequences and risks to expenditure involved in going as far as he suggests would not be acceptable. However, in a sense this is a matter of degree rather than kind and it certainly seems worth looking at his idea further.



E P KEMP



NEW HORIZONS

**A NEW  
DEAL FOR  
HEALTH  
CARE**

The Rt Hon Leon Brittan QC MP

Conservative Political Centre

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I AM greatly indebted to Graham Earles for his help in the preparation of this pamphlet.

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In common with other CPC publications this pamphlet is a contribution to discussion and not an official Party pronouncement.

CPC No. 0510-782

ISBN 085070 775 7

Published by the Conservative Political Centre,  
32 Smith Square, London SW1P 3HH and printed by  
Conservative Central Office, 32 Smith Square,  
London SW1P 3HH.  
First published February 1988

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## A NEW DEAL FOR HEALTH CARE

IF A VISITOR from another planet were to arrive in Britain and listen to the current debate about the NHS he would wonder whether those putting forward the contending arguments were talking about the same country. On the one hand he would hear apparently accurate accounts of unmet needs, and on the other hand he would hear protestations about the ever increasing amount of money devoted to the NHS. In fact the same arguments could have been heard at any time for a number of years. But the recent accumulation of highly publicised incidents has brought the debate to the forefront of public attention and to the centre of the political arena.

This has had the effect of shattering the hitherto unspoken assumption that a combination of modest administrative reforms and increased funding can solve all our problems. It is now clear that to continue to go down that road is a recipe for ever growing dissatisfaction and is politically untenable. Up to now the huge popularity of the NHS has made even the boldest politicians reluctant to touch its essential structure or funding. Almost alone of our great institutions it has been allowed to continue substantially unaltered by the major reforms of the past nine years. It is only now that the intensity of the debate has at last put radical reform on the agenda.

What, then, is the essence of the problem, and what can we do about it? Put simply, the problem is that an inevitably limited supply of money is being required to finance a constantly growing and potentially infinite demand for medical services. Paradoxically, therefore, both the Government and its critics are correct in their assertions.

The Government is right to claim that spending on the NHS has increased in England by 26 per cent in real terms since 1978/9. It can also point to significant increases in services offered: for example, the increases in coronary artery by-pass grafts for the UK from 3,191 in 1978 to 10,500 in 1984, or the number of hip replacements from 28,000 in 1978 to 38,000 in 1984. Yet, these and the many other extra services offered, and the large number of modern new hospitals that have been built, create by their very existence increased running costs in the system as a whole. As a result, critics can point to examples of

what appears to be government underfunding and neglect: the closing down of wards or local accident units, poorly decorated hospitals, and appallingly high waiting lists. To them, this is all evidence of a health service in decline. Whilst they speak of unmet demands, Government apologists reply by highlighting the increased funds that have been made available and the inefficient use of resources that still frequently occurs.

How, then, can we move from a sterile argument that proceeds at cross-purposes to the reform that is needed to deal with the underlying problem?

Our first task is a political one. It is to reassure people that whatever changes we make, however radical they are, we yield to none in our absolute belief in the fundamental principle that adequate health care should be available to everybody in the land, irrespective of their means. The credibility of that commitment will depend not only on the frequency with which it is repeated, although the importance of that should itself not be underestimated. (For politicians should not assume that people have always heard them, or taken in what they say, when they say something for the first time).

At least as important is the general tone which we use when speaking about matters unrelated to the NHS. If we show that we understand that, vital as the enterprise culture is for our survival as a nation, there are values that we share that go beyond it, we shall be more likely to be believed when we reassert our commitment to proper medical care for all.

The 'umbrella concept' philosophy behind the foundation of the NHS is a vital one. Immense benefits are derived by having a service which is substantially free at the point of use. It is this feature of the NHS which gives the feeling of security that is so highly prized, the knowledge that at an inevitably stressful time, financial worries will not be added to concern about one's health and its implications for one's job and family.

The NHS in its present form is simply the administrative and financial structure set up to give effect to the principle of the availability of care for all, irrespective of means. There is nothing sacrosanct about that structure, but there is everything sacrosanct about the principle. The structure was set up after the Second World War and reflects the thinking and perceived needs of that time. It would be astonishing if after forty years it did not require radical change. There is no need to be afraid of such change provided we are loyal to the principle which the NHS, as originally founded, was designed to implement. When a patient seeks treatment today there is no reason why he

should have any special loyalty to the monolithic system of delivery that may have seemed right in 1948, provided he is sure of getting the treatment he needs, whether he can afford to pay for it or not. In fact, he may in the future be more likely to get that treatment if we have the courage to change the system. That is the essential case for reform.

### Improving the NHS

What changes should, then, be instituted? Some can clearly take place and produce benefits within the present structure. There should, for instance, be a continuation of the drive for efficiency and 'value for money' in the NHS through the encouragement of greater cost awareness. The changes recommended in the Griffiths Report of 1983 have largely been introduced. But there is still a long way to go before the new tools are used to the full. The use, for example, of option estimates and appraisals for capital projects, such as the building of hospitals, is now well established but the time scale for deriving benefits from a change of this kind is obviously a protracted one. Similarly, a computer-based package of about 420 Performance Indicators is published annually to help managers compare aspects of their services, such as the average length of a patient's stay in hospital, with that achieved in other authorities. From this, therefore, it should be possible to identify aspects of performance that could be improved. But it is bound to take time before managers fully appreciate how best to use these Indicators to effect real changes in the working methods of their own authorities.

Savings have also been made by the process of 'contracting-out' support services, such as laundry, to private providers. At present, the money saved stands at £73m. per annum, but there is still scope for further savings, with Government estimates that just under 50 per cent of these services by value have still to be put out to tender.

The whole process of contracting out and the delegation of financial control could, of course, be taken much further. It would be possible to contract out a whole hospital. The hospital would then continue to provide free treatment, but would charge the Health Authority directly for the work done.

There are further ways of extending cost awareness to the NHS, which have so far only been proposed, but not yet implemented. There is everything to be said for accelerating the pace of their introduction. One such proposal is that direct

control over budgets should be given to clinicians. If head teachers are being asked to control budgets, there seems no reason why the same concept should not be extended to doctors. The same idea is applicable in the case of primary health care as it is in the case of clinicians working in hospitals.

A far more controversial way of increasing resources for the NHS would be to make some extensions in the charges to patients for treatment. There is no doubt that it would be possible to go some way further down this road without undermining the fundamental principle of the NHS, so long as the charges are modest and defensible in their own right. Hospital 'hotel charges', for example, would certainly be defensible on the grounds that people have to pay for their own food if they are at home, and it is difficult to see why they should not do so when they are in hospital. Nonetheless, quite apart from their unpopularity, they would certainly be difficult to administer. On the other hand even a 10 per cent cut in the bill currently footed by the NHS for such services could provide 52,000 kidney machines or 490 body scanners.

A stronger case can perhaps be made for a small charge of, for instance £1, for a visit to a General Practitioner. Such a charge would certainly be easier to administer. Its importance would lie not so much in the money raised, as in the fact that it would be a gesture of understanding that a General Practitioner's time is valuable and costs money. It would not be too great a charge to deter the visit of a person who is in genuine need of medical advice, or genuinely anxious, but it has been estimated that there would be a substantial saving in GPs' time as a result of the reduction in the number of unnecessary visits. As a result, the quality of service for those seeing their doctor would noticeably improve.

In addition to measures to increase resources, attempts should be made, going far beyond the above mentioned efficiency savings within individual hospitals, to release resources that are currently used to provide duplicate services within Regional Health Authorities (RHAs), and sometimes even within District Health Authorities (DHAs). There needs to be a greater freedom for the co-ordination of resources between different DHAs within the NHS. As has been stated in a recent work\*: 'the NHS needs to dismiss the idea that all hospitals and health authorities must be able to provide all facilities themselves'. One example of where greater co-ordination is desperately needed should demonstrate the point.

\*Peet, *Healthy Competition*, 1987.

At present there is an enormous overlap of services offered by the Public Health Laboratories, the pathology laboratories, and hospital Microbiology Units. Rationalisation of laboratory services within RHAs would both cut administrative, technical and labour costs and also build up centres of expertise. The established benefits of economies of scale would apply without any loss in service. Hospitals could then 'buy in' laboratory services as they were needed - as indeed private hospitals do already, either from the NHS, or from specialist companies such as the Jean Shanks Pathology Services Group or Federal Express. It would be difficult to sustain the argument that laboratory services in the United States were in any significant manner inferior to British services. It is revealing, therefore, that in America the idea of every hospital having its own pathology laboratory, for instance, would be ridiculed as needlessly extravagant. Rationalisation of many other medical services at Regional level on these lines, with the consequential reduction in pointless duplication would release valuable resources which could then be used to provide real improvements in patient care.

#### **Links with the Private Sector**

Above all the concept of 'buying in services' both within the NHS, and between the NHS and the private sector, should be massively extended. If there is no waiting list for a particular type of operation in one place, and a substantial waiting list in another, there is absolutely no reason why a patient should not be entitled to have the operation performed where it can be done most quickly, irrespective of whether this is within the District or Region in which he happens to live. The proposal that there should be a national, computerised information bank to enable this to be done is one which should be implemented as rapidly as possible. There will of course be many people who are either unable or unwilling to travel the distance that may be required to have earlier treatment. But that is a decision that the patient and his family should make, as customers, not an option that should be denied to him because the NHS is not organised to provide it.

Even more important is the encouragement of much closer links between the NHS and the private sector. If the NHS cannot provide a particular service in a particular place, or cannot provide it in reasonable time, it may well be better and cheaper for the NHS to buy in that service from the private

sector, rather than to seek to duplicate it at great capital cost, and with substantial recurring current costs. This already happens to a limited extent. But instead of it being regarded as unusual, extraordinary and questionable in principle, it should be positively encouraged wherever it is the most effective and efficient way of providing patient care.

By the same token, the private sector should be fully entitled to buy services from the NHS, at the proper price, not only through the use of pay beds, but also by paying for specialised facilities of a wide variety of kinds, where the NHS is already incurring the running cost of providing them, and where the use of those facilities by the private sector would not deny or delay their use by any NHS patients. If buying in of services, in both directions, expanded substantially, the division between the two sectors of health care would become much less significant than is now the case. It would be more clearly recognised that both sectors are making a contribution towards meeting the same need: the provision of proper medical care for the country as a whole.

Nonetheless, even if all these measures or changes were implemented, the resources created or released would still almost certainly be insufficient to meet fully the rapidly rising demands for health care. In 1986 the Government acknowledged that health authority services needed to grow by 2 per cent per annum in real terms in order to meet the pressures they faced. (1 per cent to keep pace with the increasing numbers of elderly people, 0.5 per cent to allow the development of medical advances, and 0.5 per cent to make progress towards government objectives such as the improvement of renal services and regular cervical smear tests for women). Moreover, as the NHS becomes more efficient and treats more patients, it necessarily generates a greater and greater demand for resources. It is difficult to see how such expansion could be financed entirely from the savings resulting from the changes suggested earlier. It is estimated that just to meet the pressures identified by the Government in 1986, spending on the NHS for Great Britain would have to rise to £42bn. per annum by 1995, compared to £21.6bn. for 1986-7.

There can, therefore, be no escape from the conclusion that whatever else may be done, the real need of the health services in the UK is for substantially increased resources, although not simply by pumping more public money into the system as it is.

The history of the last twenty years has shown that resources for health care cannot be provided by taxation alone. Under

Labour governments the attempt to increase public spending across the board ultimately led to economic disaster and massive cutbacks, in the NHS as much as elsewhere. The Conservative government, by following a more prudent financial policy, has actually been able to provide more for the NHS, but still not enough for us to equal the share of national resources devoted to health care by many comparable Western countries. To attempt to increase provision simply by increasing state spending, financed by higher taxation or borrowing, may be tempting in the short run, but would soon involve reversing the economic policies which have brought us the steady growth without which we would become less competitive, poorer individually, and in the long run less able to pay for public services too.

The only answer to this dilemma is substantially to increase private spending on health provision, provided (a) that we can do so in a way that leads to an increase in the *total* provision, both public and private, and (b) that we can do so in a way that does not destroy the central principle of proper health care for all, irrespective of means, and (c) does not relegate the publicly provided sector to a lower tier service.

If, in addition, the substantial growth of private provision leads to genuine competition with the public sector, that is likely to achieve the further benefits associated with such competition elsewhere: increased choice, greater efficiency and lower costs.

### A Fundamental Change

All these objectives *can* be achieved. But they cannot be achieved while retaining the present system of financing the NHS. For the present system provides an effective barrier to an increase in provision on the scale necessary to achieve what is required. The reason for this is simple. At the moment anyone who wishes to pay for any form of private health provision has to pay twice over, as he has to pay his full share of the cost of the NHS as well.

The necessary reform is accordingly based on three fundamental premises:

- (1) People are more likely to be prepared to pay for a service, whether publicly or privately provided, if it is absolutely clear what the cost of that service is, and if they pay for it directly (although not necessarily at the point of delivery).

- (2) People are prepared to pay more for a service, if they are making a voluntary decision to do so, than if they are forced to pay through taxation.

- (3) People are prepared to pay more in total for health care than they are currently paying, but only a minority are prepared to pay twice over for the same service.

It is on these bases that radical reform is essential if the extra resources needed for health care in this country are to be provided.

The reform proposed would centre around a fundamental change in the present method of financing the NHS.

In the last year for which figures are available, the NHS in Great Britain cost £21.6bn. £18.4bn. of that came from general taxation. Instead, the whole of the NHS should be financed by contributions to a new 'National Health Insurance Scheme'.

Insofar as existing social security benefits are paid for by employees' National Insurance contributions, that cost would be met out of general taxation instead. National Insurance contributions in their present form would be abolished for employees. Instead, they would pay the new National Health Insurance contributions, which would be set at a level to meet precisely the cost of the NHS (less charges).

The great advantage of this arrangement is that those paying the contributions would know that what they were paying was meeting the cost of the NHS, and nothing else. This transparency of funding would mean that if people asked for more money to be spent on the NHS, they would know immediately what the impact of that would be on their own National Health Insurance contributions. Whether this would lead to greater or lesser calls for increased spending, it is impossible to say, but at least the debate would be founded on a clear understanding of the financial implications of any proposal for spending that is put forward.

Just as in the case of the present National Insurance Scheme, what is proposed does not really involve the creation of a fund. It would be a pay-as-you-go scheme, but the similarities in the method of funding to the present National Insurance Scheme make it sensible to call the new scheme the National Health Insurance Scheme. This similarity of name will make it clear that the employees' contributions will now be exclusively financing the NHS, rather than social security, as is predominantly the case at present.

Perhaps of even greater importance, it is also proposed to

encourage extra resources to be provided for health care by voluntary private contributions. Individuals who belong to an approved private insurance scheme should be able to opt out of paying all or part of the new National Health Insurance contributions. They would, therefore, be able to secure health care from outside the NHS without paying twice for it. This would lead to an increase in the total volume of health care provided. For the most part those countries which spend a higher proportion of their national income on health care have a larger private sector, proportionately, than exists in the UK today.

These changes would, of course, completely alter the financing of social security as well as the financing of the NHS. Tables 1 and 2 set out how both would be funded before, and after, the establishment of the 'National Health Insurance Scheme'. As Table 2 makes clear, the employers' National Insurance contributions would remain an integral part of Social Services funding, thus allowing the present system of contributory benefits to continue. The major financial result of switching the chief source of NHS finance from taxation to insurance contributions would, other things being equal, be to increase the amount needed to be raised (above the old employees' NI contributions), from insurance contributions by a global total of £9.4bn., whilst conversely reducing general taxation requirements by £9.4bn.

The rise in insurance contributions needed to finance the NHS would be met by increasing present levels of payment pro rata. If such an increase in insurance contributions is regarded as regressive, the £9.4bn. corresponding reduction in the money needed to be raised by general taxation, could be used entirely to increase allowances, and thus take many people at the lower end of income scales out of taxation altogether.

The full distributional consequences of these changes are, however, likely to be quite complex. If a straightforward transfer of the financing arrangements in the way that I have described would lead to consequences that are not desired, there is absolutely no reason whatsoever why this should be an obstacle to the introduction of the scheme. It would be perfectly possible to make whatever adjustments are needed, either on the tax side or on the contribution side, or on both, in order to secure a distributional result broadly comparable to that at present existing, if that is what is desired. This could even, if necessary, include changes in the present regulations determining who pays National Insurance contributions, in order to ensure that payment is no longer tied to employment.

TABLE 1  
Sources of finance for NHS and Social Security, for the year 1986-7 (GB)

	<i>NHS</i>		<i>Social Security</i>	
		£bn.		£bn.
General Taxation	18.4		General Taxation	23.2
NI (employers and employees)	2.6		NI (employers and employees)	21.3
Charges	0.6			
<b>TOTAL</b>	<b>21.6</b>		<b>TOTAL</b>	<b>44.5</b>

TABLE 2  
Sources of finance for NHS and Security for 1986-7 (GB), if the 'National Health Insurance Scheme' had been in operation.

	<i>NHS</i>		<i>Social Security</i>	
		£bn.		£bn.
Nat. Health Ins.	21.0		General Taxation	32.2
Charges	0.6		NI Employers	12.3
<b>TOTAL</b>	<b>21.6</b>		<b>TOTAL</b>	<b>44.5</b>

SOURCES: The Government's Expenditure Plans 1987-90, HM Treasury 1987, Cm 56-II  
Autumn Statement, 1986, HM Treasury, Cm 14

For those who wish to opt out of the NHS, a public regulatory body would be established to ensure that they would be insuring themselves for a comparable standard of care. Proof of such cover would be required before an individual would be allowed exemption from payments towards the NHS.

An important part of the new arrangements, however, is that they would allow a considerable degree of flexibility in the pattern and choice of health care provision by permitting people to opt out of part of their National Health Insurance contributions, and be entitled to a correspondingly limited

proportion of the services provided by the NHS. They could only do so, of course, if they had bought the appropriate amount of private health insurance to give them cover for what they were no longer getting from the NHS.

For example, people could insure themselves privately for all services except emergency treatment and the use of a General Practitioner. In such cases appropriate payments would be made to both the NHS and private insurance companies. Clearly, however, it would be necessary for the NHS provision to be divided up into broad categories, with each one attracting an appropriate percentage of the total National Health Insurance contributions.

### The Benefits of Reform

The reform suggested is plainly a radical one, but if it were instituted the benefits to health provision in Britain would be substantial. Initially, most individuals would probably opt to remain in the NHS, with some perhaps partially contracting-out to private insurers. The necessary expansion of private health facilities, (needed to allow an increase in private money spent on health care), could then occur naturally as demand grew: groups such as BUPA or PPP could expand their services to compete effectively with the state for an individual's health insurance. Consequently, change would occur according to demand, without the previous top heavy re-organisations of health care in the NHS. As individuals would be free to spend what they wished on their health protection for the service they chose, the resources available for health care would be greatly enlarged. The problem of matching resources with needs will never be finally 'solved', but a major new injection of private funds would lead to a very substantial improvement on the present position.

The 'National Health Insurance Scheme' would also diffuse the more sophisticated arguments against encouraging the insertion of private finance into health care. First, the rightly sacrosanct principle behind the original creation of the NHS would remain. Treatment for all, irrespective of means, would be guaranteed.

Moreover, by the influx of private finance, and the creation of effective competition, the standard of health provision for all would increase, without increased unit costs (as has occurred in the United States, since effective competition was established there, after the US Supreme Court outlawed the American

Medical Association's ban on advertising for medical services (p. 82.\*)

secondly, the new arrangements would not lead to the NHS being relegated to a second-class service, abandoned by all who can afford to do so. It is the fear of this which has up to now been the most potent argument brandished by those opposed to any growth in private health care. Under the proposals set out above there is no reason for this fear for the following reasons:

- (1) The introduction of new resources into the provision of health care by the growth of private provision will relieve the present pressure on the NHS. The extent to which this will happen, and the pace of development, is impossible to predict, but the NHS infrastructure should, over a period of time, need to accommodate fewer patients, until an equilibrium is achieved between the two sectors.
- (2) There will be a new direct relationship between the cost of the NHS and the National Health Insurance contributions that pay for it. Consequently, if there is demand for growth in the Service, that can genuinely be weighed against the extra cost to those who would benefit from that demand being met. The inevitably political decision about the level of funding would at last be made on a realistic trade off of the cost and benefits involved.
- (3) Another important factor militating against the NHS becoming a second class service is the fact that under the new system the contrast between the NHS and the private sector will no longer exist in its present sharp form. The much greater 'buying in' of services in both directions would blur the present sharp demarcations.
- (4) In addition, the ability of people to opt out partially, rather than make an all-or-nothing choice will produce a far more flexible pattern of health provision. The distinction between NHS patients and private patients will be blurred, and it is likely that most people at some stage of their life would use both the private and the public sector.
- (5) Finally, the benefit of competition both for the NHS and for the private sector will prevent a division between a first class and a second class service. At the moment there is no effective competition, because you cannot have competition when one of the products can only be bought if you have to buy the other one as well.

\*See Green, *Challenge to the NHS: A study of competition in American health care and the lessons for Britain*, IEA, 1986.



The developing competition would increase the efficiency of the NHS, which would for the first time be under pressure all itself. It would also ensure that what has been described as 'irrational and excessive desires for health care' would not be exploited by private doctors. Rather, doctors would have to offer cost effective treatment, for as the liberalised health market developed in Britain, consumers would increasingly be offered different options for insurance. (Indeed, many suspect that it is under the present system that some doctors are able to exploit the NHS — others are now investigating these claims; a good and recent summary of these can be found in *Why are we waiting?* by Jim Yates, OUP, 1987.)

One way in which this is likely to happen would be through the development of Health Maintenance Organisations (HMOs), as in the United States. HMOs are private companies, which in return for fixed monthly or yearly premiums, provide all the services and treatment a patient may need over the corresponding period of time. They differ from standard insurance in that the HMO is both the provider and the insurer — indeed, they are often centred around one hospital. The advantage to the consumer, therefore, is that provided the service is satisfactory, the administrative costs, and hence the premiums, are much lower. The HMO also has an interest in not allowing unnecessary treatment (being both the provider and the insurer), and, hence, the experience in the United States, (where there were 393 HMOs serving 18.9m. people in June 1985, with further growth of around 20 per cent expected for 1986), is that they place great significance on preventive medicine — which is being seen increasingly as the best way to improve general health standards. The benefits of HMOs are now widely recognised. They can, however, clearly only evolve in a system of health care, in which insurance based medical provision is well established.

Anybody who offers a complete 'cure' for the current ills of the NHS is either a fool or a knave. But this does not mean that we should throw our hands up in despair or carry on much as before. There is now both the scope and need for radical change. The proposed 'National Health Insurance Scheme', together with the management changes and efficiency savings suggested earlier in this paper, would create for Britain a richer, more efficient and expanding health service. It would give effect in today's conditions to the principle upon which the NHS was founded in 1948. We do no service to that principle by maintaining a structure which in its present form is outmoded.

British health care needs more resources; and, it is ironical that the NHS, originally formed to increase the provision of health care for all, is now seen as the major barrier to higher spending. The dialogue of the deaf that has characterised discussion of the health services must now be abandoned.

The present organisation of health care needs radical reform. The best way of bringing this about is to maintain the NHS for all who want it, but also to allow the free health market to flourish. This will enable individuals to deploy their health insurance how and to whom they decide.

Letting the consumer express his choice has been a principle widely followed by this Government in housing, and now in education as well. If it has been good enough for the Government elsewhere, why not in health care too?

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## THE AUTHOR

**The Rt Hon Leon Brittan QC** was MP for Cleveland and Whitby from 1974 to 1983, and has been MP for Richmond in Yorkshire since 1983. He has been Opposition Spokesman on Devolution and on Environment, and from 1979 to 1986 served in the Government as Minister of State at the Home Office, Chief Secretary to the Treasury, Home Secretary and Secretary of State for Trade and Industry. He is a former Chairman of the Bow Group and Editor of Crossbow and is currently Chairman of the Society of Conservative Lawyers.

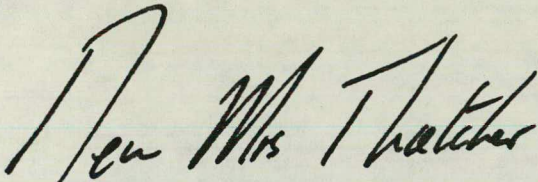
# The National Union of Conservative and Unionist Associations Western Provincial Area

Counties of: Avon Cornwall Devon Somerset  
16 Magdalen Road Exeter Devon EX2 4SZ Telephone Exeter (0392) 58231/3

*President:* DAME MARY BRIDGES, DBE  
*Chairman:* MICHAEL CARTER, CBE  
*Hon. Treasurer:* PETER HODGSON, OBE  
*Hon. Secretary:* PETER GOWER, CBE

22nd February 1988

Rt. Hon. Margaret Thatcher, FRS, MP,  
10 Downing Street,  
London SW1



At the National Union dinner I promised to let you have the information on a well-managed and positively run Health Authority. I enclose press cuttings and a short paper which I hope you will find interesting and, also, heartening. I feel there are many Authorities in the country that are similarly well-managed. It is, therefore, unfair that those which are efficiently run are lumped together with the ones which are badly run in a general and, very often, ignorant condemnation of the NHS. I have noticed over recent months that the louder some Authorities shout "cuts", the greater their managerial incompetence.

The Authorities which are currently short of funds have not suddenly arrived in their current predicament. This is the consequence of years of mismanagement. Extra funds would just cover up inefficiencies and sins of omission. If extra funds are available, they should be targeted to specific projects which are easily monitored for performance. The Somerset Health Authority is not demoralised and has an active and dynamic management, with many new ideas on how to run the service for the benefit of the patients.

/cont.....2

Rt. Hon. Margaret Thatcher, FRS, MP

22nd February 1988

- 2 -

If you would consider allowing my Chairman, Mr. Ward and the District General Manager, Mr. Smith and myself to come and see you for half an hour or so, we would be pleased to do so. I think on questioning us, you would discover new and interesting insights into the workings and otherwise of the NHS from, so to speak, the factory floor.

*Yours  
sincerely  
Michael Carter*

Michael Carter, CBE  
Chairman, Western Area

Batcombe House,  
Batcombe,  
Shepton Mallet,  
Somerset.

# SOMERSET HEALTH AUTHORITY

## 1. PROFILE

Somerset Health Authority provides health services to a population of 361,000. It has 27 hospitals, 6 day hospitals and a total of 3,086 beds. The acute services are based on a District Hospital at Taunton and a District Hospital at Yeovil. It manages its own Ambulance Service. It is one of the larger health authorities in the country.

## 2. FINANCIAL STATUS

The basic cash limits for Somerset Health Authority for 1987/88 are:

Revenue	£76 million
Capital	£1 million
Joint Funds	£1 million
TOTAL	<u>£78 million</u>

The Authority over the years has accumulated revenue reserves. This has been done by not committing to the service all the revenue funds allocated by government but rather putting some by regularly each year in order to meet the running costs of future proposals and capital schemes. These monies have been used on a non-recurring basis year by year to augment the Authority's spending usually on capital projects. This reserve currently stands at £2.6 million. It will be used in the future to fund the revenue costs of the second stage of redevelopment of the District General Hospital which will be completed in 1994 and to augment the cost of the community based strategy for services for the mentally handicapped and the mentally ill.

Apart from allowing the Authority to augment its major capital programme this strategy also puts the Authority in a good position for any "fine tuning" which may be required during the course of the year.

## 3. CAPITAL

A selection of major capital works in the period 1985/86 to 1994/95 is shown below. They have been funded from the normal capital allocation as well as by the use of the reserve fund referred to above.

continued

Schemes Completed 1985/86 to 1987/88		£ million
Musgrove Park Hospital (Acute Services)	Pathology Facilities) Mortuary ) ENT Theatre and Dept Maternity Unit Phase I Redevelopment CT Scanner Intensive Care Unit	1.4 0.8 0.6 9.5 0.2 0.6
Burnham EPD Unit	Mental Illness	0.6
		<u>13.7</u>
Schemes Planned to 1984/95		
Musgrove Park Hospital	Phase II Redevelopment	18.8
Yeovil Hospital	Radiology Department) CT Scanner ) (voluntary subscriptions involved)	2.0
Glastonbury/Street Community Hospital) Priory Hospital Redevelopment )		3.3
Williton Hospital	Elderly Services	2.2
Mental Illness Community Facilities		10.4
		<u>36.7</u>

#### 4. HOSPITAL ACTIVITY

Between the years 1982/83 and 1986/87 there has been an increase in health activity, for example, in acute hospitals inpatient cases have increased by just over 11% during this period. There has been a drop by 10% in the length of time that the average patient has stayed in hospital. The number of day cases has increased by 9%. The average number of attendances by outpatients has increased by 7%. The Accident and Emergency departments have dealt with an increase of 10% in patients. Increases have also taken place in performance in the long stay hospitals, hospitals for the mentally ill and the mentally handicapped.

#### 5. INCREASED EFFECTIVENESS

The Authority has pursued rigorous cost effective programmes resulting in, for example, a saving of £1 million per annum recurring through the competitive tendering exercise for hotel services in hospitals. This was undertaken within the time-table laid down by the government ending in 1986. Since that time a regular cost improvement programme of just over 1% per annum has been achieved each year.

continued

## 6. INTRODUCTION OF GENERAL MANAGEMENT

The introduction of General Management has been a great success in Somerset. High calibre managers have been recruited to whom clear responsibilities have been delegated and powers of decision given. Unnecessary bureaucracy has been eliminated and accountabilities are quite clear. ~~Functional management has been eliminated cutting out unnecessary professional hierarchies.~~ The ethos of general management is widely accepted within the District even by the consultants despite their contracts being with Region. Clinicians are also much keener to play a role in management and over the years good working relationships have been established with the consultants.

## 7. WAITING LIST INITIATIVES

Two waiting list reduction schemes have been successfully achieved.

## (i) East Reach Hospital Taunton

This hospital had been vacated following the transfer to purpose built facilities at the new District General Hospital. It was proposed to re-open the hospital for a limited period to carry out 400 operations in a period of two months. The estimated cost was £300,000.

The project team was set up in January 1987. By the 1 March 1987 it had set up the initiative and recruited all the necessary medical and nursing staff on fixed term contracts. Other services were provided from the District General Hospital. Some new equipment, totalling £25,000, was purchased.

The initiative was a success. 479 operations were carried out on 410 patients; the actual cost was £214,000 funded by

DHSS Initiative Monies	£100,000
DHA Monies	£114,000

Prior to expiry of contracts nurses were assessed, interviewed and where appropriate all available nurses were offered permanent posts within the Unit. All purchased equipment has been fully utilised within the Unit since the end of the project.

## (ii) Yeovil District Hospital

The waiting list initiative is taking place at Yeovil District Hospital and aims to reduce the waiting list in Gynaecology, General Surgery and Orthopaedic Surgery by 800. The estimated cost is £90,000 which is being funded by the Authority. The initiative started on 1 April 1987 and is planned to continue until 31 March 1988. Staffing is mainly from within existing establishments. Additional equipment, mostly prostheses, is estimated at £28,000. As at 31 January 1988 the initiative has exceeded its target with 813 operations as follows:-



332 Gynaecology;  
356 General Surgery; and  
125 Orthopaedic.

There are still two months for this scheme to run.

## 8. CURRENT PROBLEM

Somerset, like all other health authorities, faces uncertainty with regard to the level of funding for pay awards (particularly the review body awards relating to doctors, dentists, nurses and professions allied to medicine) for 1987/88 and for 1988/89. It will not be possible to implement the Authority's developments for 1988/89 and 1989/90 as planned unless the government fully funds, on a recurring basis, the cost of the 1987/88 pay awards and future awards. If, however, the recurring under-funding of the 1987/88 pay and price increases continues into 1988/89 and there is a fall-short of actual costs by, say, 1% then the total deficit for the Authority will be £800,000 in 1988/89 which has to be added to the £400,000 in 1987/88 giving a total funding deficit of £1.2 million.

The Authority is preparing a contingency plan for this eventuality which involves looking at its current services in order to see whether some of the unsophisticated health care in, for example, the long stay services can be left to the private sector or voluntary sector so that funds can be spent on that part of the Health Service for which it is best equipped and does best. The Authority is also looking at bringing forward cost improvement programmes and is satisfied that it will be able to find another 1% improvement in efficiency in the next two years. This will involve the closure of small, less economic hospitals.

## 9. KEY ISSUES

### (a) Consultant Contracts

The single most important change that would have widespread positive effects on the Health Service is to put consultant contracts with District Health Authorities. The contractual situation at the present time with the exception of teaching hospitals is that the contracts lie with Region. Consultants under these circumstances have loyalties neither to Region with whom they rarely come into contact nor to the District with whom they work but feel no ties of contractual loyalty. Professional independence is inculcated in the medical educational system and the contractual arrangements within the NHS serves only to reinforce that independence. The reality of the employer/employee relationship between health authority and consultant would introduce an important psychological change and a significant sanction for health authorities in a hiring and firing capacity. This sanction does not need to be used to be an important weapon in operational management terms.

continued

The District General Manager of health authorities must be seen as the ultimate Manager. He is in a position to appraise consultant performance although it would be wise for him to be professionally advised in order to do this effectively.

The ultimate aim should be short term contracts for consultants with agreed work loads accountable through District General Managers to District Health Authorities.

Consultants with large private practices, and they are likely to be surgeons and anaesthetists, can earn more working a shorter period in the private sector than they can within the NHS. There is an unhealthy temptation, therefore, to give priority to private work. A contract with greater remuneration for an agreed work load would be mutually attractive.

(b) Restriction of Service Provision

There are a number of clinical conditions which should not be an NHS responsibility, for example,

cosmetic surgery;  
 invitro fertilisation;  
 treatment of minor ailments; and  
 chiropody (except for medical conditions).

These services could be provided on a fee paying basis.

(c) Private Patients and Income Generation

There is a growing demand for private practice. Many health authorities could meet this but are currently restricted by regulations relating to the number of private beds they are allowed. This Authority would like to increase the number of private patients by the provision of a small private wing. An increase in private patient beds can only be granted where a clear demand is not being fully met within existing allocated beds. This does not allow health authorities to anticipate the demand. Somerset consultants would be prepared to support the building of a small private patient unit which would generate a significant amount of income for the Health Authority. It may be, of course, that the New Medicines Bill will address this.

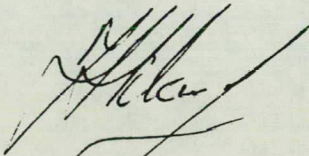
(d) Influence of Professions and Other Organisations

The influence of the professions and particularly the medical profession, and statutory bodies such as the English National Board and other organisations like Royal Colleges have enormous influence over the way that the NHS is run. It is highly questionable whether or not private institutions, commerce and industry, would be so dominated by such professional bodies. The Health Authority and the General Manager can find themselves having to meet stringent conditions which these bodies can impose on threat of withdrawal of recognition. Examples can be the Royal Colleges insisting on time-tables for consultants which do not give adequate NHS service. Recently

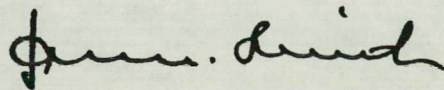
the UKCC (National Body for Nurse Training) have recommended a completely new training scheme for nurses (Project 2000) which replaces the present Health Service orientated training programme by a more expensive and broader based educational scheme centred on education institutions. The current "apprenticeship" training for nurses has served the NHS well. Its elimination will take the nurse further away from the patient bedside where she learns her skills and will have the same adverse effect on nursing which its demise had for industry and commerce.

(e) NHS Relationship with Consumer

A free Health Service at the time of need is a laudable ideal. Unfortunately, it clouds the relationship between the consumer (patient) and the supplier (Health Authority) and raises expectations without identifying the implications. What is required is a mechanism for sharpening-up the accountability of the supplier to the consumer and the consumer's appreciation of the value of the service being provided. The most effective way of achieving this is through a contribution for services given. This would not have to be a large amount, but it should be sufficiently large to be economic to collect. It could be insurable. If this charge was related to hotel services it would have the advantage of not impinging on clinical services, would give an income to the Authority which was easily identifiable, would enable the Health Authority to use that income to improve services and particularly hotel services which in turn would create an internal market for consumers to exercise some choice. At present referrals to hospital are made at the discretion of general practitioners with little involvement of the patient. Although clinical considerations would still be important this change would ensure that they would not be the only ones to influence the patient.



T A WARD  
Chairman



I N SMITH  
District General Manager

M. J. F. CARTER  
Member

February 1988

87?

## Dec/77 WAITING LISTS FALL

The Government have congratulated Somerset Health Authority on its £222,000 scheme to reduce hospital waiting lists in the county.

The scheme was carried out at the 195-year-old East Reach Hospital, Taunton, earlier this year and as a result 479 operations were carried out on 410 patients within 43 days.

In a letter, the Department of Health and Social Security say: "We regard this as an excellent example of good practice."

Mr. Ian Smith, the Authority's General Manager, said all the staff were to be congratulated on achieving excellent results.

He said that in Somerset this year there had been a 20 per cent reduction in hospital waiting lists.

This had been achieved by the East Reach facilities and other schemes, including a highly successful one at Yeovil District Hospital where the staff were already ahead of their own target.

A report shows that between December and June, the lists in Somerset dropped by 1,113 to 3,995.

Mr. Smith paid tribute to the medical, nursing and other support staff whose hard work and dedication had produced such good results.

Mr. Smith pointed out that there had been a shortening of queues for many types of operation, including general surgery, gynaecology, ear, nose and throat surgery, oral surgery and orthopaedics.

The exception was eye surgery where there had been a slight rise from 342 to 403 because the move to Musgrove Park Hospital from East Reach Hospital had caused some disruption.

Reduction in the lists are: West Somerset: General Surgery down from 1,355 to 1,104; Gynaecology down from 638 to 396; ENT Surgery down from 414 to 309; Oral Surgery down from 794 to 635; Orthopaedics down from 1,565 to 1,148 and Ophthalmology up from 342 to 403.

East Somerset: General Surgery down from 462 to 378; Gynaecology down from 532 to 440; ENT Surgery down from 91 to 76; Oral Surgery down from 209 to 181; Orthopaedics down from 237 to 206.

# Shorter wait for surgery the aim

SOMERSET Health Authority is hoping to be allowed to spend an extra £375,000 to reduce hospital waiting lists.

The authority will decide whether the money should be spent as part of a special fund set up by the Government to reduce the numbers of people waiting for operations.

In the past year Somerset has reduced the waiting lists by 20 per cent, through extra operating sessions at Yeovil and keeping East Reach Hospital, Taunton, open after the move to Musgrove Park Hospital.

In Yeovil 725 additional operations have been performed, compared with a target of 600.

The chairman of the authority, Mr Tom Ward, said on Friday that Somerset was doing "exceptionally well", in spite of the crisis in funding the national health service.

"We are by no means complacent, but we have been able to stay within our cash limit during the current financial year.

"As a result, our basic services have not been affected, while at the same time we have introduced a number of new initiatives."

Jan 88

## Patients gain from energy savings

The Authority is to launch a major campaign to reduce the cost of heating and lighting at its 28 hospitals and other healthcare buildings in the county.

The Authority spends more than £2 million every year on energy — twice the amount it spends on drugs.

Over the last 10 years the Authority has reduced its energy bill by over 25 per cent but Mr. Roger Tanner, Director of Estate Management, is convinced that further savings of up to 30 per cent can be achieved by new initiatives in this area.

A small team of energy specialists has been set up to investigate and advise on how these savings can be achieved.

Work has already started on energy surveys of the major hospital sites and these will analyse in detail how and what energy is being used on each site.

Detailed plans will also be drawn up for improving the energy performance by improving insulation, and using the latest computerised control systems, heat recovery equipment and low energy lighting schemes.

The Authority recently installed one of the country's first "zero fuel"

incinerators at Tone Vale which is now incinerating waste from all the West Somerset Hospitals without using any fuel.

The campaign will also concentrate on "good housekeeping", such as switching off unwanted lights, closing doors and windows to avoid losing heat and generally making sure that energy is not wasted.

To promote this "energy conscious" environment in all its hospitals the Authority is to introduce an Energy Newsletter, an Energy Handbook for all new employees and an Energy Saving Suggestion Scheme with cash prizes, said Mr. Tanner.

He added: "Our objective is to make Somerset Health Authority the most energy efficient Authority in the NHS.

"If we can achieve our target of 30 per cent reduction in our annual energy bill then this will release more than £0.5 million every year for improving patient services.

"One of the good things about saving energy is that not only does it save money but it usually results in better standards of comfort for patients and staff who work in our buildings."

The Authority's Chairman, Mr.

Tom Ward, has hosted a series of early morning 'Energy Breakfasts' when senior managers were told of the effects of saving energy and asked to actively support the campaign.

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*Western 8/Nov/85*

# Better health service from cash savings

SOMERSET Health Authority announced this week that patients are to benefit directly from efficiency savings of £1.6 million over the next two years.

The introduction of competitive tendering, new switchboards and savings in energy cost have helped to release the cash.

Mr Ian Smith, the authority's new general manager, said developments in the service would increasingly depend on making better use of existing money.

Among the projects to benefit is the first phase of Musgrove Park Hospital, Taunton, due to be completed next year.

Yeovil District Hospital will gain a new orthopaedic outpatient department while improvements at South Petherton Hospital include new outpatients facilities an occupational therapy department and updated physiotherapy and X-ray rooms.

The authority plans to appoint a new consultant in paediatrics specialising in the care of the handicapped as well as junior posts to help in general and acute services.

More community midwives will be appointed to cope with the expected 25 per cent increase in births over the next ten years.

There are plans to help pay for a medical director at St Margaret's Hospice and to give money towards setting up a counselling service for AIDS sufferers.

Wells is to get an extra consultant psychiatrist while the Kenneth Bailey Day Hospital in Yeovil will be opening five days a week rather than the present three.

Top priority for the mentally ill is the development of psychiatric services in North Somerset by the provision of locally-based units near the people they will serve.

## Fire at laundry

AN electrical fault sparked a small fire in a dryer at the laundry in Parkmead Road on Monday.

Amid cries of crisis from Britain's hospitals, three experts give their d

# Treating the symptoms of mass hysteria

AMONG politicians of all parties, the media and the professions concerned, there is a consensus that the National Health Service is on the rocks. Only the Government appears to dissent from the diagnosis of terminal decline and even it seems to be hunting for a magic bullet.

But what is new and different about the present crisis? There has never been a time in the 40-year history of the NHS when it has not been short of cash. No sooner had Aneurin Bevan launched it in 1948 than he had to go cap in hand to the Cabinet for more money, a process repeated every year since then. Equally, there has never been a time when NHS employees have not protested about its inadequacies. As Enoch Powell pointed out 20 years ago, those working in the NHS have a vested interest in denigrating it in order to advertise their case for more money.

The theme, therefore, is an old one. But it is now being presented as high tragedy. One reason for this might be that the NHS is indeed facing a more serious financial challenge than ever before. But first let us consider some other possible explanations. In particular, the possibility that much of the sense of crisis may be self-inflicted: a case of mass hysteria.

Everything happening in the NHS is immediately interpreted as the symptom of a cash crisis. Every player on stage, doctors, nurses and all the rest, plays up to the audience. The audience joins in. Newspapers and broadcasters seize on the drama and, by so doing, excite both actors and audience to new frenzies in the pantomime. The real problems of some of the NHS's 192 districts are generalised into a national crisis.

There are three stock scenarios used to indicate crisis. First, there is the case of closed beds, which are immediately and uncritically taken as evidence that the NHS is starved of resources. But the NHS has been doing this for 40 years, as have health services the world over. Progress in medicine has made it unnecessary to have so many beds: the best thing is to keep patients out of the dangerous hospital environment. Closing beds cannot be automatically equated with cutting services.

Second, there are waiting lists. Heart-rending stories about critically-ill patients waiting for operations are presumed to reflect the inadequacies of NHS financing. But, equally, they can reflect the inability of local management to shift resources into

priority areas or to change the working practices of consultants. There is also evidence (provided by John Yates of Birmingham University and others) of under-used operating theatres, cancelled operating sessions and absent surgeons even in prosperous times, meaning that existing resources are being wasted.

Third, there are the missing nurses. The media stories are about wards that are being closed or operations that cannot be carried out because of the lack of nurses. Again, there is an automatic presumption that a national pay award would cure a national shortage of nurses. However, information about the way in which nurses work in different parts of the country is revealing. To quote the latest Health Advisory Service report, in Wolverhampton there is a four to four-and-a-half hour hand-over period between the morning and afternoon nursing shifts on some wards. This means one-and-a-half people are paid for every nurse required on duty. Unless we take factors such as this (and patterns of absenteeism wastage) into account, we should not rush to conclude that there is a national crisis.

All this is not to argue that everything is well in the NHS. But it is a strong argument against indiscriminate knee-jerk reactions: the hysterical and automatic cry of "more money" whenever some problem surfaces. What we need to do is to unpick the so-called national crisis.

Much of the present malaise and low morale within the NHS has little to do with changing status and power. The introduction of general management has, inevitably and rightly, changed the rules of the game. The nursing hierarchy bitterly resents the diminution of its professional prestige. Consultants feel threatened, as, for the first time ever, managements start to look at the work they do for the district service. Life is clearly getting tougher for everyone in the NHS.

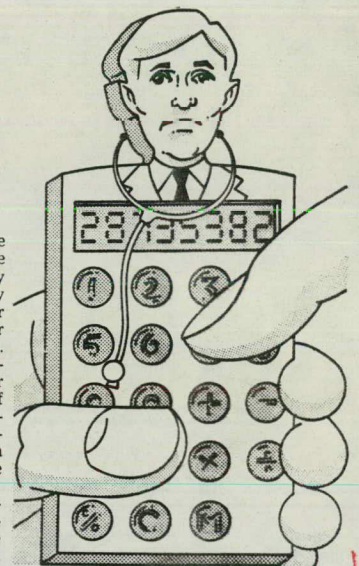
The picture is further exaggerated by stories of crisis in London hospitals. Most of these stories do not make it clear that London has always been relatively over-provided with hospital beds and staff. Unlike the rest of the country, it has therefore suffered actual cuts under the 1976 Resource Allocation Working Party formula which was designed to produce a more equitable national distribution. London is also different in

that public services there are more down-at-heel than elsewhere because of the local labour market. Finally London provides high-technology care for patients drawn from all over the country: in one district 70 per cent of the patients are imported. Thus there may be a case for a temporary infusion of funds, to cover the transitional costs of getting rid of London's excess of beds and consultants, particularly in teaching hospitals, but that is very different from calling for a general increase in the NHS budget or national pay levels.

Indeed most of the present advocacy of extra spending risks detracting from the real problems of the NHS. This is why we have ignored the battle of statistics, where no amount of juggling will ever settle the argument. There can be no formula for defining the adequacy of NHS funding: the much quoted 2 per cent annual increase, the basis of all the estimates of the deficiency in funding, is simply the invention of ingenious DHSS civil servants anxious to present a case to the Treasury.

The important thing now is to get away from hysteria about the national plight of the NHS. The way in which extra money is put in is perhaps more important than the sum involved. Simply to inject extra millions, whether raised through taxation or by ingenious wheezes designed to get more private funds, is to shore up the status quo which we should be changing.

We therefore end with two suggestions. First, health districts presenting themselves as bankrupt should be rescued only after an external professional and financial audit to find out how far their problems are

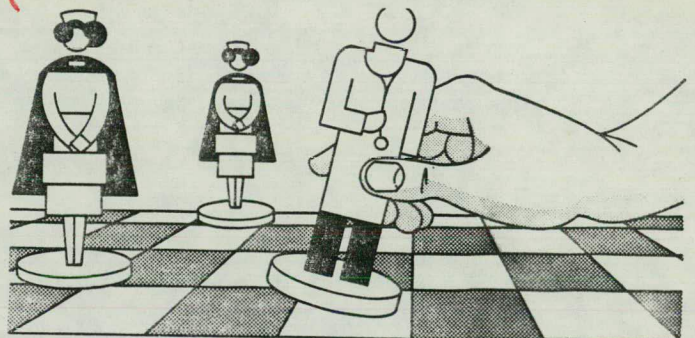


self-inflicted. Second, any extra money channelled into the NHS should not be an across-the-board increase but should be used to bring about better service provision as distinct from shoring up an ancient monument.

Over the next decade or so, health care will move towards a more diverse model, as we design different organisational solutions to different problems in different parts of the country. Only when we have the structure and organisation right, can we be clearer about how much extra money we need - and about how we should raise it.

**Patricia Day  
Rudolf Klein**

*Patricia Day and Rudolf Klein are, respectively, Senior Research Officer and Director of the Centre for the Analysis of Social Policy at the University of Bath.*





*Man* *Planes.*  
*Must help!*

*Ch/ Further minute from CST  
behind (Audit). Only arrived  
this morning*

*28/2/88.*

CST  
TO  
CY  
28 FEB

TO: Chancellor  
FROM: Chief Secretary

*mpw 29/2*

NHS REVIEW

- 1. I have given some further thought to Monday's meeting at No 10 on the NHS. (I hope now that I will be able to arrive late rather than miss the whole meeting. I will do my best to do so).
- 2. Although we are still in the stages of collating information I think our destination is becoming clearer. We need therefore, to press ahead with the work that takes us there. I have commented below on the Papers to be considered at the meeting and suggested some objectives in Para 11 et seq.

3. DHSS Papers 1 - 8

These papers have few fresh ideas and are largely for information but -

4. HC 2 (What happens to Patients)

Patient choice is an attractive principle although in practice the sick have little choice. However a Health Service-wide Computer Information System would enable patients to choose to move out of their own Health District for surgery if another District could carry it out more speedily.

- This approach a) provides a better service
- b) maximises facility utilisation
- c) offers a genuine choice
- d) would be popular presentationally.

Can we commission a Paper on the cost/ use/ benefits of such a system? It may require some variant of funding through 'top-slicing' to ensure that all Health Authorities are financially able (and willing) to receive out-of-town patients. (see Para 19).

5. HC 3 (Waiting Lists)

We should accept the Cabinet Office offer of a Paper on shortening waiting lists. The option above could play a part in this. As I mentioned on Friday, I suspect John O'Sullivan's idea of a 'maximum waiting time' for specified operations might appear also in this paper. If it does we would need to be careful of the public expenditure implications of any such approach.

This Paper should specify which operations account for most of the waiting list and why the list is so long.

HC 3 states that 46% of the waiting lists are accounted for by seven operations - mostly routine ones. If the Private Sector can cope why not contract them out to speed treatment? This would vividly illustrate the practical value to the NHS of the growing private sector. Within the NHS regional specialty centres might be appropriate to deal with large back-logs of specific surgery requirements. (See Para 10).

#### 6. HC 5 (Man-power inflexibility)

We must tackle restrictive practises notwithstanding the squabble this will cause with the BMA and Consultants. I would prefer to see the paper the Cabinet Office offers before the DHSS initiate their initiative on Consultant Contracts. Tackling restrictive practises follows logically from the Nurses Clinical Grading Review and we should regard this as a priority.

#### 7. HC 6 (Information for Management)

We should re-emphasise the necessity for speed in improving the time-table for costing and pricing improvements. DHSS ambitions are far too modest and we should press for this information as soon as possible.

#### 8 Papers 9 - 12 are ours and we discussed them on Friday.

However several points arise:-

#### HC 11 (Independent Audit)

I Minuted separately about this on Friday. I do consider we should invite the Audit Commission to audit the Health Authorities although the DHSS will oppose strongly. We could accept the Wilson fall-back, but I would prefer full Audit Commission involvement.

I do not believe we can satisfactorily establish an internal market or enable funding to follow activity level (rather than population total) without stringent auditing, and costing and VFM techniques. The Audit Commission have the skill and the track record. I believe we should use them and make the decision to do so without delay. And we should make public the efficiency comparisons that arise from Audit Commission's reports.

## 9. HC 12 (Charging)

I would avoid detailed discussion on Monday. Our present objective is simply to keep charging options on the table. We can consider details of extended charging when structural changes (and their costs) are clearer. We can emphasise that charges not only raise income they act as a discipline on expenditure.

## 10. Activity Funding

We touched briefly on 'top-slicing', and 'activity funding', on Friday.

If we wish to direct resources to reflect treatment rather than nominal population structure then activity funding has many attractions.

There can be several variants. In essence, it involves holding funds centrally (either additional funds or part of the annual PES settlement), and enabling Health Districts/Hospitals to claim those funds against specific performance levels. It provides a practical way for 'money to follow patients'. Moreover we could consider opening these funds for operations in the Private Sector too.

## 11. Summary

The above paragraphs suggest we should:-

- review Consultants Contracts and restrictive practises.
- prepare an initiative on shortening waiting lists.
- introduce the Audit Commission and VFM studies to the NHS
- examine activity funding
- consider/ cost Service wide computerisation.

12. These measures fall short of full-blooded reform but they begin to add up to a practical package that could be announced this year. I hope we can agree to press ahead with them as an Action Menu on Monday.

13. For the longer term I should like to commission some models of possible alternative systems. This should move us from discursive theory to practical problems. Officials should be asked to produce Papers on this as soon as possible.

14. We should also examine the extent to which we can maximise NHS/Private Sector co-operation through buying or jointly using surplus capacity. There is no theoretical reason why most services - pathology, surgery, Nursing, clinical services should not be bought in (or contracted out) where it is economical to do so.

15. The P.M. indicated to us last week that she was not opposed to a confidential 'time frame' for decisions. We should raise this on Monday and set one. The Dr. Johnson principle suggests a demanding target and, I think, so does political necessity.

16. The next meeting should be after the conclusion of the Budget Debate.

28th February, 1988

*John M.*  
J.M.

At the moment  
pencilled in for 17 March,  
I discover. Better move  
to following week, I assume?

mpw

29/2

*John M.*

29/2/88

HC 13

SECRET

REVIEW OF THE NATIONAL HEALTH SERVICE

ISSUES FOR MEETING ON 29 FEBRUARY

Note by the Cabinet Office

1. At its last meeting on 8 February, the Ministerial Group commissioned papers on twelve topics. These are attached.

What the papers show

2. The papers are intended primarily as a quarry of background information and analysis.

3. The first eight papers are mainly factual but illuminate some important points about the way the National Health Service (NHS) is working at present.

For instance:

i. spending on the NHS (paper HC1). Between 1978 and 1986 manpower in the Hospital and Community Health Services increased by 5 per cent. This concealed a decrease of 28 per cent in ancillary staff (largely because of contracting out) and an increase of 14 per cent in doctors and nurses. Over the same period, inpatient and day cases increased by 26 per cent, drawn particularly from the elderly and the young. Life expectancy increased across all age bands.

ii. what happens to patients (paper HC2). Patients have very little real choice within the NHS at present. The main decision they have to take is whether to consult their GP or present themselves at an accident and emergency department. All other decisions are taken by GPs and consultants.

iii. waiting lists (paper HC3). There were 688,000 people on waiting lists last March, of whom 162,000 had been waiting for more than a year. Almost all were waiting for surgery. Nearly half are thought to have been accounted for by only seven operations. Waiting times have remained broadly constant since 1975. There are considerable regional variations in the length of waiting lists with the Northern and Yorkshire regions consistently the best, and some Thames regions switching from being the best to the worst in the last eight years. There seems to be no single explanation for the length of lists. Would the Group like to have a further paper on practical ways of shortening waiting times?

*JMS*

iv. Comparison between the public and private sectors (paper HC4). The private sector concentrates primarily on elective surgery: that is, surgery for conditions which if not treated may cause discomfort but not death. It accounts for 15-20 per cent of total operations of this kind but plays little part in the treatment of geriatric and mentally ill or handicapped cases, two of the biggest demands on the NHS which cannot be covered by insurance.

A second point is the cost-comparison in Annex B which, if correct, seems to suggest that unit costs in the private sector have increased much more sharply than those of the NHS in recent years.

ws. ||  
v. manpower inflexibility (paper HC5). A combination of restrictive practices, tenure and self-regulation backed by statute may well be one of the main obstacles to reform. The Department of Health were planning to open up a major initiative on consultants' contracts in the next few weeks. Would the Group wish them to defer this initiative until its work is further advanced, but instead provide it with a paper on more radical ideas for possible change? and on ways in which the self-regulation of entry qualifications by nurses could be altered?  
yjs

vi. information about costs, budgeting and resource management (papers HC6 and 7). Local hospital managers already have considerable information about hospital activity (eg length of stay for particular illnesses, operating theatre usage) and about some costs. The next step is to develop a sufficiently accurate approach to apportioning overheads to enable cost information to be used for the purposes of pricing (setting budgets) and control (monitoring actual against expected costs). Depending on the approach, the NHS could be in a position to price the treatment of individual patients at any time between Easter 1988 and January 1990; but using this information for control purposes nationally is not expected on present plans until at least 1990. Further papers about this timetable and about clinical audits will be coming forward for the next meeting of the Group.

vii. overseas practice (paper HC8). This is a first shot. A further summary of both financing and provision in other countries will be coming forward for the next meeting of the Group.  
mtd

4. The remaining four papers contain some preliminary analyses of issues identified at the last meeting.

viii. Papers HC9 and 10 on competition and consumer choice suggest criteria for decisions on future structures. The Annex to HC10 on the State's role draws an important distinction between providing health care and financing it.  
mtd

ix. Paper HC11 suggests changes in the present arrangements for auditing the NHS. Decisions will be needed on whether changes should be made and, if so, which of the options to adopt.

x. Paper HC12 suggests ways of extending charges, as a means not simply of raising revenue but of introducing financial discipline into the present system and lowering the cliff-edge between free public services and full-cost private services.

#### Options for longer-term change

5. These papers inevitably have a short-term bias. The Group may therefore wish to commission further work on the options for longer-term change. The attached annex outlines a possible paper which officials could be asked to prepare for the next meeting of the Group, setting out the main options for reforming the NHS. More detailed assessment of selected individual options and their implications could then follow.

#### Conclusion

6. The Group is invited:

- i. to note the background papers attached, and to commission any further work on them which it may wish to have;
- ii. to commission a paper on the options for longer-term change on the lines of the Annex attached.

Cabinet Office

SECRET

OPTIONS FOR THE NHS

Outline of official paper

1. There are three broad approaches which could be adopted. They are not mutually exclusive. Some of the ideas under different headings could be combined. For instance, changes within the existing NHS could be made at an early stage as the first steps towards a more radical structure; and changes in management structure could be combined with changes in methods of financing.

Changes within the existing NHS

2. One approach would be to concentrate on refurbishing and improving the NHS without changing its basic concept. Possible options include:

i. decentralised budgeting, with many more decisions, (for instance, about priorities) being taken locally at or below hospital level;

ii. introducing an "internal market", in which District Health Authorities, hospitals and support services would trade and compete with each other;

iii. contracting-out hospital care to public or private sector providers. District Health Authorities, or perhaps hospitals would be responsible for ensuring that care and treatment were available;

iv. encouraging more personal and occupational provision eg through fiscal incentives and/or the extension of charging. Most health care would still be financed by tax.

New Structures

3. Among new structures one possibility would be to establish Local Health Organisations, similar to Health Maintenance Organisations in the United States, based on District Health Authorities or GPs or a combination of both. They would be funded partly by a transferable capitation fee and partly by topping up. Competition from the private sector could be introduced over time. So too could an element of employer-based health provision. The possibility of abolishing Regional Health Authorities would need to be examined.

Changes in methods of Finance

4. Changing the method of finance (which is a different issue from the level of finance) is another approach to reform. There are at least three different possibilities under this heading:



i. health credits/vouchers. The individual would receive the money and buy care himself. There would be maximum individual choice;

ii. social insurance with or without opting out. This could be either a new system or built on existing social security arrangements;

iii. compulsory private health insurance. There would be a safety net for those on low incomes.

#### Conclusion

5. The aim would be to set out these options clearly, with a succinct indication of the main advantages and disadvantages, including the public expenditure and fiscal implications, of each approach, without any recommendation as to which should be adopted. The next step would be to do a more detailed assessment of the implications of individual options selected by the Group.

SECRET

LIST OF PAPERS

- HC1 Spending on the NHS: inputs and outputs
- HC2 What happens to patients
- HC3 Waiting lists
- HC4 Comparison between the private and public acute sectors
- HC5 Manpower inflexibilities (consultants etc.)
- HC6 Information for Management
- HC7 NHS Budgeting and resource management
- HC8 Health care systems in other countries
- HC9 Greater competition in the NHS
- HC10 Improving consumer choice
- HC11 Scope for independent audit of efficiency
- HC12 Scope for increased charging.

LIST  
OF  
PAPERS

SECRET

## SPENDING ON THE NHS : Note by DHSS

### A. Introduction

1. This paper considers what public expenditure on the National Health Service buys, both in terms of inputs and outputs, and the efficiency with which those outputs have been provided.

2. The National Health Service comprises:

\* the Hospital and Community Health Services (HCHS), providing all hospital care and those community health services which are not provided by general practitioners such as district nursing and public health services.

\* the Family Practitioner Services (FPS), providing medical, dental and dispensing services and some ophthalmic services, and covering the costs of medicines prescribed by general practitioners.

\* Central Health and Miscellaneous Services (CHMS), a small number of services which need to be administered centrally eg European Community medical costs, welfare foods and special hospitals.

### B. Inputs.

3. The NHS is financed primarily out of general taxation (85 per cent) with the remainder coming from National Insurance contributions (11 per cent) and general charges and receipts (4 per cent). The proportion of HCHS spending which is met from charges - 0.8 per cent - is relatively small, but is expected to increase to some 1.4 per cent by 1990/91 largely as a result of the income generation initiative. The remainder of this paper concentrates on HCHS spending.

4. Spending on the HCHS accounts for 73 per cent of public expenditure on the NHS (net of charges). Table 1, which compares the distribution of expenditure across major programmes for the years 1978/79 and 1987/88, shows that this percentage has fallen relative to the growth in FPS expenditure. (Annex A describes the breakdown of expenditure within each programme).

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Table 1: Distribution of (net) NHS Expenditure (England)

	1978/79		1987/88	
	fm	%	fm	%
NHS	6275	100.0	16646	100.0
of which:				
HCHS(total)	4744	75.6	12214	73.3
HCHS(current)	4386	69.9	11374	68.3
HCHS(capital)	358	5.7	840	5.0
FPS(current)	1369	21.8	3876	23.3
CHMS(current)	155	2.5	520	3.1
Other NHS(capital)	7	0.1	36	0.2

## Hospital and Community Health Services

5. Some 93 per cent of net public spending on the HCHS represents current expenditure. Annex B shows where this expenditure goes now compared to 1978/79. Almost three quarters of gross current spending is accounted for by labour costs, of which expenditure on (NHS employed) nurses accounts for a third of the total.

6. Table 2, which shows the change in numbers employed between 1978 and 1986 by main staff group, highlights the significant increases in those (doctors, nurses and professions allied to medicine [PAMs]) most closely associated with patient care.

Table 2: Growth in numbers of HCHS staff (000s)

	1978	1986	% change
Total HCHS+	753.5	793.4	5.3
Doctors	37.8	43.2	14.3
Nurses*	351.0	402.7	14.7
PAMs	24.2	33.6	38.8
Admin & Clerical	100.3	111.4	11.1
Ancillary**	172.2	124.3	-27.8

+ Figures for HCHS staff are based on whole time equivalents

\* not adjusted for the reduction in contractual hours in 1981

\*\* reduction in numbers primarily due to the 'competitive tendering' initiative

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7. Capital expenditure represents some 7 per cent (£840 million) of net public spending. In 1987-88 this is expected to be supplemented by a further £200 million from land sales which health authorities retain.

## C. Outputs.

8. Additional resources have bought still greater increases in patient activity as Annex C shows. Between 1978 and 1986 medical and nursing staff each treated 1.2 per cent per annum more inpatients and day cases.

9. In the acute sector, which accounts for nearly half of all HCHS expenditure, this increase in activity has occurred across all ages but has particularly concentrated on the rising numbers of elderly and the very young (Table 5). The former stems largely from an ability to carry out surgical and medical procedures that were previously not possible for older people. The latter reflects the increased ability of neonatal and maternity services to keep alive premature and low weight babies.

---

Table 5: Treatment rates (per 10000 population) by age group, acute sector.

	1978	1985*	% change
0-4	1380.3	1554.2	12.6
5-14	575.9	644.7	11.9
15-64	797.6	862.7	8.2
65-74	1362.6	1668.6	22.5
75+	1736.5	2148.9	23.7
All ages	901.4	1032.7	14.6

---

\* latest available data

10. This increase in treatment rates has occurred during a period when the number of available beds has been reduced in the process of rationalising services. While increased re-admissions account for a small part of the increase in activity, by far the greatest influence on the higher number of admissions has been a significant improvement in productivity reflected in such indicators as shorter average lengths of stay and turnover intervals. Table 6 illustrates these changes for the acute sector.

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Table 6: Use of Facilities (Acute sector)

	1978	1986
No. of available beds	149913	131332
Mean duration of stay (days)- all ages	9.8	7.3
Turnover Interval*	3.6	2.5
Throughput+	28.0	37.3

\* Average length of time in days that a bed is unoccupied between the discharge of one patient and the admission of another.

+ In-patient discharges and deaths per year per available bed

11. The 'final' output of the NHS should be a healthier and longer living population. Mortality rates across all age bands have fallen since 1978 and life expectancy increased as table 7a shows. Table 7b looks at the improvement in the standardised mortality ratios (which take account of changes in the age structure of the population) for a limited range of disorders where prompt medical intervention can often prevent death.

Table 7a: Mortality rates and life expectancy by age

	1978	1986
Perinatal mortality*	15.4	9.5
Death rates:**		
Males	12.1	11.7
Females	11.4	11.4
Life Expectancy:+		
At Birth		
Males	70.0	72.0
Females	76.2	77.9
At 40 years		
Males	32.6	34.1
Females	38.1	39.4
At 60 years		
Males	15.8	16.9
Females	20.4	21.5

\* Per 1000 births

\*\* Per 1000 population, all ages and from all causes

+ In years, figures relate to triennial periods 1976-78 and 1984-86.

# SECRET

Table 7b: Potentially avoidable causes of death (England & Wales)

Cause	Age group	Percentage change in standardised mortality ratios 1978-1986
Perinatal death	-	-38
Tuberculosis <sup>1</sup>	5-64	-50
Cancer of Cervix	15-64	-7
Hodgkin's Disease	5-64	-22 <sup>3</sup>
Chronic rheumatic heart disease	5-44	-76 <sup>4</sup>
Hypertension/cerebrovascular disease	35-64	-30
Surgical deaths <sup>2</sup>	5-64	-17 <sup>3</sup>
Respiratory diseases	1-14	-58
Asthma	5-44	-25 <sup>4</sup>

(1) Omits late effects of tuberculosis

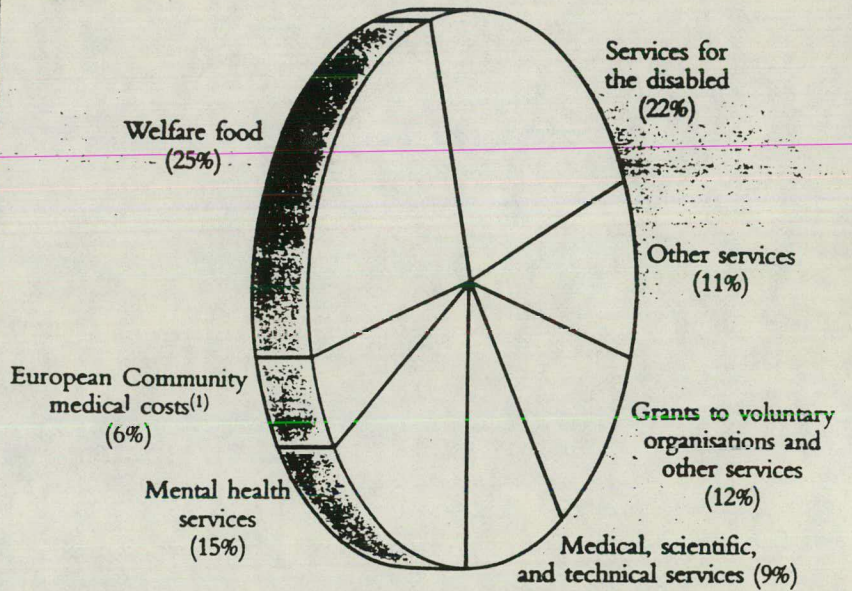
(2) Appendicitis, cholelithiasis, cholecystitis and hernias

(3) 1979-85 percentage change shown as 1978 figures not available

(4) Figures likely to be distorted by revision of International Coding of Diseases.

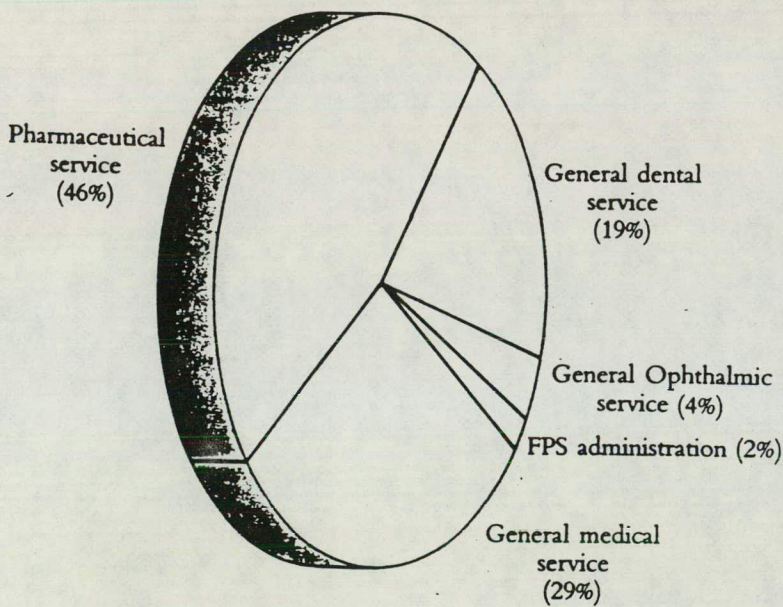
Annex A

Distribution of NHS Expenditure

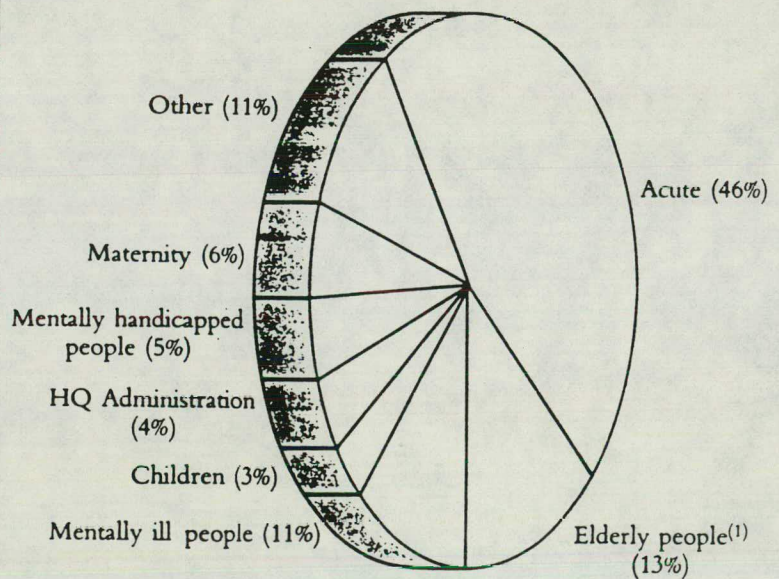


(1) The costs of medical care provided by other EC countries to people from England. Neither this nor the Welfare Food Service are subject to a cash limit.

Family Practitioner Services (gross current expenditure) 1986-87



Health Authority gross current expenditure (excluding joint finance) by service group, 1985-86



(1) Excludes expenditure on acute services.



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## Annex B: Sources and uses of funds by health authorities

	1978/79		1986/87	
	£m	%	£m	%
Income:				
Exchequer	4347.4	98.3	10162.5	98.5
Charges+ receipts	35.0	0.8	91.0	0.9
Decreases in working balances <sup>5</sup>	24.0	0.5	68.6	0.7
Central adjustments <sup>6</sup>	15.1	0.3	(-4.9)	(-0.1)
Total	4421.5	100.0	10317.2	100.0
Expenditure:				
A. Staff				
Medical + Dental	391.6	8.9	1122.1	10.9
Nurses	1353.7	30.6	3495.2	33.9
Other NHS staff	1492.6	33.8	2917.7	28.3
Non-NHS staff (agency etc)	40.6	0.9	150.1	1.5
Sub-total	3278.5	74.1	7685.1	74.5
B. Non-staff				
Drugs	128.1	2.9	318.2	3.1
Medical+ surgical equipment <sup>1</sup>	175.7	4.0	466.6	4.5
Energy <sup>2</sup>	144.1	3.3	239.4	2.3
Provisions <sup>3</sup>	132.1	3.0	189.1	1.8
Rates	55.3	1.3	166.7	1.6
Other	608.0	13.8	1458.3	14.1
Sub-total	1243.3	28.1	2838.3	27.5
Direct credits	(100.2)	(-2.3)	(206.1)	(-2.0)
Total	4421.5	100.0	10317.2	100.0

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1. Includes X-ray equipment and laboratory and occupational and industrial therapy equipment.
2. Fuel, light and power.
3. Includes contract catering
4. Includes net expenditure of services received from/ services provided to other authorities
5. eg running down of stocks, deferred payments to creditors
6. Includes advances to the Central Blood Laboratories Authority et al. and adjustments for supplies and equipment provided by the Department to health authorities without cash payments.

Note: In 1986-87 Health Authorities met some £150 million of expenditure from cash releasing cost improvements resulting from a more efficient use of resources.

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## Annex C: HCHS Activity statistics (England) -thousands

	1978	1986	% change
HOSPITAL			
Acute			
Inpatients <sup>2</sup>	4204	4894	16.4
Daycases	542	1019	88.0
Outpatients <sup>3</sup>	6757	7776	15.1
A&E cases	13360	13776	3.1
Maternity <sup>1</sup>			
Inpatients <sup>2</sup>	731	862	17.9
Outpatients <sup>3</sup>	727	728	0.1
Geriatric and younger disabled			
Inpatients <sup>2</sup>	241	405	68.0
Outpatients <sup>3</sup>	37	59	59.5
Daypatients <sup>4</sup>	1363	1662	21.9
Mental Illness			
Average daily no. of occupied beds	78	62	-20.5
Outpatients <sup>3</sup>	187	202	8.0
Daypatients <sup>4</sup>	3098	3834	23.8
Mental Handicap			
Inpatient beds	47	34	-27.7
Outpatients <sup>3</sup>	3	3	0.0
All specialties			
Inpatient & daycases	5932	7464	25.8
Outpatients <sup>3</sup>	7711	8768	13.7
A&E	13360	13776	3.1
Daypatients <sup>4</sup>	4987	6108	22.5
COMMUNITY			
Health visiting <sup>5</sup>	3597	4129	14.8
Home nursing <sup>6</sup>	3158	3433	8.7

- 
1. Includes GP maternity
  2. Discharges and deaths
  3. New outpatient attendances
  4. Daypatient attendances
  5. Persons visited
  6. Persons treated

## WHAT HAPPENS TO PATIENTS : Note by DHSS

### Introduction

1. This paper offers a summary analysis of the flow of patients into and through NHS hospitals.

### Consultation and admission

#### Primary Care

2. Ninety per cent of patient contacts with the NHS are dealt with by primary care\* services. Every year there are some 200 million general practitioner (GP) consultations (Annex, Table 1). Only a fraction of these consultations (see below) result in referral for secondary care<sup>+</sup> in hospitals.

#### Access to Secondary Care: Acute Services

3. There are three main routes to admission for in-patient or day treatment<sup>x</sup> in hospital acute services<sup>o</sup>:

- i. directly, via accident and emergency (A and E) departments.
- ii. also as emergencies, but through referral by a GP or by another consultant.
- iii. by GP referral for an outpatient appointment, followed by a decision by the consultant to admit for in-patient or day treatment as an "elective" patient (ie with no clinical need for emergency admission).

4. Overall, more than half of all acute in-patients are admitted as emergencies (2.6 million "immediate admissions" out of a total of 4.9 million in 1986 - see Table 1), ie through routes i. and ii. A relatively small proportion of A and E patients are subsequently admitted as in-patients - there were 10.5 million new A and E patients in total in 1986.

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\*"Primary care" services are those which are offered at the point of entry into the health service system. They provide simple diagnosis and treatment, preventive care, and referral of complex cases to secondary care.

+ "Secondary care" consists of specialised services, provided on referral from primary care services, which offer care and treatment which is usually more sophisticated and complicated than could be handled by a GP.

<sup>x</sup> In-patient and day treatment both involve using a hospital bed, but day treatment does not involve staying overnight.

<sup>o</sup> "Acute" services are all hospital services other than maternity, geriatric, units for the younger disabled, mental illness and mental handicap services.

# SECRET

5. Route iii. is more complex. Of the 8.8 million new out-patients in 1986, (7.8 million of whom were in the acute specialties), about half were referred by their GP, the remainder either by one hospital specialist to another or as a follow-up to in-patient or day treatment. The majority of new out-patients are not subsequently admitted for inpatient or day treatment, but many return for subsequent out-patient appointments. Of the 2.2 million elective in-patients treated in 1986 (Table 1), 60% did not know the date of admission when the decision was taken to admit. Paper HC3 offers a fuller analysis of in-patient waiting lists and waiting times, including their distribution geographically and by speciality.

## Non-acute services

6. Non-acute admissions - mainly maternity, mental illness, mental handicap and geriatric - are too varied for ready generalisation. Again, a substantial proportion of admissions (the exact figure is not known) are immediate - most maternity and mental illness admissions, for example. Some mentally handicapped and mentally ill people still reside in hospital, but many are admitted for short periods of observation, treatment or respite care. In 1986, 96% of mental handicap admissions and 74% of mental illness admissions were re-admissions.

## Tertiary Care

7. "Tertiary care" is that which follows referral from one hospital - whose facilities are inadequate to care for a particular patient - to a specialist hospital or unit for more complex diagnosis and treatment (for example cardiothoracic or neurosurgery). These specialist procedures are usually expensive. Referrals of this kind may account for some 30-70% of admissions to postgraduate and other specialist teaching hospitals.

## Decision points

8. Through the processes of consultation and admission, the key decisions - to the extent that there is real choice - are taken

- \* by patients, to consult their GP or to present themselves at an A and E department.
- \* by GPs, to refer to a consultant or to seek an immediate admission. (Rates of referral by GPs vary widely between individual GPs, Districts and Regions: the Group may like to have a fuller paper in due course on this issue and on the balance between general practice and out-patient hospital work.)
- \* by consultants, to admit a patient following an out-patient consultation.
- \* by consultants again, to refer on for tertiary care.

## Care and treatment

9. The Annex as a whole gives some summary analyses of the pattern of care and treatment in NHS hospitals. Two of the more significant features are:

# SECRET

- \* acute services account for 77% of in-patient cases treated, but only 38% of occupied beds (figure A).
- \* people aged 75 or over accounted for 16% of all in-patients and 13% of acute in-patients in 1985, but for, respectively, 34% and 26% of beds used (Table 2). (Only 6% of the England population was aged 75 or over).

A fuller breakdown of acute and geriatric services by the main diagnostic categories is in Table 3, and by types of operations in Tables 4(a), and 4(b)

10. The figures in paragraph 9 reflect relative lengths of stay. For example, the average length of stay for acute patients aged 75 and over was 14.6 days in 1986, compared with 7.3 days for all ages. Lengths of stay obviously vary widely from condition to condition: for example, in 1985 the average length of stay for stroke patients - of whom 61% were aged over 75 (Table 3) - was 48.8 days.

11. Nearly 40% of the average 264,000 NHS hospital beds in use each day are occupied by mental handicap and mental illness patients, even though such patients account for less than 4% of admissions. A large part of the patient care now provided for these groups in the community is delivered by hospital based doctors and nurses.

## Discharge

12. A decision to discharge is normally taken by the responsible consultant, often in consultation with colleagues in other professions. The decision on timing may depend on the availability of adequate community-based support. In 1986, 5.8 million in-patients were discharged home (Table 1); an unknown proportion of those concerned will have been among the 3.5 million people treated by home nurses and the 1.5 million adults seen by health visitors - many of the latter being the mothers of recently born babies.

February 1988

DHSS

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GP4/3

ANNEX

Table 1. Summary of patient flows, England 1986

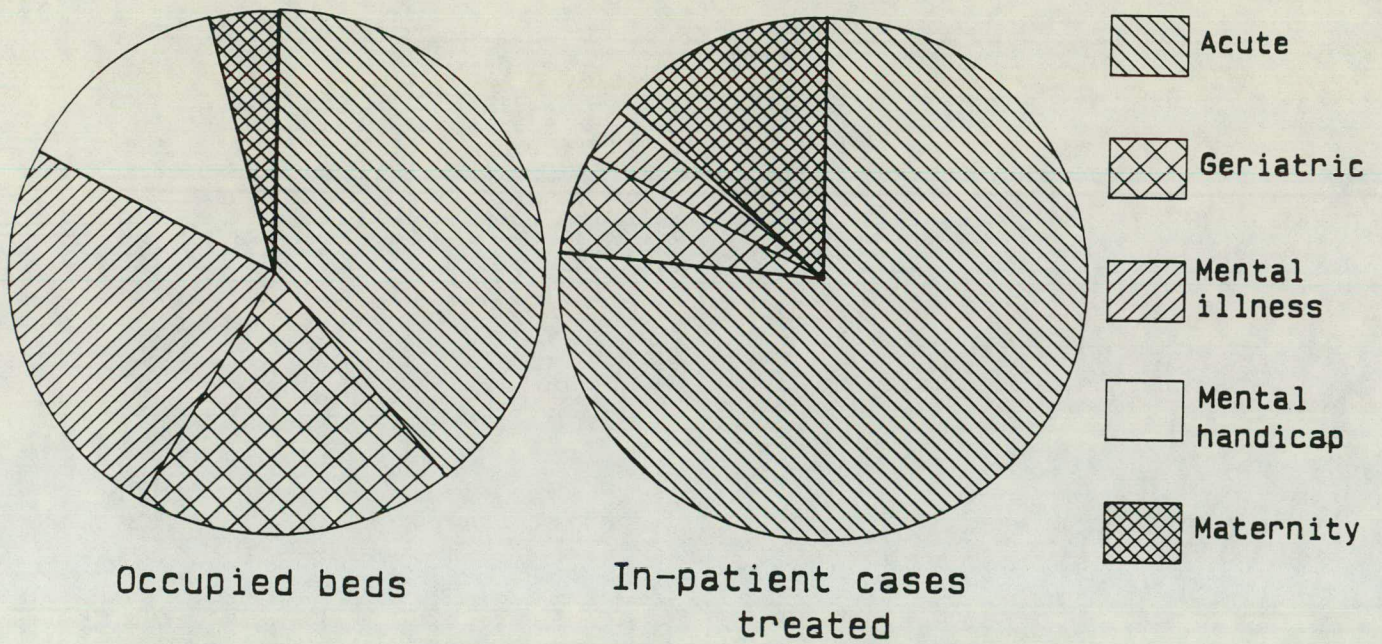
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	Millions of persons/ attendances
<hr/>	
<u>Family Practitioners Committee services</u>	
number of GP consultations (average 4 per head of population)	200
number of prescriptions dispensed	323
<u>Hospital services</u>	
- Outpatient attendances (new outpatients)	37.7 (8.8)
- Accident and Emergency attendances (new A and E patients)	13.8 (10.5)
- Day cases of which operations	1.05 (0.80)
- In-patient cases	6.4
maternity	0.9
psychiatric	0.2
geriatric and units for younger disabled	0.4
acute	4.9
of which	
Surgical	
- immediate admissions	1.1
- elective (of which booked/planned)(1)	1.8 (0.60)
Medical	
- immediate admissions	1.5
- elective (of which booked/planned)(1)	0.4 (0.29)
- In-patient operations	2.6
- In-patients destination on discharge	
- home	5.8
- died in hospital	0.3
- to another institution	0.3
all in-patients	6.4

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Note (1) Booked and planned admissions are elective (ie non-emergency) cases where the patient is given a date of admission at the time the decision is taken to admit.

Figure A: Occupied beds and cases treated  
1986, NHS Hospitals, England





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TABLE 2 Estimated number of In-Patient and Day Cases treated, and average number of beds used daily, with percentage age distribution, NHS hospitals<sup>1</sup>, England 1985

	ESTIMATED NUMBERS <sup>2</sup>					AVERAGE NUMBER OF BEDS USED DAILY				
	Percentage				Total	Percentage				Total
	0 - 14 years	15 - 64 years	65 - 74 years	75 years & over	All ages	0 - 14 years	15 - 64 years	65 - 74 years	75 years & over	All ages
<u>IN-PATIENTS</u>										
Mental handicap	28	69	2	1	43,900	2	82	10	6	36,400
Mental illness	1	65	14	20	203,900	1	42	22	35	64,800
Maternity	0	100	0	0	851,600	0	100	0	0	10,800
Geriatric	0	1	19	80	382,200	0	2	19	79	50,000
Acute	17	55	14	13	4,865,100	10	44	20	26	100,700
Units for the younger Disabled	0	96	3	0	7,300	0	99	1	0	1,300
TOTAL	14	58	12	16	6,353,800	4	44	18	34	264,000
<u>DAY CASES</u>										
Maternity	0	100	0	0	18,800					
Geriatric	0	13	31	56	700					
Acute	11	71	11	6	937,800					
TOTAL <sup>3</sup>	11	72	11	6	957,200					

Source : Hospital In-Patient Enquiry  
: SH3

- <sup>1</sup> All Specialties
- <sup>2</sup> Discharges and deaths
- <sup>3</sup> In addition SH3 recorded 450 Mental handicap and 5,110 mental illness day cases

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TABLE 3 Estimated number of in-patient cases with main diagnosis as shown, and average number of beds used daily, with percentage age distribution, NHS non-psychiatric non-maternity hospitals<sup>1</sup>, England 1985

DIAGNOSIS	ESTIMATED NUMBERS			AVERAGE NUMBER OF BEDS USED DAILY		
	Total	Percentage		Total	Percentage	
	All ages	0 - 14 years	75 years & over	All ages	0 - 14 years	75 years & over
All Causes	5,254,540	16	18	151,989	7	43
Injury and Poisoning	566,270	22	16	13,970	10	43
Neoplasms (cancer)	510,910	2	23	14,646	1	32
Diseases of the Genitourinary System	487,140	7	9	7,012	3	20
Heart Diseases	351,350	0	32	11,857	0	49
Complications of Pregnancy, Childbirth and the Puerperium	152,030	0	0	987	0	0
Abdominal Pain	133,030	17	8	1,388	10	19
Diseases of the Circulatory System	132,060	0	17	4,070	0	40
Disorders of the Eye	125,010	15	32	1,903	6	42
Cerebrovascular Disease (stroke)	123,030	0	50	16,180	0	61
Diseases of the Nervous System	106,940	12	22	8,548	5	41
Hernia of Abdominal Cavity	101,560	13	17	1,508	5	29
Arthropathies including Rheumatoid Arthritis	81,700	2	30	5,231	1	48
Pneumonia, Bronchitis and Emphysema	79,320	12	49	7,093	2	74
Other	2,304,190	26	15	57,598	13	40
POPULATION - England 1985	47,111,700	19	6			

<sup>1</sup> Equivalent to Acute Sector plus Geriatric Depts plus Units for the Younger Disabled

Source : Hospital In-Patient Enquiry

# SECRET

TABLE 4(a) Estimated number of in-patient operations performed, and average number of beds used daily, with percentage age distribution, NHS non-psychiatric non-maternity hospitals, England, 1985

	ESTIMATED NUMBERS			AVERAGE NUMBER OF BEDS USED DAILY		
	Total	Percentage		Total	Percentage	
	All Ages	0 - 14 years	75 years & over	All Ages	0 - 14 years	75 years & over
Neurosurgery	63,950	8	7	1,874	15	8
Operations on eye	115,480	16	31	1,720	7	38
of which Operations on lens	59,140	1	48	1,026	1	50
Ear Nose and throat operations	225,900	47	2	2,072	36	4
of which Tonsils and adenoids	81,820	72	0	685	65	0
Oral Surgery	86,730	15	2	664	13	5
Cardio-thoracic surgery	100,910	7	14	2,395	7	14
Abdominal operations	449,840	8	15	10,641	4	25
Inguinal hernia operations	65,780	15	13	890	7	21
Urinary operations (inc male genital organs)	233,780	16	20	4,017	7	29
of which Cystoscopy (with destruction of lesion)	87,170	1	28	1,229	1	37
Obstetric & gynaecology operations (exc assisted delivery)	426,460	0	2	4,826	0	6
of which Hysterectomy	68,170	0	3	1,898	0	5
Dilatation, curettage and biopsy of cervix	126,640	0	3	853	0	6
Orthopaedic operations	306,620	13	17	10,862	7	36
of which Treatment of fracture by operations	105,230	20	22	4,157	7	44
Arthroplasty	52,770	1	35	2,950	0	45
Operations on arteries, veins and lymphatic system	71,120	1	8	1,224	1	18
Operations on skin (inc plastic surgery)	100,380	20	9	1,967	12	20
Other Surgery & procedures	181,460	9	14	3,547	8	24
All operations and procedures	2,362,630	13	12	45,809	7	23

Source : Hospital In-Patient Enquiry

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TABLE 4(b) Estimated number of day case operations performed, with percentage age distribution, NHS non-psychiatric non-maternity hospitals, England, 1985

	ESTIMATED NUMBERS		
	Total	Percentage	
	All Ages	0 - 14 years	75 years & over
Gastric intubation	119,560	1	10
Excision and/or biopsy of superficial cyst, lesion or other skin growth	79,080	6	5
Cystoscopic operations and examinations	69,840	2	14
Ligation or excision of vas deferens (vasectomy)	42,080	0	0
Diagnostic dilatation and curettage of cervix	37,800	0	0
Sigmoidoscopy	28,330	1	9
Extraction of tooth, simple and surgical	23,740	34	1
Incision of ear drum	22,750	87	0
Incision or removal of nail	19,600	16	3
Arthrotomy and joint puncture of bone	14,170	5	5
Bronchoscopy	11,040	1	13
Spinal Puncture	9,630	2	6
Neuroloysis	9,340	0	5
Partial mastectomy	9,000	0	2
Preputiotomy & circumcision	8,470	84	1
Other day case surgery	289,700	12	6
All operations and procedures	794,130	10	6

Source : Hospital In-Patient Enquiry

## HOSPITAL WAITING LISTS AND TIMES : Note by DHSS

### Introduction

1. This paper is a background note on the composition of waiting lists and the extent of excessive waiting. The Group may wish to have a further paper in due course setting out the underlying issues and implications together with work now in hand to tackle them.

### Trends since 1975

2. On 31 March 1987 the number of patients on the in-patient waiting list in England was 688,000, some 100,000 more than in March 1975 but 60,000 less than the March 1979 peak. Over the period the underlying trend has been an increase of 1.5% a year. Industrial action in 1975, 1979 and 1982 caused the waiting list to rise rapidly, followed by periods of recovery. In March 1986 the waiting list began to rise again, but not as a result of a strike. This continuing rise is a resumption of the national trend over the years which has been masked by the peaks caused by industrial action.

3. The gradual rise in the total waiting list has matched an associated rise in numbers of patients treated. As the volume of patients treated has risen so too have the numbers waiting. In fact the 1.5% average annual increase was slightly exceeded by an increase of about 1.7% a year in the number of acute inpatient cases treated. That has allowed waiting time, which is the relevant problem from the view of the patient, to remain constant over the period. In 1985 50% of all patients admitted from the waiting list were admitted in seven weeks or less. The corresponding figure for 1976 was eight weeks.

### Extent of excessive waiting

4. At 31 March 1987 162,000 patients (23.6% of the total list) had been on the waiting list for more than 1 year. The proportion is the smallest since the statistic was first collected in 1975. Further, it overstates the extent of the problem because waiting list figures are collected at fixed points in time and therefore exclude people who have been on and come off the list in the intervening weeks.

5. Waiting lists consist almost entirely of patients waiting for surgery.\* In 1985 nearly 3 million surgical cases were admitted to hospital. Of these, 1 million were admitted immediately and 550,000, or 18%, were admitted as booked patients. Of the remaining waiting list patients, 750,000 were admitted after waiting less than 3 months, and just 87,000 (3% of all surgical admissions) after waiting over 1 year. The relevant information is summarised in Chart A. A number (believed to be small) of patients on waiting lists do not, in fact, receive treatment.

\* "Surgery" involves incision of the flesh. The "medical" specialties do not.

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## Composition of lists

6. Six surgical specialists (in order of magnitude: general surgery, orthopaedics, ENT, gynaecology, ophthalmology and oral surgery) account for some 85% of the waiting list. A high proportion of the patients are waiting for a small number of "popular" operations. A study of long waiting lists in West Midlands and Wales suggests that 46% of the total waiting list is accounted for by seven operations (varicose veins, hernias, hip replacements, arthroscopies (operating on a joint), tonsils and adenoids, sterilisations and cataracts). These results are broadly confirmed by a total census in Northern RHA of their waiting list at 31 January 1987, the results of which are summarised at Table A. In general the "popular" operations are even more prominent among patients waiting over a year.

7. For the most part, waiting list patients do not suffer from life threatening conditions, but many waiting list conditions lead to discomfort, increasing pain and disability.

## Geographical variations

8. There is considerable variation in size of waiting lists between Districts and hospitals. There are 19 districts (10%) which have less than 100 patients waiting over 1 year. The lists in 20 districts represent 25% of the total national list.

9. Obviously differences in list size are affected by differences in catchment population and numbers of hospitals. However even when the length of the waiting list is related to the amount of activity in that district - in order to determine how many days' work the waiting list represents - there are still marked variations. The district with the largest population (Leicestershire) has few waiting list problems.

10. Regional comparisons tend to mask the widest variations, but even so show significant differences. Chart B shows the deviations from average in 1980. It is notable that the regions with the least problems were Northern, Yorkshire, and 3 of the 4 Thames regions. West Midlands had the worst problem. By 1986, Chart C shows that the position had changed. Northern and Yorkshire were still at the top of the league table but the worst problems were now to be found in 3 of the 4 Thames regions.

11. DHSS analyses has shown that in general there is no consistent relationship at district level between bed capacity or numbers of patients treated and either waiting lists or times. Similarly, the work of John Yates at Birmingham University using performance indicators and activity figures has shown that the numbers of surgeons or operating theatres, absolute levels finance or efficiency (measured by operating rates per surgeon or the extent of cancelled operating sessions) are statistically unrelated to waiting lists or times at district level.

12. Experience has shown the need to look at waiting list problems and their causes individually and locally. The underlying cause of a problem list will be one or several of a range of factors, but determining which one needs local investigation. The solution will not necessarily be more money. For instance in looking at 30 of the longest lists John Yates found only one in which improvements depended on major capital work. In some places the problems lie in efficiency - a poor work rate, low throughput of beds, or inadequate discharge or admission procedures. Elsewhere the problem has been particular bottlenecks - shortages of staffing operating sessions, beds, anaesthetists or trained nurses.

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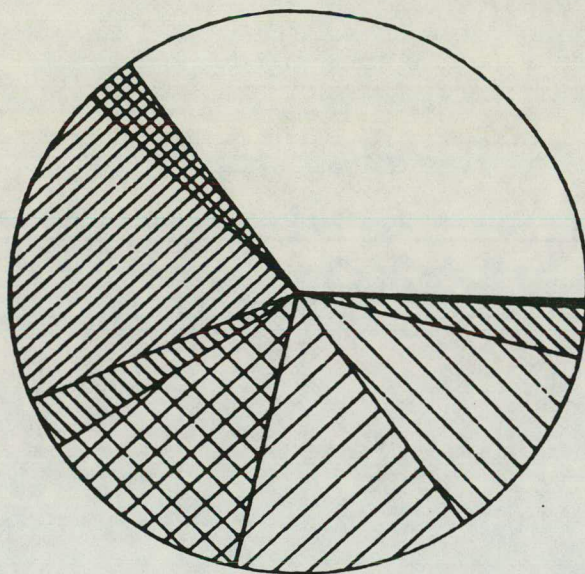
13. The waiting List Initiative has stimulated managers and clinicians in districts to identify the particular cause of their problem and the action needed to solve it, and then to put that action in hand (often supported from the waiting list fund). The aim is to develop locally accepted, achievable targets for improvements in waiting time.

DHSS

February 1988

CHART A

## Cases Treated by Source of admission, 1985 Surgical Specialties, NHS Hospitals, England.



- Immediate(1,050,190)
- ▣ Transfers(82,430)
- ▤ Booked(551,030)
- ▥ Other(87,910)
- \* ▧ 0-28 days (360,750)
- \* ▨ 29-91 days (390,630)
- \* ▩ 92-365 days(343,740)
- \* ▪ >366 days (86,930)
- \* ▫ Not Stated (10,730)

\* denotes waiting list cases



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TABLE A

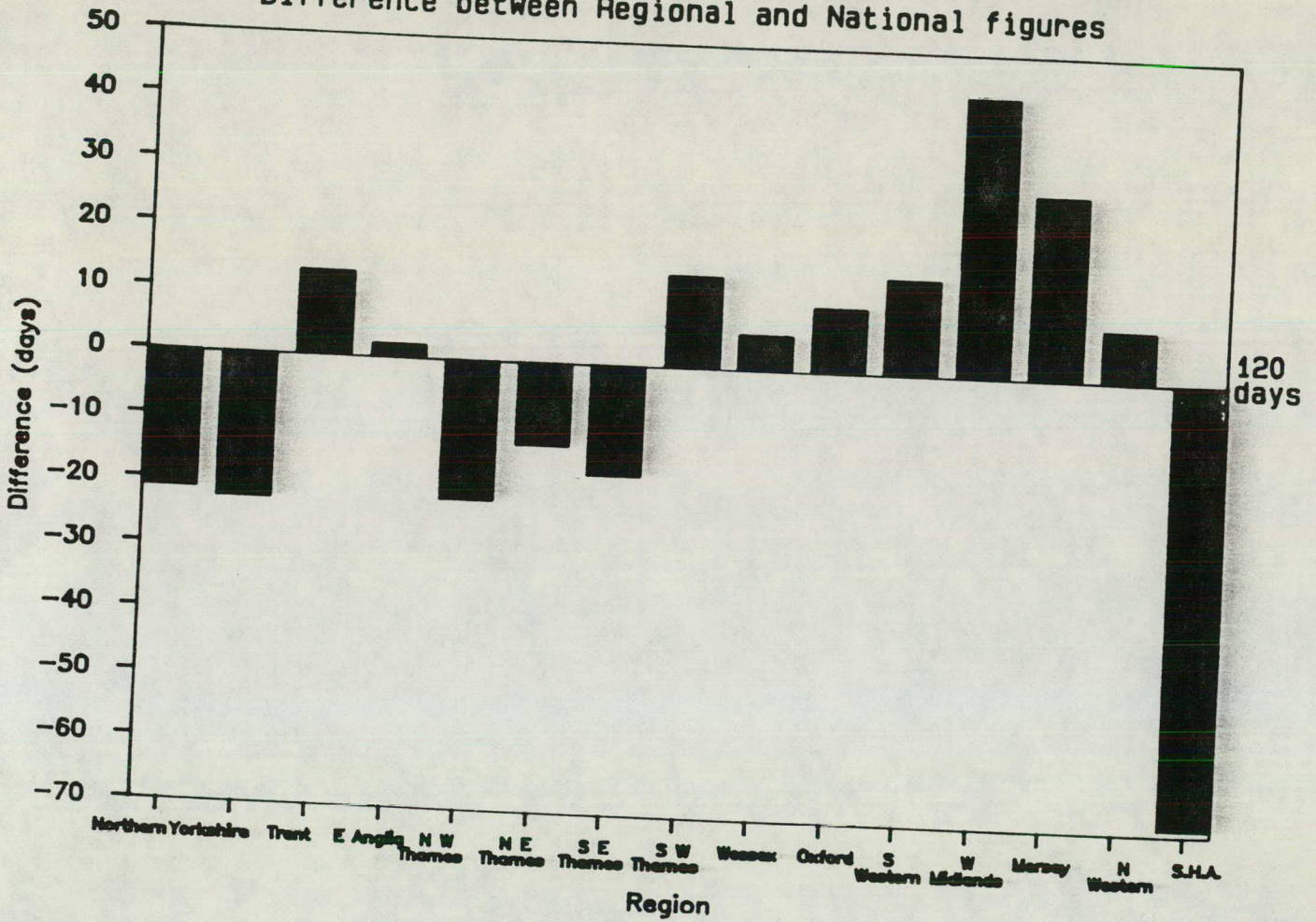
SUMMARY OF INPATIENT WAITING LIST DATA FROM NORTHERN RHA CENSUS

Specialty	% on waiting list aged 65+	% of patients waiting:		main operation for inpatients on list, with % in brackets
		6 months or more	1 year or more	
gen surgery and urology	23	37	21	veins(20), cystoscopy(14), hernia(13), cholecystectomy(4), prostatectomy(3), sigmoidoscopy(3), circumcision(3).
Orthopaedics	22	45	25	total hip replacement(14), bunion(10), knee replacement(7),
Gynaecology	5	25	10	sterilisation(32), hysterectomy(16), dilatation and curettage(13), repair of prolapse(8), examination under anaesthesia(2), termination of pregnancy(1).
ENT Surgery	3	23	7	tonsillectomy/adenoidectomy(37), incision of the ear drum(15)
Ophthalmology	6	31	15	cataract(75), squint(11).
all 5 specialties	22	35	18	

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CHART B

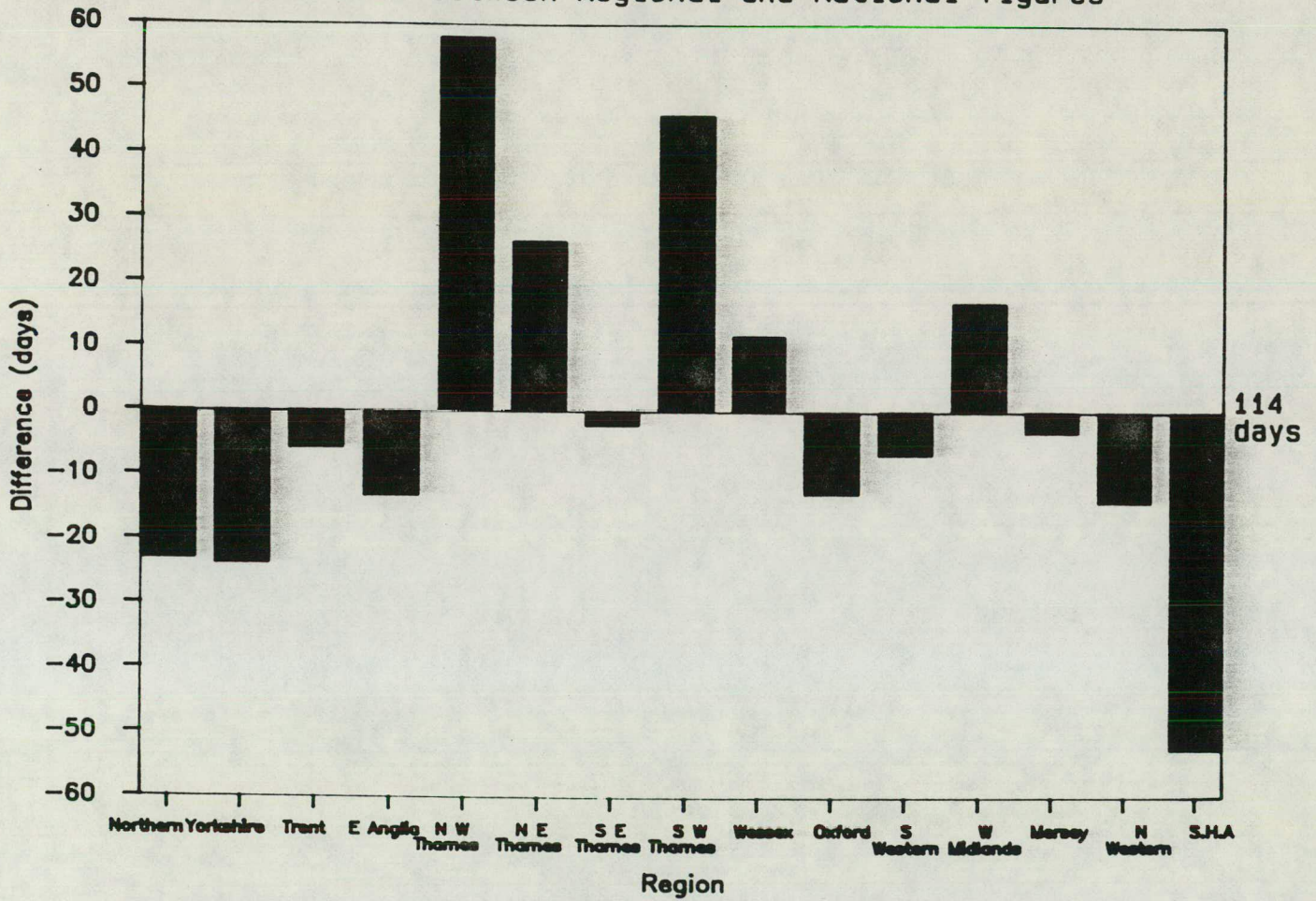
Notional time to clear waiting lists, 1980  
Difference between Regional and National figures



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CHART C

Notional time to clear waiting lists, 1986  
Difference between Regional and National figures



## A COMPARISON BETWEEN THE PRIVATE AND PUBLIC ACUTE SECTORS IN THE UK

Note by DHSS

### Introduction

This paper summarises some key characteristics of the private acute sector, and compares these briefly with the NHS. It does not cover private nursing home provision, which the Group may wish to consider separately at some stage.

### Comparison

2. Comparative information is set out in tabular form as follows:

Annex A - is a summary overview of what the private acute sector is and how it operates, with the NHS equivalent information against each entry where appropriate.

Annex B - is a financial resume of the private sector, again showing NHS equivalents where appropriate.

3. There are a number of points of comparison which are worth highlighting, and which the Group may wish to pursue in more depth through later papers:

\*There are obvious differences in the nature of the business. For example:

(i) the very different sizes of the average hospital (49 beds in the private sector against 233 in the NHS). Private units may find recruiting easier because they offer a friendlier, less stressed environment, and patients too may welcome this. On the other hand, in terms of the range of staff and equipment, and in training provision, the larger NHS units have advantages.

(ii) the differing range of work undertaken - private units concentrating on elective (pre-booked) acute surgery with the NHS tackling a much wider spectrum including accident and emergency care, intensive care and maternity care. Most people who go to the private sector for elective surgery will first have consulted their NHS GP.

(iii) differences in the characteristics of the insured and non-insured populations - in particular the fall-off in insurance cover for those over 65, caused by the high premiums (which reflect relative use of services).

\*There are important differences in the businesses' relationship with their consumers. Whether the private sector's consumer is defined as the patient, the insurer, the GP or the admitting clinician, the private unit has to attract their business.

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\*There is an important difference also in their relationships to consultants. NHS consultants have admitting rights to NHS beds, by virtue of their contracts. The private sector offers admitting privileges. Some private managers operate systems which measure each admitting consultant's use of the hospital's various clinical and support services. Those consultants who do not generate sufficient income for the unit, for example by using it for convalescence and not treatment or by cancelling theatre sessions at short notice, may have their admitting privileges withdrawn.

\*Patterns of staffing differ. The majority of private acute hospitals now have some form of resident medical cover (although far removed from NHS standards of cover). On the other hand, consultants, who in their work in private units do not have supporting teams of junior staff, give much more direct patient care. The nursing pattern is not dissimilar: in the private sector nursing care is provided only by qualified nursing staff.

\*Billing and costing systems differ in a number of respects (although there are some similar strengths and weaknesses as Sir Roy Griffiths' paper for the Group's last meeting suggested). The private sector's financial systems are designed to ensure overall cost recovery, and in general departmental cost recovery, via billing systems which divide costs across patients. These usually involve charging a calculated cost, plus a mark-up; the split of costs across patients may however be estimated rather than measured. The position in the NHS is described more fully in a separate paper. Financial information on the private sector, for example as in Annex B para 2 comes from insurers and therefore reflects the charges they bear rather than providers' costs. In particular charges may be adjusted to circumvent cost controls and maximise income.

4. The Group may wish to note this outline comparison pending consideration of some of the underlying issues in greater depth. Also attached, at Annex C, are some examples of co-operation between the NHS and the private sector.

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DHSS

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AN OVERVIEW1. What it is:

Some 184 acute hospitals (including 16 termination of pregnancy clinics) in England with 9450 beds (425 beds) giving some 20 beds per 100,000 population.

The NHS equivalent: 131,000 acute beds or 260 per 100,000 population.

There are another 3000 pay beds in NHS hospitals, generally in the acute sector.

Roughly 45% of total private hospital beds are non-profit (religious or charitable) with 2/5th of the for-profit beds being owned by American groups. Over 50% of private hospitals are no more than 12 years old. Average size 49 beds.

Average size 233 beds (NHS acute and mainly acute hospitals).

2. Where it is:

Just over 50% of private beds (plus 47% of pay beds) are in the four (NHS) Thames Regions which have 30% of the England population; outside the Thames Regions, Oxford and Wessex have average levels of private beds, with the rest of England below average.

NHS policy of geographic and population-determined resource re-allocation aimed at giving broadly equal access to services.

3. What it does:

Primarily elective surgery, where including paybeds it covers 15-20% of the GB total. For some types of operation it meets a higher proportion, eg 25% of hip-joint replacement.

As well as elective surgery, the NHS provides accident and emergency services, medical and paediatric care, virtually all intensive care, primary and community care, and disease prevention programmes.

Roughly 25% of acute procedures in independent hospitals are performed as day care.

32% of elective surgery as day care in 1985. (NB. definitions may differ.)

Length of stay: a 1983/84 study of 1981 data found that, after controlling for age and case mix, lengths of stay in private hospitals were very comparable with those in NHS hospitals. (Pay bed lengths of stay were very much shorter.) This study is now being repeated; completion March/April 1988.

4. Occupancy:

Bed occupancy is variable, but generally low. BUPA estimated overall occupancy in 1986 at 51%; it is lower in London. (NHS Pay-bed occupancy - as pay-beds - was 32% in 1986.)

Occupancy in NHS acute beds was 75% in 1986 (which does not take account of the use of beds during the day for day cases).

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## 3. Cost Control Mechanisms

While private providers therefore seek to control their costs, their billing systems, coupled with patients' reliance on insurance, allow reasonable confidence of overall costs being recovered whatever level they reach. Cost control is largely an insurer function; the insurers therefore:

(i) have moved towards preferred provider systems - insurers (or companies providing cover for employees) steering patients towards particular hospital groups with whom they have preferential rates

(ii) have established negotiating teams aiming to ensure "their" patients get the optimum prices from providers

(iii) have applied cash limits to medical fee re-imburement, based on a broad classification of operative procedures. (This classification is a system which has grown up over the years. It is not, for example, based on diagnosis related groups.)

A number of "third party administrators" have also appeared; their purpose is to administer insurance claims and potential claims with the aim of challenging unnecessary care and excessive billing.

The insurance industry is believed to be developing a variety of insurance plans to help control costs eg partial insurance.

## 4. Payment Patterns

25% of private acute treatment is paid for by the patient, the other 75% being a charge on insurance companies.

Average claim per person covered has increased from £53 per annum in 1979 to £98 in 1986 (all at 1986 prices).

Chart 2 shows the movement over time in the (real terms) average claim per person covered, with an NHS equivalent.

The average health insurance premium has increased from £165 per subscriber in 1979 to £250 in 1986 (1986 prices). Each individual subscriber covers an average of 2.15 people.

HCHS cost control operates

(i) via overall cash limit control

(ii) via centrally-run pay system - Review Bodies, Whitley. (NB. Private sector -except for medical fees - follows NHS rates.)

(iii) by paying staff salaries, not on an item of service basis.

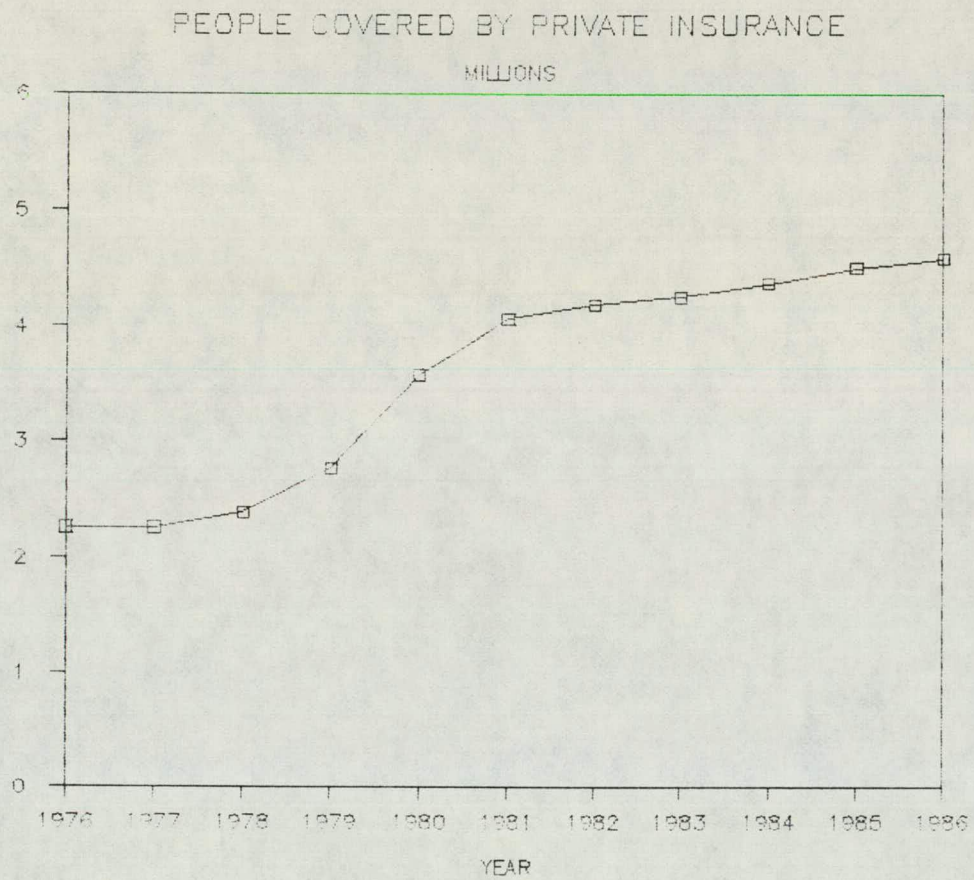
N/A

NHS acute sector expenditure per head of England population was £112 pa - allowing a notional 20% for capital - in 1985, virtually the same in real terms as in 1979.

N/A

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CHART 1





## A FINANCIAL RESUME

1. What it spends:

Estimated 1986 UK spending on private non-psychiatric acute, in-patient and out-patient, care: £683m.

Breakdown: NHS Pay Bed charges £67m  
Physicians and surgeons fees £310m  
Medical/surgical hospitals and clinics £306m

The NHS equivalent for 1985-86 in England only was £5240m.

[NB This includes a 20% allowance for annuitised capital; revenue spending was £4370m].

The figures below are those available from insurance sources as typical charges for the procedure listed; for reasons set out in 3. below these billed figures, although designed to ensure a private unit recovers cost overall, may not represent true procedure costs.

Hip replacement £2100-£4200

Heart operation £4560-£6540

Hysterectomy £1320-£2880

Duodenal ulcer £1220-£2280

Varicose veins £740-£1380

## NHS Procedure costs

£3960 (Updated 1984 central estimate)

£3000-£3960 (£3,000 is Hillingdon Health Authority's costs based on average length of stay for NHS heart operations; £3,960 is based on a Trent Region study in 1987.

£1440 (Updated 1982 study)

N/A

N/A

[NB NHS figures include notional 20% allowance for annuitised capital]

2. Cost Components:

BUPA has estimated that in-patient charges per patient treated rose by 77% over the period 1980/81 to 1985/86. (Charges have to cover the costs of capital investment. Trends in unit costs are not available.)

The equivalent NHS increase in in-patient cost per case for the period 1980/81 is 17%.

To maximise income and limit the impact of insurer-led cost containment, private providers tend to load price increases on to those items of cost that meet with least resistance - notably, in recent years, drugs.

5. Who it employs:

Registered Nurses: 7001 whole time equivalent (England December 1986) - 74 per 100 beds.

NHS Registered Nurses in acute sector was some 55,000, or about 43 per 100 beds.

Medical staff: There is no data available on the extent to which NHS consultant staff undertake private practice. Under their terms and conditions, 6,400 whole-time NHS consultants can earn up to 10% of their NHS salary through private practice; a further 5400 part-time NHS consultants face no earnings limit.

6400 whole-time consultants, 5400 part-time. (Plus 800 wte staff with honorary contracts - principally academic staff. They may also undertake private practice). 23,700 wte other medical staff from senior registrar to house officer.

[NB Medical staffing figures are not split between acute and other.]

Other Professional Staff) No data  
Support Staff ) available

355,700 wte other staff - across all sectors of NHS activity.

The sector relies on the NHS, providing only some limited nurse training, mainly post-qualification study for nurses. Attempts to establish medical training arrangements have not succeeded.

Virtually all basic nurse training (24,000 trained per year) and the great majority of post-basic training. All medical training. All other professional health training that is not in higher/further education sector.

6. Who uses it:

Over 9% of the UK population have health care insurance, and are able to recover part or all of their costs when they use the private sector. (50% of insurance is company purchase, 20% is employer-based and 30% is individual or group.) Roughly 25% of private sector use is not covered by insurance.

Chart 1 attached shows the growth in health insurance coverage.

7. Consumer Protection

The operations of the insurers protect users' financial interests.

Financial discipline imposed by cash limits.

The NHS' care standards reflect

Their care interests are safeguarded by

(i) each unit's pride in its reputation

(i) each unit's morale and ethics

(ii) the requirements of the registration system

(ii) the watch-dog role of Community Health Councils

(iii) their right to report health professions to their professional machinery eg General Medical Council

(iii) the responsibility of Authorities, and ultimately Ministers

(iv) their right to go to law.

(iv) the input of the Ombudsman

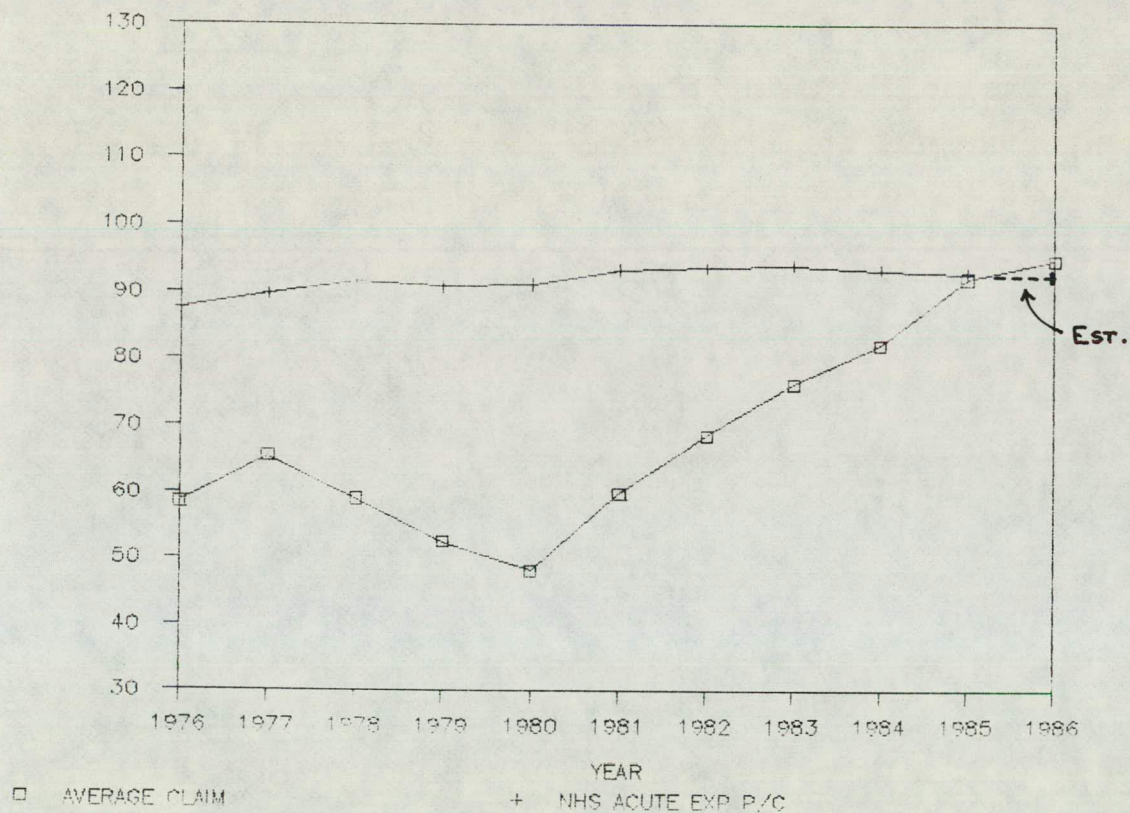
(v) the role of MPs

(vi) health profession's machinery eg General Medical Council

(vii) a patient's access to law.

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CHART 2  
NHS ACUTE SECTOR REVENUE EXPENDITURE PER CAPITA (ENGLAND)<sup>/</sup>  
AND AVERAGE CLAIM PER PRIVATELY INSURED PERSON (UK)  
(CONSTANT PRICES)\*



\* In real terms using HCHS revenue deflator (£1985/86)

<sup>/</sup> About 20% should be added to NHS expenditure to allow for annuitised capital expenditure.

## COOPERATION BETWEEN THE NATIONAL HEALTH SERVICE AND THE PRIVATE SECTOR

1. This note briefly summarises the current range of projects involving the private sector and local health authorities. In 1986, the private sector provided treatment for 41,000 cases under arrangements involving 121 health authorities. The range is considerable and the number of projects has increased significantly recently, stimulated by central initiatives such as Ministers' drive to reduce waiting lists. As part of the waiting list initiative, over 35 district health authorities have reached agreements with the private sector for treating some 4,800 NHS patients in private hospitals for certain conditions at a total cost of over £2.3 million.

2. Examples of waiting list projects include:

Portsmouth HA:	100 hip replacements (£135,000)
Doncaster HA:	100 general surgical operations (£40,000)
	200 ENT operations (£100,000)
	70 gynaecology operations (£30,000)
Burnley HA:	181 ENT operations (£66,000)
	77 hip replacements (£60,000)
Southend HA:	240 gynaecology operations (£96,000)

3. Other examples of projects involving the private sector can be sub-divided as follows:

a. The provision of expensive, specialist equipment

i. BUPA have paid another £1 million for a Magnetic Resonance Imaging Scanner at the National Hospital for Nervous Diseases, for use by both NHS and private patients;

ii. Installation of lithotripter at St Thomas' Hospital at a cost to BUPA of £1 million. About 1,000 patients treated each year, 75 per cent of which are NHS;

iii. NHS patients represent half the 2,000 annually using the whole body scanner in BUPA's London Medical Centre.

b. Preventative medicine

i. BUPA Hospital, Portsmouth is providing mammographic screening for between 5 and 8 NHS patients a week under a contractual arrangements with Chichester HA;

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ii. BUPA Hospital, Norwich is providing mammography services to NHS patients. It has also made a joint appointment with Great Yarmouth and Wave\_ney HA of a nurse tutor;

ii. In Barking, Brentwood and Havering HA, private sector heart screening takes place out of hours on NHS facilities. The HA receives 20 per cent of the gross income.

c. Innovative medicine

i. Joint venture with St Bartholomew's Hospital whereby American Medical International (AMI) Portland Hospital pays £80,000 pa for the provision of infertility services at St Bartholomew's for the treatment of 1,000 women (and some men), half of whom are NHS patients.

ii. Bioplan Holdings plc, a Hampshire - based health care company, is collaborating with Oxford and Salford Health Authorities in building joint NHS/private day surgery units.

d. "Priority care" groups

i. The NHS spends £5 million pa sending seriously disturbed young people to private psychiatric facilities, such as AMI's two units at Kneesworth near Cambridge and Langton House, Dorset;

ii. Bolton HA are holding discussions on a mixed NHS/private development of a new facility for 90 long-stay geriatric patients, 50 of whom will be from the NHS.

e. Management contracts

Guys Hospital is considering contracting out to Hospital Capital Corporation (HCC) the management of 47 paybeds in Nuffield House, its private patient wing.

f. "Priority acute" services

A number of the waiting list projects mentioned in paragraph 2 are targeted at diagnostic groups to which Ministers have asked health authorities to give priority. Other examples include:

i. East Suffolk HA have an agreement with Unicare Medical Services, a subsidiary of the US based Travenol, for the provision of renal dialysis services in Ipswich. At present, 10 NHS patients are regularly dialysing;

ii. Clwyd HA signed a contract on 19 November 1987 with AMI Manchester for the treatment of up to 20 cardiology and cardiac surgery patients to be referred each year by consultancy physicians in Clwyd;

iii. Two subsidiary private renal units, managed on behalf of the NHS by Travenol and Community Dialysis Services at Bangor and Carmarthen, were opened in 1985 under a 7 year contract. The provision of two further subsidiary units at Cardiff and Merthyr Tydfil is under consultation.

## MANPOWER INFLEXIBILITIES : Note by DHSS

### Introduction

1. It is important to promote greater flexibility in the use and deployment of staff in the HCHS. Changes in the labour market, and in particular the prospect of a substantive decline in the number of school leavers, make this the more important.

2. Manpower inflexibilities are being tackled across all staff groups. The present paper deals primarily with professional staff. It

- \* summarises relevant work currently in hand in respect of (a) consultants, and (b) the non-medical, professional workforce;
- \* considers the relationship between this work and the review; and
- \* suggests some issues for further consideration in the context of this review.

### Work in hand

#### Consultants

3. The main work currently in hand which bears on flexibilities in the medical workforce is addressing three underlying problems:

a. the fact that the present consultants' contract seeks to cover a lifetime's work during which technology, practice and service patterns will change. Appended to this paper is a background note on the consultants' contract, and on the context in which the possibility of changing that contract is currently being addressed.

b. a lack of effective mechanisms, including sanctions, for resolving problems quickly at local level.

c. a lack of common understanding about the professional (service to patients) and the managerial (resource use) elements of a consultant's duties, and about the problems of reconciling the two in daily practice.

4. Two major initiatives are currently in hand. One is the Resource Management Project - with which the Group is already familiar. The other concerns disciplinary procedures: current disciplinary procedures for hospital and community doctors and dentists can use resources which would be better spent on patient care - the costs of lengthy suspensions on full pay, for example, and high legal costs. The DHSS is currently working with the profession on the first major review of these procedures, and a report is expected later this year.

5. Other work is at this stage internal to Government. Specifically the following proposals are under consideration, not all of which are addressed

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exclusively to "inflexibilities" but which are interrelated in a variety of ways:

- a. including in the existing contract references to subordinate documents such as a specific, reviewable job description.
- b. providing for greater geographical mobility.
- c. securing a sharper assessment of a consultant's management aptitude and attitude during the appointment process.
- d. establishing a clearer role for Districts in monitoring consultants' activities, or even (despite its unpopularity with the profession) giving Districts the contracts themselves where they are currently held at Regional level (Appendix, paragraph 2).
- e. tightening the rules to prevent private practice from distorting NHS commitments (for example, by delaying the start of NHS clinics).
- f. promoting "best practice" in the management of professional work and in the exercise of managerial tasks and responsibilities.
- g. reviewing the distinction awards system, for example to reward managerial as well as clinical excellence and responsibilities and to secure a fairer distribution of awards overall.

## Other professions

6. Inflexibilities which arise with the other health professions - nurses, physiotherapists, radiographers, and so on - are being tackled on three main fronts:

(a) Greater flexibility between professional disciplines. There is potential for greater flexibility between professions; and in some cases within them. The "Project 2000" proposals for the reform of professional nurse education aim to maximise flexibility within the profession in the delivery of nursing care in and between both hospital and community settings. These aspects of Project 2000 are well accepted in the NHS and by the profession. Inter-professional flexibility is more sensitive. There are two approaches: to seek amalgamation of professions, and to seek flexibility of roles and common training. There has recently been only one successful example of amalgamation (physiotherapists and remedial gymnasts), although discussions are going on which could lead to eventual amalgamation of physiotherapy and occupational therapy. Flexibility of roles and common training are seen as a more immediately practicable approach, although still controversial with the professions. There have been some limited advances. DHSS are seeking to stimulate more.

(b) Skill mix. The potential for using vocationally trained "helpers" is recognised to varying extents by different professions. There is also varying appreciation of the extent to which recruitment problems at professional level will necessitate this approach. The Project 2000 proposals envisage a new but better prepared "helper" grade to replace

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and enlarge the existing, limited numbers of nursing auxiliaries. Ministers are currently considering how to secure this necessary expansion. Some other professions (eg occupational therapy) are working positively to expand the role and use of helpers. Others are less advanced. DHSS policy is to promote the National Vocational Qualifications approach throughout the care sector (ie social services and private and voluntary sectors as well the NHS). This will involve both "career ladders" based on vocational qualifications, with access to professional training for the more able "helpers"; and the maximum degree of common training for all helpers, to promote flexibility. The NVQ approach is being backed up by a number of skill mix studies in individual professions.

(c) Conditions of service. Difficulties here include rigid grading definitions; collective agreements which stipulate triggers for the creation of extra posts; benefits which apply to certain grades only or which are different for each staff group; and allowances, for example for unsocial hours, which can inhibit flexible shift-working. A series of grading reviews now in progress should result in a more flexible recognition of skills and responsibilities. A wholesale review of conditions of service is also under way with a view to making them better suited to local management needs.

## Wider review issues

7. The Group's work could clearly have a major impact on much of the work described in this paper. The review could, for example, have significant implications for both consultants' and general practitioners' contracts going beyond what is currently proposed, and it seems sensible to take no major new initiative with the medical profession on consultants' contracts for the time being. The Department will report as the review proceeds on any implications which may emerge from current developments.

8. There remain at least three key issues which are potentially fundamental to the review. Some if not all of these issues could usefully be illuminated by comparisons between the public and private sectors and/or between UK and overseas experience. They are:

(a) Self-regulation. Doctors are accountable to their patients for the service they give. Nurses and the other health professions are similarly responsible for the maintenance of professional standards, including safe practice and enhancing specialist knowledge. These responsibilities are underpinned by the regulatory activity of the relevant statutory bodies, in particular the General Medical Council, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and the Council for Professions Supplementary to Medicine. The value of this self-regulation needs to be weighed against the need for flexibility and management control. The Group may find it helpful to have a fuller paper on this issue, and on related issues such as limitations on professional advertising.

(b) "Tenure". Models of health care delivery which imply a less monolithic organisation of supply will have implications for the tenure for life currently enjoyed by nearly all NHS staff, including hospital



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consultants (Appendix, paragraph 2). The Group may wish to consider at a later stage whether current proposals for modifying the consultants' contract in a way which alleviates the effects of tenure - in particular 5 (a) and (b) above - will suffice (assuming that a nationally negotiated model contract remains the right approach).

(c) Skills supply. There is a major and growing problem of securing an adequate supply of many of the skills - especially nursing and some other non-medical skills - which will remain essential however health care delivery is organised. The Group may therefore wish to consider as their work progresses:

\* the potential impact of different organisational models on the supply and costs of scarce skills; and

\* how best to maintain the necessary "seedcorn" investment in professional and other skills training.

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DHSS

## Consultants' contracts

### Background

1. In the 1970s, the Government and profession sought to negotiate a more work-sensitive contract for consultants. An impasse was reached over "pricing" the new contract, and it fell. Instead, in 1979, the present Government agreed and introduced the current arrangements for private practice and promulgated a new model contract (Annex A).

2. Background information about the basis on which consultants are employed is contained in Annex B. The key features are 24 hour responsibility for patients and permission to undertake private practice as well as NHS work. The majority of consultants are appointed to the grade (with tenure for life) in their mid to late 30s and remain in the same post until retirement. Consultants' contracts are held at RHA or Teaching District level, although many consultants work only in one District.

### Objectives

3. In addressing the need for change, the NHS Management Board's aims are that consultants should

- \* be a well-motivated workforce, providing high quality, 24 hour care for their patients.
- \* provide maximum value for money and account for the resources they use.
- \* regularly evaluate their clinical practice.
- \* accept the need for the flexibility to meet changing clinical practices and service needs.

4. It is also important to secure the commitment of the consultant workforce to any changes proposed, recognising that

- \* it is difficult to provide effective services to patients without the commitment and goodwill of the consultant body.
- \* most consultants provide services in excess of their contractual commitments, and only a minority abuse their positions.
- \* many consultants are increasingly willing to participate in resource management initiatives, to secure improved efficiency, to co-operate fully with general management, and to promote more systematic clinical audit.

## RECOMMENDED FORM OF CONTRACT FOR CONSULTANTS

Dear

### APPOINTMENT OF CONSULTANT IN (SPECIALTY)

1. I am instructed by the (insert name) Authority to offer you an appointment of [whole-time]\*, [maximum]\*, [part-time]\* consultant in (specialty) from (date) subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff and to the provisions as to superannuation from time to time in force.
2. The terms and conditions of the employment offered are set out in the Terms and Conditions of Service of Hospital Medical and Dental Staff (England and Wales) and General Whitley Council Conditions of Service as amended from time to time. Copies of these may be seen at the Authority's offices.
3. The appointment is superannuable. Unless within 13 weeks of starting your employment you are notified otherwise, you will be subject to the National Health Service Superannuation Scheme and will then be contracted out of the state pension scheme. A copy of the current regulations governing the scheme may be seen at the Authority's offices and a booklet about it is attached (NHS Superannuation Scheme (England and Wales); An Explanation).
4. Insofar as they are not already covered by the Terms and Conditions of Service mentioned above the following duties have been assigned to you for the purpose of providing health services under the National Health Service Acts in the following district(s): (insert names)
  - a. Diagnosis and treatment of patients at the following hospitals, health centres and clinics; (insert names). (Insert, for part-timers only, the number of notional half-days at each)
  - b. [Domiciliary consultations as may be required from time to time].
  - c. In addition to the duties mentioned above you may exceptionally be required to undertake duties for limited periods within the districts specified above.
  - d. The diagnosis and treatment of patients occupying accommodation made available under sections 58, 65 and 66 of the National Health Service Act 1977, insofar as such patients have not made private arrangements for such treatment under section 65(2) of that Act.
  - e. (insert as necessary)
  - f. Continuing clinical responsibility for the patients in your charge, allowing for all proper delegation to, and training of, your staff.

Subsequently, the duties and places where they are to be carried out may be varied by agreement between the Authority and yourself.

5. The arrangement of your duties will be such as may be agreed between the Authority and yourself from time to time. (Insert the following sentence for whole-timers and maximum part-timers). [It is agreed that any private practice you may undertake, whether limited or not by the Terms and Conditions of Service, will in no way diminish the level of service that may be expected from you by the authority in carrying out the duties specified above].\* (Insert the following sentence for maximum part-time consultants only:) [It is also agreed that the duties specified above are regarded as requiring substantially the whole of your professional time, and that this will involve a minimum work commitment equivalent to 10 notional half-days a week].\* (Insert the following sentence for part-time consultants only:) [The duties of the appointment offered to you are assessed as amounting to notional half-days a week].\*
6. The salary of the appointment (exclusive of any distinction and meritorious service award payable to you) will be that appropriate to a [whole-time]\* [MPT]\* consultant appointment [assessed at notional half-days a week].\* Your starting salary will be (insert commencing salary). Salary will be payable monthly/quarterly. Your incremental date will be

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7. For the purposes of section 1(2)(c) of the Employment Protection (Consolidation) Act 1978, your previous employment with (insert name of previous employer) does [not] \* count as part of your continuous period of employment [and your continuous period of employment therefore began on (date)]. \* However, for the purpose of certain NHS conditions of service, previous NHS service, not treated as "continuous" under the provisions of the Employment Protection (Consolidation) Act 1978, may also be reckoned for those purposes, subject to the rules set out in the Terms and Conditions of Service.
8. The employment is subject to 3 months notice on either side but is subject to the provisions of paragraphs 190 to 198 of the Terms and Conditions of Service of Hospital Medical and Dental Staff.
9. You are required to be fully registered with the General [Medical] \* [Dental] \* Council.
10. The authority requires you to be a fully subscribed member of a recognised professional defence organisation, or, if you have an objection to such membership on grounds of conscience or on some other grounds approved by the Secretary of State, to take out and produce to the authority an insurance policy covering yourself in respect of any liability arising out of or in connection with your duties hereunder, and to produce to the Authority forthwith the receipts of the payment or renewal of subscriptions or premiums as the case may be.
11. Your private residence shall be maintained in contact with the public telephone service and shall be not more than 10 miles by road from the (insert name) hospital unless specific approval is given by the Authority to your residing at a greater distance.
12. Arrangements for leave and other absences must be approved by the Authority [but shall in the first instance be made locally]. \*
13. The agreed procedure for settling differences between you and the authority where the difference relates to a matter affecting your conditions of service is set out in Section XXII of the General Whitley Council Conditions of Service.
14. In matters of personal conduct you will be subject to the General Whitley Council agreements on disciplinary and dismissal procedures. The agreed procedures for appeal against disciplinary action or dismissal are set out in Section XXXIV of the General Whitley Council Handbook and paragraph 190 of the Terms and Conditions of Service of Hospital Medical and Dental Staff.
15. The authority accepts no responsibility for damage to or loss of personal property, with the exception of small valuables handed to their officials for safe custody. You are therefore recommended to take out an insurance policy to cover your personal property.
16. If you agree to accept this appointment on the terms indicated above, please sign the form of acceptance at the foot of this letter and return it to me in the enclosed stamped addressed envelope. A second signed copy of this letter is attached and should be retained by you for future reference.

Yours sincerely

Signature  
On behalf of

I hereby accept the offer of appointment mentioned in the foregoing letter on the terms and subject to the conditions referred to in it. I undertake to commence my duties on the

Signature

Date

This offer and acceptance of it shall together constitute a contract between the parties

Note: [ ] \* denotes "delete as necessary".

## MANAGEMENT OF CONSULTANTS IN THE NHS

### Key facts

- a. 14,000+ consultants (England and Wales).
- b. Contracts held at Regional or Teaching District level (by District in Wales).

Can be appointed as:

	<u>Proportion</u>
i. whole-time (equivalent to 11 half-days per week). Private practice must not exceed 10% of salary	48%
ii. maximum part-time (equivalent to 10 half-days per week). Unlimited private practice	32%
iii. other part-time	9%
iv. honorary (normally University employees).	11%
c. Under his terms of service, a whole-time and maximum part-time consultant is "expected to devote substantially the whole of his professional time to his duties in the NHS".	
d. Whole-time consultants' salaries start at £25,440 rising by four annual increments to £32,840. In addition, 36% of consultants receive a distinction award of between £5,790 and £29,550 p.a. 1% receive the highest award: their whole-time salary (on scale maximum) is £62,390. Some 68% of consultants are in receipt of an award when they retire.	
e. Total HCHS medical and dental pay bill for 1987/88 estimated to be £1,516 million, including some £50 million for distinction awards.	
f. In addition to their salaries - and depending upon the specialty - consultants can earn fees from domiciliary consultations (no more than approximately £10,000 p.a), category 2 work (providing reports for insurance companies etc) and family planning work.	

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HC6

INFORMATION FOR MANAGEMENT : Note by DHSS

Introduction

1. This paper
  - (i) summarises recent and current developments in HCHS management information;
  - (ii) illustrates what health authority managers can now do with the better information which is coming on stream; and
  - (iii) examines in broad terms the timetable for future action based on DRG (diagnosis related group) costing. (A fuller paper is being prepared on this in accordance with the conclusions of the previous meeting of the Ministerial Group).

The paper is relevant both to strengthening the NHS in its present form and to the development of the systems that would be needed to underpin more radical options.

Recent and current developments

2. Current improvements in the range and quality of the information available to local management have come from two main initiatives:
  - (i) Korner: the Korner Steering Group identified a minimum range of compatible data to be captured in every District. Most of the Group's recommendations have been implemented by health authorities from 1987-88, and the remainder are due for implementation from 1988-89. The result has been a radical overhaul of the Service's information systems, the fruits of which are now beginning to emerge.
  - (ii) Performance indicators (PIs): the Department has developed a set of 450 PIs, covering a wide range of both inputs and outputs. Their purpose is to help management at all levels to identify variations in performance so that necessary management action can be taken. An updated package is due for publication by the end of March. An improved, Korner-based, set relating to the financial year 1987/88 is being developed for issue in January 1989.
3. The Korner recommendations were directed primarily to the needs of District management. The data to be submitted to the Department is obviously less detailed than that needed by Districts, and has been asked for less frequently (much of it quarterly, the rest annually) than it will be needed by local managers.

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#### The uses of better information

4. Timely, accurate, reliable and accessible information is needed by management

- \* to plan effectively, and to make difficult choices between competing needs, demands and solutions.
- \* to monitor the development of services and use of resources.
- \* to evaluate the use of resources and the quality and outcome of care.

With the implementation of Korner and the development of PIs, local managers now have powerful information tools at their disposal. Some brief illustrations show what is now becoming possible.

5. On hospital activity data, for example, figure 1 at Annex A shows for each of the Districts in a Region the average length of stay in hospital for patients who have had a heart attack. Figure 2 gives a similar comparison of operating theatre usage. At local level, analysis of this kind can be further broken down by individual consultant and valuable feedback given to consultants themselves. As a different example, figure 3 shows the variations across Districts in attendances at general surgery outpatient clinics. The main items of data available on hospital activity are listed at Annex B.

6. Information on costs is being significantly improved with Korner implementation, especially through the introduction of costing by specialty (for hospital services) and by programme (for community health services). Cost control through departmental budgeting is already commonplace - by way of illustration, an extract from one hospital's financial monitoring report is at Annex C. Since health authorities now have greater freedom to set charges for private patients, some have for that purpose established the average costs of particular operations in their hospitals (using much broader patient groupings than DRGs).

7. Local managers can now construct a wide range of indicators of performance by relating costs to activity or manpower. Examples of indicators which local managers can construct from Korner data on acute services, services for the elderly, and diagnostic and other clinical support services, are at Annex D.

#### Further improvements

8. We are building on these foundations to secure further improvements. For example, it is important that measures of the outcome of treatment are developed to complement indicators of activity and efficiency. Work on outcome measures is in progress within the Department, and a further note on this can be provided if the Group so wishes.

9. Another key area for further improvement is information on costs. Korner-based specialty costing is a valuable planning and monitoring

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tool, the more so when combined with the detailed activity data which is available locally. But, as explained in Sir Roy Griffiths's paper for the last meeting of the Group, it does not by itself allow for the wide variety of conditions and procedures encompassed by a single specialty. We are tackling this for two main purposes:

- \* "pricing", the broad determination of the resources absorbed by given patient "case-mix" workloads;

- \* control, the more precise monitoring of performance on a local, hospital-specific, basis.

10. To be acceptable, information for control purposes must be based on a combination of

- \* patient activity data in which local managers and doctors have a high degree of confidence; and

- \* a system which

- attributes to individual patients and/or DRGs a significant proportion of their actual costs (such as drugs and medical tests), and

- apportions all other costs (such as clinicians' time, theatre use, hotel and overhead costs) in accordance with an agreed standard approach which offers acceptable accuracy without detailed and expensive data collection and allocation processes.

One of the objectives of the resource management project is to provide output costs on this basis both by individual patient and by DRG. Such information will be available for several of the pilot sites by 1989, but it will be at least 1990 before comparably good information will start becoming available on a wider basis.

11. It should be possible, using estimates, to develop more quickly DRG-related information which is adequate for pricing purposes (although accelerating progress would carry resource implications). There are four options:

option A - take pre-Korner 1986-87 cost account and activity data and apportion all costs largely on the basis of US experience. In this way broad average DRG costs could be computed by about Easter 1988 on a national and Regional basis.

option B - as for option A, but using (post-Korner) 1987-88 data. On this basis results could be available by October/November 1988, provided that the problems arising from the transition to Korner data prove manageable.

option C - use 1987-88 data, but apportion all costs on the basis of costing samples taken from, say, 20 UK hospitals together with the experience of several of the existing resource management sites. This could offer results by about January 1989.



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option D - as for option C, but allowing time for the development and evaluation of the resource management project to provide a more robust and acceptable database. This approach should allow well-researched DRG standard costs to be generated by January 1990, using 1988-89 data.

12. The problem with both option A and option B is that, because US and UK clinical practice is not the same, the use of unevaluated US cost weightings would be open to legitimate challenge. Option C does not face the same problem, but would be subject to two major risks:

- \* there are bound to be teething troubles with 1987-88 data, as the first following Korner implementation; and

- \* it may be more difficult to obtain the acceptance of DRGs and other resource management developments if we proceed without the evaluation provided for by option D.

13. The paper promised in paragraph 1 (iii) above will examine the timetable for further action in more detail. It will consider in particular:

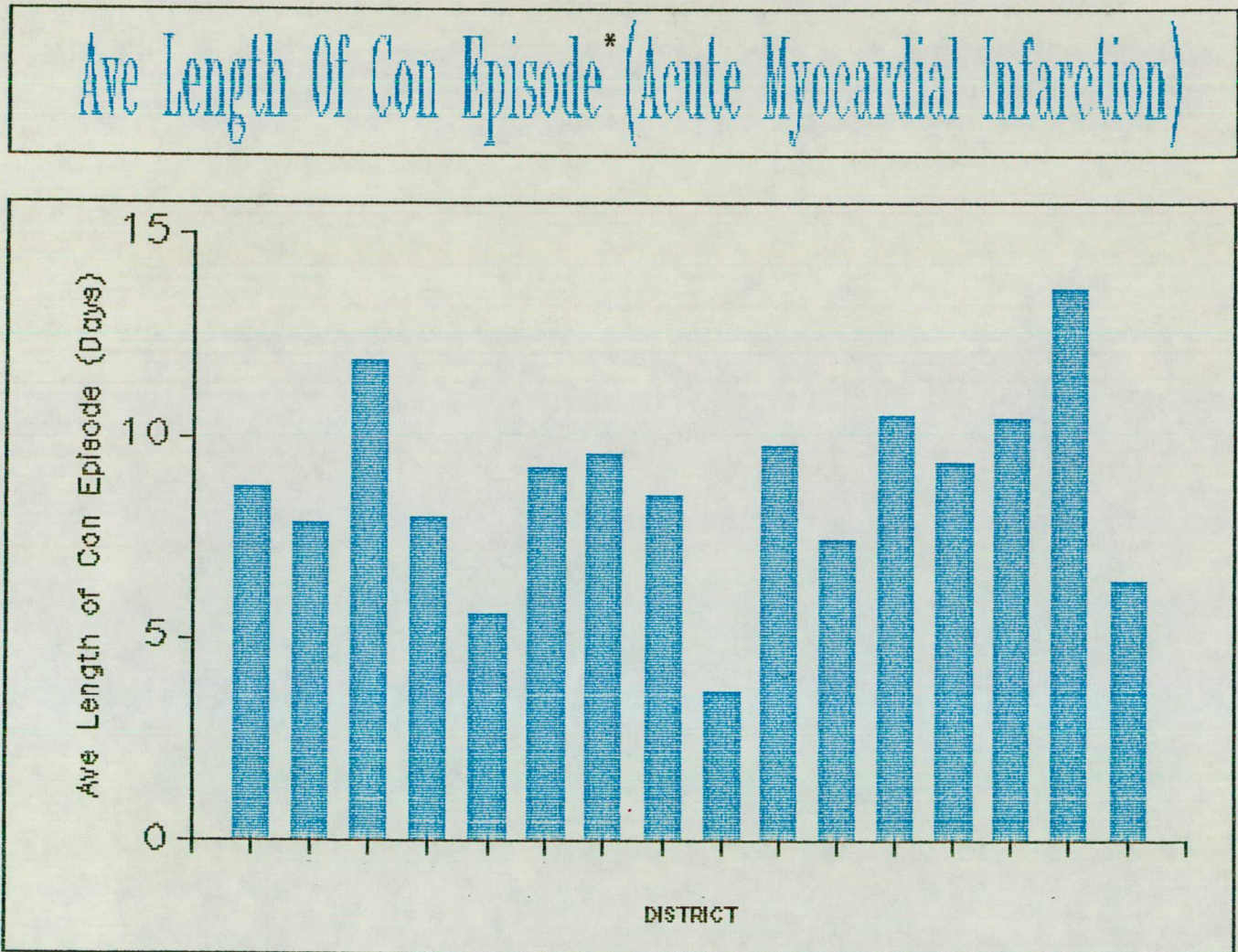
- \* how critical it will be, in the light of the development of the Group's work, to have DRG information at least by 1989;

- \* the balance of advantage between, on the one hand, introducing the DRG changes quickly and, on the other hand, introducing them more slowly but after full evaluation and consultation;

- \* whether it would be desirable to discuss option C with the medical profession; and

- \* the scope for early trials of pricing and control systems.

Figure 1



\* A period spent under the care of an individual consultant (A continuous spell of treatment may comprise more than one consultant episode).

Figure 2

Percent Theatre Sessions Held

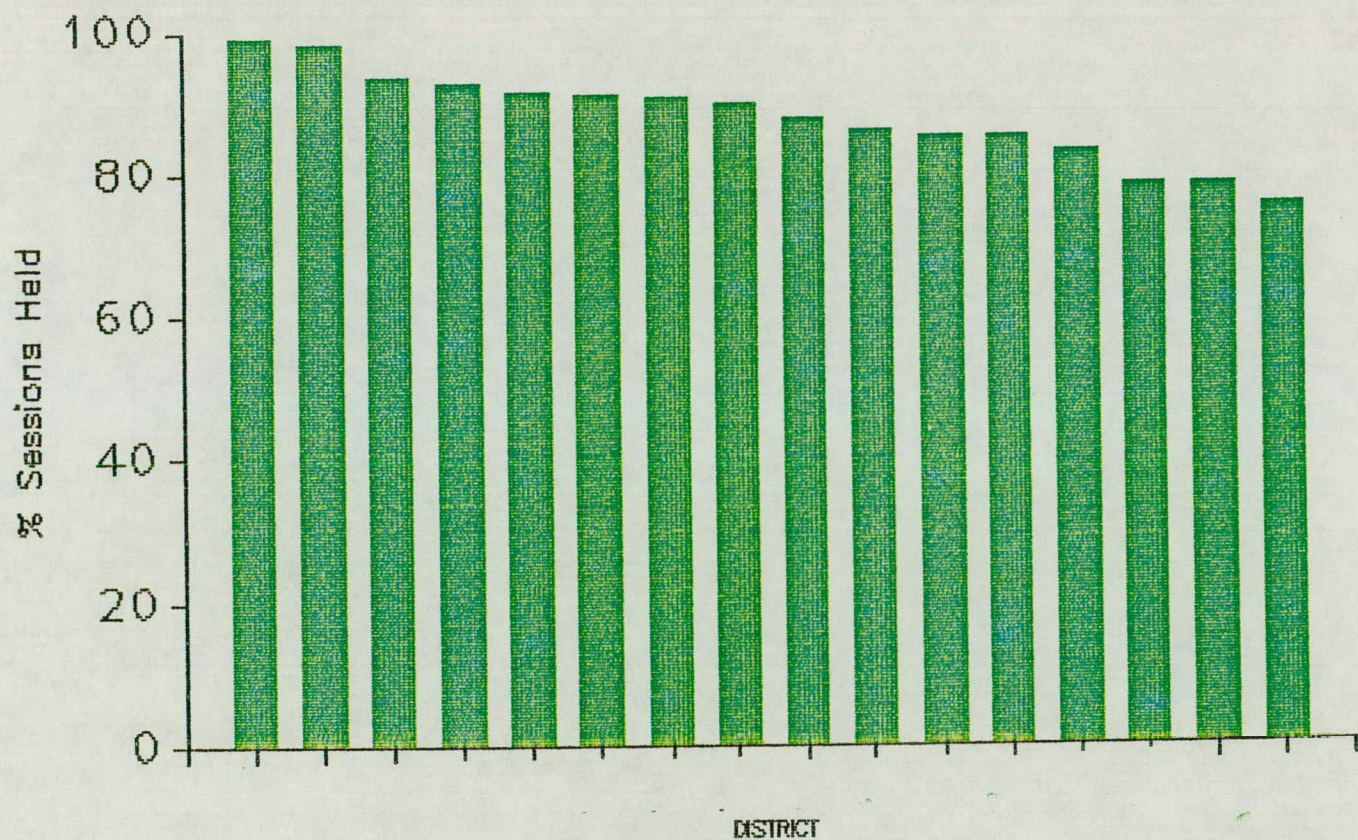
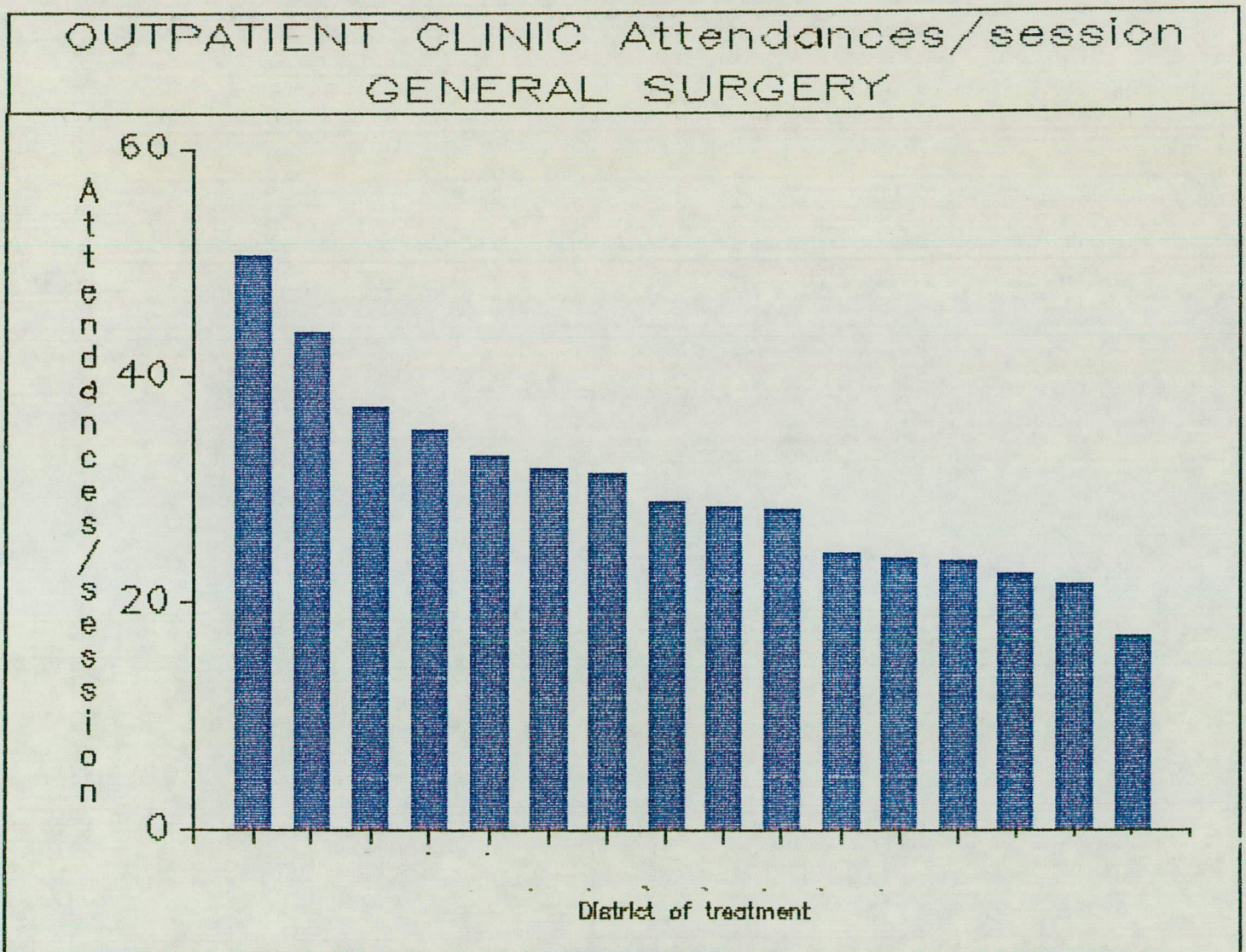


Figure 3

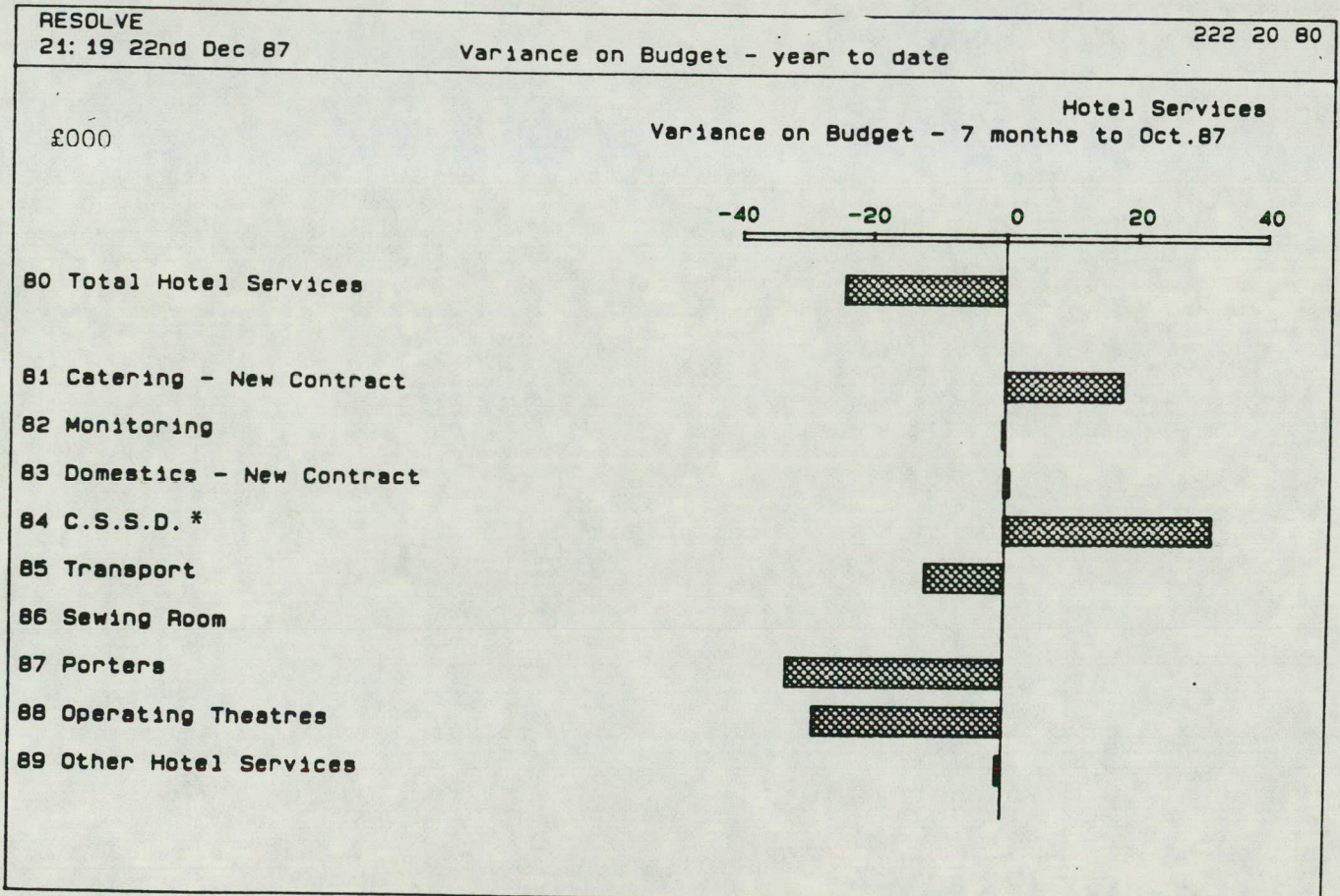
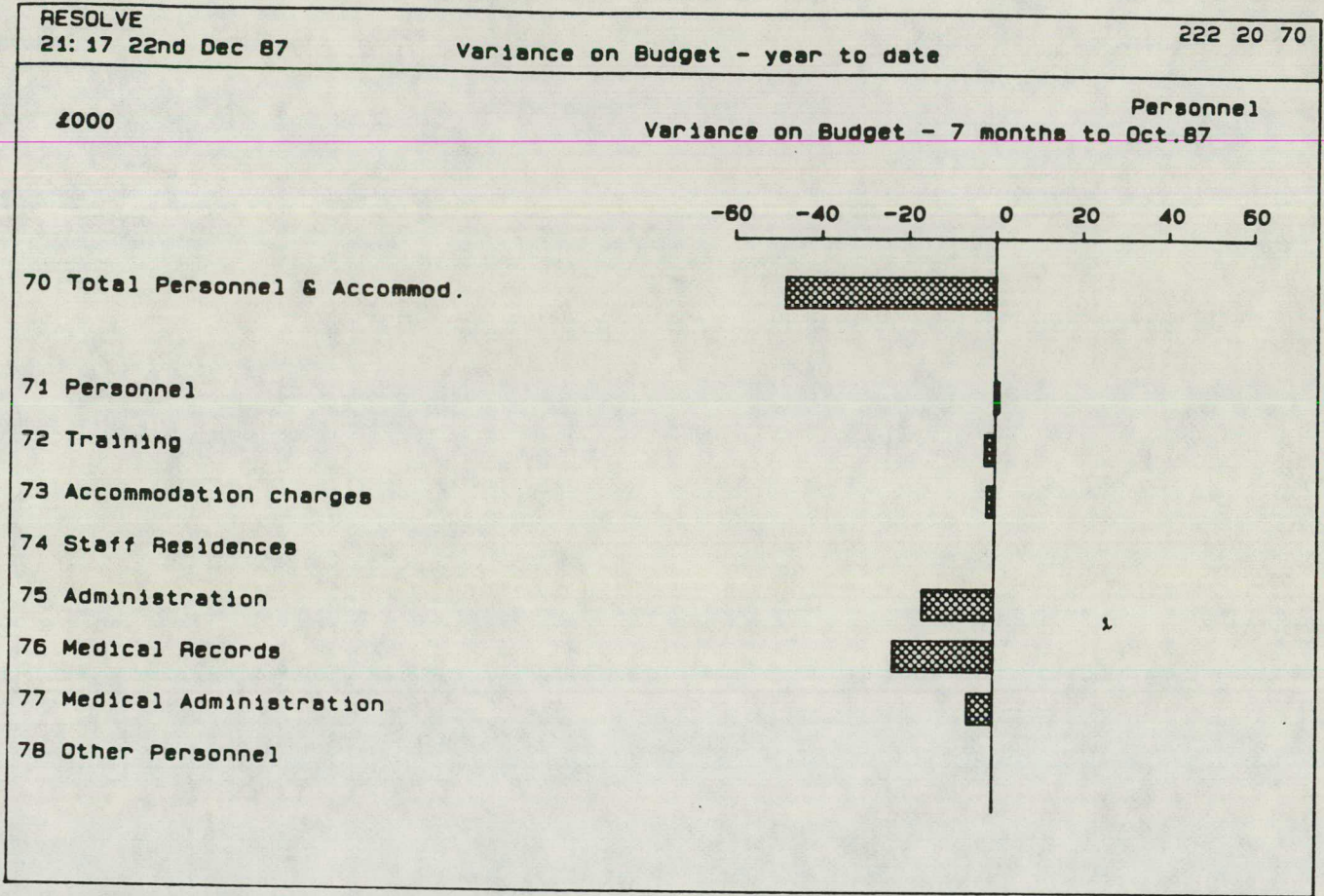


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Annex B

Examples of hospital patient activity data available (at consultant level where applicable)

Number of consultant episodes by diagnosis  
Length of stay  
Bed turnover interval  
Bed occupancy  
Bed throughput  
Number of cases operated upon  
Number of outpatients per clinic  
Number of day cases  
Waiting lists and waiting times  
Accident and emergency cases  
Numbers of laboratory requests  
Numbers of diagnostic procedures eg. Xray, ECGS.



\* Central Sterile Supplies Department

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## ANNEX D

PROGRAMME	DESCRIPTION OF INDICATOR	TYPE
ACUTE SERVICES		
Patients using a bed	Actual cost per consultant episode by acute specialty	Efficiency
Day care patients	Actual cost per attendance (day care patients) by acute specialty	Efficiency
Out-patients	Actual cost per out-patient attendance	Efficiency
Accident and Emergency Department	Accident and emergency cost per attendance - Accident and Emergency department	Efficiency
SERVICES FOR THE ELDERLY		
Patients using a Bed	Actual cost per occupied bed day - geriatric specialty	Efficiency
Out patients	Actual cost per attendance (out patients) - geriatric specialty	Efficiency
Day Care patients	Actual cost per attendance (day care patients) - geriatric specialty	Efficiency
Manpower/Community	Total annual staff costs of District Nursing staff related to the resident population aged [65+]	Efficiency/Provision
Chiropody Services	Total staff cost (chiropody staff) related to the resident population aged 75+	Access

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PROGRAMME	DESCRIPTION OF INDICATOR	TYPE
DEPARTMENTS		
Pathology	Total cost related to unweighted requests for each pathology specialty	Efficiency
	Total staff cost (pathology staff) related to unweighted requests for each pathology specialty	Efficiency
Radiology	Total cost of radiology services related to 100 weighted requests	Efficiency
	Total staff cost (radiology staff) related to 100 weighted requests	Efficiency
Radio-therapy	Total radiotherapy costs related to exposures - Radiotherapy departments	Efficiency
Nuclear Medicine	Total cost (nuclear medicine) related to weighted requests	Efficiency
Medical Physics	Medical physics revenue expenditure per number of courses of radiotherapy given	Efficiency
	Medical physics revenue expenditure per 1000 unweighted radiology requests	Efficiency
	Medical physics revenue expenditure per 1000 weighted nuclear medicine	Efficiency



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PROGRAMME	DESCRIPTION OF INDICATOR	TYPE
Pharmacy	Total staff cost (pharmacy staff) related to occupied bed days	Efficiency
	Total staff cost (pharmacy staff) related to consultant episodes	Efficiency
	Qualified pharmacists (WTE) related to total drugs expenditure	Workload
	Total pharmacy staff (WTE) related to total drugs expenditure	Workload
Operating Theatres	Total cost of Operating Theatres related to operating hours	Efficiency
	Total staff cost (theatre staff) related to occupied surgical bed days	Efficiency
Chiropody	Total cost (Chiropody services) related to 1000 resident population	Efficiency
Dietetics	Total cost (Dietetics services) related to 1000 resident population	Efficiency/ Provision
Occupational Therapy	Total cost (occupational therapy services) per 1000 resident population	Efficiency/ Provision
Speech Therapy	Total cost (speech therapy services) related to 1000 resident population	Efficiency
Catering	Total cost (patient catering) per occupied bed day	Efficiency
Domestic/ Cleaning	Total cost (domestic services) per 100 sq metres cleaned	Efficiency
Portering	Total staff cost (portering staff) related to 100 weighted bed days	Efficiency

## NHS BUDGETING AND RESOURCE MANAGEMENT : Note by DHSS

### Introduction

1. This paper offers a factual summary of current developments in budgeting within the NHS. It complements paper HC6 on "information for management".

### Background

2. Since the 1974 reorganisation of the NHS there has been a considerable sophistication of financial reporting within the Service. The extension of the management accounting function within finance departments has improved the content and timeliness of budget reports. Increasing computerisation has facilitated better workload statistics and manpower reporting as part of overall financial management. In the majority of Districts, managers can expect to receive payroll based reports within 10 days of the month end; some managers will be receiving weekly activity and cost reports.

### Links to Planning

3. It is a truism that "a budget is a costed plan", and the necessary preliminary to the budget setting cycle should be the planning cycle. In most health authorities, however, only plans for new services or curtailment of existing services have an impact on budgets, whilst cost improvement programmes tend to be finance-driven and not seen as part of the service plan. The implementation of general management, together with a sharpening up of the planning process in the past two or three years, have stimulated greater integration. But the focus of budgeting still tends to be on marginal change to existing functional budgets rather than on a fresh look at output plans.

### Current Budgetary Practice

4. There is no statutory or defined cost centre structure in NHS hospitals for budgetary reporting. Given that hospitals have different management structures, there will continue to be local variations. But there are a number of natural cost centres. Typically, budgets will be set, and individuals held accountable, for:

(i) major diagnostic departments such as radiology, chemical pathology and pharmacy.

(ii) other medical and para-medical services such as physiotherapy and psychology.

(iii) ancillary services such as domestics/cleaning, portering, transport and estate management.

5. Although in some areas - physiotherapy for example - budgets will tend to be just a financial reflection of a manpower quota, most cover workload as well as resources. Many hospitals have undertaken detailed costing and budgeting studies in departments like radiology. In addition, the competitive tendering programme has ensured cost centres such as catering have had their budgets more carefully scrutinised.

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6. More variation is found in the cost centres associated with nursing staff and medical and surgical equipment. Many (but not all) hospitals have set up wards, operating theatres, out-patient clinics and so on as cost centres. But there have been technical difficulties associated collecting data routinely on, for example, the use of consumables by a ward; and also problems of responsibility, for instance agreeing locally who is accountable for the operating theatre budget.

## Input Budgeting

7. The well established systems for monitoring actual against expected financial performance have served the NHS well in supporting strong financial controls. But current practice remains directed primarily at controlling inputs. A classic illustration of the problem this poses is the accountability of the budget holder of (say) radiology. Whilst he can be expected to run his department efficiently and produce each X-ray with the minimum labour and materials consistent with quality, he cannot be expected to control the volume of X-ray requests. Establishing this aspect of budget setting in turn requires information systems which can relate patient activity to inputs in the ways described in paper HC6.

## Output Budgeting

8. There have been a number of local experiments in the development of budgets which are better related to outputs. These have often been in teaching hospitals, frequently centred around "high-tech" specialties such as renal medicine. The nature of this and similar specialties - high cost, low patient volume, expanding, and relatively discrete in costing terms - meant that budgets could be constructed around forecast patient numbers and agreed treatment protocols.

9. Attempts to develop this process on a comprehensive basis across a hospital were formalised with the management budgeting experiments which preceded the current Resource Management Project. Despite a number of weaknesses in these first experiments, they did provide systems which could be used to start the budget setting process with forecasts of patient numbers and to provide a much stronger link to the planning process.

10. There are probably now some 50 hospital sites in the UK with at least a rudimentary form of output-driven budget setting. The timetable for developing a more sophisticated approach based on "diagnosis related groups" (DRGs) is discussed more fully in paper HC6.

February 1988

DHSS

# SECRET

HC 8

## HEALTH CARE SYSTEMS IN OVERSEAS COUNTRIES : Note by DHSS

1. Attached are a set of notes on the delivery and financing of health care systems in a selection of OECD countries, namely:

Australia	(A)
Canada	(B)
Denmark	(C)
Finland	(D)
France	(E)
Germany	(F)
Netherlands	(G)
Sweden	(H)
New Zealand	(I)
United States	(J)

The notes are intended to be brief and for information only. The Ministerial Group may wish to explore individual systems in more detail at a later date.

2. The Group may also find it helpful to have a fuller comparison, including parameters additional to those in the attached notes and covering, for example

- \* differences in total health expenditure
- \* a breakdown of health expenditure between different health care sectors and within sectors, including the efficiency with which resources are used
- \* comparisons between tax based and non-tax based systems, including the impact on people's incomes, administrative costs, and so on
- \* output comparisons
- \* differences in health status.

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AUSTRALIA

A

## Administrative Organisation

The federal government has legislative powers over the provision of pharmaceutical, hospital and sickness benefits and medical and dental services.

The supply of health care facilities and the operation of health services is shared between the state governments and the private sector.

Local authorities have limited powers and responsibilities for the protection and promotion of public health.

## Coverage

A universal health insurance scheme (Medicare) operates throughout Australia with residency as the sole eligibility criterion.

Medicare reimburses in full the cost of inpatient and outpatient treatment and accommodation in public hospitals. Patients contribute towards drug prescription costs with a flat rate fee per item.

Medicare does not cover dental services, home nursing, physiotherapy and chiropractors.

Individuals can upgrade the basic Medicare service through private insurance/ out-of-pocket payments.

## Delivery of service

### Primary care

As in the UK the general practitioner acts as the gatekeeper to the health service.

Of the 90 per cent of practitioners in private practice 40 per cent are GPs and the rest are specialists who hold part-time salaried hospital posts with (limited) rights of practice.

### Secondary care

About 80 per cent of general short-stay hospital beds are in public hospitals and the relatively high bed to population ratio means that waiting lists are virtually non-existent. Private hospitals, which tend to be owned by doctors, are licensed by the state health authority with responsibility for standards of accommodation, staffing, facilities and records.

Patients on admission (either by referral or through the A&E department) elect to be treated either as a 'hospital' or 'private' patient. The former are treated by hospital clinical staff and the cost reimbursed by Medicare. The latter are treated by the doctor of their choice and must pay a user fee.

## Source of funds

Medicare is financed from general taxation and by an earmarked levy of 1.25 per cent of taxable income (from all sources) over and above specified thresholds. There are exemptions for pensioners and social security beneficiaries.

# SECRET

State governments provide the major share of capital funds for public hospitals. In addition individual hospitals may raise bank loans guaranteed by the state health authority. —

## Hospital/ Doctor reimbursement

Public hospital operating costs are reimbursed by the federal and state governments. There are no government subsidies for private treatment and patients pay the full cost.

General practitioners are paid on a fee-for-service basis. Full-time hospital doctors are salaried, the awards set by an independent wage fixing tribunal.

# SECRET

B

CANADA

## Administrative organisation

The Department of National Health and Welfare administers national programmes, monitors provincial compliance with conditions of legislation and provides provinces with technical, consultative and co-ordinating services.

Provincial health care systems are self-contained. Each authority administers its own health insurance plan, assesses hospital and medical claims, pays providers and monitors all aspects of the programme.

## Coverage

Each province runs a universal medical insurance scheme which is portable from province to province. Coverage is compulsory but some opting out is permitted in Ontario and Alberta. Services covered vary between provinces but typical exclusions are cosmetic surgery, prescription drugs for those under 65, external appliances and ambulance transport.

## Delivery of service

### Primary care

All providers are autonomous. Some 70 per cent of practitioners are in office-based ( as against hospital ) private practice but with hospital privileges to admit and treat/ supervise the treatment of their patients.

### Secondary care

Over 90 per cent of beds are in nonfederal hospitals of which just 2 per cent are in proprietary institutions. A further 2 per cent of beds are in federal hospitals and the remainder are in provincial mental institutions. Hospitals are owned mostly by communities or by charitable institutions.

## Sources of funds

The bulk of the cost of the Canadian health service is met from provincial general revenues. The Federal government makes contributions to the provinces through block grants, conditional on the provinces meeting federal programme requirements. Employer/employee contributions vary between provinces as do user charges. Physician services tend to be re-imbursed in full.

## Hospital/ Doctor reimbursement

Hospital operating costs are met from annual prospective global budgets controlled by the provincial government. Capital budgets are granted separately on specific approval of the proposed investment.

Doctors are reimbursed either on a fee-for-service basis if self-employed (in either the primary or secondary sector) or an a salary if employed by a hospital or health centre.

# SECRET

DENMARK

C

## Administrative organisation

The State lays down the legislative framework and undertakes supervision and control of the health programme.

County councils with responsibility for hospital services, and the National Health Insurance scheme are responsible for curative health services. Preventive medical services fall to the municipalities.

## Coverage

As in the UK all residents are guaranteed the right to free medical care irrespective of income.

## Delivery of service

### Primary care

Primary health services are organised on a similar basis to the UK. Patients are treated by general practitioners in private practice with access to a wide range of community health services. If appropriate patients are referred to specialists outside the hospital system. This group of practitioners provides most services traditionally supplied in the UK by outpatient facilities.

Patients can choose between two types of GP service:

-free treatment by a GP of their choice with whom they agree to stay for at least one year. 95 per cent of the population opt for this.

-unrestricted access to any GP or specialist with the patient paying the practitioner's fee and part of the cost of treatment.

### Secondary care

Almost all the hospitals are publicly owned. Treatment is free and patients are admitted on referral by GP or through A&E service. A few private hospitals exist but are almost 100 per cent subsidised by local authorities and subject to the same regulations as public hospitals.

## Source of funds

Almost the entire cost of the Danish health system is borne by the local and state government out of general taxation and rates.

In addition charges are levied on

- medicines (upto 50 per cent of their cost)
- adult dental care
- physiotherapy
- spectacles

with exemptions for patients on low incomes.



SECRET

Hospital/ Doctor reimbursement

Doctors are under contract to local government and are paid either on a straight capitation fee (Copenhagen) or by capitation plus fee-for-service (rest of the country). Specialists are paid on a fee-for-service basis and where employed by hospitals can engage in private practice outside normal working hours either on their own premises or at the hospital. If the latter there are regulations as to the time, extent and user payments to the hospital for facilities, staff and instruments.

Hospitals are financed by local government.

### Administrative Organisation

The Ministry of Social Affairs and Health supervises three National Boards of Health, Social Welfare and Labour Protection. The provision of health services falls directly to the municipalities, or communes, which effect delivery either singly or in combination with other communes.

### Coverage

All residents are covered by a predominantly public financed system. Private insurance schemes exist but these are mainly involved in compulsory accident insurance which covers the cost of health care resulting from work or traffic accidents.

### Delivery of service

#### Primary care

The basic unit of health care is the health centre run by a commune or federation of communes. The health centre is a functional medical unit which may have more than one physical location. The services provided cover basic GP care, school health, dental care, and veterinary services. Almost all have some beds, X-ray and laboratory facilities.

One fifth of physician services in the primary sector are private. Health centre doctors may treat private patients but not in the health centre.

#### Secondary care

Virtually all hospitals are public hospitals owned by a federation of communes in each of 21 central hospital districts. Some 5 per cent of hospitals are private and may or may not be subsidised. In addition state hospitals can have upto 10 per cent of its beds designated as private.

### Sources of funds

Health services are funded from general taxation levied at central and/or local level. Gross hospital costs are shared between State and commune, the richest receiving a subsidy of 30 per cent and the poorest a subsidy of 70 per cent. (Similar arrangements apply to health centres).

### Hospital/ doctor reimbursement

Less than 10 per cent of hospital costs comes from co-payments. These are levied on outpatient visits and inpatient admissions as a day fee for stays of less than three months in hospital.

Hospital doctors are salaried as are health centre practitioners.

### Administrative organisation

There is considerable central regulation of hospital planning and spending with regional governments in control of administration and funding.

### Coverage

The national social insurance system is virtually universal.

### Delivery of service

#### Primary care

Medical care is dispensed by general practitioners and specialists in private practice. There is no limit on access to, nor prescription of care by, the practitioners and no referral by GPs to specialists.

A small but growing number of health centres have been established in recent years managed by community groups and friendly societies. The centres are officially recognised by the sickness insurance funds and medical personnel work on a contract basis.

#### Secondary care

Some 70 per cent of beds are in publicly owned (mainly by local government) hospitals. Some private owned hospitals are authorised to operate as part of the public system accepting an obligation to treat patients round-the-clock.

Most private facilities are used for maternity and elective surgery and are about 12 per cent voluntary and 18 per cent proprietary.

### Sources of funds

Health care expenditure is financed from:

- employee/employer social security contributions (which cover cash benefits too)
- patient charges. These cover roughly 25 per cent of doctors' and dentists' fees, 20 per cent of hospital treatment costs plus a small 'hotel' charge and between 30 and 60 per cent of the cost of prescribed medicines. (Social assistance beneficiaries are exempt as are consumers of essential care for serious and long term illnesses, maternity and neo-natal services).
- government contributions from the proceeds of automobile insurance premiums as well as a tax on pharmaceutical advertising costs, alcohol and tobacco. In addition the government pays lump sum subsidies towards hospital capital and operating costs.

### Hospital/doctor reimbursement

Hospitals receive about 20 per cent of their operating costs direct from the patient and the rest from the sickness insurance funds by way of prospectively set global budgets.

# SECRET

Capital costs are recovered in part through amortisation allowances in the per diems and charges. The balance of costs are financed through subsidies from the central and local governments.

In the primary sector practitioners receive a state approved fee-for-service (health centre physicians are salaried). In the hospitals doctors are paid a salary in the public sector and receive a fee-for-service in the private sector.

# SECRET

## Administrative organisation

Central government is responsible for overall supervision of the social insurance system and health matters in general but it is the state governments (Lander) that determine hospital capacity and have executive and legislative powers to fix hospital per diems, capital expenditure etc.

## Coverage

Some 90 per cent of the population is covered by the sickness insurance scheme. The remaining 10 per cent (mostly high earners and the self-employed) are covered by private insurance.

## Delivery of service

### Primary care

Primary health services tend to be delivered by general practitioners in private practice, but as in France, since patients can consult specialists directly, GPs do not have a monopoly on primary care.

All social insured patients gain access to the health system either through a GP or specialist who must be a member of a physicians' organisation or panel. Outpatient services are provided by 'polyclinics', outpatient clinics (establishments with at least 3 specialised departments), doctors practices and district nurses.

### Secondary care

The hospital sector is confined almost exclusively to inpatient services. Except in an emergency, admission is on referral by a panel doctor. The doctor's referral must be submitted in advance to the sickness fund for approval of cost, otherwise the patient must pay in full.

Over half the hospitals are publicly owned by the local communities. Some 35 per cent are private non-profit making and the remainder are proprietary.

## Source of funds

Health service expenditure is financed from:

- employer/employee social security contributions with an upper earnings limit. As a result of measures introduced last year (primarily increased charges and reduced coverage for 'inessential treatment') these contributions will be reduced in the future.
- patient charges eg prescriptions (with exemptions for children, pensioners, the disabled and expectant mothers), 'hotel' charges for the first fourteen days in hospital and transportation charges. New or increased charges have been announced for prescriptions, spectacles, hearing aids and dentures.
- government subsidies for particular occupation schemes and grants for hospital capital expenditure.

# SECRET

## Hospital/Doctor reimbursement

Hospitals are under contract to the sickness funds. Basic operating costs are reimbursed through prospective (hospital specific) per diem rates negotiated between the hospital and the regional sickness fund. These rates are subject to approval by states governments. For optional extras such as single room accommodation and treatment by a particular doctor the patient is charged directly.

Capital costs are financed by federal, state and local authorities directly out of taxation.

Regional physician panels contract with the sickness funds to provide care for the insured on an annual lump sum basis. The lump sum is then apportioned among participating doctors on a fee-for-service basis. Hospital doctors are salaried.

NETHERLANDS

## Administrative organisation

Both national and regional government have responsibility for health sector planning and the construction of facilities and the acquisition of major items of medical equipment require a government issued licence.

### Coverage

Social insurance with an approved sickness fund is compulsory for all employees under retirement age and earning less than a fixed amount. Individuals remain compulsorily insured post retirement, as do social security beneficiaries and all dependents. This covers some 70 per cent of the population. The remainder are covered by private insurance.

The 'Exceptional Medical Expenses' scheme covers the cost of medical care in cases of prolonged illness or disability requiring hospitalisation of more than a year or nursing home care for the elderly or chronic sick. It is compulsory for all residents.

### Delivery of service

#### Primary care

Patients register with a general practitioner contracted to the social insurance scheme who either treats the patient directly or refers him to a specialist operating in private practice from the outpatient department of a hospital.

Increasingly GP services are being provided in health centres alongside dentists and dispensing chemists.

#### Secondary care

Some 90 per cent of hospitals are privately owned and run on a non-profit basis by local communities and religious orders. The remainder are owned by the municipalities. Hospitals may be further classified according to whether they are 'open' or 'closed'. In the former the patient is free in the choice of specialist who in turn has right of access to the hospital. In the latter, there is a contract with a team of specialists the members of which treat patients to the exclusion of all other specialists.

Admission to hospital is via GP or specialist referral.

### Sources of funds

Health service expenditures are financed from

- equal employee/employer percentage social security contributions for ordinary care but with additional employer contributions for the 'Exceptional Medical Expenses' scheme
- patient charges for prescriptions, some dental treatments and artificial limbs and appliances
- annual lump sum government subsidies for the 'Exceptional Medical Expenses' scheme.

# SECRET

## Hospital/ Doctor reimbursement

Hospital and doctors contract to the social insurance scheme and are paid directly by the sickness funds.

GPs are paid a capitation fee, however, the size of the fee is related to the number of sickness fund patients registered with him. Compensation for the fixed costs of practice are paid out to some maximum number of registered sickness fund patients. In addition GPs with privately insured patients receive payment on a fee-for-service basis, direct from the patient who is subsequently reimbursed by the insurer.

Specialists are paid on a fee-for-service basis and on a scale agreed with the sickness fund (for sickness fund patients). Hospital doctors are salaried.



### Administrative organisation

The Ministry of Health and Social Welfare determines policy. An independent supervisory body, responsible to the government (not the ministry) is the main enforcement and planning agent but executive responsibility for all public medical services falls to the 23 counties and 3 municipalities.

### Coverage

The national health insurance scheme is compulsory for all who live and work in Sweden. It provides protection against loss of income due to illness, injury, disability or childbirth.

Benefits include part of the costs of primary care services, outpatient services in hospitals and consultations for inpatient treatment. Dental services are free upto the age of 19. Sickness benefits under the scheme amount to 90 percent of income upto some fixed maximum.

### Delivery of service

#### Primary care

'Family' doctors are employed by the counties/municipalities as district health officers providing community care in health centres. However, the use made of primary care facilities is remarkably low due in part to an 'over-investment' in hospital (including outpatient) based services to which patients have direct access without the need for GP referral. Currently only a third of all ambulatory physician visits are to district physicians (as against 50 per cent at hospital outpatient clinics).

Some 5 per cent of doctors are in private practice. They can opt to be affiliated to the public insurance system, in which case the patient pays a higher fee and the fund reimburses the doctor at the agreed rate.

#### Secondary care

Only 6 per cent of hospitals are privately owned and there are no private facilities in public hospitals. Most hospitals are owned by the counties/ municipalities.

Highly specialised hospital care is provided by six health care regions and is regulated by agreement between the county councils.

### Sources of funds

Some 65 per cent of Sweden's health care service is financed from employers' contributions. A further 15 per cent comes from state grants and the rest from patient charges.

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Hospital/doctor reimbursement

Hospital operating costs are met from annual budgets controlled by the local community councils. Capital costs are community financed by means of a specific appropriation voted by the community councils.

Doctors in the public sector receive a fixed salary for a fixed number of working hours and are prohibited from receiving direct patient fees for inpatient or outpatient services.

## NEW ZEALAND

### Administrative organisation

The Department of Health defines sector wide priorities and funds and oversees:

(1) Hospital boards (and the area health boards that are gradually replacing them). These plan and control public hospitals and (in the case of health boards) public health.

(2) Health benefits that subsidise privately provided general practitioner services, pharmaceuticals, laboratories and private hospitals.

### Coverage

Health care is available to all residents. The cost of hospital care in public hospitals is borne entirely by the state. Patients contribute to the cost of primary care and some 30 per cent of the population has private insurance to cover these charges. Free dental services are limited to those under 16 years old.

### Delivery of service

#### Primary care

Primary health is delivered by private practitioners in a contractual arrangement with the State. Patients do not have to register with any particular doctor. For access to specialist and hospital care general practitioner referral is usual; it is obligatory if health benefits are to be claimed. Choice between public hospital specialist services (for which there is no charge) and private specialist services (for which patients pay at a subsidised rate) is determined in part by assessment of waiting times, convenience of location and flexibility of appointment systems.

#### Secondary care

Private hospitals account for about 14 per cent of surgical and medical beds, 55 per cent of geriatric beds and 21 per cent of all hospital beds. Hospital care is subsidised in the private sector and provided free of charge in the public sector. A high proportion of pathology and radiology is done privately, is free or heavily subsidised to the patient, and is used extensively by the smaller hospitals on a contractual basis.

### Sources of funds

The public sector meets over 80 per cent of the total health care cost financed primarily from general taxation (with minor exceptions funded directly from the Accident Compensation Commission). A further 15 per cent represents out-of-pocket payments to meet the costs of GP visits (the State meets only half these costs) and pharmaceuticals (prescriptions are subsidised with larger subsidies available for children and elderly).

### Hospital/Doctor reimbursement.

Public hospitals are funded through budgets allocated on a RAWP type basis to Hospital Boards. Private hospitals receive subsidies in the form of a per diem payment equal to 50

# SECRET

General practitioners and specialists receive from the State a flat rate fee for items of service performed during normal hours. This is enhanced for night, holiday and week-end work and for treating certain categories of patients eg the elderly, children and chronically infirm.

Patients pay the excess direct to the GP upto a maximum charge set by an independent body. Full-time hospital doctors are salaried.

### Administrative organisation

The Federal government's direction of the health service is limited to the provision of monies tied to specific legislation and the regulations that flow from that legislation. Planning is undertaken at state and local levels. Licensure of both practitioners and hospitals falls within the powers of the state government.

### Coverage

US health care systems combine public and private interests and institutions. Some 90 per cent of the population is protected by private health insurance or a government programme or a combination of both.

The two main government programmes, Medicare and Medicaid account for about 30 per cent of health care spending. Medicare is run by the Federal government for the elderly (over 65); Medicaid is a federal/state funded programme covering the needy, regardless of age. Many Medicare patients take out 'top up' insurance to cover charges (mostly physician fees) not fully reimbursed by the scheme. Service coverage for Medicaid is wider than for Medicare but usually excludes dental services, prescribed drugs, eyeglasses and intermediate care facilities.

### Delivery of service

Patients have a significant amount of freedom to select the physician of their choice and the hospital in which care will be provided. The principal constraint is whether or not the chosen physician has the privilege of admitting patients to the hospital of the patient's choice

#### Primary care

Most physicians are in private practice and there is no clear demarcation between the role of the general practitioner and the specialist. Patients have direct access to both, who will then refer to a specialist /other specialty service as appropriate. Physician practice is office based -house calls are very rare.

An increasing number of physicians -approximately 25 per cent - now practice in single or multi-specialty groups. Health Maintenance Organisations (HMOs), where the emphasis is on prevention, tend to be large multi-specialty groups which contract with a population (usually an employee group) to provide comprehensive health services in return for regular payments, irrespective of whether the enrolled use service or not.

#### Secondary care

Over 60 per cent of all hospital (and nursing home ) beds are privately owned of which some 85 per cent are in non-profit making institutions. The rest are federal (intended for the armed forces, veterans and American Indians and not accessible by the general public) state and locally owned. The latter have provided a charitable 'last resort' function and their importance is diminishing.

Access to private hospitals is by the referring physician with rights of practice, who personally provides /supervises hospital care and determines when to discharge the patient.

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## Sources of funds

Federal and local/state government monies together account for just over 40 percent of direct total health expenditure. The remaining 60 per cent divides equally between direct out-of-pocket payments and third party (insurance) payments. Medicare is a social insurance programme. One part covering hospital, nursing home and home care is financed through the social security system by compulsory salary deductions. The second part covering physicians services is financed by general taxation and voluntary contributions. Medicaid is a non-contributory programme financed from general taxation.

## Hospital/doctor reimbursement.

Since 1984 the Federal Medicare programme has reimbursed hospitals on the basis of prospectively established payments per case (diagnostic related groups (DRGs)). Individual state Medicaid systems and private insurers use a variety of approaches, predominantly retrospective cost or charge based.

Capital reimbursement tends to be included in the payment rate, however, fixed. Principal government subsidies for capital are through the tax exemption of financing instruments for health care institutions.

Patients pay on a fee-for-service basis in the primary sector but doctors may be reimbursed in a variety of ways ranging from fee-for-service to salary to percentage of group income (for group practices and HMOs). Hospital doctors are either paid on fee-for-service basis or a salary.

## GREATER COMPETITION IN THE NHS

HC 9

## Note by HM Treasury

1. The NHS is an administered rather than market-based system. There is little effective competition between suppliers and little financial incentive to attract customers. This has led outside observers to discuss the "internal market" and other means of introducing market forces.

2. The essence of a market-based system is a distinction between buyers and suppliers. At present patients do not act as buyers, as they do not pay directly for services; there is little charging for services; and there is little competition between alternative suppliers. Many possible models can be envisaged, for example:

Within hospitals: hospital managers as buyers, clinical teams as suppliers.

Between hospitals: districts or GPs as buyers, hospitals (public or private) as suppliers.

Between districts: one district as buyer, another as supplier.

For all health services: amalgamated district/FPC as buyer, contracting GPs, hospitals etc as suppliers.

We do not need yet to construct detailed models. But we need to identify the conditions which must be fulfilled if an element of competition is to be introduced into the NHS. This paper should be read in parallel with that on providing consumer choice; it should be noted that the objectives of choice and efficiency do not always coincide.

3. If suppliers are to be able to compete with each other in a way which improves overall efficiency:

- they need financial incentives to attract customers;
- buyers need information on which to base their decisions and budgets to encourage cost-effective choice.

Without all these, there is a danger that competition would be solely in terms of quality of service, and hence generate further cost pressures. Choices in the system need to be reinforced by financial transactions which determine resource allocation: in other words, the money should follow the patient.

4. This brings us up against a fundamental problem: service delivery is organised in a completely different way from the allocation of resources.

5. Service delivery is dealt with by the medical profession. It starts with the patient approaching his GP. Two distinct stages follow: diagnosis and treatment. The GP may do both himself (eg by writing a prescription for an antibiotic). Alternatively the diagnosis may be clear, but he needs to refer the patient to a hospital consultant for treatment. A third possibility is that the patient is referred to a consultant for diagnosis, and perhaps onwards within the hospital system several times before eventual treatment. In the course of treatment, the consultant and his team will call upon a number of specialist services: radiology; pathology; physiotherapy; occupational therapy; and so on.

6. Resource allocation is largely separate from this process. Funds are allocated by districts to hospitals, and within hospitals, on the basis of an overall assessment of needs. Efforts are of course made at all levels to accommodate clinical requirements. But the structure - from PES to RAWP to day-to-day decisions in hospitals - is quite different from the clinical decisions described above. Thus, the level and quality of service



has little bearing on resource allocation and, conversely, there is little resource incentive to improve performance. Indeed there exist perverse incentives not to improve efficiency. A surgical team that improved its efficiency and so was able to treat more patients in a year would, as a result, also have higher costs and so would risk coming up against its budget limit before the year end, as may have been happening in the current year.

7. Even within the present organisation of the NHS, competition could be introduced into at least some of these decisions. One form of the "internal market" - with districts trading with each other and the private sector on the basis of comparative cost - could be introduced once the better costing information now in the pipeline starts to come through. Clinical budgets, with medical support services as cost centres, offer the prospect of competitive tendering for pathology, etc. Good progress has been made in competitive tendering for ancillary services, with cumulative savings now over £100m a year, but no steps have yet been taken to introduce it into clinical areas.

8. In considering specific options for changing the future structure of the NHS, the following criteria need to be met if the result is to be improved competition:

- a. Does the new structure clearly distinguish buyer and supplier?
- b. Is the buyer in a position to make informed choices?
- c. Do resource allocation decisions match up with clinical decisions?
- d. Is the good supplier thereby better rewarded than the less good?
- e. Are there incentives for suppliers to maximise their efficiency?

**CONSUMER CHOICE****Note by H M Treasury****Objectives and scope**

There are two main objectives in extending consumer choice in health care:

- (a) the ability to exercise choice is desirable in itself; and
- (b) choice stimulates competition among the suppliers of health care and so encourages greater responsiveness to consumer demands.

Moreover, if, associated with appropriate financing mechanisms, choice enables individuals to decide for themselves how much they want to spend on health care. In this connection, it is important to be clear about the appropriate role of the state - see Annex.

2. There are, however, a number of potential constraints:

- it is not generally realistic for consumers to exercise choice over clinical decisions. This would be impossible in relation to, for example, much casualty work. But there is greater scope for patient choice in other areas (eg maternity) and more generally giving patients more information about the clinical alternatives;
- consumer choice may in some circumstances conflict with efficiency. For example, an internal market under which health authorities traded with each other (and with the private sector) would imply directing patients to particular hospitals and so overriding consumer choice;

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- if health services are provided free at the point of use, consumers have no incentive to be cost-conscious; allowing more choice is thus likely to put upward pressure on expenditure, as patients would generally choose on the basis of quality rather than cost.

If steps were taken to introduce greater choice, therefore, it would need to be clear that the benefits outweighed the costs inevitably associated with it.

3. Leaving aside clinical decisions, where the scope is limited as explained above, the main areas for the exercise of consumer choice are as follows:

- (a) choice of doctor (GP and consultant);
- (b) choice of place of treatment (eg choice of hospital);
- (c) choice of timing of treatment;
- (d) choice of optional extra (eg better hotel services in hospital); and
- (e) choices in financing (eg in insurance-based systems consumers may be able to choose between alternative levels of cover according to the premiums paid).

**Present system**

4. In principle, NHS patients already have the right to choose their GP and also the NHS hospital and consultant from whom they are to receive their health care. In practice these choices appear to be little exercised: very few people change their GP except when moving to a different locality; and most people rely on the GP to refer them to a consultant. One major reason is lack of readily available information on the services available.

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Little choice is offered by NHS hospitals over the timing of treatment, eg out-patient consultations or non-urgent operations. Nor do patients have any choice over the standard of hotel services. ~~The one optional extra available in NHS hospitals is use of an "amenity bed" in a separate room, on payment of a relatively small charge; but take-up of this option is low.~~

6. These limitations in the NHS mean that the main route for patients wishing to have more choice is to go private, usually by joining a private health insurance scheme. But this is a costly decision, as it effectively means paying twice for part of their health care. And it is only by going private that patients are able to exercise any choice over the financing of health services, as there is no scope under the NHS either for opting out (ie providing for ones own care in return for reduced contributions to the state system) or for topping up (ie paying at the margin for extra services).

**Options for increasing choice**

7. Some steps are already being taken to extend the scope for consumer choice in the NHS. For example, the 1987 White Paper "Promoting Better Health" has as an objective "to give patients the widest choice in obtaining high quality primary care services". To this end it is proposed:

- to improve the availability of information on local health services, including discussion with the General Medical Council of the removal of the ban on advertising by GPs;
- to make it easier to change doctor; and

- to raise the proportion of GPs' incomes accounted for by capitation payments, so as to provide a greater financial stimulus for GPs to be responsive to patients' wishes.

8. Other options within the present structure include:

- (a) improved provision of information, along the lines of the primary care White Paper but extended to the whole range of health services. This might involve improved communication between GPs and hospitals on the hospital services and specialists available and on waiting times in different locations;
- (b) more choice over the timing of hospital treatment, for example by requiring hospitals and consultants to offer alternative appointment dates and the option of short-notice cancellation bookings for out-patient attendances and elective surgery;
- (c) increased provision of optional extras in NHS hospitals, available for a fee. As well as separate rooms, these might include special menus, accomodation for visitors and facilities such as private telephones and TVs.

9. When more radical options for the future of the NHS come to be considered, further ways of improving consumer choice will open up. Structural changes within the NHS - for example, if we went down the road of competing Health Maintenance Organisations - might enable patients to choose between different methods of providing health care. And financing changes (for example, allowing people to opt out of certain types of NHS care in return for paying a reduced contribution) may make the alternative of private care the more

**SECRET**

real choice for many people than it is at present. Such options will need to be considered in the next stage of the Group's work.

THE ROLE OF THE STATE

1. In considering the question of choice in particular, but also other questions (eg of competition), the role of the state needs to be considered.

2. The state's primary role is to ensure that everyone has access to adequate health care at a price they can afford.

3. For that purpose, it is not necessary for the state to provide the care itself. At present the state does provide most of the health care of the nation. There is some private sector provision, part of which is purchased by the state and part of which is bought directly by the patient (or via an insurance company). But that is comparatively small (and the state even sells some of its provision to the private sector).

4. It would be possible to move, gradually or quickly, to a system where most health care services were provided by private sector organisations, competing with each other to a greater or lesser extent. The process might be fastest with hospitals, where private sector provision has already made the greatest inroads, but could also include primary health care.

5. The State would be left with an enabling and regulatory role. As regards the enabling role, there are various ways in which people could be enabled to finance their purchase of health care, and these can be considered in the further work to be done.

## SCOPE FOR INDEPENDENT AUDIT OF EFFICIENCY

HC 11

Note by HM Treasury

1. There is at present no systematic attempt to carry out studies which would enable the efficiency of different parts of the NHS to be compared, so that best practice may be easily established and disseminated and poor performance highlighted. Experience suggests that a valuable way of doing this would be to build on the collection and analysis of information by auditors.

2. The objectives would be to use the information systems now being developed in order to produce deeper efficiency and value-for-money (VFM) studies across a broader range of NHS activity. The reports need to be demonstrably independent. They also need to be published regularly and widely in order to stimulate public interest and discussion.

Current Structure

3. There are currently three layers of audit function in the NHS:

- (a) Internal audit within individual health authorities and family practitioner committees.
- (b) The main statutory external audit of individual authorities and FPCs carried out by DHSS.
- (c) Audit by the NAO of the summarised accounts for the hospital and family practitioner services as a whole and of the Appropriation Accounts for the relevant Votes.

Other VFM work under existing arrangements is carried out by the Health Advisory Service, which promulgates good practice in community care, and through efficiency scrutinies by regions.

4. At present none of these audit tiers carries out systematic service-wide VFM audit. It is a function which could fall to either NAO or DHSS in the present system. The NAO have begun to do more comparative VFM work - the recent report on operating theatres is a good example - and this is to be encouraged. But NAO



(and PAC) are not best placed to take on the more wide-ranging role envisaged in paragraph 1. The DHSS statutory audit teams have begun to give greater priority to VFM work, and 30 studies are currently in progress.

#### Possible Options

5. Most of the suggestions for change have focussed to some extent on the analogy of the Audit Commission, following the techniques which it uses in its audit of local authorities. In many cases, the auditors themselves are private firms, but all report to the Commission and are paid for by the authorities. The Commission instructs these auditors in the course of their audit to gather figures for specific activities. The Commission then assembles and compares these figure and produces models of best practice. A report is produced for each authority, comparing their performance with best practice, and the auditors are instructed to follow up the authorities' progress in improving performance.

6. In its VFM studies, the Commission uses maximum publicity, and threats to expose bad practice, in order to force councillors to agree to efficiency improvements rather than face questions from their electors. Much is achieved by appealing to the professional pride of chief officers, but ultimately the accountability is to local councils.

#### (i) Improve existing arrangements

7. This could be done by a variety of measures, including greater outside recruitment into the DHSS Audit Directorate; more exchanges of staff with the private sector and the Audit Commission; contracting more audits out to private sector firms (15% of health authority audits are already contracted out but the Audit Commission proportion is 30%); and introducing multi-disciplinary audit teams which included doctors and non-clinical professionals as well as accountants. The statutory audit branch might be given a quasi-independent status within DHSS, reporting direct to the NHS Management Board, and charged with producing more wide-ranging VFM reports.

8. The advantages of this approach are that it would be readily accepted by the parties presently involved (Parliament, NAO, DHSS, and NHS staff) and would build on the progress now being made. It is also likely to be less expensive than alternative options involving organisational change. The disadvantages are that it would provide less initial impetus than the other options, and that the process would not be wholly independent of Government and the NHS.

(ii) A new independent audit authority

9. A second option would be to hive off the DHSS' statutory audit service with an independent role and strengthened staffing. This would follow the precedent of the Audit Commission, which was originally set up from the former District Audit Service of the DOE. For individual health authorities, the new body would provide statutory audit reports as they do now. Wider studies on value for money and efficiency on a national basis could also be prepared for the NHS Management Board or for publication generally. An annual report would be laid before Parliament.

(iii) Give statutory audit to Audit Commission

10. A further option would be to remove the audit function from DHSS completely and give it to the Audit Commission instead of setting up a new, and to some extent rival, body. DHSS audit staff would then transfer across to the Audit Commission. The NAO would continue to audit the consolidated accounts, so that the PAC retained its role in relation to the large sums of voted money which go to the NHS.

11. The advantage of this option would be that responsibility would fall to a body with proven expertise. In contrast, there would inevitably be a period of uncertainty while the new NHS audit body suggested under (ii) above established a track record for itself. Given the links between health authorities and local authorities, it might be thought logical to have one body dealing with the two.

12. There are however constitutional difficulties. The Audit Commission reports to local authorities, who are in turn responsible to their electorates, subject to a statutory power of surcharge where defined rules are broken. The NHS, on the other hand, is a part of central government, with a Minister responsible to Parliament. The lines of accountability are quite different. If the Audit Commission became responsible for NHS external audit, it would have to become responsible to DHSS Ministers (either directly or through health authorities), which would represent a major change in its hitherto independent constitution.

13. There is also a possibility of conflict with the NAO who, as mentioned above, have the right to conduct VFM studies in the NHS and do so. The NAO might resent the intrusion of another audit body into what they may consider as their territory and this would require careful handling.

#### Conclusions

14. The pros and cons of the three options for achieving this may be summarised as follows.

- (i) Beef up DHSS statutory audit. The least disruptive option, and much could be done; but lacks the impetus that would be given by a new organisation, and a question mark would remain over its independence and capacity for publicising reports.
- (ii) Create a new, hived-off audit body, similar to the Audit Commission. Greater independence and relatively few constitutional problems; but the new body would have to prove itself and might find itself in competition with the Audit Commission and the NAO, with increased risks of duplication and overlap.
- (iii) Give statutory audit to the Audit Commission. Enables Commission's prestige and track record to be tapped, provides some consistency in treatment

**SECRET**

of local authorities and health authorities, and avoids proliferation of bodies in this field. But there could be constitutional problems in the Audit Commission reporting to DHSS and there might well be tension created with the NAO.

15. Under all these, the PAC would continue its oversight, with NAO retaining its present audit responsibilities. This is inevitable, given the large amount of voted money going to the NHS. But it will be important to ensure that the NAO and the statutory auditors work together rather than in competition. And changes should be made only after first discussing them with the C & AG.

## SCOPE FOR INCREASED CHARGING

## Note by HM Treasury

1. NHS charges potentially serve important functions in any structure of health care.
  - a. They act as a price mechanism and hence as regulators of demand on the system. They are the only price mechanism in a largely free service to consumers.
  - b. They lower the cliff edge between free public services and full-cost private services.
2. Most charges arise on the Family Practitioner Service - prescription, dental and ophthalmic charges. But since the FPS is frequently the point of entry into the system, the benefits of improved charging mechanisms there should be felt throughout the NHS.

Prescription charges

3. About 75% of prescriptions are free. Most of these (45% of all prescriptions) are to pensioners, who have a blanket exemption. This means that
  - the economic benefits of prescription charges are largely blunted because only 25% pay them
  - where demand is highest (among the elderly) the price mechanism is entirely absent.

An obvious first step would be to remove the exemption for pensioners over income support level, thus putting them on the same footing as those below pension age. Because of their greater needs, however, there may be a case for mitigating this, perhaps by a reduced "season ticket" rate, or providing that prescriptions after the first, say, half dozen were free. Even so, this change would raise perhaps £100m a year. The same principle - exemptions only for lower income groups - could be extended to children under 16, who at present account for 10-15% of prescriptions.

4. Prescription charges are a flat rate, currently £2.40. This means that the only incentives to cost effective prescribing, apart from exhortation, are the dissemination of cost information to GPs (which FPCs are increasingly doing) and the requirements, through the limited list, to prescribe generic equivalents. Significant savings have been achieved in this way. But more would be possible if prescription charges were put on a cost-related scale, subject to some maximum (say £10 a prescription). There would then be pressure from patients for doctors choose the cheapest drugs wherever close substitutes were available.

#### Charges for visits to GPs

5. While GPs are an important filtering system, they are undoubtedly subjected to many unnecessary consultations. Their only means of discouraging this are limited and fully booked surgery hours, and determined receptionists. A small charge per consultation - say £2 - would help to discourage unnecessary visits. Again, there would be exemptions, and perhaps "season ticket" arrangements. On the present prescription charge

exemptions, a £2 charge would raise £100m a year. If exemptions were limited to low income groups, the revenue would be £240m. But the more important gains from this would be:

a impressing on the public that health care has to be paid for;

b reducing unnecessary demands on GPs' time (including provision of 'medical certificates' requested to justify absence from work for whatever reason).

#### Hospital hotel charges

6. While in its full form this has been ruled out, it might be worth considering charging for extras - TV, private room, telephone, better food, etc. The present amenity bed scheme is not popular, possibly because the standard of accommodation is relatively poor for the money (which is also one of the common criticisms by patients who use pay beds to get private treatment). Nor is this being pursued under the income generation scheme as yet, mainly because of difficulties in defining the "basic" service and what it would be reasonable to charge for additionally.

#### Outpatient visits

7. If charges were introduced for GPs, there would be a case by analogy for introducing them for outpatient clinics. A £2 charge might raise £25-50m, depending on the scope of exemptions.

Accident and emergency departments

8. It might be possible to make a charge for visits to casualty departments, provided this was done after the event.

Administration

9. If new charges were introduced, provision would be needed for their collection. This would involve some extra administration and cost, and should clearly be integrated from the start into new budgetting systems which may follow the resource management initiative. While this paper has been drafted in terms of the patient paying, there are other possibilities (like insurance, employer or local authority billing) which can be considered later in discussion of financing.

Pledges

10. The 1987 Conservative Manifesto did not refer to NHS charges. The Campaign Guide however said

"The Conservative party has always maintained that those who can afford to should make a fair contribution to the costs of the NHS and thus to the overall resources available for spending on health. Revenue from charges contributes to the development and extension of medical services, from which everyone can benefit."

The Prime Minister has ruled out hotel charges (which we take to mean "basic" charges, rather than charges for optional extras) for the duration of this Parliament. This was most recently reaffirmed in an exchange with Mr Kinnock at oral questions on 28 January this year - the relevant Hansard extract is attached. The only other reference we have found is an oral answer by the Prime Minister in January 1980 ruling out charges for visits to GPs. This does not appear, however, to have been repeated subsequently.



CC PMG  
 SIR P. MIDDLETON  
 MR ANSON  
 SIR T. BURNS  
 MR PHILLIPS  
 MISS PERSON  
 MR TURNBULL  
 MR PARSONAGE  
 MR GRIFFITHS  
 MR LALL  
 MR TYRIE



10 DOWNING STREET  
 LONDON SW1A 2AA

CH/EXCHEQUER	
REC.	29 FEB 1988 ✓ 29/2
ACTION	CST
COPIES TO	

SECRET

*Handwritten notes in red ink:*  
 PSB  
 Approvals  
 own ways  
 Andrew Pat  
 who after  
 long  
 see this.

29th February 1988

Dear Chancellor,

You will remember that at this morning's meeting on the NHS, the Prime Minister quoted from a paper sent to her by Mr. Michael Carter, the Chairman of the National Union's Western Area, on the performance of the Somerset Health Authority. I thought you might find it useful to have this paper and I therefore enclose a copy.

Yours sincerely,

*John Whittingdale*

JOHN WHITTINGDALE  
Political Secretary

SOMERSET HEALTH AUTH.

The Rt. Hon. Nigel Lawson, MP

# Urges Back call for more NHS cash

By Alan Pike, Social Affairs Correspondent

A COMMONS committee with a Conservative majority yesterday unanimously urged the Government to invest about £1.5bn more in the National Health Service during the next two years.

At a press conference to launch the report of the Social Services Committee, Conservative members were as vocal as their Labour colleagues in arguing that the NHS needed more money now, regardless of the outcome of the Government's review of the health service.

"We believe our recommendations represent, at a time when the economy is buoyant, a realistic programme which will bring the NHS back up to scratch and restore the morale of its staff - who represent the most fundamental and essential resource of the NHS," says the report.

The committee was convinced

there were "grounds for serious concern" about the levels of service the hospital sector will be able to maintain in 1988-89.

Mr John Moore, Social Services Secretary, responded by taking issue with some of the committee's specific recommendations and stressing that there would be "no blank cheques" for the NHS.

However, health service organisations were quick to rally round the committee, which concludes that the NHS has suffered a cumulative funding shortfall of £1.896bn since 1980-81.

The British Medical Association and the National Association of Health Authorities said the report supported their view that the NHS needs an immediate injection of money.

Mr Robin Cook, Shadow Social Services Secretary, said the report showed that "the Government cannot convince even their own backbenchers that our hospitals are properly funded."

The committee makes four recommendations which, together, would cost about £1.5bn in the next two years:

- The Government should commit itself to fully funding NHS pay settlements to which it agrees in 1988-89;
- The Government should make available finance necessary to cover health service inflation and for a 2 per cent development in services in 1988-89
- A £95m shortfall in funding of pay and price inflation in 1987-88 should be "made good forthwith" by the Department of Health and Social Security, and a further sum of not less than £1bn should be allocated over the next two years to specific priorities:

● Urgent attention should be given to improving measurements of NHS effectiveness.

Mr Moore said the call for an extra £1bn was arbitrary, and that the proposed £95m to cover inflation in 1987-88 failed to take account of the additional £75m announced in December, or of efficiency savings.

But the committee's recommendations will add to the pressures on Mr Moore, particularly as its Labour chairman, Mr Frank Field, has succeeded in carrying a Conservative majority with him.

However, the report does acknowledge that money is not the only solution to the problems of the NHS, that there is scope for significant improvement in efficiency and that "there may also be better ways of funding health care."

*Resourcing the NHS: Short Term Issues Social Services Committee HMSO £4.20*  
Complaints against NHS rise, Parliament Page 12

*pyf*

THE TIMES

# Moore to announce a new national health yardstick

By Nicholas Wood, Political Correspondent

Mr John Moore is expected to announce the first steps towards the creation of a national "health index" tonight. His speech will take the controversy over medical care into new and uncharted waters.

The aim of the yardstick, which is being likened in Whitehall to a retail price index, is to take Britain's pulse by providing a clear-cut means of measuring a battery of aspects of the country's health.

Its findings will help the Government to set strategic policy goals and underpin the fundamental changes in health care financing and delivery expected to emerge from the ministerial review set up by Mrs Margaret Thatcher.

For instance, data on the prevalence of high blood pres-

sure and cholesterol levels in the population could be married with existing information on life expectancy, morbidity rates, infant mortality and the effects of smoking and diet to build up a comprehensive picture of national trends.

The index could also be adapted to reflect the effects of stress and lifestyle.

It is intended to be entirely separate from the performance indicators that the Department of Health and Social Security is already developing as a way of measuring health service cost and efficiency in the drive for greater value for money.

The Secretary of State for Social Services will spell out the case for a new emphasis on health data in a speech to the council of the British Medical Association in London.

While giving few clues to the outcome of the policy review, he will restate the Government's determination that access to medical care should not depend on ability to pay.

Mr Moore is expected to argue that the well-being of the general population should be the focus of the current debate rather than the "obsession" with spending levels.

While there is plenty of information about treatments and operations, very little is known about their eventual impact on public health and even their benefits to individual patients, Mr Moore is expected to say.

He will also suggest that there is no necessary link between big health care budgets and healthy populations. He will point out, for instance,

that of the EEC countries, Greece spends the lowest proportion of Gross Domestic Product on public health care but has the highest male life expectancy. Ireland, meanwhile, is top of the cash league, but has almost the lowest male life expectancy.

Mr Moore is expected to tell the leaders of the medical profession that he has already asked his officials to examine the feasibility of putting together a portfolio of health indicators from which the index would be constructed.

He will acknowledge the technical difficulties of the exercise but argue that it is worth the effort to achieve better planning, more precise measurement of trends and clearer assessment of priorities.

SECRET

FROM: DP GRIFFITHS

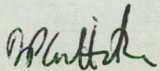
DATE: 7 MARCH 1988

MR SAUNDERS

cc Chancellor  
Chief Secretary  
Paymaster General  
Sir P Middleton  
Mr Anson  
Sir T Burns  
Mr Phillips  
Miss Peirson  
Mr Turnbull  
Mr Parsonage  
Mr Satchwell  
Mr Tyrie  
Mr Call

NHS REVIEW

I attach a revised version of the check list of key Treasury points for the paper which officials are to produce for the next Ministerial meeting. The check list incorporates the amendments which the Chief Secretary wanted included.



D P GRIFFITHS

HMT  
CHECK  
LIST

LIST OF KEY TREASURY POINTS FOR NHS REVIEW PAPER ON LONGER-TERM  
OPTIONS

1. Changes Within the Existing NHS

(i) Decentralised Budgeting

- Timetable for introducing clinical budgets and compulsory competitive tendering for clinical services.
- Scope for medical audit.
- Scope for clinical productivity audit.

(ii) Internal Market

- Timetable and method for introducing direct financing (as opposed to delayed adjustment through RAWP) of cross-border patient flows, ie "money following the patient"; to include consideration of activity funding.

(iii) Contracting Out Hospital Care

- Implications of contracting out patient care to private sector.
- The special case of teaching hospitals.
- Regulation? (to prevent eg monopoly pricing by centres of excellence).

(iv) Fiscal Incentives/Charging

- The pros and cons of tax relief (separate paper to be put forward post-Budget covering such issues as deadweight cost, behavioural effects, relief on insurance premiums or expenditure, relief to employers or individuals).

(v) Other

- Consultants' contracts (employment by DHA's; short-term contracts).
- Nurses entry qualifications.
- Non-hospital issues (computerised information for GPs; resource management for GPs; drugs - note the E(CP) reviews of the PPRS and pharmacists' contracts).

(Separate papers being prepared on waiting lists, the ten best DHAs. Audit to be handled bilaterally).

2. New Structures

- Amalgamating DHAs and FPCs. The status of GPs' employment (employed or on contract).
- Relationship between hospitals (suppliers) and DHAs (enablers). Implications for cost control.
- Local health organisations. Implications for cost control.

- Competing public and private sector HMOs. Implications for cost control; state regulation (whether of the patients HMOs must accept, or of the services they must provide); the scope for HMOs to be employer-financed as well as enrolling individuals.
- The management of capital programmes in the event of abolishing RHAs. The interaction between the "private finance" rules and private health provision.
- Land sale receipts if RHAs go. Should districts be allowed to keep them? Implications for the control total.
- The administration costs of new structures.

3. Changes in Methods of Finance

- How to stop public finance (vouchers, credits or capitation fees) substituting for private finance (existing private health insurance) and financing uncontrolled increase in public sector health care costs.
- The pros and cons of the "health stamp" (problems of hypothecation; employer/employee split; whether income-related; whether covers elderly and unemployed).
- The implications of contracting/opting out (partial or complete; compulsory or voluntary; problem of adverse selection, in which the better health risks contract out, leaving the public sector with more expensive patients).

- The implications of "topping-up", for both public expenditure and the private health insurance industry. If topping-up covers essential services, how to prevent 2-tier system? If not, how to prevent uncontrolled publicly-financed expansion?
- Remuneration and methods of payment (eg fee-for-service) to service providers. Implications for cost control. Use of charging as a discipline on demand for health care.
- Distributional consequences of compulsory insurance; a "poll tax"?
- Tax relief (see earlier).

SECRET



FROM: CHIEF SECRETARY  
DATE: 7 March 1988

CHANCELLOR

CC:  
Paymaster General  
Sir Peter Middleton  
Mr Anson  
Sir T Burns  
Mr Phillips  
Miss Peirson  
Mr Saunders  
Mr Turnbull  
Mr Parsonage  
Mr Griffiths  
Mr Satchwell  
Mr Tyrie  
Mr Call

*Contra L.*

CST  
→  
CHLEX  
7/3

## NHS REVIEW

I have seen Mr Phillips' minutes of 2 and 4 March and Mr Saunders' of 4 March.

2 Insofar as Mr Phillips' minute is concerned it is essential that our short-term measures merge into our long-term objectives and the agreed Paper will be constructed with that in mind.

3 For that reason I strongly support Mr Phillips' view that the consideration of long-term changes should begin with 'models' of where we wish to end up (so that we can consider the practical difficulties en route and make appropriate decisions) rather than the DHSS preference of building on the present NHS as it exists. The DHSS approach is fundamentally flawed and would have no structure or objective.

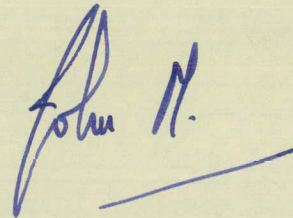
4 We should endeavour to keep charging on the table as part of the discussions on financial discipline since, as I said in my note last week, it is relevant to curtailing expenditure as well as raising revenue.



SECRET

5 I have discussed with Mr Saunders his comprehensive check list of Treasury priorities and am content with it as amended.

6 Officials will now discuss the Paper for the next meeting with DHSS and the Cabinet Office with the intention of a single agreed Paper being produced. We will reserve the right to submit a Treasury Paper in need.

A handwritten signature in blue ink, appearing to read "John M.", with a horizontal line extending to the right from the end of the signature.

JOHN MAJOR