PO-CH/NL/0102

PART H

Part H.

SECRET

(Circulate under cover and notify REGISTRY of movement)

Begins: 24/6/88.
Ends: 28/6/88.

PO -CH /NL/0102
PART H

Chancellor's (Lawson) Papers:

THE NATIONAL HEALTH SERVICE REVIEW

Disposal Directions: 25 Years

10/8/95.

PO -CH /NL/0102
PART H

ps.mr/week.20.6/mr.22

SECRET

FROM: H PHILLIPS
DATE: 24 June 1988

CHANCELLOR

cc Chief Secretary
Financial Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Mr Turnbull
Miss Peirson
Mr Saunders
Mr Parsonage

Mr Corlett)
Mr Kucys) Inland Revenue

Ch/OK? mpm. Continue v.

NHS REVIEW: TREASURY PAPERS

We need to decide whether to adjust your paper on tax relief and the Chief Secretary's paper on financing hospitals in the light of today's meeting with Mr Moore. Perhaps you and the Chief Secretary could let us know on Monday whether the following suggestions accord with your own views.

2. On tax relief I do not see that any change need be made to the paper. You will wish in the discussion with the Prime Minister to say that there should be a more up-to-date analysis of what is now going on in the private sector but if it is right that demand is already running strongly there then anything more than you have proposed would actually be counterproductive.

he may, as he threatened, continue to argue for it

3. Mr Heppell is going to advise Mr Moore not to table his contracting out paper. We have therefore at least succeeded in getting them into the position that if there is a case for any further demand boost contracting out is not the way to approach it. Incidentally if Sir Roy Griffiths was right to say that demand for company scheme development was coming from the shop floor then we presumably do not need to encourage it.

4. On the Chief Secretary's paper (financing hospitals) I do not think much needs to be done to the paper although some softening of the references to Korner performance indicators might help. I

have asked Mr Saunders however to revise the draft covering note to indicate more clearly that further work is needed on how money would be targeted at improvements in efficiency rather than whether it should be; and that we are not in business to reward the inefficient simply because their task in improving themselves is the easiest. I think Sir Roy Griffiths can again be helpful here and I am arranging to talk to him about the detail. Mr Saunders will let the Chief Secretary have a revised covering note, and a speaking note for the meeting.

5. Are you content with these suggestions?

H PHILLIPS

PWP

24/6/88.

HEALTH BRIEFING MEETING

Ch / Hayden's note behind goes through circulated papers. To that agenda you might add, at end;

- where do we stand on bringing in the Audit Commission? (PEM won't be there to report, but pps behind tell dismal story - DHSS dispute conclusions of bilateral, Chris France still not on side) How best proceed now?
- tactics for PM bilateral? [Hayden will have all the gossip on how she's being briefed] In particular, how much does she know about progress of quadrilaterals? Also, should you raise Trafford bilaterally?
- when should you send in workplace nurseries note?

MPW.

ps.mr/week.20.6/mr.21

SECRET

TEACH-ING HOSPITALS

FROM: H PHILLIPS
DATE: 24 JUNE 1988

CHANCELLOR

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

CH/X OK? √

mpm

NHS REVIEW: TEACHING HOSPITALS

We have discussed teaching hospitals as probable candidates for independent status within the NHS, and you should see the attached note from Mr Satchwell about how they have been dealt with pre and post-1974.

2. I am sure there will be a view, in DHSS, and in non-teaching parts of the NHS hospital sector, that independence for teaching hospitals will be a retrograde step - although Mr Moore does not seem to have expressed this view. Indeed it would be retrograde if all we did was to put the clock back without tackling the issues described in paragraphs 9-11 of Mr Satchwell's note. We clearly do not want to set up a system which produces hospitals which are more expensive and inefficient, distributes the best staff badly, and prompts uncontrolled lobbying for more money.

3. We therefore may need to make it clear in discussions that we are not proposing simply to revert to a pre-1974 position. Would you be content with a stance which said we were keen for hospitals to gain independent or self-governing status where they met conditions about budgetary discipline, involvement of consultants

in management, set and met efficiency targets etc? On this basis, and put crudely, Guys would qualify, St Thomas's would not. I think this approach would also fit in with what I think Sir Roy Griffiths is talking about in relation to "contracts".

HP.

H PHILLIPS

st2.127

FROM: R C M SATCHWELL
DATE: 23 June 1988

1. MR PHILLIPS (HP see separate note)

2. CHANCELLOR

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

NHS REVIEW: TEACHING HOSPITALS PRE-1974

It was suggested at your recent quadrilateral meeting with DHSS Ministers that teaching hospitals might be good candidates for any pilot scheme of "independent" or "self-governing" hospitals. This minute sets out the position of teaching hospitals prior to the 1974 reorganisation of the NHS, and looks at how they have fared since then as a result of being integrated into the general NHS structure.

Old System

2. Prior to the 1974 reorganisation, all but 7 provincial teaching hospitals in England and Wales were administered and funded differently from other hospitals. Ordinary hospitals were run as individual units by a hospital management committee, and funded by the DHSS through a regional hospital board. Outside Greater London, these boards were broadly equivalent in geographical coverage to the present regions. Though a direct comparison with the current system is not really valid, since they were responsible only for hospital services, and not for the other services (community nurses, health visitors, school health service) now run by RHAs.

3. Teaching hospitals on the other hand were administered by boards of governors and funded directly by the Secretary of State.

In order to aid co-ordination of services, these boards of governors included not only members of staff from the hospital itself and from the relevant university, but also representatives from the local region. And in Greater London, where most of the teaching hospitals were located, a Joint Working Group existed to advise on hospital services throughout the capital.

4. In Scotland and Northern Ireland, teaching hospitals were (and are) administered in exactly the same way as other NHS hospitals.

The 1974 Reorganisation

5. The main reason for including teaching hospitals in the 1974 reorganisation was that it was thought that, despite the multi-disciplinary nature of the governing boards and the efforts of the Joint Working Group, the distinction between the two types of hospital hindered service delivery. It was difficult, particularly in London, to find the right balance between the provision of services to consumers and the needs of teaching and research. The former tended to lose out to the latter and to the interests of the doctors. To quote the White Paper:

> "Teaching hospitals have in recent years gone a long way in providing district hospital services. Unification will help them to take this further, and, in so doing, will bring great benefit to the districts concerned".

6. The 1974 Act thus abolished the separate boards of governors for teaching hospitals, and transferred responsibility for their administration to the new, Area Health Authority. AHAs which included a teaching hospital (AHA(T)s) received additional funding, through the Service Increment for Teaching, which was (and is) top-sliced out of the total NHS budget. The special arrangements for London were also dismantled.

7. The only exceptions to this reorganisation in England and Wales were the 12 specialist postgraduate teaching hospitals in London (Great Ormond Street, Royal Marsden etc). Because of the

high rate of referrals to these hospitals from other consultants, it was not clear whether it would be better to integrate them into the local administrative structure or leave them as separate bodies. In the end, it was decided to leave their administrative and funding arrangements unchanged, for the time being. As part of the 1982 mini-reorganisation which, inter alia, abolished AHAs, a couple of the 12 were integrated into districts; but the remaining 8 (after allowing for mergers) were formed into Special Health Authorities, run by DHSS and funded directly by the Secretary of State. So, in effect, these hospitals still have the same administrative and funding arrangements as pre-1974.

Effects of the Reorganisation

8. By far the biggest effect was that it broke established working practices and (crucially) funding patterns. The relationship between the teaching hospitals and the rest of the NHS had long been a source of contention. Before 1974, the teaching hospitals were said to have a disproportionate influence and a disproportionate share of the available resources. The 1974 reorganisation, and the introduction of RAWP, was intended to reduce the duplication of facilities, and unwind the distortions in the distribution of resources across the country which sucked an unduly large proportion towards London. In general, this has now been achieved; though it is arguable that the process needs to continue through a further rationalisation of acute hospital services in inner London.

9. The generally accepted view was that the teaching hospitals, particularly in London, were expensive and inefficient, dominated as they were by the top consultants in the country, on whom few checks were applied. Since then, some (like Guy's) have managed to develop a less deferential culture and to streamline their management. But others have so far been less successful.

10. The second major effect has been in terms of a more even distribution of quality staff throughout the country. Teaching hospitals have always occupied a position of privilege in the

health service because of their historical and professional status, and so have always been able to recruit the best staff. But their integration into the NHS as a whole has encouraged more of the most talented doctors to go to good, new district general hospitals, often in the provinces.

11. Thirdly, it has reduced the opportunities available to individual consultants and the teaching hospitals to lobby the Government for additional resources. Prior to 1974, DHSS were in direct negotiations with individual teaching hospitals about money, and faced demands which in practice were more difficult to resist than when negotiations are (as now) conducted at one remove, through health authorities.

R. Satchwell

R C M SATCHWELL

RB 27/6

1. MR SAUNDERS

2. CHIEF SECRETARY

DPG

FROM: D P GRIFFITHS
DATE: 24 JUNE 1988
cc Chancellor
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull

REVIEW OF RAWP

The letter of 20 June from Mr Moore's Private Secretary seeks clearance of terms of the proposed Government statement to be made when the report on the RAWP Review is published. All that would be said is that the Government will consider the report in the context of the wider NHS Review. There is nothing to which we should object in this.

2. DHSS are also proposing that the resource assumptions on which health authorities should base their 1989/90 plans should be determined on the basis of the existing RAWP formula. But the authorities would be asked to plan on a range of assumptions so that final decisions on allocations can take account of developments between now and December.

3. We are in favour of authorities producing plans for different resource scenarios but we do not accept that the allocations should have to be made on the existing RAWP formula. First, we consider that the speed of the current resource redistribution process is at least in part responsible for the in-year difficulties which some authorities- notably the Thames Regions - are facing. Slowing the process down would help alleviate these problems. The outcome of the review of the RAWP formula makes it easier to justify doing this. Second, DHSS have put in a £50m PES bid for a substantial increase in the RAWP bridging fund - the pot of money used to mitigate the effect of the redistribution process on those Regions judged to be over-provided and hence losing out under RAWP. In resisting this bid our argument would be that these funds would not required if RAWP were slowed down. Our hand would be weakened if health authorities' planning for 1989/90 was allowed to proceed on too narrow a range of resource assumptions all based on the existing RAWP formula.

490/6

4. We should therefore press DHSS to ensure that the range of assumptions is wide enough to take account of a possible slowdown in RAWP next year.

5. I attach a draft Private Secretary reply.

D P GRIFFITHS

DRAFT LETTER FROM PS CHIEF SECRETARY TO: -

Geoffrey Podger Esq
Private Secretary to the
Secretary of State for Social Services

Copies to PS/Prime Minister
PS/ SOS Wales
PS/SOS Scotland
PS/SOS Northern Ireland
PS/ Sir R Butler

REVIEW OF RAWP

Thank you for sending me a copy of your letter of 20 June to Paul Gray. We have seen his reply of 24 June.

The Chief Secretary too is content with the terms of the proposed statement. As regards the basis for health authorities' 1989-90 plans, he considers that the resource assumptions should not be based too rigidly on the existing formula but should be wide enough to encompass a deceleration of the RAWP redistribution process.

I am copying this letter to recipients of yours.

SECRET

NHS REVIEW: TAX RELIEF

Paper by the Chancellor of the Exchequer

1. At the meeting on 7 June we agreed that:-

   a. the question of restricting tax relief for the elderly to the basic rate should be looked at again; and

   b. a more limited benefits-in-kind exemption, targeted on those with earnings below a specified level, should be considered.

This paper reports on both points.

Tax Relief for the Elderly

2. Providing tax relief for private medical insurance for the over-60s at basic rate only would benefit 300,000 existing policyholders at a deadweight cost to the Exchequer of about £25 million. Allowing relief at the higher rate, as well, would be of additional benefit to about one-quarter of this group - 75,000 policyholders. The Exchequer cost would rise to a little over £30 million. There would also be some additional administrative complication. That is because, while basic rate relief would be provided at source through a MIRAS-type arrangement, higher rate relief would have to be dealt with by tax offices, through individuals' PAYE codes or tax assessments.

The question is whether these additional costs are likely to be worthwhile.

3. Clearly, in principle, the higher the rate of tax relief, the greater will be the effect on behaviour of those who benefit: a 40 per cent relief is likely to bring in more new subscribers than a 25 per cent relief. But a 50 per cent increase in take-up would be needed before the extra money going into private health care exceeded the cost of tax relief, compared with an increase of 33 per cent if relief were given at basic rate only. Only those over-60s with incomes comfortably over £20,000 would benefit from this further concession: those with income below that level would gain nothing at all from higher rate relief. So, on the one hand, the additional impact of higher rate relief would be strictly limited; while, on the other, it will give further ammunition to opponents of the scheme.

4. There is a further complication with giving higher rate relief. In my previous paper I pointed out that it might be attractive to let tax relief flow to whoever paid the premiums for a person over 60, so there would be encouragement for people of working age to pay their elderly parents' BUPA subscriptions, and this was generally welcomed. But if higher rate relief were available in such a case, it could provide a strong incentive to dress up payments by the parent as payments by the son or daughter - regardless of the true position - thus adding to the cost of the relief. In order to guard against this abuse, some additional irritating safeguards would be unavoidable.

5. In conclusion, tax relief for the elderly at the higher rate would increase the complications of the scheme, and provoke unnecessary criticism. The closest precedent for health insurance premium relief, life assurance premium relief, was (and, for pre-1984

policies, still is) given at half the basic rate, for basic rate taxpayers and higher rate taxpayers alike.

Benefit in Kind Treatment

6. For company health insurance schemes, the suggestion was to raise the limit below which employees escape tax liability on this particular benefit in kind. Since company schemes at the moment are concentrated among the higher paid, this would have the advantage of reducing the deadweight cost and targetting the incentive where it is most needed.

7. I have therefore considered the possibility of raising the limit from its present £8,500 to something in the region of £20,000 - roughly the point at which higher rate income tax liability starts. It would mean that the proportion of employees who would be exempt from tax on medical insurance would go up from 17 per cent to 65 per cent at a deadweight cost of some £m25.

8. But while this approach has its attractions, it also has some further disadvantages to add to those relating to a general benefits-in-kind exemption which I described in my minute of 3 June.

9. First, having a second income limit would be a significant added complication for employers, increasing their administrative costs. The Revenue, in conjunction with the Deregulation Unit, is currently engaged in finding ways of minimising the compliance costs of taxing benefits-in-kind: this would be a move in the opposite direction.

10. Second, it would increase the pressure to raise the £8,500 P11D limit across the board. Our consistent

policy has been gradually to bring the tax treatment of payment in kind and cash into line by allowing the real value of the P11D limit to fall. The limit has not been increased since 1979. It is now widely recognised that it is anomalous to have any income limit in taxing benefits, and that it is right to let the present limit wither away. We are well on the way to success with this policy, since there are now relatively few full-time employees with cash pay plus benefits of less than £8,500. But there also continues to be pressure, as we have seen again in this year's Finance Bill debates, to increase the limit substantially. Setting a new limit for medical insurance - one of the commoner benefits-in-kind-would clearly add to this pressure, and make it more difficult to resist.

11. Third, it would add to the sense of unfairness already felt by those whose employers do not run a company health insurance scheme, or who are self-employed.

Benefits-in-kind and Relief for the Elderly

12. But if we decide to introduce a new tax relief for premiums paid for the over 60's, then we could, I believe, provide a parallel relief for the benefits-in-kind charge on corresponding premiums. The argument is exactly the same in relation to the over 60's as it is for employees and the self-employed generally - we should ensure that there is no difference in tax treatment between those who pay their premiums privately, and those who get them paid by their employers.

13. Including benefits-in-kind in the relief for the over 60s, and confining relief to the basic rate, would

increase the cost, at current levels of provision, to £35 million and would benefit 65,000 employees as well as 300,000 individual policyholders. This is the most far-reaching tax package I would be prepared to recommend.

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

24 June 1988

Dear Geoffrey,

REVIEW OF RAWP

Thank you for your letter of 20 June. The Prime Minister is content for an announcement on the basis now suggested.

I am copying this letter to Jon Shortridge (Welsh Office), David Watkins (Northern Ireland Office), David Crawley (Scottish Office), Jill Rutter (Chief Secretary's Office) and Trevor Woolley (Cabinet Office).

Yours,
Paul

PAUL GRAY

Geoffrey Podger, Esq.
Department of Health and Social Security

27.6.5

SECRET

27/6/88 MP

FINANCING HOSPITALS: INTRODUCTORY SPEAKING NOTE

1. Proposal is intended as a modification to present system. Idea is to introduce real incentives to efficiency and to get away from present system under which those who improve their efficiency run straight into a resource constraint. On this basis, need to develop a practical scheme which provides clear and open rewards to encourage those seeking to improve their efficiency.

2. Important that rewards for improved efficiency get carried forward into future years. But also cumulative effect over several years should not be to starve some regions and districts - that would create difficult problems for Government. So system needs some flexibility built into it, while retaining its incentive effects. Ultimately for districts to deploy funds among their hospitals to maximise efficiency and bring about improved services locally.

3. How to measure efficiency a tricky problem. Korner performance indicators a useful starting point - but not perfect, and further work needed here.

4. Paper also suggests separate "top-slicing" to tackle waiting times. If go for this, would have to consider relationship to existing waiting list initiative. On the face of it, however, attractions in a systematic approach to the problem, setting quantified targets and basing funding on performance.

5. Leads to question of performance and efficiency targets generally. Proposed system rewards best-performing districts. Districts will need to encourage their hospitals to do better by setting specific targets, to which funding is related.

DEFENSIVE: Most efficient will be penalised because they have least scope for further improvement?

6. Unlikely. Some inefficient districts may be able to make quick gains, eg by accelerating competitive tendering. But longer term the best managed should continue to show most efficiency improvements.

7. More generally, remember this is not the whole resource allocation system. Regions and districts will still be able to redirect the underlying allocations to maximise efficiency. Top-slicing is not intended to reduce flexibility over the rest of the budget.

22.6.2

SECRET

old version

HS REVIEW: FINANCING HOSPITALS

Note by the Chief Secretary, Treasury

At our meeting on 24 May, I was invited to prepare a note about how the system of allocating resources to health authorities might be improved to reward hospitals which attracted more patients by greater efficiency. I attach a note which my officials have prepared on how a scheme of this sort might work.

2. The real growth in HCHS expenditure - which, realistically, we must expect to continue for the foreseeable future - would be earmarked for allocation on the basis of performance. Regions would be given funds for distribution to districts on broadly the same basis as now, based on inflation-adjusted total their districts received the previous year. The remainder would be allocated to the best performing.

3. On the specific points raised in the paper, my views are as follows:

a. I think it makes sense, initially at least, to build on the present performance indicator system and make allocations to districts rather than trying from the centre to target the best-performing hospitals.

b. I have no strong views on whether the allocations should be made by regions or by the DHSS, and would welcome the views of colleagues on this.

c. I hope our officials can be invited to draw up a suitable indicator or set of indicators quickly. Clearly, the measure should not be so crude as to meaningless, but it should also not be so sophisticated that there is a long time lag before it is available.

d. I agree that the bulk of the money should be allocated on the criterion of improved efficiency. But I see attraction in allocating some of it on the basis of increased activity in the areas where waiting lists are longest, replacing the present waiting list initiative.

e. When we have reached conclusions on the Secretary of State's paper on self-governing hospitals, we can consider how to adapt this system for them. But this should not present overriding difficulties.

4. I believe a scheme of this nature has a number of attractions. It would:

- provide real incentives for health authorities to improve their efficiency

- direct resources towards those areas where efficiency was being given priority; and

- thereby allow money to flow to those who improved their capacity to treat patients.

SECRET

FINANCING HOSPITALS

Note by the Treasury

This paper examines the scope for rewarding the best performing parts of the NHS through a "top-sliced" element of the health budget. It is intended to tackle quickly the problems that exist now. It does not necessitate structural change in the NHS and involves only relatively modest change at first. But it could be adapted readily to an evolving NHS structure.

The problem

2. The present resource allocation system is based on need. Money is distributed to regions on the basis of the relative priorities revealed by the RAWP formula, and then from regions to districts. The criteria applied by regions in allocating funds to districts vary, and by no means all follow RAWP-style methods. But in general the system takes no account of efficiency or performance.

3. In theory, the main incentive to improve efficiency is that it enables a hospital to provide a greater volume of services within a fixed budget. But in practice this turns out to be only partially true, because treating extra patients of itself generates increased costs. In general, if throughput is improved so that more patients can be treated within existing capacity at existing staffing levels, unit costs do not fall commensurately, so that the improved treatment rates cannot be achieved without increased funding. So the incentives to improve efficiency are not as great as they could be.

Top-slicing

4. In outline, the system would be quite simple. Most current expenditure would be allocated as now: distributions to regions in the previous December; allocations by regions to districts completed by late February. The amount allocated in this way might be equal in real terms to the total of health authority budgets the previous year, leaving the balance to be allocated on the basis of performance. Typically, after allowing for pay awards, notably to doctors and nurses, this has left room for real growth of around 2%, or £250m.

5. This would be in February, so that hospitals would go into the year in full knowledge of their budgets. The total available for distribution would have been determined in the previous public expenditure survey. If, for the sake of argument, it was 2% of the total, the extra performance-based allocations might vary between 0 and 5% of initial allocations. The distribution within the total sum available for these allocations could be settled only when the overall performance of all health authorities had been assessed.

6. The interaction between the system and that for allocating resources generally would be complex, but it should be possible to ensure that rewards were carried forward into baselines for future years, and were not lost at the end of the year. Initial allocations to regions would be based on the previous year's total allocation (including performance awards). If there were to be further movement to RAWP targets, allowance would have to be made: either (and this would be very controversial in RAWP-losing regions) by adjusting these allocations up or down; or by using some of the growth money for RAWP adjustment rather than rewarding performance. Regions would be asked, in their allocations to districts, to take full account of previous performance awards, alongside the other criteria they apply. So a district's allocation should reflect the carrying forward of previous awards, possibly with some adjustment for other factors.

7. A number of questions need however to be addressed:

- to whom would the performance-based allocations be made: hospitals or districts?

- how would their performance be measured?

- would the objective be to reward activity or efficiency?

- would performance be measured against some external standard, or would the criterion be improvement in measured performance?

District or hospital?

8. Allocations direct to hospitals, or even to departments within hospitals, would provide the most direct incentives to improve efficiency. Money would be diverted to the best performing parts of the health service in a very direct way. But it could be difficult for DHSS to interpret sensibly information coming forward from individual hospitals. Moreover, such information is not yet available in the required detail.

9. Performance-based allocations to districts could, in principle, be introduced much more quickly. The new district-level information system, based on the Korner report, was introduced from 1 April 1987. In principle, this could be adapted for the purpose of top-slicing. Giving the money to districts would enable them to allocate it both in accordance with local priorities and so as further to improve efficiency, in the knowledge that this could be expected to result in further financial rewards. Districts could be asked to link allocations to units on performance and efficiency targets. This would be a first step towards a more contractual style of management.

10. Whether allocations to districts should be made by regions or by the department is a matter for judgement. Regions would have considerable scope to undermine the effect of the performance-based allocations by offsets in their disbursements to districts. On the one hand, it could be argued that separating the two processes by the department making the performance-based allocations would minimise the scope for this. On the other, it could be argued that the commitment of the regions to the new system would be best secured by giving them responsibility for allocating the money. Ministers are invited to consider the balance of argument between giving the function to regions or the department.

How to measure performance?

11. Ideally, an objective measure would be devised, based initially on performance indicators for districts. The measure would obviously need to be as up-to-date as possible. If allocations are to be made in the February before the start of the financial year, it might be possible to base them on performance

the 12 months to the previous 30 September, although this would involve speeding up considerably the present timetable for producing the performance indicators.

12. Officials will need to do more work urgently on the development of measures based on performance indicators, if Ministers wish to pursue this route.

Activity or efficiency?

13. This depends on the area being considered. Where waiting times are excessive, increasing activity levels - and maintaining the increase - is the only way to get them down. But increased activity is not a good measure of performance in other areas - for example, psychiatry.

14. This suggests a two-pronged approach. In order to introduce the right incentives and to deal with the problems identified in paragraph 2 above, the general criterion for distributing the top-sliced money should be efficiency. But the concept could be imported into the present efforts to tackle excessive waiting times for routine procedures. A separate top-sliced allocation, replacing the present waiting list initiative, could be distributed to those who had done most to increase activity in certain defined areas, thus reducing waiting times, in order to encourage them to go further, if necessary taking patients from waiting lists in other nearby districts.

Absolute performance or improvement in performance?

15. Any attempt to devise a "standard" performance measure would be very complicated. The formula would have to take account of the size and distribution of hospitals within the district, the range of specialties covered, the characteristics of the local population. It might also have to cover factors like how many

sites hospitals are spread over, and their layouts, which affect efficiency but are beyond the control of the local management. No matter how sophisticated the formula, many would continue to argue that they were subject to special factors which were not given their due weight.

16. Such problems would be avoided by measuring performance over the most recent 12 months and comparing it with the previous period. It would be much more difficult to argue that there were special factors which inhibited improvement in performance, as opposed to the absolute level of that performance. Rewards based on improved performance would also offer more immediate incentives to management. Those who started well down the league might need to spend several years improving their efficiency before qualifying for extra money if the criterion were absolute level of performance. Management might get discouraged in such circumstances, whereas they could start to benefit immediately if it was improvement in performance that was being rewarded.

17. One difficulty with rewarding improvement in performance is that it might be the least efficient authorities with most scope for improvement (eg because they had been slow to introduce competitive tendering) who would benefit most. But once the system had been running for a few years, the best authorities should have found ways of improving their efficiency as well over time. So long as the system ensured that the allocations were built into baselines for subsequent years, the best districts should be able to reap suitable rewards.

Implications for self-governing hospitals

18. The system would need to be adapted for self-governing hospitals, independent of districts. It is difficult to say what form this would take, without clear decisions on the nature and structure of such hospitals. Among the questions to be considered are:

- whether their allocations should distinguish "baseload" functions (service to the local community, just like any other district general hospital, referrals by GPs etc) from any functions as "centres of excellence", eg the referral by consultants in other hospitals of particularly difficult cases

- whether the financing of their "baseload" services should be able to share in the growth money given out to the rest of the system in performance-based allocations

- if so, whether they too should be subject to the same regime of performance measurement

- whether the "centre of excellence" functions could be financed differently, eg by direct payments from the budgets of other hospitals whose consultants referred their patients on.

PS2/57M

SECRET

BF 28/6

FROM: MISS M P WALLACE
DATE: 27 June 1988

MR PHILLIPS

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

NHS REVIEW: PAPER ON HEALTH SUPPLY AND DEMAND

The Chancellor has now had the opportunity to look at the supply and demand paper attached to your minute of 23 June. I attach a version on which I have marked his initial drafting comments.

2. However, there are some further points that he would like incorporated in the paper if possible. He would like some more concrete illustrations of the effects of boosting demand, perhaps drawing on the points in paragraph 7 of your covering minute. He thinks we ought to point out clearly that the problem now is that demand exceeds supply, and that, so far as the private sector is concerned, the problem is that the price is so high (we should explain why): the way to encourage its growth is to bring down the price, which means improving supply, not boosting demand.

3. I should be grateful if you and others could consider how the paper could be amended to cover these points. I should be grateful for any comments by close tomorrow: the Chancellor wants to circulate the minute on Wednesday.

MOIRA WALLACE

DRAFT

PRIME MINISTER

NHS REVIEW: SUPPLY AND DEMAND

As the work of the review moves forward we shall need to examine the emerging proposals against the objectives we have set ourselves in the context of ~~and~~ an economic analysis of the supply of and demand for ~~in~~ health-care. I hope it will be useful to you, and other colleagues if I set out the essential points of ~~this approach.~~ such an analysis

Our main objectives in the review are:

(a) to make the NHS more cost-effective; and

(b) to increase the contribution of the private sector.

We shall also want to ensure that when we come to look at the results of our reforms, some success has been achieved in meeting specific pressure points in the system.

2. These ~~The~~ primary objectives will not be met by ~~simply~~ measures whose main effect is ~~making available more resources~~ to expand demand. Indeed, the problems we are seeking to address ~~redress~~ would in all likelihood be made worse. The key to ~~lasting~~ success must be better performance on the supply side.

3. This is of course a lesson we have learned and applied in many other areas of policy. There is no reason

why health should be different in this regard. Indeed, there are features of the supply of and demand for health care which make it especially important that we should get the design of our reforms right in this area.

4. First, on the demand side, we must recognise ~~acknowledge~~ the almost complete absence of the price mechanism as a means of regulating the level of output. This is most obviously the case in the state sector, where prices and ~~or~~ charges play a negligible role, particularly in the hospital service. ~~Patients tend to judge the standard of treatment by its cost, and~~ It follows that patients (and their doctors, too) will always tend to press for high cost options. But even in the private sector, where patients have to pay in full, the price mechanism works in a very muted way.

5. Private treatment is mainly financed out of insurance. This effectively means that at the point of use services are free to the individual patient, just as they are in the NHS. Once services are required, there is no financial reason for the patient to limit his demands. In time higher expenditure on hospital and other services will be reflected in higher premiums, but this is a weak and indirect check, especially on those in company schemes whose premiums are paid by a third party. As experience in the United States has shown, ~~the effect~~ this discipline would be even more attenuated if private insurance were underpinned by general tax relief.

6. The lack of an effective price mechanism working on consumers is reinforced by a lack of cost consciousness

among doctors and other suppliers. As we have noted many times in the course of the review, budgeting and information systems in the NHS are ill-designed for the purpose of encouraging cost-effectiveness and economy. Those who commit resources are not financially accountable for their decisions, nor are they given adequate information on the costs of what they are doing. Systems are better in the private sector, but doctors everywhere cling to their outmoded tradition of non-involvement in the management of resources. Under present arrangements, the demands of patients are more likely to be amplified than constrained by the decisions of doctors.

7. The absence of price signals for both patients and doctors has resulted in a chronic tendency towards excess demand. Some of this demand is suppressed, for example by controls on expenditure in the NHS, and remains latent as only because patients are put off by ~~excessive~~ lengthy waiting times.

8. An increase in effective demand in any market can have two effects, depending on the supply response. It can call forth extra output, or it can push up costs. It goes without saying that the split between these two effects is of some importance. There is nothing to be said for boosting demand if supply does not respond and it simply leads to a bidding up of pay and prices.

9. Without fundamental changes to the incentives faced by hospitals and other suppliers, ~~there are reasons for~~

~~thinking that~~ the supply of health output will only adjust slowly to increases in demand, at least in the short to medium term.

10. The starting point is the availability of skilled manpower - doctors, nurses, therapists, technicians etc. The supply of these resources cannot be turned on and off like a tap. There are inevitable lags in the system resulting from the requirement to recruit and train specialist staff.

11. In addition, these constraints are compounded by institutional and other rigidities stemming from the way in which we presently organise our affairs. The problems here are well known and have been discussed in earlier papers. Particularly important in my view are inflexibilities on the manpower side: restrictive practices, overspecialisation, promotion blockages, reward systems unrelated to performance, national pay rates, and so on. But there are rigidities throughout the system resulting from weak or perverse incentives and the absence of market forces.

12. Finally, even within the limits imposed by these constraints, there are failures to use resources efficiently and to direct them towards the uses where they will have maximum effect. The scope for improving supply performance is amply demonstrated by the evidence of substantial variations in efficiency and output between different units within the NHS.

13. It is clear, therefore, ~~I am thus led to the conclusion~~ that there is little to be said for measures which simply affect the demand for health care and have little impact on supply behaviour. The likely effect would be higher costs, not higher output. This is true whether the extra demand is directed towards the public or the private sectors. One part of the market cannot be isolated from the rest; for example, a large increase in the demand for specialist staff in the private sector would inevitably have repercussive effects in the NHS, not least on wage levels.

14. I recognise that some measures to increase demand will in time lead to desirable supply side consequences. Indeed, it is largely for this reason that we are seeking to expand the contribution of the private sector. But the scale and timing of any such measures will be crucial, and in my view there is little case for any early introduction of wide-ranging demand measures. It follows that our strategy for reform should instead focus more directly on the supply side, with the aim of promoting a much more flexible and responsive supply capability. There is much to be done in tackling the problems I have mentioned of manpower and other inflexibilities. Only then can we be sure that additional demand will be ~~fully~~ translated into additional provision, rather than simply dissipated in higher costs.

15. I started by referring to our main objectives in the review. In the course of our work we have identified a wide range of measures which might help to secure these aims. The next step is to put together a credible and coherent

package of reforms, and in doing so we must test each individual proposal against the analysis I have set out in this paper, working through the supply and demand consequences. There is no need for me to ~~remind colleagues of the~~ underline the crucial importance of getting this right.

16. Copies of this minute go to John Moore and Tony Newton, John Major, Sir Roy Griffiths and Sir Robin Butler.

NH6/14M

SECRET

FROM: MISS M P WALLACE

DATE: 27 June 1988

MR PHILLIPS

cc Chief Secretary
Financial Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Mr Turnbull
Miss Peirson
Mr Saunders
Mr Parsonage

Mr Corlett) IR
Mr Kucys)
PS/IR

NHS REVIEW: TREASURY PAPERS

The Chancellor was grateful for your minute of 24 June. He is content with your suggestions, subject to any comments the Chief Secretary may have.

MOIRA WALLACE

ps2/58M

SECRET

FROM: MISS M P WALLACE
DATE: 27 June 1988

MR PHILLIPS

cc PS/Chief Secretary
PS/Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Parsonage
Mr Griffiths
Mr Sussex
Mr Tyrie
Mr Call
Mr Satchwell

NHS REVIEW: TEACHING HOSPITALS

The Chancellor was grateful for your minute of 24 June. He is content with the approach you propose.

MOIRA WALLACE

PLP

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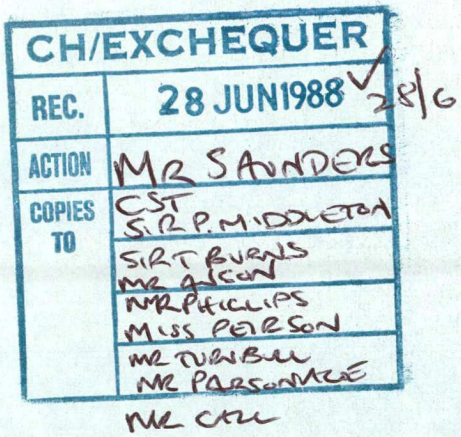
FROM THE PRIVATE SECRETARY
TO THE SECRETARY OF STATE
FOR WALES

27 June 1988



CT/5345/88

CONFIDENTIAL

Dear Paul,

NHS REVIEW

Thank you for copying to me your letter of 14 June to David Crawley.

My Secretary of State would be delighted to join the Ministerial Group for its meetings from 8 July onwards.

Mr Walker has nominated Mr J W Lloyd, the Under Secretary (and Deputy Secretary designate) dealing with health policy issues here, to join the group of officials chaired by Richard Wilson.

I am copying this to David Crawley (Scottish Office), David Watkins (Northern Ireland Office), Alex Allan (HM Treasury), Jill Rutter (Chief Secretary's Office), Geoffrey Podger (Department of Health and Social Security), Miss Jenny Harper (Minister for Health, DHSS), Trevor Woolley and Richard Wilson (Cabinet Office).

Yours sincerely

John Shortridge

J D SHORTRIDGE

Paul Gray Esq
Private Secretary to
The Prime Minister

003/3292

pmp

FROM: JILL RUTTER
DATE: 27 June 1988

MR H PHILLIPS

cc:
2 - Chancellor
Financial Secretary
Sir Peter Middleton
Sir T Burns
Mr Anson
Mr Turnbull
Miss Peirson
Mr Saunders
Mr Parsonage

Mr Corlett) Inland Revenue
Mr Kucys)

NHS REVIEW

The Chief Secretary has seen your minute of 24 June. He had the following comments.

2 On the financing paper the Chief Secretary thinks it would be helpful to carry Sir Roy Griffiths with us or amend the drafting to emphasise the agreements between Treasury and DHSS and identify how we tackle the areas of disagreement. The Chief Secretary believes we also need to consider a line on how to defend the fact that improvements in efficiency which attract extra funding are easiest to achieve for the currently inefficient. The Chief Secretary thinks that Sir Roy Griffiths "98 - 102 per cent" also merits inclusion.

Jill Rutter

JILL RUTTER
Private Secretary

week.1.6/m.11

SECRET

KEY POINTS FOR A STANCE ON THE NHS

1. Probably agreed on a number of things that need to be done:

eg acceleration in resource management initiative
tackling consultants contracts/restrictive practices
contracting out and market testing
rewarding efficiency [top slicing]

But on all these, and others, have got to have affordable and practical steps.

Therefore important, do you agree, that we get on to the detail quickly?

2. Hope we can be reasonably radical on consultants? What do you have in mind?

3. You know our fears about boosting the demand side heavily (ie tax relief/contracting out). Very real dangers: high public expenditure cost profile and no certain benefits;

highly dubious behavioural assumptions;
real actual danger (as opposed to political opposition of two tier health

4. What do we mean by self-governing hospitals within the NHS and the PM's ideas of contracts for services? Must be careful to avoid anything which turns out to be costly reorganisation, and upheaval, without some short as well as long-term benefits?

5. Feel strongly about vfm audit and the great advantage of the Audit Commission (discuss with Mr Moore next week). But if we make that change and resource management initiative the doctors will have to come into line ie medical audit, peer review etc. isn't this the right approach?

6. Need practical supply side measures to boost private sector? [HP's note to Chancellor of 6 June] Do they agree?

7. Link with Survey. Cannot expect to make progress on bids unless can agree in the review a package of measures which can be achieved, with costs and benefits appraised, and supply and demand effects assessed. Isn't the problem with buyer/provider models/ self-government for all hospitals plus contracts is that these are further away; second-stage developments?

8. What about the FPS and GPs?

9. How do you see the Griffiths community care link?

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for Social Services

Mr Griffiths
Looks OK
to me

P R Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

28 June 1988

RRB
29/6

Dear Paul,

NHS SPEECH 4 JULY 1988

I attach for information the draft speech on the NHS which my Secretary of State proposes to deliver before an invited audience at the Centre for Policy Studies on 4 July. My Secretary of State sees the speech as a substantive response to the Opposition speeches on the NHS which are planned over the next few days on the occasion of the fortieth anniversary of the NHS.

I am copying this letter to Alex Allan (Chancellor of the Exchequer's Private Office) and to Miss Rutter (Chief Secretary to the Treasury's Private Office).

yours sincerely,
Geoffrey Podger

G J F PODGER
Private Secretary

544/6

SAFE IN OUR HANDS

1 By now, no one can have failed to notice that the NHS is forty this week. And like all of us at that age, it's certainly a time for celebration. But it must also be a time for a moment's reflection and some thought for the years ahead - What shape are we in? -- How closely have we met the goals we set ourselves? -- And where do we want to be in five, ten or twenty years' time?

2 For the Government, I have no hesitation in saying to the NHS: 'Congratulations and well done. You're looking better every year. And we're very proud of the role we have been able to play in building up the NHS -- a record which is better than any other Government's in history'.

3. And I am sure, too, that our congratulations to the NHS would be echoed by those people who had the vision to create the health service -- not just those in Government forty years ago, but those in Churchill's wartime coalition, in 1944, who were the real inspiration behind the idea. Without doubt, the health service today is beyond their wildest aspirations. More doctors and nurses are looking after more patients, with more sophisticated treatment in more advanced hospitals than ever before.

4. And thanks to the medical advances in the NHS and greater awareness of health issues throughout our society, all of us can look forward to longer, healthier and more fulfilling lives than our parents. Already, we have almost wiped out a whole range of illnesses, which were incurable just forty years ago -- TB, smallpox, diptheria and scarlet fever now belong to the medical history books and not the medical text books. And now we are on the verge of eradicating other illnesses, such as mumps, measles and german measles.

5. The vision forty years ago was to provide health care for all of our people -- and to provide it regardless of their ability to pay. And this Goverment remains as dedicated to that principle, as any Government has ever been.

6. Of course, over those four decades, most Governments can demonstrate their support for the NHS. But I believe that history will look back and say that this one outshone all the others -- because we have shown our commitment both in terms of the resources dedicated to the NHS and, now, by our determination to reform the health service, so that it meets the challenges and needs of the decades ahead.

7. We can measure our success in many ways, but the most reliable method of all is to look at the number of patients being treated. Every time a new treatment is developed, a new waiting list is developed along side it. So, it is only when we look at the incredible numbers who have benefitted from the health service, that we can really assess the immense scale its achievements.

8 Each week, some eight million people use the health service. That's the equivalent of the entire population of London, or of Scotland and Wales combined, using the health service -- and the opinion polls tell us, that about 90% of them are satisfied with the treatment they receive.

9 But don't just look at the bald statistics, look too at how many more people we are treating today than just a few years ago. Last year, our hospitals treated a million more in-patients than when the Government came to power in 1979 and over four million more day cases and out-patients. And the number of in-patients has more than doubled since 1948.

10. Yet these are not just figures. Each one is a person cared for -- an illness treated. And for all of them, it has been our commitment to care, and the commitment of all the staff in the NHS, which has made their treatment possible.

11. People, who just a handful of years ago, would have been left to suffer in pain and discomfort, can today be given a new lease of life.

12. For example, under this Government, the number of heart by-pass operations has almost quadrupled, with more than 12,000 taking place last year -- and we have carried out more heart transplants than any other country in Europe. We are also the leading country in Europe for kidney transplants, with an outstanding 75 per cent increase on 1978 -- and the success of our donor programme means that this year should see a further dramatic increase.

13 Right across the board, the number of patients treated has increased under this Government. But these increases don't just happen. We are treating more patients than Labour ever did because we are committing more resources to the NHS than they ever could -- that's not surprising, because you cannot give more resources to the causes you care about, if the country is bankrupt, as it was under Labour in the 1970s.

14 Our economic policies have turned Britain into a high growth, low tax society. And it is that increased wealth, combined with the fact that we place a higher priority on health than Labour, which accounts for today's record levels of spending.

15 Today, through the taxpayer, we spend 5 1/2% of our GDP on health. Labour spent just 4.8% and actually chose to reduce NHS spending as a proportion of GDP. In real terms we are putting six and a half thousand million pounds more into the health service than Labour could afford. That's enough to cover the entire nurses' pay bill. Apart from social security, we spend more on health than on any other aspect of Government -- each and every family contributes over £1600 a year to the NHS.

16 And the truth is, that that money has gone directly into patient care. And to it, has been added all the extra five hundred million pounds from the cost improvement programme which is growing larger every year. Since Labour left office, we have increased the number of doctors and dentists by 14,000. We have increased the number of nurses and midwives by over 65,000. And perhaps most importantly, we are able to pay them better and plan their training better than ever.

17 But that alone would not be enough without better facilities. In 1979 we were still trying to deliver twentieth century healthcare in nineteenth century hospitals -- because we inherited a situation where the hospital building programme had been abandoned because of Labour's cash crisis.

18 But now, we are putting that right. In the largest hospital building programme ever, we have already completed 286 schemes costing over £1 million each and there are 500 more in the pipeline. And that is backed by a solid commitment to help our hospitals operate at the very frontiers of medical science -- for example, we are introducing lithotripters, which bombard gallstones with lasers, so they can be removed without the need for painful and expensive surgery.

LABOUR'S RECORD

19 Now, against that background of unparalleled investment and commitment, Labour's own record was a shambles and a disgrace. The only measure where they can beat us, is in the volume of crocodile tears -- as we've seen by the bucket load this week. But every time we hear them shriek: 'All it needs is a few more billions', their record should be brought back to haunt them.

20 Just imagine, for one awful moment, if Labour had been reelected in 1979 -- and in 1983 -- and again in 1987. On their own record, where would be today?

21 Well, it's not good news for towns like Goole, Bromsgrove, Chester and Maidstone. Because all of them and 150 more towns and cities all over Britain would never have had their new hospitals or major hospital developments built. Their patients would not be treated in modern, well-planned hospitals, as they are today after our building programme.

22 And what about the nurses, who Labour talk as if they care so much about? When they were in office they showed how much they really cared -- they let nurses' pay fall by over a fifth. If that trend had continued, a staff nurse on the maximum scale in London would get Just £5,573, well under half the twelve and half thousand they will actually get from recent pay awards. And it has only been our economic success which has made it possible to tackle the twin-challenges of clinical regrading and a training structure which meets today's needs.

23 But Labour must think our memories are as short as theirs. This week, for example, we have seen a great deal of them celebrating the NHS at forty. But, in reality, no Party ever did more to undermine the NHS than the last Labour Government. In five years, they managed to increase waiting lists by half. And on that performance, had they stayed in office, today we would have a monumental 1.4 million patients waiting for operations, which is more than double the number we actually have.

24. And they seem to have forgotten, too, the horrors of the Winter of Discontent. And well they might try -- because it should be on their conscience forever that it was pickets, not doctors, who decided which patients should go into hospital and when all basic sanitation was ignored.

25 They recognised the realities well enough when they were in office but now they pretend that matters are somehow different. It is no wonder that a party of such short-term opportunism has become a party in such long-term opposition.

THE FUTURE

26 However, as I said at the outset, the NHS's fortieth birthday must be a time when we look ahead, just as much, or even more, than we look back.

27 The clear message from our record over the past nine years is twofold -- firstly, Conservatives can manage the economy and so put more money into the Health Service -- and secondly, Conservatives can manage the Health Service and so get more patient care of higher quality.

28 So if more spending and better management were the whole story, then we should just carry on as we were. But like every other advanced country there are deeper questions we need to face up to, to make sure that we are providing healthcare in a way that takes account of changes in demography, medicine and methods of delivery. No decisions have yet been made on the way ahead -- but I am very pleased we have stimulated such a lively and helpful debate. And already some clear messages are emerging.

29 At last we have shifted away from the easy assumption that the NHS was perfect and all it needed was more money. That misconception is very tempting, of course -- as any reactionary afraid of change in the NHS can always ask for more money instead.

30 But now, new ideas for reforming and improving the NHS are bursting forth -- not just from think-tanks like the CPS, but also, and perhaps more importantly, from within the health service itself. So now the reactionaries are beginning to shift their ground and argue instead that we are about to dismantle the NHS. We must not let them get away with that trick -- the NHS will not be dismantled, but it does need to change. The people who say we are going to dismantle it are, in truth, those who really want to see no change at all.

31 Over the past year, the debate has changed beyond all expectations. And one of the most important changes has been the escape from the lure of the aggregate -- that is the easy belief that every problem in the NHS is about resources, that everybody in the NHS is the same, that every hospital is equally efficient and every doctor equally proficient. Behind this lies the thought that if only we had more cash, all would be well. But John Yates's work has shown clearly that the length of waiting lists varies enormously, and quite independently of the level of spending.

32 The King's Fund have recently produced a fascinating report on variations in the quantity and quality of healthcare. And our own performance indicators show that we could treat thousands of extra in-patients if the least efficient districts raised their performance to the level of the most efficient.

33 And we have also seen some admirably blunt talking from those leaders of the medical profession, who realise that change is needed, and indeed inevitable. It was Sir Raymond Hoffenberg, President of the Royal College of Physicians, in a lecture last Autumn, who pointed out that doctors must accept closer scrutiny of their performance and, at the same time. greater budgetary responsibility. Those were wise words. And that is exactly the spirit of our resource management initiative.

34 We saw the same approach in the recent inquiry by surgeons and anaesthetists into avoidable deaths in hospitals. Doctors will always want to take part in the argument about the right level of funding in the NHS -- but if so, they cannot shirk the medical debate about clinical performance. I think that is better recognised now than it was.

35 And over the past year, we have seen new ideas and new operating methods emerging from the Districts and the Regions. That is where the focus of change has to be -- and our aim now is to unleash the entrepreneurial energies of the managers who are already in place.

36 That means some of the cumbersome centralised restrictions, going back to the days when the NHS was administered rather than managed will have to go. We cannot go on, for example, telling managers to get on with the job of managing, but then say that they can't promote a member of staff one grade, after only two years in the previous grade, without clearance from Whitehall.

Check with Roy.

37 We must also tackle the deep-seated tendency within the NHS to self-denigration. While private commercial organisations gain customers and new investment by proudly boasting of how well they are doing and how their service is unmatched, publicly financed services try to extract more money from politicians by saying how badly they are doing.

38 This might look like a shrewd policy in the short run. But in the long run, it can only breed a terrible cynicism. Self denigration can soon become self destruction. This Government is not a threat to the NHS -- the only real threat comes from those who claim it is failing, yet pretend that little needs to change.

39 It has also become very evident over the past year that, whilst the NHS has very strong control over its total budget, there are relatively few incentives for good performance at the local level. We have got to establish how we can reward good performance, reward efficient hospitals and hard working doctors, without putting in jeopardy the legitimate interest of any government in controlling the total level of public spending.

40 So increasingly, there is an understanding that the NHS does two very different things.

41 On the one hand, there is the right of access to healthcare, regardless of the ability to pay. That is what British citizens treasure and must not be taken away from them. But the NHS was also in danger of showing many of the attitudes of a bureaucratic producer-dominated monopoly.

42 We have already seen clearly from the waiting lists' initiatives that it can be cost-effective for districts to buy in services from the private sector -- but we must make sure that those districts, which treat a lot of patients from other districts, are given a fair deal for their cross-boundary flows -- as they are engagingly called in what we all thought was a National health service.

43 That is why organisations like the Institute of Health Service Management have urged us to look at an internal market. They can see the attractions to this approach -- caring remains publicly financed, yet at the same time a properly competitive market is created for delivering that care. Districts have shown that they can use our special waiting list funds in this way and I want to build on their experience.

44 But I also know that many people - both in the NHS and outside it - want to see experiment and variety, rather than enforcing radical change immediately on everyone. I understand that. We need to see much greater variety in the NHS, with individual hospitals or regions trying out different ways of organising healthcare. They will have my backing and suppport -- but everyone must recognise that the right to experiment and to be different also means the right to fail. Not every experiment will be a success and we need the courage to accept that.

45 We also need the courage to be adventurous in finding new ways to bring new resources into healthcare. For a long time now, I have also been stressing the need for more private spending on health care in this country, because that is where the real gap lies between Britain and other advanced Western nations.

46 But then people ask me, what the role of the private sector should be. They talk about the danger of a two-tier system -- but if any single measure encouraged a two-tier health system in this country, it was the policy of the last Labour Government, acting out of spite and malice, and driving private medicine off NHS sites into small separate hospitals, as a perk for the few.

47 I want to see private spending on health care spreading to the many. I want to see companies taking out health cover for all their employees - and I mean for all of them. I applaud the partnership ventures between private health companies and the NHS. And I want to see the NHS itself competing and succeeding in that market, by expanding pay beds, amenity beds and other add-on services. There needs to be only one guiding principle -- that nobody loses from these changes. They should add extra options and not take anything away.

48 The Review is about building up the health service. And as a Government, we are totally committed to creating a National Health Service in Britain that can justly aspire to be the envy of the world.

49 The dream behind the health service more than forty years ago is the same dream that lies behind our determination now to equip the health service to meet the challenges of the years ahead. And as we celebrate the NHS being forty, my message is clear -- it has never been in safer hands, but the best is yet to come.

28/6/88.

SECRET

HC 26

CONTRACTING OUT

DHSS CONTRA-ING OUT

Note by the Secretary of State for Social Services

We are agreed that an important element in our overall strategy is to develop a thriving mixed economy of public and private health care, which will give more competition and more choice.

2. With this in mind, we have agreed that we should give tax relief for private medical insurance premiums paid by or on behalf of the elderly. We have not however reached agreement on any stimulus for private health insurance for those of working age. And the Chancellor has now advised against any change in the present arrangements for exempting from tax employees who are members of company health insurance schemes, except for the over 60s.

3. I believe we should do more to encourage people in work to take out health insurance. While the annual growth in company schemes has been around 5% in recent years, the annual growth for privately arranged and paid schemes has been about 1½%. If the Chancellor does not favour encouragement through the tax system, I recommend we do so through the national insurance system.

4. My officials have prepared the attached note which sets out how such a scheme might work.

5. The essence of the scheme is:

first, it is a limited scheme, carefully targetted at an area which is giving us considerable difficulty - cold elective surgery.

second, it draws very substantially on the model of contracting-out of the state earnings related pension scheme and would use the machinery already developed in the DHSS Newcastle Office for personal pensions. So it would be readily understood by the public.

third, under the scheme, those paying national insurance contributions would be able to contract out of NHS funded provision of cold elective surgery in return for a contribution rebate. For the sake of simplicity, such a rebate should be flat rate and not age related. It would be a condition of contracting-out that, like personal pensions, the employee concerned was covered by an appropriate health insurance policy with an approved insurer.

fourth, there would be no need for anybody to carry any health identification card. No one would be denied emergency treatment by an NHS hospital.

SECRET

6. I emphasize that this is a scheme for limited contracting-out. There is likely to be an initial deadweight cost, as there was with pensions. But I believe that, as with pensions, the development of health care contracting-out would generate a positive response whereby the overall extra resources attracted into private health care more than outweighed any deadweight costs. On top of that, it would encourage competition, provide more choice and have a major impact on one of our weak spots - waiting times for cold elective surgery.

June 1988

CONTRACTING OUT

1. This note describes a limited scheme for contracting out incorporating two key features:

- adoption of the idea contained in the Chancellor's paper. "A scheme for contracting out of the NHS" to increase the NHS element of National Insurance Contributions (NICs), with an increased Treasury Supplement.

- the facility for NIC payers to "contract out" of NHS funded provision of elective surgery in return for a contribution rebate. This rebate would contribute to the cost of an appropriate health insurance policy with an approved insurer.

2. The way in which a scheme of this sort might operate is discussed below. A number of more technical questions are covered in the Annexes. However, the major operational consequences of the scheme would be:

- Tax and NI rates could remain unchanged. This would avoid the disadvantagous distributional effects of a wholesale transfer to NI funding, although without gaining the important advantage of transparency of expenditure explicit in complete hypothecation.

- There would be no question of NI contributions establishing entitlements to treatment. All who wished to do so would remain entitled to the full range of state funded NHS treatment. Only those who voluntarily chose to contract out would lose entitlements to state funded elective surgery.

- Although people would remain at liberty to insure privately against as wide a range of medical contingencies as they wished, the major stimulus of the rebate scheme would be to the new low cost policies covering elective surgery increasingly offered by the major private insurers.

Operation of the scheme

3. Finance

- The value of tax and NI revenues for the NHS and social security implied by the Treasury's contributions scheme are shown in the table in Annex 1.

4. Collection of contributions

- Employers would continue to collect health and appropriate NI contributions from employees.

- As the NHS would be only partially financed from NICs employers are not required to identify their employee's monthly health contributions separately on pay slips.

5. Contracting out

- Contributors may contract out of state funding for elective surgery on behalf of themselves and their immediate dependants.

- As a condition of the rebate individuals must arrange, at least, a minimum approved insurance cover, either through their employers or on a personal basis. The required minimum insurance would cover a defined list of the main elective surgical procedures. A number of policies covering precisely these procedures are already on the market, for example the "Budget BUPA" plan (see Annex 2).

The contracted out patient's route to treatment

6. Non-emergency admissions:

- Following consultation with a GP, a contracted out patient would be referred to either a private health care provider or for admission to an NHS pay bed.

- Both public and private health care providers would ascertain the willingness of insurers to pay for private treatment before admitting a patient.

7. Emergency admissions:

- In the case of emergency admission to an NHS hospital, the health authority concerned would be empowered to seek any payment due from private insurers. As all patients must be either privately insured or fully "contracted in" to the NHS, there could be no question of patients being denied treatment which they urgently required.

8. Pre-existing conditions:

- These will not generally be covered by private insurers.

- Patients' GPs, being aware of the existence of these conditions and any exclusions from private health cover that they involve, could make references for state funded treatment as appropriate.

- Patients in these circumstances will have a guaranteed entitlement to state funded treatment for those conditions not covered by their private policies.

9. **Exclusion from state funded treatment of those contracting out**

In practice, exclusion would be self policed, as non urgent treatments are those for which waiting times apply in the NHS but immediate access and treatment is available in the private sector.

10. Rejoining the state scheme

Contracted out patients could rejoin the state scheme at the end of their private insurance contract periods. Private insurers would be responsible for informing DHSS that a policy with a particular subscriber has lapsed. However insurers should be prevented from encouraging patients to return to the state scheme in the case of mid contract episodes of ill health. For this reason it may be necessary to make insurance policies offering excesses, co-insurance and no claims bonuses ineligible for the rebate.

11. The value of the contracted out rebate

- could be based on the average costs incurred by the NHS in providing elective surgery to those contracting out.

- In order to limit the tendency for low risk individuals to contract out while high risk ones remain in the state scheme, rebates could be related to both age and family size (a possible method for this is given in Annex 2).

- Alternatively, in order to simplify the scheme, a flat rate rebate could be offered for each individual contracted out of state funded treatment.

12. Payment of rebates

- Rebates would be paid annually, in arrears, direct to the insurer by DHSS. This follows the procedure for the payment of contracted out rebates in the personal pensions scheme and avoids additional burdens on employers.

- Private insurers would claim rebates by submitting a list of policy holders (with their NI numbers) and dependants covered by medical insurance direct to DHSS, guaranteeing that all those contracting out were covered by an appropriate policy.

13. Growth of the private sector

The growth in private insurance cover following the introduction of a contracting out scheme would depend on:

- the proportion of annual premiums represented by the rebate
- the responsiveness (or elasticity) of the demand for health insurance to reductions in its price.

Annex 2 examines the first of these points for a representative set of household groups and makes an estimate of the resulting increased coverage of private health insurance. The available elasticity estimates are, however, tentative and subject to wide margins. The overall effect would largely depend on the response of the private insurance industry.

Annex 1

THE NATIONAL INSURANCE FUND AND NI FINANCING 1988-89

The Chancellor's scheme to increase the NHS allocation from the NI fund proposed raising employee's NHS contributions from 0.95% to 2.4%, with additional increases in contribution rates for both the self employed and employers. The sources of NHS income which would result from this arrangement are shown in the table.

	£bn
Employees contributions	4.3
Employers contributions	2.2
Self employed contributions	0.2
General taxation	14.4
	21.1

The value of employees' contributions in this scheme would be more than sufficient to underpin a contracting out arrangement of the sort described in this paper. Total expenditure on NHS surgical acute specialties, that is, those for which contracting out is envisaged, is in the region of £2bn for 1988/89.

It should be noted that a possible feature of the scheme is that some low earners may be entitled to rebates which are in excess of their annual NHS contributions. Excess rebates of this sort would score as public expenditure. In practice, however, this is unlikely to be a serious problem. A married couple in their mid 50s with two children would have to have earnings of less than £100 per week before being eligible for rebates in excess of their health contributions.

Annex 2

THE VALUE OF REBATES AND THE EXPANSION OF PRIVATE SECTOR

Unless rebates reflect, in some way, the risks represented by groups in the population, the consequence of a contracting out scheme may be that low risk cases tend to leave the state scheme while high risk ones remain.

Age is an important determinant of the risk of requiring elective surgery. The table below shows the value of NHS expenditure per head on surgical acute specialties.

Age Band	Expenditure per head (1988/89 prices)
All ages	41
0-4	13
5-14	16
15-24	21
25-34	24
35-44	29
45-54	37
55-64	54
65-74	88
75+	154

Eight of these specialties account for in excess of 90% of cases from the waiting list, and cover procedures typically offered by most private health insurance policies. These average cost figures would therefore form the best basis of a contributions rebate for contracting out of elective surgery.

Insurance premiums

An indication of the contribution of these rebates to the cost of private health insurance is given below. The table expresses the value of rebates as a percentage of premium costs for a variety of family types. The family rebate consists of the sum of the age specific rebates (calculated on the

basis of expenditure on people in five year age bands applicable to each family member. The costs of premiums are those applicable to BUPA's recently launched "Budget BUPA" plan. This covers 85 in-patient and 30 day care elective surgical procedures which represent the majority of operations on NHS waiting lists.

Family type	Rebate as % of undiscounted Budget BUPA premium
Single person age 20	23.5
Couple mid 20s	23.7
with 2 children	27.5
Couple mid 30s	23.2
with 2 children	26.7
Couple mid 50s	26.9
with 2 children	28.3
Couple mid 60s	29.9

Expansion of private health insurance

US experience, which has to be applied cautiously to the UK, suggests that the demand for private health care insurance rises by about ½% for every 1% fall in the cost of premiums. On this basis the number of private insurance subscribers might be expected to increase by between 12 and 15% as a result of a rebate scheme of this sort. Using estimates produced by the Institute of Health Services Management of the number of people with private health insurance in 1987 as a base, the contracting out scheme could:

- increase the coverage of private health insurance from 6 million -to around 7 million people

- boost the annual value of premiums paid to between £850 and £875 million, an increase of in excess of £100 million.

However on the basis of a rather more optimistic elasticity estimate where the demand for private health insurance increased by 2% for every 1% fall in the cost of premiums, an additional £350 to £375 million of expenditure could be generated. This would bring about a significant increase in net private sector resources going into health care.

To the extent that, over time, those newly attracted into the private insurance market 'trade up' to more comprehensive policies, the value of private expenditure is likely to rise still further.

TAX RELIEF Ch's NEW PAPER

NHS REVIEW: TAX RELIEF

Paper by the Chancellor of the Exchequer

1. At the meeting on 7 June we agreed that:-

   a. the question of restricting tax relief for the elderly to the basic rate should be looked at again; and

   b. a more limited benefits-in-kind exemption, targeted on those with earnings below a specified level, should be considered.

This paper reports on both points.

Tax Relief for the Elderly

2. Providing tax relief for private medical insurance for the over-60s at basic rate only would benefit 300,000 existing policyholders at a deadweight cost to the Exchequer of about £25 million. Allowing relief at the higher rate, as well, would be of additional benefit to about one-quarter of this group - 75,000 policyholders. The Exchequer cost would rise to a little over £30 million. There would also be some additional administrative complication. That is because, while basic rate relief would be provided at source through a MIRAS-type arrangement, higher rate relief would have to be dealt with by tax offices, through individuals' PAYE codes or tax assessments.

The question is whether these additional costs are likely to be worthwhile.

3. Clearly, in principle, the higher the rate of tax relief, the greater will be the effect on behaviour of those who benefit: a 40 per cent relief is likely to bring in more new subscribers than a 25 per cent relief. But a 50 per cent increase in take-up would be needed before the extra money going into private health care exceeded the cost of tax relief, compared with an increase of 33 per cent if relief were given at basic rate only. Only those over-60s with incomes comfortably over £20,000 would benefit from this further concession: those with income below that level would gain nothing at all from higher rate relief. So, on the one hand, the additional impact of higher rate relief would be strictly limited; while, on the other, it will give further ammunition to opponents of the scheme.

4. There is a further complication with giving higher rate relief. In my previous paper I pointed out that it might be attractive to let tax relief flow to whoever paid the premiums for a person over 60, so there would be encouragement for people of working age to pay their elderly parents' BUPA subscriptions, and this was generally welcomed. But if higher rate relief were available in such a case, it could provide a strong incentive to dress up payments by the parent as payments by the son or daughter - regardless of the true position - thus adding to the cost of the relief. In order to guard against this abuse, some additional irritating safeguards would be unavoidable.

5. In conclusion, tax relief for the elderly at the higher rate would increase the complications of the scheme, and provoke unnecessary criticism. The closest precedent for health insurance premium relief, life assurance premium relief, was (and, for pre-1984

policies, still is) given at half the basic rate, for basic rate taxpayers and higher rate taxpayers alike.

Benefit in Kind Treatment

6. For company health insurance schemes, the suggestion was to raise the limit below which employees escape tax liability on this particular benefit in kind. Since company schemes at the moment are concentrated among the higher paid, this would have the advantage of reducing the deadweight cost and targetting the incentive where it is most needed.

7. I have therefore considered the possibility of raising the limit from its present £8,500 to something in the region of £20,000 - roughly the point at which higher rate income tax liability starts. It would mean that the proportion of employees who would be exempt from tax on medical insurance would go up from 17 per cent to 65 per cent at a deadweight cost of some £m25.

8. But while this approach has its attractions, it also has some further disadvantages to add to those relating to a general benefits-in-kind exemption which I described in my minute of 3 June.

9. First, having a second income limit would be a significant added complication for employers, increasing their administrative costs. The Revenue, in conjunction with the Deregulation Unit, is currently engaged in finding ways of minimising the compliance costs of taxing benefits-in-kind: this would be a move in the opposite direction.

10. Second, it would increase the pressure to raise the £8,500 P11D limit across the board. Our consistent

policy has been gradually to bring the tax treatment of payment in kind and cash into line by allowing the real value of the P11D limit to fall. The limit has not been increased since 1979. It is now widely recognised that it is anomalous to have any income limit in taxing benefits, and that it is right to let the present limit wither away. We are well on the way to success with this policy, since there are now relatively few full-time employees with cash pay plus benefits of less than £8,500. But there also continues to be pressure, as we have seen again in this year's Finance Bill debates, to increase the limit substantially. Setting a new limit for medical insurance - one of the commoner benefits-in-kind-would clearly add to this pressure, and make it more difficult to resist.

11. Third, it would add to the sense of unfairness already felt by those whose employers do not run a company health insurance scheme, or who are self-employed.

Benefits-in-kind and Relief for the Elderly

12. But if we decide to introduce a new tax relief for premiums paid for the over 60's, then we could, I believe, provide a parallel relief for the benefits-in-kind charge on corresponding premiums. The argument is exactly the same in relation to the over 60's as it is for employees and the self-employed generally - we should ensure that there is no difference in tax treatment between those who pay their premiums privately, and those who get them paid by their employers.

13. Including benefits-in-kind in the relief for the over 60s, and confining relief to the basic rate, would

increase the cost, at current levels of provision, to £35 million and would benefit 65,000 employees as well as 300,000 individual policyholders. This is the most far-reaching tax package I would be prepared to recommend.

SECRET

Inland Revenue

Policy Division
Somerset House

FROM: A W KUCZYS
28 JUNE 1988

1. MR CORLETT not available

2. PS/CHANCELLOR (MISS WALLACE)

NHS REVIEW: TAX RELIEF

As requested in your note of 23 June, I attach an aide memoire (largely Mr Walker's work) for the Chancellor's use:

a. at his bilateral with the Prime Minister tomorrow; and

b. at the meeting of the Ministerial Group on Thursday.

TAX RELIEF

The question of latest figures on the growth of company schemes is covered in a separate note from Mr Satchwell. In the light of the figures he has obtained, we have revised upwards the deadweight cost of benefit in kind exemption for company schemes, from £80 million to £100 million plus.

A W KUCZYS

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cc PS/Chief Secretary
PS/Financial Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Mr Turnbull
Miss Peirson
Mr Culpin
Mr Saunders
Mr Parsonage
Mr Call
Mr Battishill
Mr Isaac
Mr Beighton
Mr Corlett
Mr Lewis
Miss Rhodes
Mr Eason
Mr Kuczys
Mr Walker
Mr I Stewart
PS/IR

AIDE MEMOIRE

NHS REVIEW: TAX RELIEF

Factual

(i) The package you are offering for the over-60s comprises:

- tax relief at basic rate on private medical insurance premiums paid for the over-60s (whether paid by them, or by their children, or others)

- exemption from tax on the benefit in kind of medical insurance paid by employers for over-60s only.

(ii) Cost: £35 million at existing level of provision (ie deadweight). Cost will rise as tax relief encourages additional take-up above present, low, level.

(iii) An increase in take-up, among the over-60's, of around 33 per cent is needed if the extra money going into private health care is to exceed the cost of tax relief.

(iv) Numbers of over-60s with cover now:

- 300,000 individual policyholders; plus

- 65,000 in company schemes

Total covered (including dependants): 600,000 to 700,000 (ie about 5 per cent of the 12 million people over 60).

Positive

(i) Package for over-60s targets the group least provided with private medical cover and heaviest users of NHS.

(ii) Basic rate tax relief at source makes it attractive for sons/daughters to pay their elderly parents' subscriptions.

Defensive

(i) Relief should be at marginal rate?

- closest parallel is with life assurance premium relief (for pre-1984 policies) at flat rate (half basic rate): no implications for other tax reliefs

- unlikely to be a "good buy": would require increase in take-up of 50 per cent, rather than 33 per cent, to achieve net increase in private provision

- majority of over-60s would not gain any additional incentive, and they are more likely to have cover now (ie higher deadweight proportion: less than 5 per cent of over-60s, but about 25 per cent of those who have private medical insurance, are higher rate taxpayers).

  For general arguments about giving relief at basic or higher rate, see Annex 2 (provided by Mr Isaac).

(ii) Need to boost company schemes?

- Unnecessary: company schemes growing faster than non-company sector, and continue to grow strongly (latest figures: well over 1 million employees covered, growing at about 7 per cent)

- Danger that a boost in this expanding sector would just lead to higher costs

- Exempting medical insurance as a benefit (deadweight cost now £100 million and rising) would widen gap between fortunate employees in company schemes, and

less fortunate employees and self employed; danger of repercussive pressure on other benefits/other forms of opting out

- Sir Roy Griffiths' proposal (special P11D limit - cost £25 million if limit set at £20,000) has same disadvantages plus

  o fuels pressure to increase P11D limit generally

  o significant added complication for employers

[IF PRESSED: Better form of targeting would be benefit in kind exemption where the company scheme applies to all employees. NB Needs study to see if workable.]

For further arguments on benefit in kind treatment see Annex 1 (provided by Mr Lewis).

For latest statistics see separate note today from Mr Satchwell.

(iii) Package too small: need to do something more?

If you judge that you need to concede something further, our suggested order of preference is:

1. relief at marginal rate for the over-60s

2. lower age limit - say 55 - for relief for the elderly

3. a boost to company schemes through benefit in kind exemption (possibly only where cover available to all employees)

Sir Roy Griffiths' P11D proposal is worst of all.

NHS REVIEW: TAX RELIEF

BENEFITS-IN-KIND

ANNEX 1

a. A higher threshold for medical insurance benefits

1. One of the problems with a general benefits-in-kind exemption is that it would be perceived as unfair by employees and the self employed who pay their own premiums.

2. Your draft paper suggests that there would be additional unfairness with a separate threshold for medical insurance benefits as between those above and below the threshold and directors who would not benefit.

3. It may be argued that that does not matter because the same unfairnesses are inherent in the £8,500 threshold.

4. This is not so. At the time it was introduced, in 1948, the P11D threshold was equivalent in present day earnings terms to over £50,000. At that time benefits were virtually confined to directors and the very highly paid, so there was no unfairness in making the rules apply only to them.

5. Over the years, in part because of the existence of the threshold below which benefits were tax free, and partly because of other factors such as restrictive pay policies, benefits have become much more common at all income levels. So it did become the case that the threshold was unfair as between those above and below it.

6. Partly for this reason the Government's policy has been to let the threshold wither in real terms to the point where it will, in practice, apply to virtually all (full-time) employees. So we are fast approaching the point at which any unfairness in the threshold becomes fairly residual.

7. Against that background, introducing a new threshold for medical benefits at a substantially higher level would be quite a

different matter from the existing threshold, and would introduce a new, more marked unfairness as between those above and below the new threshold.

b. Why resist a general benefits exemption when other benefits such as sports facilities and canteens are exempt?

8. It may be suggested that there is no difference in principle between exempting sports facilities and canteens and medical insurance benefits. That is not the case.

9. As far as sports facilities are concerned, they are in principle chargeable, but we would not normally pursue the charge in relation to traditional sports facilities because the amounts attributable to any employee would be too small to make it worthwhile. So that is essentially an administrative disregard.

10. Canteen benefits can be much more substantial and ought in principle to be taxed. But so far this has had to be ruled out because of the substantial compliance burden for employers in determining the level of subsidy in their canteen facilities and the amount applicable to each employee. The statutory exemption for canteens applies only for meals in a canteen in which meals are provided for the staff generally, although, as you know, that concept has been extended considerably in long standing extra statutory concessions. Nevertheless there is the central concept that, for subsidised meals to be exempt from tax, they should be available to everyone.

11. So canteen meals are not unconditionally exempt at present; and there is no good reason for building on the present exemption, which arises from employer compliance considerations, to exempt medical insurance benefits, which are among the easiest benefits to tax.

ANNEX 2

NHS REVIEW: TAX RELIEF

RELIEF AT MARGINAL OR BASIC RATE

There is no absolute rule of principle, dictating that all reliefs against income tax should be given either at the basic rate, or at marginal rates. It is something which needs to be considered in each case in the light of

- the place of the tax relief within the general tax structure and
- the policy objectives;
- the administration and compliance cost.

Tax structure

Some reliefs clearly should be given at marginal rates, on obvious fiscal/economic principles:

To take just two of the most obvious examples:

- Capital allowances for the self-employed represent expenditure which the businessman incurs, in order to earn profits. His eventual profits are taxed at marginal rates of income tax. His expenses should be given relief at the same rates.
- Tax relief at marginal rates should be given for savings (as with much of pension contributions), where the full amount of money withdrawn from savings (for example the full amount of the pension) is taxed at marginal rates.

SEC AJW11

Policy objectives

By contrast, there are other reliefs where there is no clear-cut argument of principle. An obvious example is BES, where it was an open policy question discussed as such by Ministers, whether relief should be given at basic rate, or marginal rate. In the event, relief was given at marginal rates, having regard inter alia to the facts that

- the scheme was targeted on high risk investments;

- the scheme was aimed deliberately at higher rate taxpayers (because of that high risk); and

- the scheme was restricted to minority shareholdings in unquoted companies (and because of the marketability problem, these shareholdings commonly stand, other things being equal, at a discount).

By contrast with the now obsolescent life assurance premium relief, relief has for many years been related to basic rate only - and in this case, a fraction of basic rate.

Administrative considerations

To the extent that Ministers are currently concerned with "value for money" in Government, administrative and compliance costs should also carry <u>some</u> weight. As a pretty reliable generalisation

- where relief is given for payments or expenses incurred by a taxpayer on a personal basis, a MIRAS-type scheme is <u>much</u> the most cost-effective - and "value for money" then points clearly in the direction of relief limited to basic rate;

- where one is concerned with expenses etc incurred by or otherwise known to an employer, there is a cost-effective solution through "net pay" arrangements under PAYE. In that case, relief is given at least administrative cost at marginal rates."

Previous Ministerial statement

The Financial Secretary said in 1986:-

"The Government sees nothing wrong in allowing relief at the higher rates of tax as the natural consequence of our progressive tax system. If tax system on mortgages is to continue - the Opposition have promised to continue it - it is reasonable that it should apply to borrowers at all rates of tax."

(Finance Bill 1986: Report Stage.
Hansard 17 July 1986 Col 1257

LSE PAPER

Number WSP/32

Welfare State Programme

Mr Griffiths - ST2 cc PS/CST
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Mr Culpin
Mr Passmore
Mr Call
Mr Kuczys IR

The famous pamphlet reported in yesterday's Independent. Thanks for yr. help in tracking down.

mpr

Reform and the National Health Service

28/6/88.

Nicholas Barr
Howard Glennerster
and Julian Le Grand

Directed by A B Atkinson, Julian Le Grand and John Hills

STICERD
Suntory Toyota International Centre for Economics and Related Disciplines

REFORM AND THE NATIONAL HEALTH SERVICE

Nicholas Barr, Howard Glennerster
and Julian Le Grand

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Discussion Paper
WSP/32
May 1988

The Welfare State Programme
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Editorial Note

This paper is a slightly revised version of a Memorandum requested by the House of Commons Social Services Select Committee to assist the Committee in its inquiry into resourcing the National Health Service. It was submitted to the Committee in April 1988. The authors are, respectively, Lecturer in Economics, LSE, Professor of Social Administration, LSE, and Professor of Public Policy, Bristol University, and Suntory-Toyota International Centre for Economics and Related Disciplines, LSE. They would like to acknowledge helpful comments from John Hills on an earlier draft.

REFORM AND THE NATIONAL HEALTH SERVICE

Nicholas Barr, Howard Glennerster and Julian Le Grand

SUMMARY OF PRINCIPAL POINTS

This submission seeks to establish the following points.

1 The fact that Britain spends less on medical care as a proportion of Gross Domestic Product than most other OECD countries is a cause for celebration, not complaint. There is no indication that the UK suffers from these relatively low levels of spending: on the contrary, according to most macro-indicators, Britain is at least as healthy as most other developed countries. In fact, there is no obvious relationship between a country's medical spending and the health of its inhabitants. This should not be surprising, for, at a micro-level, few medical techniques have been shown to be effective in curative terms. This suggests that a highly desirable feature of a health care system is its ability to curb wasteful spending in an equitable way.

2 Private insurance is efficient only in clearly-defined theoretical conditions; and these conditions fail comprehensively for medical insurance. It is therefore not surprising that practical systems based on private insurance create inefficiencies in the form of excessive expenditure on medical care, and also lead to gaps in coverage. Health Maintenance Organisations reduce the former problem but do little to resolve the latter. In addition, both forms of insurance distribute medical care less equally than the NHS, both by income group and by risk category. Private medical insurance is not, therefore, a useful model for prospective reform.

3 Medical care should continue, for the most part, to be publicly funded, either through the tax system, as currently, or through a well-designed specific NHS contribution with no opting out.

4 The NHS strategy is sound in theory and highly successful in practice, compared with systems elsewhere. We therefore strongly urge that reform should seek to improve the NHS rather than replace it. Our preferred reforms are listed as points 5 - 8.

5 There is a case for *some* local experiment, more competition between providers, and greater accountability in the delivery of services.

6 Standards of excellence could be improved by holding the medical profession to account more effectively. Local authorities should have a statutory duty to monitor and promote health in their communities.

7 If local managers are to use resources effectively, they must be able to plan ahead through medium-term financial limits secured against nationally agreed pay settlements and general price increases.

8 In conclusion, we strongly oppose substantial privatisation of the *finance* of medical care. There is somewhat more scope for private activity on the *production* side, though caution is needed here too. Our opposition to radical privatisation in both cases is mainly on *efficiency* grounds.

REFORM AND THE NATIONAL HEALTH SERVICE

This submission is organised round three key aspects of medical care: the appropriate level of funding, methods of finance and methods of delivery. The final section assesses the considerable success of the National Health Service in comparison with systems elsewhere, and concludes by dividing reforms into those which we regard as potentially disastrous, and a menu of reforms which we favour.

THE LEVEL OF FUNDING

The issue There is widespread agreement that Britain is not spending enough on medical care. But *are* we in fact spending too little? The argument is usually based on two kinds of evidence: 'shroud-waving' anecdotes from doctors about babies and others dying due to inadequate facilities, and, a little more scientifically, comparisons of the percentage of national resources that Britain devotes to health care in comparison with other countries.

The anecdotes undoubtedly reflect genuine human misery and cannot be dismissed out of hand. However, their credibility suffers from the fact that similar stories are heard whenever medical practioners want extra resources, regardless of the legitimacy of their demands. Sad though many of the stories are, they tell us little about the genuine state of the medical services. Even if we were to devote the whole of our Gross Domestic Product (GDP) to medical care, some babies would still die who in principle could have been saved, had yet more resources been available.

There is more substance to the argument, when it comes to the percentage of national resources devoted to medical care, that Britain does not do well. The Table below shows some recent OECD estimates of the percentage of GDP spent on health care. Britain spends around 6 per cent,

compared with over 7 per cent in Italy, over 8 per cent in Germany, between 9 and 9½ per cent in Sweden and France and nearly 11 per cent in the United States. In fact, out of 23 OECD countries, Britain is fourth from bottom, above New Zealand, Portugal and Greece.

COUNTRY	HEALTH SPENDING AS PER CENT OF GDP (1984)		LIFE EXPECTANCY (latest available year)		INFANT MORTALITY (1983)
	Public Spending	Total Spending	Males	Females	Per 1000 live births
United Kingdom	5.3	5.9	71.4	77.2	10.2
France	6.5	9.1	70.4	78.5	8.9
Italy	6.1	7.2	69.7	75.9	12.2
Sweden	8.6	9.4	73.0	79.1	7.0
West Germany	6.4	8.1	70.2	76.8	10.2
United States	4.4	10.7	70.5	78.2	10.9

Sources : OECD (1985), Central Statistical Office (1987).

The difference does create an expectations problem for the NHS. British medical practitioners look at the high level of technical and other resources available to their equivalents abroad; they also look at their high incomes. Naturally, this often provokes strident calls for more resources (and higher salaries), and creates tensions within the NHS of the kind that we are currently observing.

Increasing the share of national resources going into medical care would undoubtedly alleviate some of these tensions. But would it do anything apart from that? The international comparisons of GDP shares

refer only to the 'inputs' into medical care. They say nothing about its 'outputs', i.e. the effectiveness of medical care in improving the health of the people living in the countries concerned. Measuring the effectiveness of medical systems is notoriously difficult; but one thing which can be done relatively easily is to compare broad indicators of a nation's health, such as life expectancy or infant mortality, and see how these relate to the pattern of high and low spenders.

Aggregate performance indicators for medical systems Some of the relevant figures are given in the Table. Of the countries listed, Britain, with the lowest proportion of GDP going to health care, has the highest life-expectancy for men of all the countries listed except Sweden, and has a higher life-expectancy for women than Germany or Italy. Although these figures vary over the years, and too much should not be made of the exact rankings, the fact remains, regardless of how much is spent on medical care, that men in most Western countries have a life-expectancy of just over 70 and women of close to 80 -- and Britain is no exception.

The position with respect to infant mortality is similar, with Sweden having the lowest, the USA the highest and Britain around the middle. There is no room for British complacency here -- our infant mortality rate actually increased in 1986. The point is simply that there is no guarantee that increasing the percentage of national income going to medical care will improve matters.

We find a similar picture if we look at inequality in mortality. The conventional way of measuring such inequality -- comparisons of the mortality rates between the different Social Classes -- is difficult to apply across countries because of different definitions of class. But it is possible to take a rather different approach to inequality, by comparing differences in individual lifespans within each country. One such study (Le Grand, 1987) compared these differences for 32 developed

countries, and found (perhaps a little surprisingly) that England and Wales were among the countries with the least difference, with Scotland and Northern Ireland not far behind.

Now mortality is affected by many factors other than medical care, such as nutrition and smoking habits. Nor is reducing mortality necessarily the be-all and end-all of medical care (although it must surely be a major concern). So we have to be careful about drawing any simple conclusions from these kinds of figures about the overall effectiveness of medical resources. But what we can say is that the figures offer no support for the view that increasing the percentage of national resources devoted to medical care will in and of itself significantly add to people's life spans.

The effectiveness of different types of treatment Another way of assessing the effectiveness of medical care is to look at the results of controlled trials of different kinds of treatment. Unfortunately this is often impossible for, astonishingly, the effectiveness of many forms of treatment has not been properly assessed. Perhaps this is not actually so surprising, for such trials as have been done are often far from reassuring. A celebrated study of the usefulness of coronary care units found that they either made no difference at all or made things worse. Studies of gastric freezing techniques for duodenal ulcers and the use of corticosteroid treatment for viral hepatitis came to similar conclusions.

In the absence of proper trials, it is difficult to determine with any precision the effectiveness of many forms of treatment. But most unbiased experts agree that many -- perhaps most -- treatments are largely ineffective in curative terms. There is little that medicine can do about such major killers as heart disease and cancer. Treatments for the most common forms of cancer, such as surgery or chemotherapy, usually relieve symptoms only temporarily and at a considerable cost in terms of side effects. Few curative treatments for diseases of the nervous system have

been found. There is little that medicine can do about many diseases of bones and joints, including rheumatism and arthritis. And there is no cure in sight for AIDS.

Of course, there are treatments whose efficacy has been convincingly established. A classic example is the use of insulin to treat acute-onset diabetes (although controlled trials of some other antidiabetic drugs suggest that they increase the risk of heart attacks). Some antibiotics and some emergency surgery can lead to dramatic health improvements. Organ transplants are both effective and, relative to the alternatives, surprisingly economical in their use of resources. And, even if most other medical care has little curative power, it can alleviate suffering and anxiety. But how much should we spend on a system whose principal function may be simply to provide (an often illusory) reassurance?

Implications for the level of funding Some people will draw the conclusion that, instead of pouring resources into curative medicine, we ought to increase expenditure on preventive medicine, such as health education and screening programmes. Here, unfortunately, the situation is equally dismal. Very few health education programmes have been demonstrated to be effective (those which are effective are mostly concerned with immunisation in third world countries). Screening is generally very expensive and often generates as many false positives as true ones, thus wasting more resources and causing needless, but often intense, anxiety.

What all this amounts to is that the case for devoting a much larger part of national resources to medical care is less strong than is generally believed. What is needed, as we argue later, are limited additional resources to provide competitive salaries for nursing and other auxilliary staff and a much greater degree of certainty about the resources managers can plan to use.

METHODS OF FINANCE

An implication of the previous section is that a key function of any system must be to contain costs. We shall argue that the NHS is a very successful mechanism for doing so; and that private insurance not only fails to contain costs but is *per se* a major cause of uncontrolled cost explosions.

Private Insurance: an Inappropriate Model

Theoretical background Though we are concerned to discuss practical policy, it is helpful to start with a brief theoretical discussion of the uses and limitations of private markets. According to its supporters, a competitive market system maximises benefits to participants in a way which the state or other allocative mechanisms cannot match. The free market is a highly efficient, self-adjusting information system; and the state has not as much information, nor an ability to acquire it as cheaply, nor a capacity to respond to it as quickly. Policy should therefore rely on the market system to achieve efficiency, supported by a system of income transfers to the poor to achieve distributional objectives.

Rather than dispute these proposals on ideological grounds, it is more fruitful to take a *technical* approach. The pro-market argument is well-known. What is less widely appreciated is that its validity in the markets both for goods (in this case medical care) and insurance, is hedged about by stringent conditions of which, in this context, the most crucial is the requirement that consumers and firms are well-informed.

Conditions for private insurance Because the argument is so important, it is worth spelling out the conditions which are necessary if private insurance generally, and private medical insurance in particular, is to be

efficient. The likelihood that I will (say) break a leg must:

1 Be less than 100 per cent.

2 Be known or estimable.

3 Involve no *adverse selection*. That is, I must not be able to conceal from the insurance company that I am a high-risk applicant.

4 Involve no *moral hazard* I should not, without the insurance company's knowledge and *at no cost to myself*, be able to affect the likelihood of breaking a leg.

5 Not enable me without the insurance company's knowledge to affect the amount, and hence the cost to the insurance company, of the treatment I receive (the failure of this condition causes what is known as the *third-party payment problem*).

It should be noted that the failure of conditions 2 to 5 all arise where insurance companies lack information about the risk status and behaviour of their clients.

The case for private markets is, therefore, valid in clearly-defined theoretical circumstances; and as a matter of policy these circumstances apply well enough in a wide variety of cases, including food, clothing, burglary insurance, car insurance, and the like. But this theoretical argument also shows the circumstances in which markets are *not* efficient (for fuller discussion, see Barr, 1987). And it is precisely in the area of information, in terms of which the market system is so often rightly praised, that an important class of problems arises both with health care and with medical insurance.

Problems with private medical insurance take the form of inefficiency in two ways: gaps in coverage, and incentives to excessive consumption of medical care. Gaps arise, first, because private policies generally offer incomplete (or no) coverage of *chronic or pre-existing* medical problems (because the likelihood of requiring treatment is too high, i.e. condition

1 fails), nor of the medical costs associated with *pregnancy* (since pregnancy is often the result of deliberate choice, and so violates condition 4). In addition, *the elderly*, if they can obtain insurance at all, generally have to pay very high premiums: this is partly because, on average, they require a considerable amount of medical care; furthermore, many private medical insurance companies, especially in the USA, believe (rightly or wrongly) that elderly people are often able to conceal potential medical problems, and so can hide their true riskiness from the insurance company (this is the issue of adverse selection, i.e. a failure of condition 3).

In addition to such gaps, private medical insurance can also face third-party payment problems, leading to exploding costs: where doctors are paid a fee for service, and treatment is paid in full by the insurance company, both doctor and patient can act as though medical care were free, which encourages excessive use of expensive medical resources (i.e. a failure of condition 5). At risk of sounding trite, a more familiar example of the driving force here is the way individuals behave in restaurants of the 'all you can eat for £8.95' variety, in comparison with their behaviour in restaurants with per-item pricing.

These theoretical arguments receive empirical support from private systems elsewhere. It is not sufficiently appreciated that the American private medical system is buttressed by government spending on a very substantial scale in precisely those areas where private medical insurance has gaps: Medicare (for the elderly), Medicaid (for the poor), Veteran's benefits (often chronic health problems) and maternity and child welfare. Equally predictably, given the third-party payment problem, the cost of these publicly funded schemes has come close to running out of control

Inspection of the comparative figures is both instructive and startling. The UK currently spends around £400 per person per year on medical care, about £360 via the NHS, and the rest private. In the USA

public spending on medical benefits (ignoring tax relief on private medical expenditure) is around £470 per person per year, and private spending about £670, giving a total of £1140, not far short of three times the UK figure. We should be clear what these figures say: that *public* spending in the USA is *higher* per head than in the UK; that the US spends nearly 1½ times that amount *in addition* on private medical benefits; yet health in the two countries, as we have seen, is broadly comparable. Other countries, (West Germany, France, Australia and Japan, to name but a few) face similar problems of massive, and largely uncontrolled costs (see, for instance, McLachlan and Maynard, 1982).

Limitations of Health Maintenance Organisations (HMOs) One response in the USA to this cost explosion has been the spread of HMOs.[1] This is not the place for a detailed assessment, save to point out briefly their limitations. First, HMOs have grown in the USA largely as a device for cost containment, in which activity they have had some success. Second, though HMOs reduce expenditure, they do nothing to resolve the other problem of private medical insurance -- that of gaps in coverage. Indeed, it can be argued that HMOs look good in a US context largely because the previous system was so ill-conceived; furthermore, the NHS is a considerably more successful device for containing costs. HMOs, in other words, are aimed at a problem the UK does not really have, and their relevance to the UK, on that account, is strictly limited.

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[1] Private HMOs in the USA work as follows. Individuals (or their employers) pay a lump-sum annual contribution to a 'firm' of doctors (the HMO), which promises in return to provide the contributor and his/her family with a comprehensive range of medical services. The doctors provide primary care themselves, and buy in and monitor hospital care as necessary. The HMO's income, which consists of the contributions of its members, is used to pay for health care, including the salaries of the doctors. Any surplus (like that of any firm) can be distributed to the doctors as additional income, or to members in the form of lower contributions, or ploughed back into the HMO to improve its service.

In addition, even in a US context, HMOs are facing problems. They are increasingly trying to limit membership to the best risks, raising difficulties about the insurance treatment of poorer risks; and those who are sick and on low incomes tend to do less well in HMOs than under traditional insurance. The problem is not one that can be ducked: if there are no strict limits to expenditure (e.g. medicare) the outcome is a cost explosion; if expenditure is kept within limits (as with HMOs) there is an inherent conflict between cost reduction, on the one hand, and the maintenance of quality, on the other. It is precisely for this reason that any body which imposes *de facto* rationing should be publicly accountable.

HMOs also face substantial administrative costs, mainly because of billing. Markets, as we have seen, are rightly praised because they gather vast amounts of information cheaply and use it effectively. This argument does not apply in a medical context, because much health care is not a standard commodity like food, but more a one-off item like an antique or old master.

Distributional aspects It should be noted that systems based on private insurance have distributive effects in two ways. First, the difference in medical care, both quantity and quality, between low- and high income groups is much larger under systems of private insurance than under the NHS. Second, the NHS distributes health care much more equally across risk groups than do systems based on private insurance. Indeed, it is the essence of actuarial insurance that those who systematically need the most medical care are charged the highest premiums.

Solutions The argument, in conclusion, is that private insurance is efficient only in clearly-defined theoretical conditions; and that these conditions fail comprehensively for medical insurance. It is therefore not surprising that systems based on private insurance create inefficiencies in

the form of gaps in coverage, and excessive expenditure on medical care. In addition, such systems distribute medical care less equally than the NHS, both by income group and by risk category.

Given these problems with pure private insurance, what generic solutions are on offer? One possibility, at least in principle, is modified private insurance. HMOs, as we have seen, have some advantages in reducing costs but do little *per se* to deal with gaps in coverage. Other forms of insurance can circumvent some of the gaps. But problems remain for any mixed system of private insurance buttressed by public funding. In any such system, 'easy' cases (i.e. the insurable risks of non-poor individuals) are financed through private insurance. The two obvious difficulties are non-insurable risks, and the poor. The former, as we have seen, lead to gaps, with which the state could deal either by subsidising private insurance premiums or by paying for treatment itself. The poor could be assisted similarly.

But there are major problems with this approach. First is that of defining borderlines, both as between the types of health care problem which qualify for state assistance, and over the income level below which the poor are subsidised. Second, and related, policing would be necessary in most private systems to prevent oversupply. Third, the poverty trap would be aggravated if subsidised medical treatment for the poor is withdrawn as their income rises.

Actuarial insurance, even in modified form, is not applicable to major areas of medical care nor to important groups of people, and is therefore not a very useful model for prospective reform. We therefore turn next to methods of finance which are not primarily insurance based.

Public Funding

Pure public funding, at its simplest, finances medical care out of general taxation. This is the case currently for about 85 per cent of NHS revenue, with an additional 9 per cent deriving from the National Insurance Fund. The advantage of this system is that it is flexible and based, at least broadly, on ability to pay. The disadvantage is that there is no mechanism whereby consumers/the electorate can easily signal willingness to pay for more/better health care.

Publicly organised health insurance, if sensibly constructed, is an alternative. A key feature if such a scheme is to be successful, is that membership should be compulsory, with no opting out. Such a scheme would have two major advantages in comparison with private insurance. First, compulsory membership makes it possible without *major* inefficiency to base contributions on ability to pay rather than on individual risk. Second, it is possible for a public scheme of this sort to offer universal coverage with respect both to individuals and type of illness. It is important, however, to be clear that such institutions, to the extent that they avoid the gaps of private schemes, are less like actuarial insurance and more like earmarked taxation. Indeed, it is precisely because they are *not* true insurance that such schemes can offer universal cover.

An NHS tax This brings us to consideration of ideas advanced recently for an explicit NHS contribution to be deducted from payslips, alongside income tax and national insurance contributions. A proposal of this sort has been advocated by Leon Brittan. His scheme is deficient in several important ways. First, it is based on national insurance contributions, which are not levied above the upper earnings limit, nor on investment income. If income tax is reduced in consequence, the resulting shift towards national

insurance contributions reduces the progressivity of the tax system, a distributional effect with which not everyone would agree.

Major problems arise also because individuals buying appropriate private insurance would be allowed to opt out. This causes adverse selection: those who opt out will be those best able to obtain private insurance, i.e. people who are (a) healthy and (b) with higher incomes. Because of (b), tax expenditures are likely to be large; and because of (a) the NHS, disproportionately, will be left with the less healthy, the elderly, etc. Tax revenues foregone will therefore be substantial, with relatively little saving to the NHS. In public expenditure terms, opting out is likely to be counterproductive.

Further costs include, first, a substantial 'deadweight' tax loss, since those who already have private medical insurance could claim back their NHS contribution without increasing the amount they spent privately on medical care. Second is the cost of a bureaucratic mechanism to distinguish who was and who was not entitled to treatment under the NHS. Third, it would be harder to control spending on medical care. On one view, this does not matter, since the additional spending is private. But in practice it is likely that a great proportion of such additional spending would be by employers, with adverse effects on competitiveness.

The hidden assumption in these arguments is that the same level of NHS funding would continue even when large numbers of high-income, articulate consumers had ceased to use it. A more realistic public choice analysis suggests that public support for tax funding would decline disproportionately as such users contracted out. Thus a further criticism of this approach is the quality differential it would open up between the private and public sectors (if there were no quality differential, why would anyone use private medical care?). At its worst, public medical care would become largely residualised -- see, for example, the state of much free public medical care in the USA.

To gain the advantages of public health insurance without any of the problems of private mechanisms it is necessary to have a specific NHS contribution as part of the tax system, with 'topping up' permitted but no possibility of opting out. One way of doing so would be to hypothecate the first 10 per cent or so of income tax to the NHS (i.e. the yield of charging 10 pence per pound of taxable income). Such an arrangement would have at least four major advantages: it would be a buoyant revenue source in the face of increasing financial pressures on the NHS; it would avoid the problems already discussed of private insurance; it would make clear to individuals the fact that the NHS has costs; and it would make it possible for individuals (*inter alia* via surveys of public opinion) to signal their willingness to pay more to finance a larger/better health service.

The conventional argument against hypothecation is 'where will it end?'; if there is a specific NHS tax, why not a specific tax for defence, for housing, etc.? The answer is that the demand for health care rises with income, and that health care therefore needs a buoyant source of funding; since health care is popular, an NHS tax, by conforming with people's preferences, will be less unpopular than other taxes. Separately, health care, uniquely, is (a) costly, (b) important to the whole population, and (c) relevant for the whole of each person's life.

As a longer-run possibility, the NHS contribution could be co-ordinated with national insurance contributions. We do not regard this as desirable in terms of existing institutions, since the upper earnings limit makes the contribution regressive over certain income ranges. If in the long-run the upper earnings limit were abolished, and the national insurance contribution at lower incomes aligned with the income tax threshold (a reform which we regard as desirable in its own right), the NHS contribution could then easily be superimposed.

DELIVERY

We have argued that the present method of financing health care in the UK is broadly both efficient and equitable. Nevertheless, some experiments could be undertaken in the forms of delivery, so long as the results are properly monitored.

Local experiments in competition within the NHS could usefully pursue several avenues.

1) A full-cost basis for charging inter-district transfers of patients should be developed. This would encourage districts to develop specialisms in which they had a comparative advantage and promote some competition. The accounting problems are considerable and the limits this would imply to GPs' freedom to refer would be unpopular. It would, therefore, be desirable, at least initially, to confine the exercise to certain costly treatments as an experiment.

2) Widening the scope of services a health centre or group practice can undertake or buy, and increasing the capitation fee accordingly.

3) Institute some experimental consumer health co-ops. GPs wishing to serve as employees of local health co-ops run by consumers, offering a range of services including community health, should be able to contract to do so and the co-op be paid an appropriate sum.

4) Firms wishing to provide comprehensive primary health care and occupational health care on their own premises should be encouraged to do so, with partial grants and tax reliefs, but on condition that the services were available equally to all their employees. These could be evaluated to test impact and use.

Though carefully-monitored competition may well have advantages, a note of caution is appropriate. Research in the USA (Luft, 1987) suggests that competition between hospitals for customers can lead to *increased* costs.

Results, based on a sample of 6000 community hospitals in 1982, show that hospitals in areas with eleven or more hospitals within a 15 mile radius have admission costs and patient day costs which are 26 per cent and 15 per cent higher, respectively, than comparable figures for hospitals with no immediate competitors. In addition, between 1972 and 1982, cost increases were largest in the most highly competitive areas. For these and other reasons the optimal amount of competition is likely to be less than the maximum possible.

Encouraging excellence Despite the claims by proponents and opponents of socialised medicine, the paradox is that the medical profession within the NHS is remarkably free from social audit. Though change would be difficult to achieve, the logical case for the following changes seems clear:

1) Consultants and GPs should be appointed by districts and should hold renewable contracts subject to adequate performance and peer review.

2) The size of a consultant's resource budget should be related to a contractual scale of work to be undertaken.

3) The nursing advisers' function should be strengthened. Many districts have lost, post Griffiths, a clear district-wide responsibility for nursing recruitment, retention, and professional standards. Middle management roles need to be more clearly defined (Owens and Glennerster, 1987 and 1988). There is a tragic waste of some of the most able and committed young people, mainly women, who enter nursing. Given the right support, better training and broader management opportunities early in their careers, these young women could be the general managers of the future.

4) The original ideals of community medicine have not been achieved (Lewis, 1986). The old public health ideals have been lost in the medical provision that dominates the NHS. Local authorities could be given responsibility for promoting *health* in their communities -- health

education, environmental health, monitoring the health standards of their communities and the standards achieved by the health care services in their areas. Local community forums could be briefed and used to hold health service managers and clinicians to account.

More equal access The higher income groups gain a disproportionate share of resources from the health service (Le Grand, 1982). This is despite the NHS's comparative success in equalising access compared with the health care systems elsewhere we have already cited. Greater knowledge of the importance of preventative health care, dependent as it is on education, will initially accentuate these effects. The reasons lie both in the economic costs of access, which bear heavily on the poor, and in the social status distinctions of our society over which the NHS has little power. Yet something can be done through improvements in primary care targetted on those areas with the lowest income groups and highest health care needs. Statistical indicators have been devised to enable us to do that. Special funding to community health care teams in priority areas would also improve the access roads to the other more expensive areas of medicine.

Providing local managers with medium term resource dependability While it is impossible to isolate any public service or private activity from the effects of an economic crisis, in ordinary times any organisation's effectiveness is gravely impaired if its managers are forced into a series of short term emergencies.

The former regime of volume terms public expenditure planning may have gone too far in isolating public sector managers from economic reality and encouraging private contractors to maximise their prices, yet the present system of cash limits and underfunded pay awards creates its own perverse effects. Governments are tempted to agree to pay increases that they are not prepared to pay for, leaving local managers to double-guess the outcome

of future pay negotiations, scrambling to make the books balance by closing wards or not opening new facilities. Central government then blames local managers. What is needed is a modified form of cash limit secured over the medium term.

Central government should make district allocations according to a RAWP type formula. At the moment both the Region and the Family Practitioner Committees are unnecessary complications, which muddle the clear line of political accountability that should exist between the cash giver - central government - and a single cash spender in each locality - the district health authority.

The district cash limit for the coming year would also contain resource targets for the coming three years. These would have three elements: wage and salary costs, which would be updated in line with nationally-agreed pay awards, other revenue expenditure indexed to the previous year's GDP current deflator, and a capital allocation linked to the previous year's capital deflator. (As with local authorities, this should merely be a ceiling permission to borrow, not a cash grant.)

Central government could keep back a small slice for promoting special projects and regional specialities. The DHSS could award funds for well-produced four year plans with a good public consultation process, and penalties for plans unfulfilled at the end of the four years.

DHSS should revert to the extremely useful practice it began in the mid 1970s with the publication of its *Priorities* document. This set out the range of demographic and medical trends affecting demands for service and the cost implications of these trends. More could be added by way of alternative options. This would give districts a framework and a methodology within which to present their own plans and help to provoke an informed debate.

Effective community care Successive reorganisations of the health and social services, housing policy and social security funding have left services for the elderly, the mentally ill and handicapped in something of a mess. The Griffiths Enquiry was meant to produce a resolution but the government's response is something of a disappointment. Yet it is these groups which present some of the most difficult resource issues, precisely because they cross so many statutory jurisdictions and because in the local battle for funds within the NHS the acute sector usually has the most powerful voice. Notwithstanding the limited experiment with joint finance, local authorities have little incentive to provide services that will reduce dependency on NHS resources, such as services permitting early discharge with intensive domiciliary support.

There is a case for funding the so-called priority groups separately, and transferring responsibility to local authorities. The present social service departments are overloaded with very high profile emergency work on child abuse and child care. They have little or no psychiatric expertise and they do not control sheltered housing. New community care departments could employ geriatricians, community psychiatric staff, specialist social workers, domiciliary workers and either provide or purchase residential care and sheltered housing through other agencies including housing associations. In some areas the mixture would be more private than public in other areas the reverse. This is a legitimate field for local debate and preference. Specific funding for this activity at perhaps 75% with a ring fence around it, as proposed for the housing revenue accounts of local authorities, would be perfectly feasible and subject to national inspection. Patterns of need and current provision vary so sharply that, initially at least, such funding will be necessary.

This would leave the NHS responsible for a legitimately national health service, seeking to provide uniform services with equal access. This would be more streamlined, and simpler to comprehend, fund and hold accountable.

CONCLUSION: THE SUCCESS OF THE NHS STRATEGY

The success story to date Given the problems with private markets both for health care and for medical insurance (problems, it should be stressed, which raise *technical* questions much more than ideological ones), the advantages of the NHS, both theoretically and in practice, stand out clearly.

The NHS strategy is theoretically sound. It is based on four interlocking strands which, together, go a long way to resolve the technical problems discussed earlier and, we argue, do so more effectively than any alternative based substantially on private markets. First, treatment is decided (mostly) by doctors, largely resolving the difficulties caused by consumer ignorance. Second, health care is financed (mostly) out of tax revenues, and is (mostly) free at the point of use. These features avoid the gaps in private insurance cover by abandoning the insurance principle even as a fiction; and medical care is available without stigma to the poor. Third, doctors receive little or no fee for service, thus reducing third-party payment incentives to oversupply. Fourth, health care is explicitly rationed by the NHS budget and, within that budget, by administrative means.

The NHS in practice has numerous advantages. Indeed, its current problems are tiny by international standards (it would be highly instructive to ask governments elsewhere whether they would swap the current difficulties with their health care systems for those of the NHS). The NHS, first, is remarkably cheap by international standards. The focus of concern in almost every other developed country is on medical overspending rather than underspending. Britain's relatively small expenditure on medical care as a proportion of Gross Domestic Product is thus much more an advantage than a disadvantage.

Much of the credit for this, moreover, goes to the NHS itself. Contrary to the present Government's claims, the health service is an excellent instrument for curbing wasteful health expenditures. The fact that medical practitioners are generally paid on a salary or capitation basis, rather than one of fee-for-service, means that they have no incentive to undertake expensive treatment of dubious value (this is a feature which particularly impresses visiting American health economists, imbued with pro-market beliefs, who generally come prepared to criticise, but leave singing the praises of the NHS). Payment via a salary, together with the NHS role as an almost monopoly employer, means that doctors' incomes (and hence their claim on national resources) are kept under control.

The NHS, again contrary to general belief, also has low administrative costs. An OECD study (1977) found them to be about half that of other countries as a proportion of total health expenditure.

Despite being cheap, the NHS is remarkably popular, and health standards in the UK, as we saw earlier, are on a par with those in comparable countries where real spending per head on health care is higher, and often considerably higher. In addition, though it has been shown that the middle classes receive more than their *pro rata* share of NHS resources (Le Grand, 1982, Ch. 3; Goodin and Le Grand, 1987) nevertheless the variation in the quality and quantity of treatment by income level is smaller than in most other countries, and is capable of further improvement. Treatment is free whatever the extent and duration of illness; no one is denied access because of low income; and no one goes in fear of financial ruin.

False trails and blind alleys The short-term funding problems caused by the Government's failure fully to fund pay awards made in an election year have been used by a range of critics of the NHS to suggest the need for alternative funding arrangements, the use of private finance and the

introduction of various kinds of competition within the NHS. In this submission we have challenged a number of common myths which have emerged in various proposals for major change.

Myth 1: The NHS needs a substantial increase in funding As we saw in the first part of the paper, Britain spends less on medical care as a proportion of Gross Domestic Product than most other OECD countries. This should be a cause for celebration, not complaint. There is no indication that the UK suffers from these relatively low levels of spending: on the contrary, according to most macro-indicators of health status, Britain is at least as healthy as most other developed countries. In fact, there is no obvious relationship between a country's medical spending and the health of its inhabitants. This should not be surprising, for, at a micro level, few medical techniques have been shown to be effective in curative terms. This suggests that the most desirable feature of a health care system is its ability to curb wasteful spending in an equitable way.

Myth 2: Health care finance is a problem unique to the NHS As we saw above, this is untrue. A recent OECD study (1987) shows that on average in the member countries the income elasticity of health care spending was high in the 1960s and early 1970s. For every one per cent increase in national income per head, OECD health care spending rose by 1.6 per cent. The UK relative rate of expansion was considerably higher than the OECD average 2.1 per cent. After the 1973 oil shock this ceased to be true. OECD health care spending in the 1980s rose at half the rate of per capita income. The UK followed the OECD trend, and so did countries with more mixed forms of finance. All European countries have undertaken cost containment measures, as have the USA and Canada (Abel-Smith, 1984). The only questions are how do we contain spending, on whom, and how effectively? Britain has one of the fairest, most effective and most

socially accountable forms of cost containment of any country.

Myth 3: Private finance would relieve the burden on the NHS Private insurance would hamper efforts to contain costs, would bias treatment towards acute conditions and would have substantial gaps in coverage. In addition, systems of mixed public and private funding, if not very carefully designed and controlled, are likely to reduce the quality of the NHS and simultaneously to cause inefficiently high levels of total spending on health care. Any major expansion of the private sector would inevitably lead to an increase in physician incomes and other costs, which the NHS would be forced to match. A major expansion of private health care is a recipe for the kind of health care cost explosion which has bedevilled the rest of the developed world; and it would, in addition, aggravate disparities in medical treatment by social class and income level.

Myth 4: The market for health is just like other markets Some recent proposals would tie an average cash sum funded out of taxation to each patient, and give the GP, a health maintenance organisation or a private insurer the job of allocating that cash between a range of competing suppliers of health care. These proposals ignore the peculiarities of health care markets. In particular, there is enormous variety in the costs of treatment, in individual risks and in the class- and occupation related patterns of illness, all of which give strong incentives to GPs, HMOs and insurance companies to select out potential high-cost patients. It was precisely these problem which were exhibited in the nineteenth century by the forerunners of HMOs -- the sick funds and provident societies. The alternative is large risk pools, i.e. large patient lists or catchment areas, and hence minimal choice.

Many of the proposals for an internal market have been made in remarkably superficial terms (see the critique by Robinson, 1988). Changes like

clinical budgets or the subsequent resource management initiative on which a lot of work *has* been done have proved difficult enough to introduce.

In conclusion, we strongly oppose substantial privatisation of the *finance* of medical care. There is somewhat more scope for private activity on the *production* side, though caution is needed here too. Our opposition to radical privatisation, in both cases, is mainly on *efficiency* grounds; and for the same reason we are against *substantial* increases in NHS funding.

Our Favoured Reforms

1) Funding should remain substantially public, either via general taxation, or through an appropriately designed NHS contribution with no opting out.

2) Give districts medium term financial limits secured against general price increases.

3) Create new community care departments within local authorities, with clear responsibility for services which provide continuing care for the priority groups, funded initially by a percentage grant.

4) Take a series of steps to increase the accountability and monitor the performance of medical and nursing staff.

5) Improve primary care especially in deprived areas. Give local authorities responsibility for promoting health and monitoring standards of health in their communities.

6) Promote some local experiments in resource allocation, such as full cost charging and inter-district contracts for expensive treatments, and some health consumer co-operatives.

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SECRET

FROM: H PHILLIPS
DATE: 28 June 1988

CHANCELLOR

cc Chief Secretary
Financial Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Culpin
Miss Denison
Mr Turnbull
Mr Parsonage
Mr Saunders
Mr Griffiths
Mr Call
Mr Lewis)
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NHS REVIEW: SUPPLY AND DEMAND AND THE PRIME MINISTER'S NEXT MEETING

Supply and Demand

1. Attached is a revised draft of your proposed minute to the Prime Minister on supply and demand in health. We have attempted to capture the current growth in the private sector, and the supply constraint it faces in paragraph 14 onwards.

2. I have sent you separately a note from Mr Satchwell about the growth of private medical insurance. The figures, from DHSS, run up to the end of last year. For this year so far, and for the forward look, I can confirm what I reported to you from AMI. (I have spoken again to their finance director who is reporting what the health insurance industry tell him.) BUPA tell him they are planning on the basis of a doubling in the number of subscribers over the next two years. PPP report that their subscriptions grew by 20% in the first few months of this year, which was the whole of their earlier planned growth expectations for the two years 1988 and 1989. AMI, as a private provider of healthcare, do not

see how they can cope with a consequent increase in take-up of actual services as opposed to insurance, without substantial price increases, unless action is taken to tackle supply side constraints.

Tax Relief and Contracting Out

3. All this information is good news in support of your approach on tax relief. The bad news is that Mr Moore has decided to put in his paper on contracting out, rejecting advice to the contrary on the grounds that if you were going to put in your tax paper he would put in his. The only purpose in this must be an attempt to bid up what you are prepared to offer on benefits in kind in the hope that the Prime Minister will support him.

Financing Hospitals

4. Mr Saunders has revised, and resubmitted to the Chief Secretary his paper on top-slicing following the meeting he and I had today with Sir Roy Griffiths. If we can get a conclusion from the Prime Minister's meeting which endorses the objectives and principles of the scheme, then we can do useful work with DHSS on the mechanics, criteria and timetable. What we have to watch is that the clarity and sharpness of directing growth money in the way we propose is not clouded and blunted by DHSS concern to adapt our proposal to what they are already doing, rather than the other way round.

Self-Governing Hospitals

5. Mr Moore's paper has a revised covering note which reflects the impact of your meeting on Friday. Although it says that the proposals do not resurrect the idea of buyers and providers, and that GP's can be fitted in to the scheme, we remain sceptical about these points. What is more welcome are the indications that

a) hospitals would be selected for independent status - which means they ought to meet conditions about budgetary

discipline, involvement of consultants in management, efficiency targets, in order to attain it;

b) contracts in this context would be about financing such hospitals in relation to performance (something more of the flavour of "Next Steps" agencies than contracts in the ordinary sense of the term);

c) such hospitals would be pilots rather than the planned way ahead for all; and that

d) all this will take time ie is probably a matter for Green rather than White Papers.

If the discussion can be built towards this formulation, and the objectives and principles of the Chief Secretary's paper are accepted, some progress might be made.

6. But we shall still need to be much clearer about, and find acceptable, the advantages of self-governing status. These will undoubtedly include requests for greater flexibilities in relation to capital and current expenditure, and in particular the chance to operate at full or increased capacity if income can be raised to cover costs from the private sector or other parts of the NHS. More detailed work is needed here.

Consultants Contracts

7. The paper is little changed from that you saw last week. Its two main changes are that

a) it leans towards not touching existing distinction awards; and

b) confirms that the £50 million PES marker bid included nothing for short term contracts. (It indicates a cost of £7 million a year for putting newly appointed consultants only on such contracts, up to £108 million a year for buying out all those below the age of 55).

8. I am not sure the paper is yet doing enough to open up the supply side: there are no references to the development of junior and senior consultant posts, nor to promoting greater part-time consultant work.

9. But the paper provides a good basis for a first discussion of what might be done and of how much political argument with the medical establishment and financial cost will be necessary or tolerable to achieve sufficient change.

Medical Audit

10. As you know we are not opposed to this paper but we cannot sign up to it until the cost of introduction is quantified and acceptable.

HP

H PHILLIPS

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for Social Services

SECRET

28/6

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

28 June 1988

Dear Paul,

TONY PLEASE SEE BOOK FOR RIGHT LIST

NHS REVIEW

I enclose four papers for the meeting of the Prime Minister's group on the NHS Review which is to take place on 4 July.

The papers are:

- Moving towards self governing hospitals
- Consultants
- Medical Audit
- Contracting out

Copies of this letter and enclosures go to the Private Secretaries to the Chancellor, the Chief Secretary, the Minister for Health and Sir Roy Griffiths; to Professor Griffiths and Mr O'Sullivan at the Policy Unit; and to Richard Wilson at the Cabinet Office.

Yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

SECRET

pse.jf/mp/mp.1D
28.6.88

MMP

DRAFT

PRIME MINISTER

NHS REVIEW: SUPPLY AND DEMAND

As the work of the review moves forward we shall need to examine the emerging proposals against the objectives we have set ourselves in the context of an economic analysis of the supply of and demand for health care. I hope it will be useful to you, and other colleagues if I set out the essential points of such an analysis.

2. Our main objectives in the review are:

(a) to make the NHS more cost-effective; and

(b) to increase the contribution of the private sector.

We shall also want to ensure that when we come to look at the results of our reforms, some success has been achieved in meeting specific pressure points in the system.

3. These primary objectives will not be met by measures whose main effect is to expand demand. Indeed, the problems we are seeking to address would in all likelihood be made worse. The key to success must be better performance on the supply side.

4. This is of course a lesson we have learned and applied in many other areas of policy. There is no reason why health should be different in this regard. Indeed, there are features of the supply of and demand for health care which make it especially important that we should get the design of our reforms right in this area.

5. First, on the demand side, we must recognise the almost complete absence of the price mechanism as a means of regulating the level of output. This is most obviously the case in the state sector, where prices and charges play a negligible role, particularly in the hospital service. It follows that patients (and their doctors, too) will always tend to press for high cost options. But even in the private sector, where patients have to pay in full, the price mechanism works in a very muted way.

6. Private treatment is mainly financed out of insurance. This effectively means that at the point of use services are free to the individual patient, just as they are in the NHS. Once services are required, there is no financial reason for the patient to limit his demands. In time higher expenditure on hospital and other services will be reflected in higher premiums, but this is a weak and indirect check, especially on those in company schemes whose premiums are paid by a third party. As experience in the United States has shown, this discipline would be even more attenuated if private insurance were underpinned by general tax relief.

7. The lack of an effective price mechanism working on consumers is reinforced by a lack of cost consciousness among doctors and other suppliers. As we have noted many times in the course of the review, budgeting and information systems in the NHS are ill-designed for the purpose of encouraging cost-effectiveness and economy. Those who commit resources are not financially accountable for their decisions, nor are they given adequate information on the costs of what they are doing. Systems are better in the private sector, but doctors everywhere cling to their outmoded tradition of non-involvement in the management of resources. Under present arrangements, the demands of patients are more likely to be amplified than constrained by the decisions of doctors.

8. The absence of price signals for both patients and doctors has resulted in a chronic tendency towards excess demand. Some of this demand is suppressed, for example by controls on expenditure in the NHS, and remains latent only because patients are put off by lengthy waiting times.

9. An increase in effective demand in any market can have two effects, depending on the supply response. It can call forth extra output, or it can push up costs. It goes without saying that the split between these two effects is of some importance. There is nothing to be said for boosting demand if supply does not respond and it simply leads to a bidding up of pay and prices.

10. Without fundamental changes to the incentives faced by hospitals and other suppliers, the supply of health output will only adjust slowly to increases in demand, at least in the short to medium term.

11. The starting point is the availability of skilled manpower - doctors, nurses, therapists, technicians etc. The supply of these resources cannot be turned on and off like a tap. There are inevitable lags in the system resulting from the requirement to recruit and train specialist staff.

12. In addition, these constraints are compounded by institutional and other rigidities stemming from the way in which we presently organise our affairs. The problems here are well known and have been discussed in earlier papers. Particularly important in my view are inflexibilities on the manpower side: restrictive practices, overspecialisation, promotion blockages, reward systems unrelated to performance, national pay rates, and so on. But there are rigidities throughout the system resulting from weak or perverse incentives and the absence of market forces.

13. Finally, even within the limits imposed by these constraints, there are failures to use resources efficiently and to direct them towards the uses where they will have maximum effect. The scope for improving supply performance is amply demonstrated by the evidence of substantial variations in efficiency and output between different units within the NHS.

14. It is clear, therefore, that there is little to be said for measures which simply affect the demand for health care and have little impact on supply behaviour. Demand already exceeds available supply, and the likely effect of any further expansion would be higher costs, not higher output.

15. The analysis remains broadly the same whether the extra demand is directed towards the public or the private sectors. One part of the market cannot be isolated from the rest. For example, a large increase in the demand for specialist staff in the private sector would inevitably have repercussions in the NHS, not least on wage levels.

16. A shortage of demand is not the main limiting factor on expansion of the private sector. There is healthy growth in the numbers taking out private insurance, particularly in company schemes, and all the expectations are that this growth will continue. The key constraints on private sector expansion are rather to be found on the supply side.

17. One example is the limited availability of specialist staff such as anaesthetists and radiologists. Another is the capacity of the private health insurance industry to respond to any sizeable increase in demand; reports are that it is already fully stretched in meeting the existing rate of growth. And a third is the often unhelpful attitude

of the consultant establishment, for example towards joint public/private ventures and in the setting of fees for private work which lead to unnecessarily high costs of private treatment.

18. We all want to see an increase in the contribution made by the private sector. The way to achieve this is to bring down its price to the consumer. This in turn means improving supply, not boosting demand.

19. Our strategy for reform, as it affects both the NHS and the private sector, should therefore focus directly on the supply side, with the aim of promoting a much more flexible and responsive supply capability. There is much to be done in tackling the problems I have mentioned of manpower and other inflexibilities. Only then can we be sure that additional demand will be translated into additional provision, rather than simply dissipated in higher costs.

20. I started by referring to our main objectives in the review. In the course of our work we have identified a wide range of measures which might help to secure these aims. The next step is to put together a credible and coherent package of reforms, and in doing so we must test each individual proposal against the analysis I have set out in this paper, working through the supply and demand consequences. There is no need for me to underline the crucial importance of getting this right.

21. Copies of this minute go to John Moore and Tony Newton, John Major, Sir Roy Griffiths and Sir Robin Butler.

SECRET

28/6/88

HC 28

MOVING TOWARDS SELF GOVERNING HOSPITALS

Note by the Secretary of State for Social Services

The attached paper sets out a practical way forward towards our goal of giving hospitals greater freedom and responsibility for managing their own affairs. It differs in a number of respects from my earlier proposals for a buyer-provider model, particularly in the way that hospitals would continue to operate within the present framework of overall planning priorities and resource constraints set in general by the Government and in detail by health authorities. But it is still aimed at creating in due course the conditions in which hospitals operate within market disciplines rather than top down controls. This is the crucial change.

SELF -GOV HOSPS

2. The main features of my revised approach are:

first, the emphasis is on building up the responsibilities and capabilities of the individual hospital for running its business and on involving doctors in the allocation of resources.

second, the process of change will take time. Hospitals generally have neither the necessary information nor the management capacity to move directly to self governing status.

third, as part of the process of change the present health authority structure would be slimmed down, so that overall we reduce bureaucracy.

3. It is important that we are able to fit GPs into the new arrangements. The proposals achieve this. I see no need for any reduction in the present freedom of GPs to refer patients to hospitals. Indeed they will have better information about where to refer patients. There will also be better local control of what is happening, because GPs will have a closer relationship with health authorities.

4. An important element in the process of change will be trying out the new arrangements on a pilot basis. I have in mind that we might:

* encourage a selected group of hospitals to apply for greater freedom e.g in staffing matters under the control of boards of management

* try out the "contractual" model of service planning in a selected number of district health authorities.

* invite a regional health authority to expand the trading of hospital services within that region.

June 1988

SECRET

MOVING TOWARDS SELF GOVERNING HOSPITALS

Introduction

1. This paper outlines a framework for giving hospitals greater freedom and responsibility for managing their own affairs, building on existing initiatives within the service. The paper puts forward a model for self governing hospitals as the end-point of an evolutionary process, and outlines an action plan for getting there. The paper sets out:

- the scope within the existing system for devolving more responsibility and freedom to hospitals, as a key precursor to self government;
- the consequential slimming down of the health authority hierarchy;
- the main features of self governing hospitals compared with the existing system; and
- a practical evolutionary path which leaves room for experiment and initiative, without imposing a monolithic solution.

Increased freedom and responsibility

Building up the hospitals

2. The present thrust of development in the NHS is to devolve management responsibility to the lowest level. This driving down of responsibility lies at the heart of the new framework for the hospital services. It needs to be continued and developed along three lines:

- build up the responsibility of hospital management (including clinical staff) and ensure that they have the information they need to control the resources they use;

- make specific services subject to "contracts" between DHA and unit;

- introduce greater flexibility and freedom for hospital management in the access to, and deployment of, the key resources, capital and manpower.

3. The first of these developments is already under way in the resource management initiative. The information aspects of the initiative will be described in more detail in a separate paper. The fundamental aim is to give clinicians, as the main users of NHS resources, responsibility for, as well as power over, those resources. This needs to be embodied in a new contract for consultants, which is discussed in a separate paper. Clinicians will therefore be accountable for the way resources are used, and will have detailed, timely and accurate information on patients and the costs attributable to their treatment. Thus, for example:

- doctors will be answerable for providing the most cost-effective treatment regime;

- managers will be able to identify the more efficient units for expansion;

- it will be possible to decide in a more informed way whether to provide a service in-house, or to buy it from a neighbouring hospital.

4. Secondly, the introduction of a "contractual" style of management between DHA and hospital would make more explicit the respective responsibilities of the DHA and the unit. This would build upon the availability of effective management information in the hands of those who actually deploy resources. For their local "baseload" services, hospitals would be committed to agreed performance targets in terms of the level and quality of the services they provide, including waiting times. Correspondingly, DHAs would be committed to a level of funding which reflected the targets set. "Contracts" with both the "home" and other DHAs - and with the private sector - could be introduced specialty by specialty for services beyond the "baseload", concentrating mainly on elective surgery. Thus for example:

- non-achievement of (or indeed exceeding) set performance targets would be apparent not only to managers on both sides, but also to GPs and patients;

- "contracts" would provide the basis on which hospitals, on their own initiative, could extend their services to other DHAs, or to the private sector;

- GPs' freedom of referral would be maintained within firm overall expenditure limits by retaining funds specifically for special or ad hoc referrals not covered by the main contract(s). Balancing GPs' freedom against firm management control is important, but in practice that freedom is already heavily constrained by growing reluctance to accept "out of area" referrals. The "market" approach will open up choices for GPs and patients.

Not at all clear what these assertions based on

5. Thirdly, to match the greater control of resources flowing from better information, and the greater commitment to specific performance arising from the "contractual" approach, hospital management could be given more freedom, within a reformed Whitley system, to set local pay and conditions. Regional pay, and pay flexibility, are already under consideration; reform of the

consultants' distinction awards is discussed in a separate paper. Further detailed work will be needed on the extent of flexibility - especially over pay - which would be possible. However, for example:

- skilled staff could be deployed in new ways to meet service needs, and non-medical manpower could substitute for junior medical staff in supporting roles, subject to necessary professional, ethical and legal considerations;

- more flexible pay could be offered to attract or retain key staff involved in delivering important service "contracts";

- enable pay to match local labour market conditions, which might result in reduced costs.

6. The scope for increasing hospitals' freedom over capital is subject to further discussion between Treasury and DHSS officials.

Slimming down the health authorities

7. The devolution described in paragraphs 2 to 6 would represent a shift in responsibility from RHAs and DHAs to the hospitals themselves. As a result, DHAs would have fewer operational management responsibilities, and could concentrate more on the procurement of comprehensive hospital and community health services for their resident population - and for the GPs who refer patients to these services. This brings closer together the new functions of DHAs with the present ones of FPCs. It would therefore be possible over time steadily to reduce the number of DHAs by around a half, and to combine their functions with those of FPCs in a smaller number of geographically larger authorities. These combined authorities, referred to as "DHAs" for the rest of this paper, would contract with GPs much as the FPCs do at present.

8. RHAs too could devolve further responsibilities and contract out others. The net result might be that both RHAs and DHAs would each employ about half the number of staff. Most of the costs would devolve upon the hospitals in the first instance, but their concentration at that level, together with the scope for competitive tendering for a wide range of support services, should bring about significant net savings. RHAs would retain responsibility for health service planning and for ensuring the effective provision of specialised services, and of funds for capital investment. RHAs could ensure adequate provision of training posts by placing contracts with hospitals for specified training services, the price reflecting the overheads incurred. In addition, they would continue to serve as a bulwark against unnecessary Ministerial involvement in operational controversy. It might be possible over time to reduce the number of RHAs, perhaps to ten.

9. The resulting management regime needs to be considered from three viewpoints:

Funding would continue to flow from DHSS via RHAs to DHAs on a population-based formula. Most hospitals, and most services, would be planned, funded and managed by the DHA on the basis of "contracts" with the hospitals.

Capital would continue to be allocated by the health authorities according to their strategic plans, but if hospitals were required to meet capital costs this would both bring economic criteria to the fore, and involve hospital management more closely in capital planning. Any development of charging for capital would imply corresponding increases in revenue allocations recovered via receipts. Hospitals would have some scope for accumulating reserves which they could apply to minor capital projects.

Accountability for the use of resources, and for delivery of services, would continue to flow up the management line to the Secretary of State.

Self government

Statutory independence

10. Most of the initiatives described above are under way to some degree. They all develop, but remain within, the existing constitutional structure of the NHS, with hospitals (other than the London Post-graduate Teaching Hospitals) as operational arms of the DHAs, both being subordinate to the RHAs. The key break with the existing pattern of health service management would be to form each hospital into an autonomous organisation - a self governing hospital.

11. This would require the creation of a statutory Board of Management for each hospital. The Board of Management could comprise the key members of the hospital management team, plus two or three "non-executive directors" drawn from business and the community. Further consideration would be needed as to whether the Secretary of State should have a role in the appointment of board members, in particular the chairman.

12. The board of management would be a formal legal entity which would be empowered to employ staff, enter into contracts with health authorities and private health insurance companies etc, and hold financial reserves. By comparison with the developments described above, the self governing hospital would, for example:

- in principle, be free to grade, deploy and pay its staff - including consultants, who would also be hospital employees - as the board thought fit, bound only by arrangements to safeguard training to ensure a continued supply of skilled professional staff. However the need for additional constraints on pay would need further detailed consideration;

- be free to enter joint capital ventures with the private sector, and to allocate the funds earned through contracts to "revenue" or "capital" expenditures at will;

- be free to develop new packages of services which take advantage of technological advance, or meet new demand.

- be free to sell their services to whichever DHAs (or RHAs, for regional specialties) needed them, or to private sector health insurance companies;

13. Thus for fully self governing hospitals:

Funding would flow from DHSS to RHAs on the basis of their resident population. RHAs would allocate funds to the DHAs according to strategic plans. At both stages, funds for supra-regional and regional contracts with self governing hospitals would be held for payment direct to the hospitals. DHAs would use funds to provide those services for which they remained operationally responsible, and to finance their contracts with whichever self governing hospitals could provide the best packages of services. Contracts would be contestable by other public and private sector hospitals.

Capital assets used by a self governing hospital would remain in public ownership. The hospital would charge through its contracts for its use of these assets. Subject to RHA approval (to prevent asset-stripping) the board of management could dispose of assets and re-invest the proceeds in new developments. Funds for new investment would be available from the RHA's capital programme, according to priority, and

to meeting the capital charges from their own resources. Self governing hospitals would also be free to allocate their own resources from contract income to capital investment.

Accountability for the delivery of services would flow from the self governing hospital to the DHA or other authority which placed the contract for the services. The hospital would be subject to the usual market disciplines. As regards the hospital's use of public assets, the board of management would be answerable via the RHA to the Secretary of State.

14. Not all the 1800 hospitals in England would be suitable for self governing status. 750 of them have fewer than 50 beds, and many are in practice closely interdependent. The hospitals fall within 600 or so management units. Some units could become self-governing as they stand; others might sensibly be subdivided. Yet others would not fit the self governing mould, and DHAs would be likely to retain operational responsibility for their services, perhaps especially community and public health functions and at least some psychiatric services. DHAs would also need to ensure, both by operational management (where appropriate) and by contract planning, that the necessary integration of hospital and community-based services was not undermined. The DHAs would deal with self governing hospitals on the same basis as they would with private sector hospitals: as contractors providing a service. They would nevertheless be expected to plan local services in close cooperation with the boards of management, and might need reserve powers for use if necessary to ensure that a basic range of core, local services were maintained.

Legislative implications

15. Although existing legislation provides for special health authorities to be created by Order of the Secretary of State (and this is the constitutional model of, for example, the London Post-graduate Teaching Hospitals), it would be preferable to introduce into primary legislation the new statutory model for the hospital management boards. This would set them apart as entirely new bodies, and in particular, would avoid the presumption

of direct funding by DHSS. Primary legislation would also be needed to empower health authorities to cross-charge for services, and thus to establish the scope of the "internal market".

16. Minor changes to the health authority network - for example amalgamating authorities - could be made by secondary legislation. However, more radical change, such as combining the functions of FPCs and DHAs would require primary legislation, as would changes to the representative nature of membership of DHAs (for example, local authority members).

17. It follows that the gradual or experimental introduction of the changes proposed in this paper would need to be carried out - and would be best understood - within the framework of enabling primary legislation which would open up an evolutionary path for the new NHS.

A practical evolutionary path

18. Having set out the main features of self governing hospitals, and the freedoms and responsibilities they would enjoy, the task is to plan a practical evolutionary path towards that goal. It would not be possible, nor sensible, to attempt this in one step; an evolutionary approach would be essential. This requires the staged implementation of the various changes outlined above.

19. The risks of such a staged process of change would lie in giving some hospitals additional freedoms (say over pay levels, or over selling additional services) but not others. This could harm the competitive chances of the non self governing hospital eg because they lose their key staff to competing hospitals. Careful planning and regulation would therefore be necessary during the transitional period. The risk of unfair competition would be lessened by introducing full self government in discrete "blocks". Regions would offer the most appropriate framework for such staged implementation, and RHAs would have a key role in planning region-by-region changeover.

20. Managing the transition would be made more difficult by the fact that, under the existing system, hospitals have no "personality" at all. There would therefore be no formal "body" which, at the outset of transition, could participate (on the hospital's side) in the orderly introduction of full independence. It might therefore be advantageous to introduce the Boards of Management early in the process. In this way, the hospitals could be "up and running" in a constitutional sense, during the "building up the hospitals" phase described in paragraphs 2 - 6, but before they achieved full self government. RHAs would then be dealing with experienced and semi-autonomous bodies during the region-by-region implementation of fully self governing hospitals. A further advantage of early introduction of Boards of Management would be that it would be a visible and popular signal of change.

21. In summary, an action plan for the development of self governing hospitals might be in four overlapping phases:

Phase 1: complete the introduction of devolved management and information systems.

Phase 2: create Boards of Management for all hospitals.

Phase 3: allow regions to introduce the "contractual" model of service planning and management, applying it first to "baseload" services for the "home" DHA and then extending specialty by specialty to elective surgery for other DHAs. Hospitals would win funds according to their performance under these "contracts", in line with an internal market.

Phase 4: allow regions successively to implement self governing status for their hospitals, ensuring an orderly introduction of greater freedom to deploy their resources as they judge appropriate. For these hospitals the contractual framework would become the means by which DHAs paid for hospital services.

22. The path through these steps might well be quicker in some regions than in others - and in any case the phasing would necessarily overlap. The key would lie in appropriate experimentation, rather than the "big bang" introduction of a new system.

SECRET

28/6/88

HC 30

MEDICAL AUDIT

Note by the Secretary of State for Social Services

Background

1. Medical audit is a critical analysis of medical activity in terms of process, outcome and implications for the management of resources. It is a potentially powerful tool for improving the quality of care and use of resources. It encompasses measurement of clinical outcome, scrutiny of clinical efficiency and productivity, assessment of patient satisfaction and fulfilment of contractual duties. As a full understanding of medical practice is essential, much of the analytic activity in medical audit is undertaken by colleagues in the same specialty - so called "peer review".

2. There have been encouraging developments in medical audit recently. Examples are:

* the Confidential Enquiry into Perioperative Deaths, a major study of all deaths within 30 days of surgical operation in 3 regions, now to be extended nationally with DHSS funding.

* a working party of the Royal College of Physicians, which is studying ways of extending the use of medical audit.

* the development of national protocols for checking standards in several branches of pathology.

Action proposed

MEDICAL AUDIT

3. The major unresolved problem at present is that consultants most in need of audit can refuse to participate. There are two specific steps we can take to help deal with this problem, and I propose that we do so:

* A number of medical Colleges are moving towards making participation in audit a condition of a unit being allowed to train junior doctors. We should press them hard to do this.

* We should make participation in an audit programme a condition of employment under a revised consultant contract, and require junior doctors to participate also.

We must also make sure that our other proposals serve to embed medical audit into the system, for example through the criteria for hospitals to become "self-governing"; and that we encourage similar developments in nursing.

SECRET

4. We need to determine responsibility for undertaking and overseeing medical audit, and to establish a new national body to support and monitor the initiatives which are needed at local level. I suggest we invite the Colleges to take this on in the first instance, with suitable non-medical representation. But if they are unwilling we should be ready to set up a body ourselves, with professional assessors.

5. Associated with the process of medical audit are two other developments which I suggest we should promote:

* further work on health outcome assessment: at present there is a paucity of information on the effectiveness of medical care to back up measurements of efficiency.

* continuing education: it is crucial that consultants maintain and develop their skills throughout their careers. We need to ensure that both managers and the medical Colleges reinforce this by making clear what they expect consultants to achieve in this regard.

6. There will be some modest additional costs associated with an expansion of medical audit, health outcome assessment and continuing education, and we shall need to assess these and take them into account in the normal PES process.

June 1988

Trafford's bits

1. FPCs absorbed in SHAs & funds for primary care cash-limited.

2. Change in contracts (7 yrs)
[This disagrees with Tony's statement]

3. More competitive tendering (non clinical areas)

4. NHS real audit challenge

5. Clinical budgets (etc
[Rest v.s. cap spend]

28.6.1

SECRET

FROM: R B SAUNDERS

DATE: 28 June 1988

CHIEF SECRETARY

cc Chancellor
Paymaster General
Sir Peter Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Sussex
Mr Satchwell
Mr Tyrie
Mr Call

[CST approved this version for circulation - not time to show to Ch]

TOP SLUNG

NHS REVIEW: FINANCING HOSPITALS

I attach a new draft of this paper, together with some speaking notes on which you may like to draw at the Prime Minister's meeting on Thursday. The paper will need to go round as early as possible tomorrow.

2. The main changes are to the covering note, and seek to bring out some of the points made at the quadrilateral with Mr Moore on Friday, and at a useful meeting which Mr Phillips and I had with Sir Roy Griffiths this morning. I have made lesser amendments to the full paper, notably to downplay the references to performance indicators, and to bring out (in paragraph 9) the idea of linking this scheme to performance targets set for hospitals by districts.

3. Our meeting with Sir Roy Griffiths suggested that we are very close to him on objectives, but that we have a difference of emphasis on the method of achieving them. I think the differences are less than the common ground, and that is encouraging. We agree that a system for distributing money based purely on equalisation of need is not enough, and that efficiency incentives need to be brought to bear.

4. Sir Roy believes this can be done through resource management and budgetting. Success in meeting performance targets would be one element in a more sophisticated system for allocating money from regions to districts and from districts to hospitals. He believes it would be possible to do this within the present RAWP system of allocating money from the department to regions. We

SECRET

argued, however, that, while this might be so longer term, an element of top-slicing at regional and national level was necessary in order to send out loud and clear the signal that efficiency and performance are henceforth to be explicitly rewarded. Otherwise, there would be a danger of letting things slide without real reforms coming through.

5. Sir Roy favours directing the money to where it would be used to best effect. He called it "parameter budgetting" - asking managers how they would allocate the same resources as last year, and what they would do with incremental increases or decreases of 1%, 2%, etc. He ultimately wants resources (including real growth) to be allocated following dialogue between regions and districts, and districts and hospitals, on the basis of such analysis. He was concerned that the apparent emphasis in our paper on performance indicators introduced too mechanistic and over-simple an approach. He held up the existing waiting list initiative as a good example of what he had in mind: the money here had been specifically given to areas where it was clear that spending only a little more money would have a disproportionate effect in improving results.

6. I do not think we would want to disagree with any of this. Getting districts to tie hospitals down to output and performance targets, and linking funding to that, would clearly be most welcome. We think it fits well with our idea of rewarding districts who improve their efficiency and do not therefore accept Sir Roy's misgivings about top-slicing. It would encourage districts to make allocations in the knowledge that if their hospitals improved their efficiency more money would be made available. A financial incentive like this would sharpen up the management system no end. And top-slicing would be a way of making sure the message was clear both to health authorities and to the public.

7. We think a satisfactory outcome to the meeting would be broad agreement on the principle of rewarding efficiency and of doing so in a visible way, with Treasury and DHSS officials (including Sir Roy Griffiths) given a remit to work up a full scheme.

Ann Reeves

pp R B SAUNDERS

NH6/13M

SECRET: C.M.O. UNTIL 27 JUNE 1989

COPY NO. 3 OF 4

Treasury Chambers, Parliament Street, SW1P 3AG
01-270 3000

Geoffrey Podger Esq
PS/Secretary of State for Social Services
Richmond House
LONDON SW1

28 June 1988

Dear Geoffrey,

NHS REVIEW

Your Secretary of State met the Chancellor and Chief Secretary on Friday morning to discuss the papers circulated with your letter of 23 June, and mine of the same date. Also present were Sir Roy Griffiths, Mr Heppell (DHSS), Mr Wilson (Cabinet Office), and Mr Phillips (Treasury).

Tax Relief and Contracting Out

2. The Chancellor said he thought it helpful to take these two papers together. Both addressed the question of how the private sector could be enabled to expand faster. However, the Chancellor said he thought the need for demand boosting measure of this kind was questionable. It had been said, for example, by AMI that there had been considerable recent growth in coverage of private health insurance schemes - more rapid than was suggested by the figures the Group had considered before, which only covered the years up to 1986. This was not surprising, as, for example, the abolition of the NIC Upper Earnings Limit in 1985 created a substantial incentive for employers to offer health insurance rather than cash pay, and the effects of this might well have taken some time to flow through. The Chancellor therefore did not think the case for boosting demand was made out. Rather we should be looking at the cost of private health care, which was being kept high by supply side problems, notably the restrictive practices of consultants and others. If the Government brought about an increase in demand for private sector care, without addressing the supply side issues, costs would rise rapidly with a serious read across to NHS costs.

3. Nonetheless, the Chancellor said he recognised the political attractions of some scheme to boost demand in an area where it had been slow to take off. He was willing to offer tax relief for

insurance premiums paid by the over-60s, and, as he had now indicated, to extend this to benefit-in-kind exemption for the over-60s in company schemes. He had considered the case for providing this relief at the marginal rate, but had come to the view that this extra concession offered little further gain to offset the considerable administrative complications. He was, however, strongly against any further moves to expand demand, including the DHSS contracting out scheme. He accepted the need to do something to tackle waiting times, but he thought the best way of doing this was to work up the top-slicing scheme put forward by the Chief Secretary.

4. Your Secretary of State said that he agreed there was a need to tackle supply side problems, and he was concerned about the effect of any demand boosting measures on costs. He agreed that the proposed tax relief for over-60s was a politically attractive move: he had no strong views on whether it should be at basic or marginal rate, although he was conscious of the parallel with mortgage interest relief. However he remained of the view that simply to offer tax relief for the over-60s would not fufill the remit from the last No 10 meeting. He would not argue that the contracting out scheme was perfect, but it did meet a number of his objectives: it would increase the resources going into private health care, and would bring costs home to the consumer. He would be happy to consider other ideas, and remained very attracted to the idea of benefit-in-kind exemption for those in company schemes: admittedly, this had a deadweight cost, though lower than that of the contracting out option envisaged in his paper. He thought employers' cost-consciousness would bring useful downward pressure to bear on health premiums, and he thought they would not be put off by any compliance costs.

5. Sir Roy Griffiths said that he thought it very likely that the demand for private health insurance had increased markedly recently partly because of fears about the NHS and partly as a result of greater affluence. However, the case for boosting the private sector was that greater competition would bring greater efficiency in the NHS. Introduction of tax relief for the over-60s might have some political and psychological effect, but in practice he doubted whether on its own it would do much to remove the considerable disincentives for the elderly to insure privately.

6. The Chancellor said that if it were demonstrated that private health insurance needed a boost of some kind, he agreed with the Secretary of State that a benefit-in-kind exemption was preferable to the contracting out scheme. The latter had a massive dead weight cost, was potentially very repercussive - particularly in the education field - and had unattractive overtones of a two-tier system. He would therefore not be prepared to support it at all. He proposed that officials should now set about obtaining much more up to date statistics on the coverage of private health insurance schemes. If it then emerged that growth was inadequate, and that

some kind of stimulus was needed, then he would be prepared to look again at the case for action on the PllD limit for health. Your Secretary of State agreed that officials should proceed with this work. However, he reiterated his view that more needed to be done on the demand side and he said that he would therefore continue to argue the merits of his contracting out proposal.

Financing Hospitals

7. The Chief Secretary introduced his paper. It set out a scheme where the real growth in HCHS expenditure - which typically had been around £250 million in recent years - would be allocated via a separate mechanism to reward improvements in efficiency. It left a number of points for discussion. For example, who should judge performance, and how? The Chief Secretary had no definite view on whether this should be done by the Department or by the regions, but he thought the best basis for judging was the Korner performance indicator system, improved as necessary. He also recognised the arguments for rewarding not merely performance, but also activity: there might be a case for a separate allocation, also top-sliced, replacing the present waiting list initiative. The interaction of this financing system and any scheme of self-governing hospitals was complicated, and would need to be deferred until more progress had been made on the latter.

8. Your Secretary of State said he had a number of concerns about the proposed scheme. First, he thought there was a danger of enshrining the notion of automatic real terms increases every year. Secondly, he was worried about how the system might work on the ground: relating extra allocations specifically to efficiency could overlook other factors, such as demographic changes which might also require extra resources. Finally, he was instinctively inclined against a top down method of resource allocation, to be superimposed on the existing RAWP. He thought this was undesirably centrist. He thought that many of the objectives at which this scheme was aimed could be achieved through a gradual move towards self governing hospitals, combined with some form of contracts. This was still the approach he favoured.

9. The Chief Secretary said that, on the first point, he thought it only sensible to accept the reality that there would be continued real increases in the health programme. He accepted that there might be scope for making the performance indicators more sophisticated, but in his view they were certainly an improvement on a simple population formula. He also pointed out that the scheme could be introduced much more quickly than any structure of self governing hospitals, and would not require primary legislation. But it would not be inconsistent with such a scheme, if it were adopted.

10. Sir Roy Griffiths said that he saw advantage in some scheme that would hold back a part of overall resources. But this would have to be done sensitively: there were some areas which might not meet the efficiency improvement criterion, but where problems would be accentuated rather than solved by withholding funds. But he did see advantages in a scheme that would force clinicians and managers to concentrate more on efficiency.

11. Summing up this discussion, the Chancellor said that all seemed to be agreed that the objectives of the scheme were desirable. Further work should concentrate on refining the criteria by which the top slicing allocations would be distributed. In particular, officials should consider who should make the decisions; whether they should take account of demographic changes; and how far they could reward hospitals or areas with an already good record of efficiency.

Self-governing Hospitals

12. Your Secretary of State introduced his paper on self governing hospitals. It set out what was in his view a practical evolutionary way of introducing more devolution into the NHS. The introduction of contracts between hospitals and districts would enforce accountability, and act as a spur to efficiency.

13. The Chancellor said he had reservations about the evolutionary path with its implicit assumption that everyone would move together to the same point. He thought it might be premature to speculate about the eventual outcome, until pilots had been established and assessed. The Chief Secretary added that he saw this as the material for a Green Paper: more work was needed, even before a pilot scheme could be set up. In particular this should address the practicalities of the proposed contract arrangements, and problems associated with the misalignment of accountability and responsibility between GPs and health authorities. The group would also need practical examples of how delegation of decisions on pay and conditions would work. The question of capital expenditure was even more complex, and it was agreed that this should be addressed separately in a paper on its own.

14. Sir Roy Griffiths agreed that a great deal of work remained to be done. Devolution in the NHS could be achieved by one of two routes - either through an increased emphasis on management, or by the contractual route. The latter would require extensive planning if was to work.

15. It was agreed that officials should consider further the terms in which some initiative of this kind could be trailed, as a "green" proposal, in an autumn package. There could then be a number of pilot schemes, of hospitals that were suitable and keen. Endorsement of this strategy would be sought at the next No 10 meeting.

Medical audit

16. There was a very brief discussion of your Secretary of State's paper on medical audit. Your Secretary of State noted that he was now minded to require rather than encourage the medical Colleges to make participation in audit a condition of a units being permitted to train junior doctors. The Chief Secretary enquired about the additional costs mentioned in the paper, and your Secretary of State confirmed that this would represent a bid for extra resources over and above those he had already submitted.

Consultants' Contracts

17. There was agreement that this issue was absolutely crucial to any package that might emerge from the review. It was important to change contracts so that if consultants did not perform to standard, contracts would be ended. There was also a question as to whether contracts should be with hospitals rather than districts: some consultants would prefer this because of the political nature of their districts. The Chancellor gave his initial reactions to the proposals in the DHSS paper. He thought it might make sense to distinguish between the treatment of new contracts for consultants and existing ones. There would be violent objection to attempts to make significant changes to existing contracts, and he wondered whether it was wise to aim for great change, although some might be possible. We could go further on new contracts. He also thought it important to tackle merit awards, perhaps by making them non-pensionable. To the proposals in your Secretary of State's paper, he would add the suggestion that we should do more to encourage part-time NHS consultants. Your Secretary of State raised the question of tactics, and suggested that it might be wise to seek advice from some "trusties" within the profession. The Chief Secretary noted that timing of any action on consultants contracts should be considered against the background of the other proposals in the package. A first dicussion at the next meeting at No 10 was essential. The Chief Secretary said he would like the paper to bring out more clearly both the political difficulties, and the costs of "buying out" consultants, distinguishing between compulsory and optional variants of the new contract proposal. It would also be necessary to have better statistics on the coverage of merit awards.

18. I am sending a copy of this letter to Jill Rutter in the Chief Secretary's Office.

Yours

Moira.

MOIRA WALLACE

ps.mr/week.27.6/mr.2

Dan file.

SECRET

FROM: H PHILLIPS
DATE: 28 June 1988

CHANCELLOR

cc Chief Secretary
Financial Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Culpin
Miss Denison
Mr Turnbull
Mr Parsonage
Mr Saunders
Mr Griffiths
Mr Call
Mr Lewis)
Mr Kuczys) IR

H Phillips → CHEX 28/6

NHS REVIEW: SUPPLY AND DEMAND AND THE PRIME MINISTER'S NEXT MEETING

Supply and Demand

A has further revised — in separate action folder.

1. Attached is a revised draft of your proposed minute to the Prime Minister on supply and demand in health. We have attempted to capture the current growth in the private sector, and the supply constraint it faces in paragraph 14 onwards.

immediately behind

2. I have sent you separately a note from Mr Satchwell about the growth of private medical insurance. The figures, from DHSS, run up to the end of last year. For this year so far, and for the forward look, I can confirm what I reported to you from AMI. (I have spoken again to their finance director who is reporting what the health insurance industry tell him.) BUPA tell him they are planning on the basis of a doubling in the number of subscribers over the next two years. PPP report that their subscriptions grew by 20% in the first few months of this year, which was the whole of their earlier planned growth expectations for the two years 1988 and 1989. AMI, as a private provider of healthcare, do not

see how they can cope with a consequent increase in take-up of actual services as opposed to insurance, without substantial price increases, unless action is taken to tackle supply side constraints.

Tax Relief and Contracting Out

3. All this information is good news in support of your approach on tax relief. The bad news is that Mr Moore has decided to put in his paper on contracting out, rejecting advice to the contrary, on the grounds that if you were going to put in your tax paper he would put in his. The only purpose in this must be an attempt to bid up what you are prepared to offer on benefits in kind in the hope that the Prime Minister will support him.

Financing Hospitals

4. Mr Saunders has revised, and resubmitted to the Chief Secretary his paper on top-slicing following the meeting he and I had today with Sir Roy Griffiths. If we can get a conclusion from the Prime Minister's meeting which endorses the objectives and principles of the scheme, then we can do useful work with DHSS on the mechanics, criteria and timetable. What we have to watch is that the clarity and sharpness of directing growth money in the way we propose is not clouded and blunted by DHSS concern to adapt our proposal to what they are already doing, rather than the other way round.

Self-Governing Hospitals

5. Mr Moore's paper has a revised covering note which reflects the impact of your meeting on Friday. Although it says that the proposals do not resurrect the idea of buyers and providers, and that GP's can be fitted in to the scheme, we remain sceptical about these points. What is more welcome are the indications that

a) hospitals would be selected for independent status - which means they ought to meet conditions about budgetary

discipline, involvement of consultants in management, efficiency targets, in order to attain it;

b) contracts in this context would be about financing such hospitals in relation to performance (something more of the flavour of "Next Steps" agencies than contracts in the ordinary sense of the term);

c) such hospitals would be pilots rather than the planned way ahead for all; and that

d) all this will take time ie is probably a matter for Green rather than White Papers.

If the discussion can be built towards this formulation, and the objectives and principles of the Chief Secretary's paper are accepted, some progress might be made.

6. But we shall still need to be much clearer about, and find acceptable, the advantages of self-governing status. These will undoubtedly include requests for greater flexibilities in relation to capital and current expenditure, and in particular the chance to operate at full or increased capacity if income can be raised to cover costs from the private sector or other parts of the NHS. More detailed work is needed here.

[The paper still, regrettably, has much to say about capital — on which we agreed at Quadrilateral best left to separate paper]

Consultants Contracts

7. The paper is little changed from that you saw last week. Its two main changes are that

(para 13)

a) it leans towards not touching existing distinction awards; and

b) confirms that the £50 million PES marker bid included nothing for short term contracts. (It indicates a cost of £7 million a year for putting newly appointed consultants only on such contracts, up to £108 million a year for buying out all those below the age of 55).

8. I am not sure the paper is yet doing enough to open up the supply side: there are no references to the development of junior and senior consultant posts, nor to promoting greater part-time consultant work.

9. But the paper provides a good basis for a first discussion of what might be done and of how much political argument with the medical establishment and financial cost will be necessary or tolerable to achieve sufficient change.

Medical Audit

10. As you know we are not opposed to this paper but we cannot sign up to it until the cost of introduction is quantified and acceptable.

HP.

H PHILLIPS

DNP.

CONFIDENTIAL

FROM: D P GRIFFITHS
DATE: 28 JUNE 1988

CHIEF SECRETARY

cc Chancellor
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Saunders
Mr Parsonage
Mr Sussex
Mr Satchwell
Mr Call

NHS REVIEW: GLOSSARY OF TERMS

There are a number of terms which frequently come up in the course of the Review but whose precise meaning is not immediately obvious. The attached glossary may therefore be helpful. I should point out, however, that for some terms there may not be universal agreement on their exact meaning. "Internal Market" is a case in point.

2. The glossary is not intended to provide a comprehensive list of all the terms which might come up but can be expanded as necessary.

D P GRIFFITHS

GLOSSARY OF TERMS

Acute Sector

All hospital activity except accident and emergency, psychiatric/ mental illness, geriatric and maternity services. Its coverage is therefore far wider than treatment of life-threatening diseases, and it accounts for 46% of HCHS Current expenditure.

Capital And Asset Accounting Initiative

An experiment in changing the approach to managing capital assets in the NHS. Pilot schemes in 3 Regions seek to redefine NHS capital expenditure in line with private sector understanding; compile asset registers; introduce asset accounting incorporating values of assets in Balance Sheets; and introduce accounting charges for the use of capital assets. The objective is to make NHS managers aware of the full cost of the resources they are using and get away from the treatment of capital assets as a "free good". Evaluation of the pilot schemes is scheduled for completion by Spring 1989.

Clinical and Non-Clinical services

Clinical services include surgery, anaesthetics, medical investigations and treatment plus support services such as pathology (analysis of samples), radiography (X-rays etc) and radiology (radiotherapy). Non-clinical services are the hotel services - portering, cleaning, cooking. There are also paramedical services such as occupational therapy, physiotherapy etc.

Cost Improvement Programmes

These are measures such as the use of competitive tendering which

result in services being performed more cost effectively, thereby releasing resources which can be used elsewhere. Targets are set for each financial year.

Diagnostic Related Groupings

A system for classifying medical conditions into categories according to the treatment they require. The DRGs can thus used as the basis for charges for treatment.

Elective Surgery

Also known as cold surgery. All non-emergency surgery. There are usually waiting lists for this type of surgery.

Growth Money

The funds available for volume increases in services. (Cost improvement savings and monies raised by income generation schemes etc are taken into account in the calculation.)

Income Generation Programmes

Schemes undertaken by health authorities or individual units to generate additional funds through commercial activities. These can include charges for car parking, leasing of space in hospitals to shops, use of laundering/catering facilities to provide a service to third parties etc. The programmes are co-ordinated by a new income generation unit within DHSS. Revenues are separately identified in health authority accounts.

Internal Market

Hospitals and health authorities trading with each other and with the private sector and receiving direct remuneration for the activity they carry out. There are many variations possible around this central principle.

Korner Data/ Korner Indicators / Performance Indicator Package

Health services activity, financial and other information collected by District Health Authorities as an aid to district management, based on recommendations by a group chaired by Mrs Edith Korner. Forms the basis for the development and calculation of a Performance Indicator Package (or Korner indicators). Centrally compiled DHSS Performance Indicator Package as a result extended from 400 indicators to around 1400. Broken down by areas of activity and by clinical speciality they cover matters such as:

- how many people are receiving hospital care
- how long people have to wait for treatment
- what it costs to treat patients
- length of stay in hospital
- how long beds lie empty while waiting for new patients
- doctors and nurses per in-patient case or per bed
- neonatal mortality rate
- how quickly are emergency calls answered by ambulance services.

The package not only indicates a District's performance in absolute terms but also in comparison with other Districts and the national average.

Medical Audit

This is also called peer review. It involves an analysis of medical activity in terms of process (how patients are treated), outcome (what happens to them), and the use of resources. Quality of care, clinical efficiency and productivity, and patient satisfaction are all covered. There is some potential overlap with value for money audit of whether resources are being used efficiently. However, it is necessary to have a proper understanding of medical practice and therefore much of the activity in medical audit is undertaken by colleagues in the same speciality.

RAWP

Resource Allocation Working Party. This devised a formula for measuring the distribution of HCHS resources required to equalise provision across the country. The intention is that each English Region should have the same ratio of services to need. There is a target level of resources for each Region and resources are being redistributed over time to bring Regions up (or down) to target. In practice this means switching resources away from areas such as London which have historically been over-provided with hospitals to Regions such as East Anglia, Oxford, Trent, Wessex and the South West.

Resource Management Initiative (RMI)

A project which seeks to organise and manage hospital resources by increasing the involvement of all types of clinical staff in its management. It will provide them with accurate and useful information about their clinical practice and its costs compared with plans and past experience and also with colleagues in the same hospital, district or region. Information is collected from all major systems in the hospital and held on a computer data base. Patient activity will be linked to the costs of running services so that clinicians will have computerised patient records and will know the comparative costs of the treatments they are prescribing. Resource Management will enable the operation of clinical and support department budgeting and budgetary control. Pilot schemes are presently being run at 6 acute hospital sites and 13 community service sites. Dependent on the outcome of the evaluation and review of the pilots (to be completed by the Autumn of 1989), it is planned to install resource management systems at 160 districts by early 1992 and the balance of 31 districts soon after.

Top-slicing

Most of the HCHS current expenditure budget is distributed to Regional Health Authorities but some is held back by DHSS for

allocation for specific purposes eg the waiting list initiative, money for teaching hospitals in recognition of their additional costs.

Units

Combinations of individual hospitals (not necessarily all of the same type) which have been grouped together into one management unit. (Some hospitals are big enough to count as units on their own.) In England there are some 600 units and 2000 major hospitals in the 191 District Health Authorities, which in turn come under 14 Regional Health Authorities.

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CONFIDENTIAL

This is for use if the PM mentions Lord Trafford's paper. His new main proposal is to remove existing controls on capital expenditure and on the appraisal of capital projects. This causes great difficulty for us, of course, but I do not recommend allowing a discussion of that question to develop.

28/6

FROM: R C M SATCHWELL
DATE: 28 June 1988

1. MR SAUNDERS
2. CHANCELLOR

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Sussex
Mr Wellard
Mr Tyrie
Mr Call

NHS REVIEW MEETING 30 JUNE: PAPER BY LORD TRAFFORD'S GROUP

This paper may be mentioned at the Prime Minister's meeting on Thursday.

2. We gave you preliminary advice on the paper in my note attached to Mr Phillips' minute of 15 June. If asked for your views, you might take the following line.

repeatedly weeded out - behind - but got in root - Toronto boxes

- Welcome contribution to the debate, which addresses most of the key issues.

- Contains some good ideas, particularly:

  recognition that simply putting in more money is not the answer

  greater emphasis on cost transparency

  obligatory medical audit

  the introduction of clinical budgets and a better integration of clinicians into the management process

525/6

extension of competitive tendering to clinical areas

revised consultant contracts

the merging of FPCs and DHAs to provide a complete health care service for the resident population.

- But leaves unresolved a number of difficult problems:

although the paper's proposals would reduce bureaucracy in some areas, they would add to them in others (eg the proposed new "Health Inspectorate")

the proposals do nothing to encourage the growth of private sector provision.

if money follows the patient in an internal market to the "best" (ie in practice most expensive) hospitals, how do districts keep control of costs without restricting GP's freedom over referrals?

how do you sell to GPs the concept of GP unemployment?

the package might reduce, rather than increase customer choice

- And is silent on other issues.

pay

the system of allocating funds to individual DHAs.

R. Satchwell.

R C M SATCHWELL

st2.151

CONFIDENTIAL
COMMERCIAL IN CONFIDENCE

FROM: R C M SATCHWELL
DATE: 28 June 1988

1. MR PHILLIPS
2. CHANCELLOR

This is useful as far as it goes. There is certainly no point in further boosting company schemes.

HP.
28/6.

cc Chief Secretary
Financial Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Culpin
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Saunders
Mr Griffiths
Mr Sussex
Mr Call
Mr Kuczys) IR
Mr Walker)

PRIVATE MEDICAL INSURANCE

NHS REVIEW: PRIVATE MEDICAL INSURANCE

1. Following your meeting with Mr Moore last Friday, we have got hold of some more up-to-date statistics on the market for private medical insurance.

2. The attached figures were given to us by DHSS who in turn received some of them in confidence from the companies concerned. They show quite clearly that:

a. between 1984 and 1986, the overall market grew steadily, even after allowing for the fact that 1985 was a disastrous year for one of the non-provident (ie profit-making) companies

b. at least for BUPA and PPP combined (which account for some 80% of the market), that growth continued into 1987; though within the total, PPP managed to increase its business substantially, partly by eating into BUPA's market share.

c. within the steady growth increase of recent years, there has been a sharp rise in company-based schemes, which have more than offset the relative decline of individual and employee policies (though PPP has managed to increase its

business in the personal sector, again partly at the expense of BUPA).

This scenario is borne out by anecdotal evidence elsewhere, notably in the Orros report commissioned by NAHA, which you have seen.

3. Overall, this reinforces the case against tax measures to stimulate the demand for company schemes, since they are already expanding quite rapidly. Indeed, the figures from PPP and BUPA suggest that the total market for company schemes is now of the order of 1.3 to 1.4 million subscribers. This is substantially bigger than the figure of roughly 1 million subscribers which we have been using up until now, and which underpinned the Inland Revenue costings in the recent paper on tax relief. So the deadweight cost of introducing any relief for company schemes would be correspondingly greater.

R. Satchwell.

R C M SATCHWELL

new figs
m'tony
Knays' aide memoire.

PRIVATE HEALTH INSURANCE MARKET

	1984	1985	1986	1987
Subscribers (at year end, 000)				
BUPA	1,394	1,436	1,428	1,423
PPP	448	472	513	577
Other Provident	228	254	291	
Non-Provident*	206	164	217	
	2,276	2,326	2,449	
Growth rate (%)				
Provident		4.4 %	3.2 %	3.0 %**
Non-Provident		- 20.4 %	32.3 %	
Total		2.2 %	5.3 %	
People covered (at year end, 000)				
BUPA	3,052	3,145	3,099	3,100
PPP	947	978	1,052	1,286
Other Provident	516	563	655	
Non-Provident*	439	349	445	
	4,954	5,035	5,251	
Growth rate (%)				
Provident		3.8 %	2.6 %	5.7 %**
Non-provident		- 20.5 %	27.5 %	
Total		1.6 %	4.3 %	
Gross Premia Paid (£m)				
BUPA	277	308	365	
PPP	109	130	151	
Other Provident	38	45	61	
Non-Provident	25	31	37	
	449	514	614	
Growth rate (%)		14.5 %	19.4 %	

* Drop in 1985 caused by a 60% loss of business at one (unknown) company

** BUPA and PPP only

st2.153

GROWTH IN BUPA AND PPP BUSINESS 1982-87

BUPA	Individual (000)	%	Employee* (000)	%	Company (000)	%
1982	371		301		692	
1983	363	- 2.2	286	- 5.0	690	- 0.3
1984	359	- 1.1	293	+ 2.4	742	+ 7.5
1985	357	- 0.6	281	- 4.1	780	+ 5.1
1986	353	- 1.1	262	- 6.8	793	+ 1.7
1987	355	+ 0.6	257	- 1.9	811	+ 2.3
1982-87 Overall		- 4.3		- 14.6		+ 17.2
PPP						
1982	147		77		169	
1983	160	8.4	83	+ 7.9	199	17.9
1984	168	5.4	78	- 6.0	202	1.9
1985	176	4.6	77	- 1.4	220	8.7
1986	188	6.9	79	+ 2.7	246	12.0
1987	204	8.7	75	- 4.6	298	20.8
1982-87 Overall		38.8		- 2.6		76.3

Combined	Individual and Employee (000s)	Company (000s)
1982	896	861
1987	892	1109
% increase	- 0.4	28.8

* Negotiated by an employer on behalf of its employees, but paid by the employee out of taxed wages.

Ch/don't know
Have copy got to FST - but interesting

CHRISTOPHER GILL MP

HOUSE OF COMMONS
LONDON SW1A 0AA

For information:
cc: PPS, PS/CST,
Sir P. Middleton,
Mr Anson, Mr Phillips,
Sir T. Burns, Mr Culpin,
Mr Saunders,
Mr Kuczys IR,
Mr Walker IR,

M.

Rt Hon John Moore MP
Department of Health and Social Security
Richmond House
79 Whitehall,
London SW1A 2NS

28 June 1988

Health Insurance Tax Relief

There is speculation that the Government might introduce Tax Reliefs for (Private) Health Care.

Whilst at one time attracted to this idea I am now totally opposed for the following reasons:-

1. As with so many other existing or former reliefs, Government, whilst entering into this field with the best of intentions, would eventually find the burden of cost intolerable (e.g. Mortgage Interest Relief currently running at 5 Billion per annum).

2. There is ample evidence that without any artifical inducement the incidence of Private Health Care Insurance will continue to rise (particularly as individual affluence increases).

3. Development of Private Health Care will be on a much sounder long term footing if it results from the decision of individual citizens rather than Government stimulus.

4. Tax Relief would necessarily benefit most those on higher incomes (i.e. the least needy).

5. Tax Relief on existing policies would achieve nothing but inevitably cost the Exchequer dearly.

6. Any Relief would act against the overall thrust of Government fiscal policy to bring tax rates down.

7. There is ample evidence that individuals have a better record of establishing priorities (and obtaining value for money) than Governments. Tax Reliefs distort this process.

8. Another new Tax Relief opens the floodgates to pleas for other worthy causes (e.g. Education). The Ultimate aim should be the total elimination of all Tax Reliefs.

9. It is not the role of Government to arbitrarily decide which trade, profession or industry should be incentivised but rather to create the environment in which all can prosper equally.

10. Tax Relief for Private Health Care provision almost certainly would be construed as evidence of political interest to create a two tier system of Health Care.

11. The NHS will struggle to compete on the present basis without giving unfair advantage to its rivals.

I can see no good reason for creating yet another tax relief at a time when considerable progress has been made towards simplifying the Tax system. Such an innovation would be totally contrary to the philosophy of allowing market forces to operate freely in a competitive economy.

Yours sincerely,

SOMMET·TORONTO·SUMMIT

OK & use your version as James suggested ✓

* Grateful if you could let us know asap if you want to send round, so we can warn other offices eh!

m.

Ch/

Revised draft from Mike Parsonage under his minute behind. Bout still a bit bland + overlong. Version directly behind is amalgam of Robert, Alex + my comments. If you think this OK, we can still send off tonight*. But otherwise circulating tomorrow pick going to irritate everyone and might be better to

(i) read points onto record tomorrow at meeting?

or (ii) send in more considered version before next mtg.

psl/55A

SECRET

28/6/88

DRAFT MINUTE TO THE PRIME MINISTER

NHS REVIEW: SUPPLY AND DEMAND

In the work we are doing on the review, it is vital that we do not lose sight of some of the basic features of the economics of health care.

Put simply, the demand for health care exceeds the supply. In the public sector, that is inevitable: with a "free" service financed out of general taxation, demand will always be virtually unlimited. Our objective for the public sector must be to provide health care as efficiently and effectively as possible, and we get the best possible output for the money we put in.

In the private sector, there is a price mechanism. But prices are too high, because of inefficiencies in supply and restrictive practices by the medical profession - for example, the rule that all operations must be carried out by consultants. Our objective for the private sector must be to improve the supply performance and hence bring down prices and encourage growth.

Some of the measures we are considering, in particular on the tax side, would add to demand. But if we simply boost demand without improving supply, the inevitable result will be higher prices and little real growth in private health care. No one will thank us for that, except the professionals whose pay will go up.

So the priority must be the supply side. This is exactly the prescription we have successfully followed in many other areas of policy. There is no reason why health should be any different. Indeed, if anything the case for supply side reforms is even stronger.

In the NHS, prices and charges play a negligible role, particularly in the hospital service. Indeed, charges now raise only 3½ per cent of the costs of the NHS, compared with 5 per cent in the 1950s. So patients (and their doctors too) will always tend to press for high-cost options.

Doctors have no incentive to be cost-conscious. Budgeting and information systems in the NHS are ill-designed. Those who commit resources are not financially accountable nor are they given adequate information on the costs of what they are doing. Doctors everywhere cling to the outmoded belief that they should not be involved in the management of resources.

It is not surprising that this produces a chronic tendency to stimulate demand which cannot be satisfied. We re looking at ways in which we can improve efficiency in the NHS and enable it to meet more of the demands on it. But we shall also be looking to an expanding private sector to meet more of this demand.

This is already happening. Since we last discussed this ~~our~~ my officials have obtained more up to date statistics. The ~~results are~~ evidence is striking. For example, ~~PPP~~ Private Patients Plan (PPP) report that their subscriptions grew by 20% in the first few months of this year, which was the whole of their earlier planned growth expectation for the two years 1988 and 1989. BUPA say that they are planning on the basis of a doubling in the number of subscriptions over the next two years.

It is clear that, in the private sector, shortage of demand is not the problem. The companies themselves recognise that they are fully stretched. In these circumstances, boosting demand further without doing anything to improve supply will simply raise prices. Pay rates will go up, and this will inevitably read across to staff costs in the NHS.

This is the last thing we want. We must concentrate not on boosting the demand but on making sure that the private health sector can respond. At the moment it, too, suffers from restrictive practices and other

inefficiencies: too much work, for example, is done at too senior a level, particularly by consultants. And many of the problems of a lack of cost-consciousness also apply in the private sector too. There is, also, a clear limit to how fast the private sector can expand without bidding scarce staff away from the public sector. Recruiting and training new staff will inevitably take time.

In putting together a credible and coherent package of reforms, what we must do is work carefully through the supply and demand consequences. There is no need to underline the crucial importance of getting this right.

I am copying this minute to John Moore, John Major, Tony Newton, Sir Roy Griffiths and Sir Robin Butler.

[N.L.]

28 June 1988

Treasury Chambers, Parliament Street, SW1P 3AG
01-270 3000

MP
28/6/88

Ch/ Lots of paper, but much of it you have seen before. And an exemplary brief from HP, fortunately. Some points to note:

(i) A confession. I did a bit of last-minute surgery on your tax relief paper before circulating, which I hope you will retrospectively authorise. At the end of one para (below) there were a couple of extra sentences on why the self-employed deserved tax relief so very much. It looked to me as if that might set another hare running – à la workplace nurseries – which we could do without. Robert had the same thought & Hayden agreed, so we took it out (you were stuck in the House & the paper had to go to DHSS). If I have erred, I resign (again).

(ii) Tony Kuczys was anxious that you shd be reminded that benefit-in-kind exemption for over-60s would of course, effectively be at marginal rate even if rest of relief kept to basic rate. Robert thought you should ask who is over 60 and paying higher rate tax and doesn't already have insurance?

(iii) Hayden will be letting you have aide memoire on Trafford paper should you wish to discuss with PM at next wk's bilateral & Tony K will do one on tax relief.

(iv) No need to re-read DHSS contracting out paper. It is exactly same as draft Dich showed us few wks ago.

MPW

limit at £20,000. It would not be easy to justify the difference in treatment between two employees receiving medical insurance from the same company where one is just above and the other just below that arbitrary dividing line. But what would be virtually impossible to justify would be the difference in treatment between two people on the same income, where one gets company provided insurance with tax exemption and the other pays for his own insurance. That is, we would be calculating the tax of the employee who earns £20,000 and pays £500 of premiums privately on £20,000, while the man next door who earns £19,500 and gets his premium of £500 paid by his employer would pay tax on only £19,500.

Will this be seen as invitation to go further - be more radical"?

~~Exactly~~ the same ~~question would arise in relation to~~ the self-employed. They particularly would regard a benefits exemption as unfair since there is no possibility of a self-employed person getting his employer to pay his insurance. And arguably the self-employed, who cannot expect sick pay from an employer, have a greater need to be insured against ill-health.

Need a cover-all clause that makes all these phrases unnecessary

14. This is the fundamental objection to a benefits-in-kind exemption - and why I continue to believe we should rule it out, either in its general or this more limited form.

Benefits-in-kind and Relief for the Elderly

15. But if we decide to introduce a new tax relief for premiums paid for the over 60's, then ~~that relief should also run~~ for the benefits-in-kind charge on corresponding premiums. The argument is exactly the same in relation to the over 60's as it is for employees and the self-

mjd 3/183m

SECRET

cc- CST, FST, Sir P Middleton
Sir T Burns, Mr Anson
Mr Phillips, Miss Peirson
Mr Turnbull, Mr Culpin
Mr Saunders, Mr Prescott

OUR TAX RELIEF PAPER

Treasury Chambers, Parliament Street, SW1P 3AG
01-270 3000 Mr Gray PS/12

28 June 1988

Paul Gray, Esq
Private Secretary
No.10 Downing Street
London SW1

Dear Paul,

NHS REVIEW

I enclose the Chancellor's paper on tax relief for discussion at Thursday's meeting of the Review. The Treasury's other paper - on financing hospitals - will be circulated separately, later today.

I am copying this letter and the enclosure to Sir Roy Griffiths, Geoffrey Podger, Jenny Harper (DHSS), and Richard Wilson (Cabinet Office).

Yours, Moira.

MOIRA WALLACE
Private Secretary

NHS REVIEW: TAX RELIEF

Paper by the Chancellor of the Exchequer

1. At the meeting on 7 June we agreed that:-

   a. the question of restricting tax relief for the elderly to the basic rate should be looked at again; and

   b. a more limited benefits-in-kind exemption, targeted on those with earnings below a specified level, should be considered.

This paper reports on both points.

Tax Relief for the Elderly

2. Providing tax relief for private medical insurance for the over-60s at basic rate only would benefit 300,000 existing policyholders at a deadweight cost to the Exchequer of about £25 million. Allowing relief at the higher rate, as well, would be of additional benefit to about one-quarter of this group - 75,000 policyholders. The Exchequer cost would rise to a little over £30 million. There would also be some additional administrative complication. That is because, while basic rate relief would be provided at source through a MIRAS-type arrangement, higher rate relief would have to be dealt with by tax offices, through individuals' PAYE codes or tax assessments.

The question is whether these additional costs are likely to be worthwhile.

3. Clearly, in principle, the higher the rate of tax relief, the greater will be the effect on behaviour of those who benefit: a 40 per cent relief is likely to bring in more new subscribers than a 25 per cent relief. But a 50 per cent increase in take-up would be needed before the extra money going into private health care exceeded the cost of tax relief, compared with an increase of 33 per cent if relief were given at basic rate only. Only those over-60s with incomes comfortably over £20,000 would benefit from this further concession: those with income below that level would gain nothing at all from higher rate relief. So, on the one hand, the additional impact of higher rate relief would be strictly limited; while, on the other, it will give further ammunition to opponents of the scheme.

4. There is a further complication with giving higher rate relief. In my previous paper I pointed out that it might be attractive to let tax relief flow to whoever paid the premiums for a person over 60, so there would be encouragement for people of working age to pay their elderly parents' BUPA subscriptions, and this was generally welcomed. But if higher rate relief were available in such a case, it could provide a strong incentive to dress up payments by the parent as payments by the son or daughter - regardless of the true position - thus adding to the cost of the relief. In order to guard against this abuse, some additional irritating safeguards would be unavoidable.

5. In conclusion, tax relief for the elderly at the higher rate would increase the complications of the scheme, and provoke unnecessary criticism. The closest precedent for health insurance premium relief, life assurance premium relief, was (and, for pre-1984

policies, still is) given at half the basic rate, for basic rate taxpayers and higher rate taxpayers alike.

Benefit in Kind Treatment

6. For company health insurance schemes, the suggestion was to raise the limit below which employees escape tax liability on this particular benefit in kind. Since company schemes at the moment are concentrated among the higher paid, this would have the advantage of reducing the deadweight cost and targetting the incentive where it is most needed.

7. I have therefore considered the possibility of raising the limit from its present £8,500 to something in the region of £20,000 - roughly the point at which higher rate income tax liability starts. It would mean that the proportion of employees who would be exempt from tax on medical insurance would go up from 17 per cent to 65 per cent at a deadweight cost of some £m25.

8. But while this approach has its attractions, it also has some further disadvantages to add to those relating to a general benefits-in-kind exemption which I described in my minute of 3 June.

9. First, having a second income limit would be a significant added complication for employers, increasing their administrative costs. The Revenue, in conjunction with the Deregulation Unit, is currently engaged in finding ways of minimising the compliance costs of taxing benefits-in-kind: this would be a move in the opposite direction.

10. Second, it would increase the pressure to raise the £8,500 P11D limit across the board. Our consistent

policy has been gradually to bring the tax treatment of payment in kind and cash into line by allowing the real value of the P11D limit to fall. The limit has not been increased since 1979. It is now widely recognised that it is anomalous to have any income limit in taxing benefits, and that it is right to let the present limit wither away. We are well on the way to success with this policy, since there are now relatively few full-time employees with cash pay plus benefits of less than £8,500. But there also continues to be pressure, as we have seen again in this year's Finance Bill debates, to increase the limit substantially. Setting a new limit for medical insurance - one of the commoner benefits-in-kind-would clearly add to this pressure, and make it more difficult to resist.

11. Third, it would add to the sense of unfairness already felt by those whose employers do not run a company health insurance scheme, or who are self-employed.

Benefits-in-kind and Relief for the Elderly

12. But if we decide to introduce a new tax relief for premiums paid for the over 60's, then we could, I believe, provide a parallel relief for the benefits-in-kind charge on corresponding premiums. The argument is exactly the same in relation to the over 60's as it is for employees and the self-employed generally - we should ensure that there is no difference in tax treatment between those who pay their premiums privately, and those who get them paid by their employers.

13. Including benefits-in-kind in the relief for the over 60s, and confining relief to the basic rate, would

increase the cost, at current levels of provision, to £35 million and would benefit 65,000 employees as well as 300,000 individual policyholders. This is the most far-reaching tax package I would be prepared to recommend.

SECRET

Treasury Chambers, Parliament Street, SW1P 3AG
01-270 3000

28 June 1988

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

cc: CST
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Ms Peirson
Mr Turnbull
Mr Saunders
Mr Parsonage
Mr Call

Dear Paul,

NHS REVIEW

... I now enclose the second of the two Treasury papers for Thursday's meeting - a note by the Chief Secretary on financing hospitals.

I am copying this letter and the enclosure to Sir Roy Griffiths, Geoffrey Podger and Jenny Harper (DHSS), and Richard Wilson (Cabinet Office)

Yours,
Moira.

MOIRA WALLACE
Private Secretary

NHS REVIEW: FINANCING HOSPITALS

Note by the Chief Secretary, Treasury

At our meeting on 24 May, I offered to prepare a note about how the system of allocating resources to health authorities could be improved to reward hospitals which attracted more patients by greater efficiency. This I attach.

2. The scheme involves "top-slicing" some of the total budget for hospital expenditure and distributing it to districts according to their success in improving their efficiency. A further allocation might be made on the basis of activity in those areas where waiting times are longest, if attractions were seen in replacing the present waiting list initiative with a more systematic arrangement.

3. These allocations would be built into baselines for future years. There would continue to be scope for regions to adjust the baselines on account of population changes and in order to target improved services. Similarly, districts would be free to allocate funds to hospitals according to local management priorities, which might involve building up some services or spending money to remove obstacles to improving efficiency in particular areas.

4. On the specific points raised in the paper, my views are as follows:

a. While it may make sense, initially at least, to build on the present performance indicator system, it is by no means ideal for this purpose and we must set work in hand to devise

a clear and open method for introducing the right incentives while commanding reasonable confidence among health authorities.

b. I have no strong views on whether the allocations should be made by regions or by the DHSS, and would welcome the views of colleagues on this.

c. When we have reached conclusions on the Secretary of State's paper on self-governing hospitals, we can consider how to adapt this system for them. But this should not present overriding difficulties.

5. I think a scheme of this nature has a number of attractions. Further work is needed on how it would work in practice, but it should be possible to secure three desirable objectives:

- providing real incentives for health authorities to improve their efficiency

- directing resources towards those areas where efficiency was being given priority; and

- thereby allowing money to flow to those who improved their capacity to treat patients.

SECRET

FINANCING HOSPITALS

Note by the Treasury

This paper examines the scope for rewarding the best performing parts of the NHS through a "top-sliced" element of the health budget. It is intended to tackle quickly the problems that exist now. It does not necessitate structural change in the NHS and involves only relatively modest change at first. But it could be adapted readily to an evolving NHS structure.

The problem

2. The present resource allocation system is based on need. Money is distributed to regions on the basis of the relative priorities revealed by the RAWP formula, and then from regions to districts. The criteria applied by regions in allocating funds to districts vary, and by no means all follow RAWP-style methods. But in general the system takes no account of efficiency or performance.

3. In theory, the main incentive to improve efficiency is that it enables a hospital to provide a greater volume of services within a fixed budget. But in practice this turns out to be only partially true, because treating extra patients of itself generates increased costs. In general, if throughput is improved so that more patients can be treated within existing capacity at existing staffing levels, unit costs do not fall commensurately, so that the improved treatment rates cannot be achieved without increased funding. So the incentives to improve efficiency are not as great as they could be.

Top-slicing

4. In outline, the system would be quite simple. Most current expenditure would be allocated as now: distributions to regions in the previous December; allocations by regions to districts completed by late February. The amount allocated in this way might be based on the total of health authority budgets the previous year, leaving the balance to be allocated on the basis of performance. Typically, after allowing for increased costs, including pay awards to doctors and nurses, this has left room for real growth of around 2%, or £250m.

5. This would be in February, so that hospitals would go into the year in full knowledge of their budgets. The total available for distribution would have been determined in the previous public expenditure survey. If, for the sake of argument, it was 2% of the total, the extra performance-based allocations might vary between 0 and 5% of initial allocations. The distribution within the total sum available for these allocations could be settled only when the overall performance of all health authorities had been assessed.

6. The interaction between the system and that for allocating resources generally would be complex, but it should be possible to ensure that rewards were carried forward into baselines for future years, and were not lost at the end of the year. Initial allocations to regions would be based on the previous year's total allocation (including performance awards). If there were to be further movement to RAWP targets, allowance would have to be made: either (and this would be controversial in RAWP-losing regions) by adjusting these allocations up or down; or by using some of the growth money for RAWP adjustment rather than rewarding performance. Regions would be asked, in their allocations to districts, to take full account of previous performance awards, alongside the other criteria they apply. So a district's allocation should reflect the carrying forward of previous awards, possibly with some adjustment for other factors.

7. A number of questions need however to be addressed:

- to whom would the performance-based allocations be made: hospitals or districts?

- how would their performance be measured?

- would the objective be to reward activity or efficiency?

- would performance be measured against some external standard, or would the criterion be improvement in measured performance?

District or hospital?

8. Allocations direct to hospitals, or even to departments within hospitals, would provide the most direct incentives to improve efficiency. Money would be diverted to the best performing parts of the health service in a very direct way. But it could be difficult for DHSS to interpret sensibly information coming forward from individual hospitals. Moreover, such information is not yet available in the required detail.

9. Giving the money to districts would enable them to allocate it both in accordance with local priorities and so as further to improve efficiency, in the knowledge that this could be expected to result in further financial rewards. Districts should be asked to link allocations to hospitals to performance and efficiency targets. This would be a first step towards a management system in which funding is tied more closely than now to performance and to meeting activity and efficiency targets.

10. Whether allocations to districts should be made by regions or by the department is a matter for judgement. Regions would have considerable scope to undermine the effect of the performance-based allocations by offsets in their disbursements to districts. On the one hand, it could be argued that separating the two processes by the department making the performance-based allocations would minimise the scope for this. On the other, it could be argued that the commitment of the regions to the new system would be best secured by giving them responsibility for allocating the money. Ministers are invited to consider the balance of argument between giving the function to regions or the department.

How to measure performance?

11. Officials will need to do more work urgently on ways of measuring performance. An obvious starting point would be the Korner information system, introduced from 1 April 1987. But the performance indicators produced by this system are primarily intended to be aids to local management rather than objective measures of performance, and it might be necessary to find a way of supplementing them.

Activity or efficiency?

12. This depends on the area being considered. Where waiting times are excessive, increasing activity levels - and maintaining the increase - is the only way to get them down. But increased activity is not a good measure of performance in other areas - for example, psychiatry.

13. This suggests a two-pronged approach. In order to introduce the right incentives and to deal with the problems identified in paragraph 2 above, the general criterion for distributing the top-sliced money should be efficiency. But the concept could be imported into the present efforts to tackle excessive waiting times for routine procedures. A separate top-sliced allocation, replacing the present waiting list initiative, could be distributed to those who had done most to increase activity in certain defined areas, thus reducing waiting times, in order to encourage them to go further, if necessary taking patients from waiting lists in other nearby districts.

Absolute performance or improvement in performance?

14. Any attempt to devise a "standard" performance measure would be very complicated. The formula would have to take account of the size and distribution of hospitals within the district, the range of specialties covered, the characteristics of the local population. It might also have to cover factors like how many sites hospitals are spread over, and their layouts, which affect efficiency but are beyond the control of the local management. No matter how sophisticated the formula, many would continue to argue that they were subject to special factors which were not given their due weight.

15. Such problems would be avoided by measuring performance over the most recent 12 months and comparing it with the previous period. It would be much more difficult to argue that there were special factors which inhibited improvement in performance, as opposed to the absolute level of that performance. Rewards based on improved performance would also offer more immediate incentives to management. Those who started well down the league might need to spend several years improving their efficiency before qualifying for extra money if the criterion were absolute level of

performance. Management might get discouraged in such circumstances, whereas they could start to benefit immediately if it was improvement in performance that was being rewarded.

16. One difficulty with rewarding improvement in performance is that it might be the least efficient authorities with most scope for improvement (eg because they had been slow to introduce competitive tendering) who would benefit most. But once the system had been running for a few years, the best authorities should have found ways of improving their efficiency as well over time. So long as the system ensured that the allocations were built into baselines for subsequent years, the best districts should be able to reap suitable rewards.

Implications for self-governing hospitals

17. The system would need to be adapted for self-governing hospitals, independent of districts. It is difficult to say what form this would take, without clear decisions on the nature and structure of such hospitals. Among the questions to be considered are:

- whether their allocations should distinguish "baseload" functions (service to the local community, just like any other district general hospital, referrals by GPs etc) from any functions as "centres of excellence", eg the referral by consultants in other hospitals of particularly difficult cases

- whether the financing of their "baseload" services should be able to share in the growth money given out to the rest of the system in performance-based allocations

- if so, whether they too should be subject to the same regime of performance measurement

- whether the "centre of excellence" functions could be financed differently, eg by direct payments from the budgets of other hospitals whose consultants referred their patients on.

22.6.2

SECRET

HC 27

NHS REVIEW: FINANCING HOSPITALS

Note by the Chief Secretary, Treasury

At our meeting on 24 May, I offered to prepare a note about how the system of allocating resources to health authorities could be improved to reward hospitals which attracted more patients by greater efficiency. This I attach.

2. The scheme involves "top-slicing" some of the total budget for hospital expenditure and distributing it to districts according to their success in improving their efficiency. A further allocation might be made on the basis of activity in those areas where waiting times are longest, if attractions were seen in replacing the present waiting list initiative with a more systematic arrangement.

3. These allocations would be built into baselines for future years. There would continue to be scope for regions to adjust the baselines on account of population changes and in order to target improved services. Similarly, districts would be free to allocate funds to hospitals according to local management priorities, which might involve building up some services or spending money to remove obstacles to improving efficiency in particular areas.

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a clear and open method for introducing the right incentives while commanding reasonable confidence among health authorities.

b. I have no strong views on whether the allocations should be made by regions or by the DHSS, and would welcome the views of colleagues on this.

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SECRET

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10. Whether allocations to districts should be made by regions or by the department is a matter for judgement. Regions would have considerable scope to undermine the effect of the performance-based allocations by offsets in their disbursements to districts. On the one hand, it could be argued that separating the two processes by the department making the performance-based allocations would minimise the scope for this. On the other, it could be argued that the commitment of the regions to the new system would be best secured by giving them responsibility for allocating the money. Ministers are invited to consider the balance of argument between giving the function to regions or the department.

How to measure performance?

11. Officials will need to do more work urgently on ways of measuring performance. An obvious starting point would be the Korner information system, introduced from 1 April 1987. But the performance indicators produced by this system are primarily intended to be aids to local management rather than objective measures of performance, and it might be necessary to find a way of supplementing them.

Activity or efficiency?

12. This depends on the area being considered. Where waiting times are excessive, increasing activity levels - and maintaining the increase - is the only way to get them down. But increased activity is not a good measure of performance in other areas - for example, psychiatry.

13. This suggests a two-pronged approach. In order to introduce the right incentives and to deal with the problems identified in paragraph 2 above, the general criterion for distributing the top-sliced money should be efficiency. But the concept could be imported into the present efforts to tackle excessive waiting times for routine procedures. A separate top-sliced allocation, replacing the present waiting list initiative, could be distributed to those who had done most to increase activity in certain defined areas, thus reducing waiting times, in order to encourage them to go further, if necessary taking patients from waiting lists in other nearby districts.

Absolute performance or improvement in performance?

14. Any attempt to devise a "standard" performance measure would be very complicated. The formula would have to take account of the size and distribution of hospitals within the district, the range of specialties covered, the characteristics of the local population. It might also have to cover factors like how many sites hospitals are spread over, and their layouts, which affect efficiency but are beyond the control of the local management. No matter how sophisticated the formula, many would continue to argue that they were subject to special factors which were not given their due weight.

15. Such problems would be avoided by measuring performance over the most recent 12 months and comparing it with the previous period. It would be much more difficult to argue that there were special factors which inhibited improvement in performance, as opposed to the absolute level of that performance. Rewards based on improved performance would also offer more immediate incentives to management. Those who started well down the league might need to spend several years improving their efficiency before qualifying for extra money if the criterion were absolute level of

performance. Management might get discouraged in such circumstances, whereas they could start to benefit immediately if it was improvement in performance that was being rewarded.

16. One difficulty with rewarding improvement in performance is that it might be the least efficient authorities with most scope for improvement (eg because they had been slow to introduce competitive tendering) who would benefit most. But once the system had been running for a few years, the best authorities should have found ways of improving their efficiency as well over time. So long as the system ensured that the allocations were built into baselines for subsequent years, the best districts should be able to reap suitable rewards.

Implications for self-governing hospitals

17. The system would need to be adapted for self-governing hospitals, independent of districts. It is difficult to say what form this would take, without clear decisions on the nature and structure of such hospitals. Among the questions to be considered are:

- whether their allocations should distinguish "baseload" functions (service to the local community, just like any other district general hospital, referrals by GPs etc) from any functions as "centres of excellence", eg the referral by consultants in other hospitals of particularly difficult cases

- whether the financing of their "baseload" services should be able to share in the growth money given out to the rest of the system in performance-based allocations

- if so, whether they too should be subject to the same regime of performance measurement

- whether the "centre of excellence" functions could be financed differently, eg by direct payments from the budgets of other hospitals whose consultants referred their patients on.

psl/55A

SECRET

This version incorporates Chancellor's initial comments. He wants to look at it again later, with any comments from copy recipients. Can we have comments by 3.30 today please? mpw 29/6

cc: PS/FST
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Mr Culpin
Miss Peirson
Mr Saunders
Mr Parsonage
Mr Call

28/6/88

NHS REVIEW: SUPPLY AND DEMAND

In the work we are doing on the review, it is vital that we do not lose sight of some of the basic features of the economics of health care.

Put simply, the demand for health care exceeds the supply. In the public sector, that is inevitable: with a "free" service financed out of general taxation, demand will always be virtually unlimited; it is regulated partly by waiting lists, and partly by the safety valve of private sector care. Our objective for the public sector must clearly be to ensure that it provides health care as efficiently and effectively as possible, so that we get the best possible output for the money we put in.

In the private sector, there <u>is</u> a price mechanism. The problem there is to a large extent that the price is so high, because of inefficiencies in supply and restrictive practices by the medical profession. We need to improve the supply performance and hence bring down prices and encourage growth. If we simply boost demand without improving supply, the inevitable result will be higher prices and little real growth in private health care.

This prescription is exactly the one we have successfully followed in many other areas of policy, where we have shown decisively that the route to improved performance is to concentrate on the supply side. There is no reason why health should be any different. Indeed, there are features of the supply and demand for health care which make it especially important that we should not look simply at demand in isolation.

First, as I have already indicated, we must recognise the almost complete absence of the price mechanism as a means of regulating the level of output in the NHS. Prices and charges play a negligible role, particularly in the hospital service. Indeed, charges now raise only X per cent of the costs of the NHS, compared to Y per cent in 1947. It follows that patients (and their doctors too) will always tend to press for high-cost options.

There is a danger of this in the private sector too. Private treatment is mainly financed out of insurance. This means that once someone needs treatment, there is little reason for the patient to limit his demands.

These problems are reinforced by a lack of cost-consciousness among doctors and others. As we have noted many times in the course of the review, budgeting and information systems in the NHS are ill-designed for the purpose of encouraging cost-effectiveness and economy. Those who commit resources are not financially

accountable for their decisions, nor are they given adequate information on the costs of what they are doing. The position is somewhat better in the private sector, but doctors everywhere cling to the outmoded belief that they should not be involved in the management of resources. Under present arrangements, the demands from patients are more likely to be amplified than constrained by the decisions of doctors.

The result has been a chronic tendency towards excess demand. In the NHS, some of this demand is suppressed, for example by controls on expenditure, and remains latent only because patients are put off by lengthy waiting times. Some of it has been channelled into growing use of private health care - a trend we all wish to see continue. Indeed, there is some evidence that recent growth in the take-up of private insurance has been extremely rapid.

But private health care is extremely expensive, [in large part because of the various rules enforced by the medical profession: the insistence that all operations must be carried out by consultants, for example]. This inevitably holds back the demand.

Some of the steps we are considering would act to boost that demand. As with any other product, a demand for health care can have one of two effects: it can bring forth extra output, or it can push up costs. It goes

without saying that the split between these two effects is of crucial importance. There is nothing to be said for boosting demand if supply does not respond and if it simply leads to a bidding-up of pay and prices.

Without fundamental changes to the incentives faced by hospitals and other suppliers, the supply of health output will adjust only slowly to increases in demand, at least in the short to medium-term.

The starting point is the availability of skilled manpower - doctors, nurses, therapists, technicians etc. The supply of skilled manpower cannot be increased over-night: there are inevitably lags as a result of the need to recruit and train specialist staff.

In addition, there are numerous institutional and other rigidities stemming from the way in which health care in this country is currently organised. The problems here are well known and have been discussed in earlier papers. Particularly important in my view are the inflexibilities on the manpower side: the restrictive practices, over-specialisation, promotion blockages, reward systems unrelated to performance, national pay rates, and so on.

[Even within the limits imposed by these constraints, there are failures to use resources efficiently and to direct them towards the uses where they will have the maximum effect. The scope for improving supply

performance is amply demonstrated by the evidence of substantial variations in efficiency and output between different units within the NHS.]

It is clear, therefore, that there is little to be said for measures which simply affect the demand for health care and have little impact on supply behaviour. The likely effect would be higher costs, not higher output. This is true whether the extra demand is directed towards the public or the private sectors. One part of the market cannot be isolated from the rest; for example, a large increase in the demand for specialist staff in the private sector would inevitably have repercussive effects in the NHS, not least on wage levels.

Shortage of demand is certainly not limiting the expansion of the private sector. As I indicated earlier, there is healthy growth in the numbers taking out private insurance, particularly in company schemes, and all the expectations are that this growth will continue. The companies themselves recognise that the key constraints are on the supply side: they are already fully stretched in meeting the existing rate of growth, which has greatly exceeded their plans. There are shortages of several groups of specialist staff, such as anaesthetists and radiologists. And the attitude of the consultant establishment remains unhelpful, for example towards joint public/private ventures.

It follows that our strategy for reform must focus much more directly on the supply side, with the aim of promoting a more flexible and responsive supply capability. There is much we can do to tackle the problems I have mentioned of manpower and other inflexibilities. Only then can we be sure that additional demand will be translated into additional provision, rather than simply dissipated in higher costs.

In putting together a credible and coherent package of reforms, what we need to do is to test each individual proposal against the analysis I have set out in the paper, working through the supply and demand consequences. There is no need to underline the crucial importance of getting this right.

I am copying this minute to John Moore, John Major, Tony Newton, Sir Roy Griffiths and Sir Robin Butler.

[N.L.]

28 June 1988

psl/55A

SECRET

cc Sir P Middleton
Sir T Burns
Mr Phillips
Mr Anson
Mr Culpin
Ms Peirson
Mr Turnbull
Mr Parsonage
Mr Saunders
Mr Call.

28/6/88

Treasury Chambers, Parliament Street, SW1P 3AG
01-270 3000

PRIME MINISTER

NHS REVIEW: SUPPLY AND DEMAND

In the work we are doing on the review, it is vital that we do not lose sight of some of the basic features of the economics of health care.

Put simply, the demand for health care exceeds the supply. In the public sector, that is inevitable: with a "free" service financed out of general taxation, demand will always be virtually unlimited. Hence the persistence of waiting lists. Our objective for the public sector must be to see that, despite the absence of the price mechanism, it provides health care as efficiently and effectively as possible, and we get the best possible output for the money we put in.

In the private sector, there is a price mechanism. But prices are too high, because of inefficiencies in supply and restrictive practices by the medical profession - for example, the rule that all operations must be carried out by consultants. Our objective for the private sector must be to improve the supply performance and hence bring down prices and encourage growth.

Some of the measures we are considering, in particular on the tax side, would add to demand. But if we simply boost demand without improving supply, the inevitable result will be higher prices and little real growth in private health care. No one will thank us for that, except the professionals whose pay will go up.

So the priority must be the supply side. This is exactly the prescription we have successfully followed in many other areas of policy. There is no reason why health should be any different. Indeed, if anything the case for supply side reforms is even stronger.

In the NHS, prices and charges play a negligible role, particularly in the hospital service. Indeed, charges now raise only 3½ per cent of the costs of the NHS, compared with 5 per cent in the 1950s. So patients (and their doctors too) will always tend to press for high-cost options.

Doctors have no incentive to be cost-conscious. Budgeting and information systems in the NHS are ill-designed. Those who commit resources are not financially accountable nor are they given adequate information on the costs of what they are doing. Doctors everywhere cling to the outmoded belief that they should not be involved in the management of resources.

It is not surprising that this produces a chronic tendency to stimulate demand which cannot be satisfied. We are looking at ways in which we can improve efficiency in the NHS and enable it to meet more of the demands on it. But we shall also be looking to an expanding private sector to meet more of this demand.

This is already happening. Since we last discussed this my officials have obtained more up to date statistics. The evidence is striking. For example, Private Patients Plan (PPP) report that their subscriptions grew by 20% in the first few months of this year, which was the whole of their earlier planned growth expectation for the two years 1988 and 1989. BUPA say that they are planning on the basis of a doubling in the number of subscriptions over the next two years.

SECRET

It is clear that, in the private sector, shortage of demand is not the problem. The companies themselves recognise that they are fully stretched. In these circumstances, boosting demand further without doing anything to improve supply will simply raise prices. Pay rates will go up, and this will inevitably read across to staff costs in the NHS.

This is the last thing we want. We must concentrate not on boosting the demand but on making sure that the private health sector can respond. At the moment it, too, suffers from restrictive practices and other inefficiencies: too much work, for example, is done at too senior a level, particularly by consultants. And many of the problems of a lack of cost-consciousness also apply in the private sector. There is, too, a clear limit to how fast the private sector can expand without bidding scarce staff away from the public sector. Recruiting and training new staff will inevitably take time.

In putting together a credible and coherent package of reforms, what we must do is work carefully through the supply and demand consequences. There is no need to underline the crucial importance of getting this right.

I am copying this minute to John Moore, John Major, Tony Newton, Sir Roy Griffiths and Sir Robin Butler.

Moira Wallace

pp [N.L.]

28 June 1988

(Approved by the Chancellor and signed in his absence.)

28/6/88

BRIEFING PAPER

4

HEALTH FINANCE

ASSESSING THE OPTIONS

KING'S FUND INSTITUTE

HEALTH FINANCE

ASSESSING THE OPTIONS

LIST OF CONTENTS

ACKNOWLEDGEMENTS

This Briefing Paper has been prepared by the King's Fund Institute. We are grateful to the members of our Working Group on Health Service Finance who generously shared their time and expertise with us (see Appendix). We also wish to express our gratitude to the many individuals with special knowledge of the health care system who, through discussions, have enabled us to draw on a wide range of views and experiences. However, neither the Working Group nor others who have helped us necessarily agree with all of the contents of this Paper. These are the sole responsibility of the Institute.

Michaela Benzeval
Chris Ham
David Hunter
Ken Judge
Ray Robinson (Convenor)

King's Fund Institute

SUMMARY

In the current debate surrounding methods of health finance, there has been no shortage of proposals for reform. However, there has been a serious shortage of careful analysis of these proposals. This is the main aim of this Briefing Paper. Through a systematic examination of policy choices, it seeks to inform and illuminate debate.

The principal findings of the Paper are set out below.

- The central short-term problem facing the NHS is in relation to the hospital and community health services. Despite more being spent on these services than ever before, and improvements in productivity, growth in demands resulting from increased numbers of elderly people, advances in medical technology and new service developments have made it increasingly difficult to maintain standards of service. Measuring the amount of additional finance which is required is notoriously difficult. Nonetheless, despite the considerable uncertainty surrounding these calculations, our best estimate is that by 1987/88 an extra £390 million would have been needed to re-establish the purchasing power expenditure level of 1981/82, bearing in mind the growth in demand that has taken place since then.

- Tight public expenditure constraints, coupled with a commitment by the government to review all available options, are focusing attention on supplementary and alternative sources of finance. These include: income generation from non-clinical activities; the sale of clinical support services to an expanding private sector; the possible introduction of new NHS charges; increased use of NHS pay beds; and the joint finance of projects through partnerships with the private sector. All of these strategies offer scope for raising additional sums of finance but careful consideration needs to be given to their advantages and disadvantages in the light of the underlying aims of the NHS.

- Arguments for more radical, insurance-based systems need careful scrutiny. The case for substituting private insurance for public finance is weak. By attracting more funds into health care, private insurance presently provides useful additions to publicly financed health expenditure. But experience from the UK and other countries suggests that it cannot on its own be expected to offer universal and comprehensive coverage. As such, its role is likely to remain as a supplement to mainstream public finance for certain groups of people and certain procedures. Social insurance is a more feasible substitute for general taxation. It could offer comprehensive coverage for the whole community. Moreover, as an earmarked tax, it could have many of the properties of an income tax, including universality and progressivity. It could also establish a closer link between tax payments and what is actually spent on health care than is possible in the case of general taxation. Traditionally the Treasury has been opposed to earmarked taxes because they reduce its flexibility over expenditure decisions. Whether health care should be treated as a special case is a matter for debate.

- No matter what the level or method of funding, there is a pressing need to ensure that maximum value for money is obtained from NHS budget allocations. Effective management is crucial. There is a need to build on current experiments involving doctors, nurses and other professional staff in the management of resources. These must extend to the evaluation of outcomes, including assessments of the effectiveness of clinical procedures.

- Incentives for improved performance are also important. Competition between health authorities — as envisaged within an internal market — could lead to increased efficiency. At the moment there is insufficient evidence to support the wholesale introduction of such a scheme. But there is a case for a limited experiment which would permit an assessment of its strengths and weaknesses.

- The supply of private health care has grown rapidly in the 1980s. Company financed insurance schemes are now a major part of this market. This trend can be expected to continue in the future as greater reliance is placed on the mixed economy of health. Partnership schemes between the NHS and the private sector can offer real benefits to both NHS and private patients. But care must be taken to ensure that they do not distort NHS objectives and priorities.

Many of these findings have resulted from investigations in areas where there is little or only partial empirical evidence. Moreover, the pace of change is rapid. As new and better information becomes available, some of these findings may be subject to revision. In no way do we consider them to be our last word on the subject. Rather we shall continue to monitor trends and options and comment on them as seems appropriate. In the meantime, we hope that our work, and that of others examining health finance options, will encourage the Government to be far more explicit about the principles which it believes should underpin health finance in the 1990s.

INTRODUCTION

The NHS is in a state of turmoil. Spiralling demands and tight funding have precipitated a more fundamental debate about methods of health care finance than has been seen at any previous stage in its history. Serious doubts are now being raised about the feasibility of continuing to provide a universal free-at-point-of-use, tax financed system.

It was an early appreciation of these circumstances that led to the formation of the King's Fund Institute Working Group on Health Finance in July 1987. The Group — comprising Institute staff, NHS managers, independent experts and private sector representatives — set out to investigate the precise nature of the funding problems facing the NHS and the policy choices facing the Service in the medium term future.

Over the last six months, the Institute — with the Group's help — has carried out extensive investigations and discussions. The results of these enquiries, and our analysis of the information obtained, are reported in the ensuing sections of this Briefing Paper. These deal with:

- The resources context within which the NHS has been operating in the 1980s;
- Choosing the appropriate level of public expenditure on health;
- Supplementary and alternative sources of finance for the NHS;
- Ways of obtaining more value for money from public spending;
- New approaches to rationing services;
- The changing role of private health care;

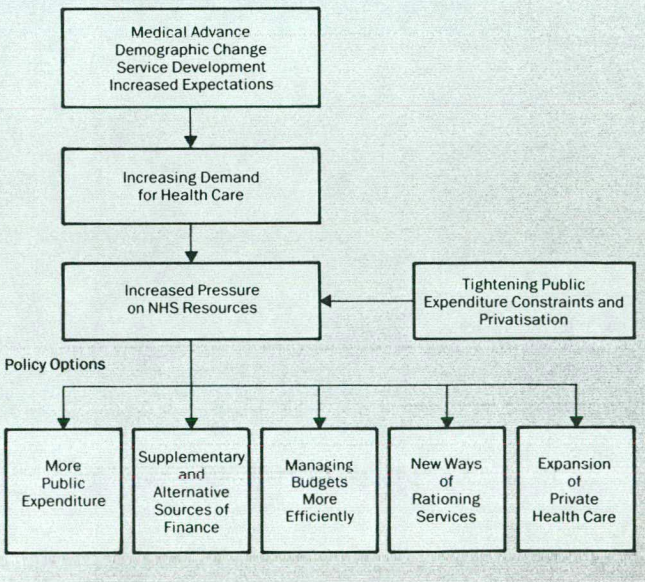
However, before we address these specific questions, it is important to emphasise three key features of the approach adopted in this paper.

First, the paper is concerned centrally with the NHS and the problems and choices it faces. In the tidal wave of debate about the future of health finance, there is a very real danger of understating the considerable achievements and potential of the NHS. We do not believe that it is sensible or desirable to neglect these, or to start a policy investigation from first principles on the assumption that the NHS does not exist. Rather, we have taken the health system as it exists today — one in which the NHS obviously dominates — and have sought to identify practical ways in which its performance may be improved.

Second, this paper does not seek to press a single point of view or particular policy direction. Our view is that the problems facing the NHS are too complex to be amenable to a single, global solution. It is far more likely that policy changes will be based on incremental change in a number of different areas. But it is our hope that *guided* incrementalism within a coherent strategy will prevail rather than the more familiar *disjointed* variety. With this in mind, the paper seeks to inform and illuminate the debate and to clarify a number of policy options. These options often incorporate political values as well as technical issues and it is not our intention to make political judgements. For the most part we have confined our role to one of making clear the advantages and disadvantages associated with different courses of action.

Third, the paper lays no claim to being exhaustive. Most of the financial problems facing the NHS impact most heavily on the hospital services. These account for approximately 70 per cent of total NHS expenditure and it is these services that we concentrate upon here. However, there are important developments in other sectors of the NHS — which will also have major implications for its financing needs and future shape — which are not dealt with in this paper. The recently completed review of community care and the White Paper on primary health care are two notable examples. Indeed, as far as primary health care is concerned, it has been argued that some of the problems of the hospital services derive directly from a conscious policy decision to redirect resources away from the acute sector to the family practitioner services. Other problems arise for unplanned reasons, e.g. when acute beds are occupied by elderly people because of the lack of appropriate community services. Clearly, these interdependencies should be borne in mind when considering the needs of the hospital sector.

FIGURE 1
HEALTH FINANCE: PROBLEMS AND POLICY OPTIONS



Note:
Based on a format suggested by Jones and Prowle (1987)

THE RESOURCES CONTEXT OF THE 1980s

A rate of increase in the demand for health care that is greater than the rate of growth in the supply of service is nothing new. Certainly the belief of the early architects of the NHS — that there was a finite stock of ill health that would gradually be eliminated as the Service was expanded — has long since been replaced by a view of continually growing demand facing limited supply. Indeed, as the 1979 Royal Commission on the National Health Service pointed out:

> *we had no difficulty in believing the proposition put to us by one medical witness that "we can easily spend the whole of the gross national product".*

But despite the persistence of this general state of excess demand, there do seem to be some special circumstances surrounding the experience of the 1980s. These relate to both the demand and supply of health care. On the demand side, two factors distinguish the period. First, there has been substantial growth in the size of the elderly population, especially in the numbers of very elderly people. Second, there have been rising expectations.

Increasing Numbers of Elderly People

Between 1981 and 1986 the number of people of 75 years of age and over grew by 400 thousand or 12 per cent. Over the five years up to 1991 the numbers in this age group are expected to increase by another 300 thousand, with 200 thousand of these in the 85 and over age group (see Table 1). Because the annual average hospital and community health service (HCHS) costs incurred by a person of 75 years of age and over are more than nine times those of a person of working age, the growth of this section of the population clearly constitutes a source of considerable extra demand. In recent years it has become a routine part of the public expenditure planning process for the DHSS to include an assessment of the increase in funding necessary to meet the extra demands on HCHS resulting from demographic change. In 1987, for the first time, tentative published estimates were extended to the family practitioner and personal social services (see Table 2).

TABLE 1 · INCREASING NUMBERS OF ELDERLY PEOPLE

	Millions		
	75-84	85+	Total 75+
1971	2.2	0.5	2.7
1976	2.3	0.5	2.8
1981	2.7	0.6	3.3
1986	3.0	0.7	3.7
1991*	3.1	0.9	4.0
1996*	3.1	1.1	4.2

**Projections*

Source: Social Trends (1987; 1988)

Apart from the inevitable uncertainty surrounding estimates of the extra costs incurred by an ageing population, it is important to note that these estimates are based on existing levels of service provision. At the moment health services for the elderly are rationed through waiting lists and other devices in the face of considerable excess demand. Over the years cumulative unmet demands have resulted in a substantial backlog of cases and unreasonably long waiting times. Moreover, much unmet demand does not become visible until service levels offer a realistic chance of treatment. Estimating the full costs of meeting this backlog is, of course, extremely difficult. But it does mean that estimates of the annual increases in expenditure necessitated by demographic change, given in Table 2, should be regarded as minimum estimates.

TABLE 2 · FUNDS NEEDED TO MEET DEMOGRAPHIC CHANGE (Per cent increase per year)

	Hospital and Community Health Services	Family Practitioner Services	Personal Social Services
1979-80	1.2	0.4	n.a.
1980-81	1.1	0.4	n.a.
1981-82	0.4	0.1	n.a.
1982-83	0.4	0.0	n.a.
1983-84	0.5	0.1	1.0
1984-85	0.6	0.3	1.2
1985-86	1.3	0.6	1.2
1986-87	1.0	0.6	1.2
1987-88	1.0	0.4	1.2
1988-89	1.0	0.4	1.2
1989-90	1.0	0.4	1.1
1990-91	0.9	0.4	1.0
1991-92	0.7	0.4	1.0
1992-93	0.6	n.a.	n.a.
1993-94	0.3	n.a.	n.a.
1994-95	0.4	n.a.	n.a.

Sources:

(1) House of Commons (1986), Weekly Hansard, *No 1388 (23 June)*

(2) House of Commons (1987), Weekly Hansard, *No 1403 (20 January)*

(3) House of Commons (1987), Weekly Hansard, *No 1408 (23 February)*

(4) House of Commons (1987), Public Expenditure on the Social Services, *Social Services Committee, Session 1986-87.*

Rising Expectations

A second more speculative factor leading to excess demand is related to increasing expectations. It has been suggested that people's expectations of health care provision are increasing at an exponential rate and that this is producing a widening gap between expectations and NHS service levels (Thwaites, 1987). Certainly international studies suggest that in those countries where people are able to choose the amount that they spend on health care, the share of their income so spent increases as their income rises. This is consistent with the exponential expectations hypothesis. On the other hand, in considering

international evidence on health expenditure, it is important to distinguish between the *price* paid per unit of service and the *volume* of services received. Obviously, if increased expenditure is accounted for by higher p[illegible]s, it does not correspond to higher levels of health ca[illegible]provision. And we do know that the NHS has been successful at containing input costs in comparison with systems based on private or social insurance. Physicians' earnings, for example, are only 2.4 times average earnings in the UK compared with multiples of 5 times in Germany and the USA (OECD, 1987). But it is questionable whether higher prices totally explain the larger proportion of GDP spent on health in most other OECD countries.

It is sometimes argued that, within the UK, a growing number of people are aware of the latest medical possibilities and the highest standards of care — through, for example, foreign travel, press and TV coverage, etc — and that they increasingly expect the latest technologies to be made available to them. Doctors, as the suppliers of health care, also play an important part in determining these expectations. Greater emphasis on screening is one possible result of this trend. Similarly, the recent growth of the private sector has been cited as evidence of rising expectations that are not being met by the NHS. Yet another argument is that more demanding standards are evidenced by the increased incidence of medical litigation.

Clearly the subject of expectations is a complex one. Our own judgement is that the case for an *acceleration* in the rate of growth of expectations is not proven. If there is a problem in connection with expectations, it centres more on the failure of supply to match steadily increasing demand. It is to this issue that we now turn.

Supply-side problems of the 1980s centre on three main issues: tightening public expenditure constraints; the privatisation programme; and the scope for greater efficiency in the use of NHS resources.

Public Expenditure Constraints

The macro economic environment within which the NHS funding position is determined has been subject to some abrupt changes since the mid 1970s when the prolonged postwar period of general economic growth came to an end. Substantial increases in oil prices in 1973/74 and then again in 1979/80 exerted severe contractionary pressure on the world economy. Inflation and escalating wage costs led the government to introduce a series of restrictive macro economic measures. A key component of this strategy was the desire to contain public expenditure. During the 1980s, this general policy stance tightened. The control of public expenditure has assumed even more central importance in the formulation of general economic policy. At the same time, the shift of emphasis from planning public expenditure in volume terms to planning in cash terms, and a system of rigidly enforced cash limits, offers far greater control over programme expenditure levels. Previously, if the actual rate of inflation exceeded the expected rate, so that cash expenditure tended to overshoot its target, cash shortfalls were made good in the following year. This is no longer the case. Thus since the mid 1970s — but especially during the 1980s — the NHS has operated within the context of extremely tight public expenditure constraints.

This tightening of public expenditure controls is amply demonstrated by falling rates of growth in spending on health care. In the decade prior to 1974 the annual rate of increase in spending on Health and Personal Social Services — after adjusting for general inflation — was around six per cent per year, whereas in the second half of the 1970s it grew at an average annual rate of less than three per cent (Judge, 1982). Hence it is clear that the tightening of constraints on funding predates the 1980s. But equally there has been no relaxation during the 1980s. However, as Table 3 shows, it has been current expenditure on the *hospital services* that has been particularly tightly constrained. Between 1980/81 and 1985/86 this grew at an average rate of less than one half per cent per year in real terms (ie cash expenditure adjusted by general price inflation), although in 1986/87 and 1987/88 real terms growth rates were considerably higher. Expenditure in purchasing power terms (ie cash expenditure adjusted by the NHS pay and price index) grew even more slowly and revived less in the last two years. Over the full seven-year period it grew at an average rate of just over one half per cent.

In addition to the constraint imposed by the national funding position, there are two other more local sources of funding difficulty that have affected a number of district health authorities in recent years. First, there are those difficulties associated with the redistribution of funds: as part of the Resource Allocation Working Party (RAWP) process of interregional redistribution; or as part of subregional allocations between districts; or as part of a redistribution from acute to community services. RAWP and other redistributive arrangements were planned originally as a levelling-up process. However, in a period when there has been only slow growth in HCHS purchasing power, redistribution has become a largely a zero-sum gain. Below target districts can only gain at the expense of cuts in the absolute funding levels of above target districts.

A second local problem has arisen because some districts — notably those in inner London — have suffered from the inability to recruit nursing and ancillary staff because of the uncompetitive level of NHS salaries in relation to local labour market conditions. The response to this difficulty has often been to appoint staff at higher levels on the incremental scale or to recruit agency staff at higher rates of pay. But given the existence of cash limits, neither of these strategies makes it possible to employ the full complement of staff at these higher rates of pay. Thus the widening of pay differentials between different parts of the country has posed an added problem for an organisation such as the NHS that is at present committed to national rates of pay.

For the short term future, the expenditure plans announced at the time of the 1988 Public Expenditure White Paper indicate a planned increase of £709m in current spending on HCHS in 1988/89. However, after adjusting for the additional £75 million for 1987/88 already announced on 16 December 1987, the increase becomes £634 million. General inflation at 4.5 per cent is expected to account for £515m of this. Of the remaining £119m, approximately £70m is due to be top sliced for the AIDS programme, action on waiting lists and the special problems of London districts. Clearly if NHS pay and prices rise more rapidly than 4.5 per cent, little — if any — growth in districts' purchasing power allocations can be expected.

TABLE 3 · HOSPITAL AND COMMUNITY HEALTH SERVICES — CURRENT EXPENDITURE
£ million and per cent increase per year, ENGLAND

(1) Year	(2) Cash £m	(3) Cash %	(4) GDP deflator %	(5) HCHS inflation %	(6) Real Resources %	(7) HCHS Purchasing Power %
1980-81	6995*	—	—			
1981-82	7717*	10.3	9.9	8.2	0.4	1.9
1982-83	8284	7.3	7.2	6.5	0.1	0.8
1983-84	8709	5.1	4.5	5.1	0.6	0
1984-85	9205	5.7	4.3	5.8	1.3	−0.1
1985-86	9699	5.4	6.0	5.2	−0.6	0.2
1986-87	10421	7.4	3.0	6.9	4.3	0.5
1987-88	11427+	9.7	4.2	8.25*	5.3	1.3

* King's Fund Institute Estimates
\+ Public Expenditure White Paper Allocation plus £75 million announced 16.12.87 less an estimated £30 million transfer to capital.

Sources: *H M Treasury (1988)* The Government's Expenditure Plans, 1988-89 to 1990-91, *Vol II, Cm 288, January, HMSO, London.*
House of Commons (1987), Public Expenditure on Social Services, *Social Services Committee, HMSO, London.*

Privatisation

The second supply-side factor which distinguishes the 1980s from earlier periods is the widespread privatisation programme. Since 1979 the government has embarked on a vigorous programme aimed at replacing systems of public ownership, provision and finance with private ones. Reasons cited in support of this strategy have emphasised the superior efficiency of the private sector; the greater freedom and autonomy it offers managers; the benefits of more widespread share ownership and, implicitly, the greater discipline of the market facing trades unions in the private sector.

To date, this programme has only had a major effect at the periphery of the NHS, i.e. through sub-contracting ancillary services. However, there is no shortage of more radical privatisation proposals from various think tanks and pressure groups such as the Institute of Economic Affairs, the Centre for Policy Studies and the Adam Smith Institute. Moreover, there are clear indications that Ministers are receptive to these ideas. Taken together these developments suggest that a system such as the NHS — which is still dominated by public finance and provision — is now subject to far greater scrutiny. At the very least it will need to indicate an ability to respond to the challenges that this new context poses for it.

Efficiency Savings

The third supply-side factor which has been particularly evident during the 1980s is the increased need for the HCHS to meet service development aims through savings generated from existing budgets. Since 1984/85 every district has been expected to include a cost improvement programme within its short-term plan. At the aggregate level, the additional sums that are expected to be generated from cash releasing cost improvement programmes have been quantified and added to basic cash allocations as part of the public expenditure planning process. In a period of only modest growth in purchasing power expenditure these additions have been a crucial source of finance for service development. In 1987/88 new cash releasing cost improvement programmes were expected to produce £152m or 1.3 per cent of the IICHS current expenditure budget. New *plus* recurrent savings from the previous three years amounted to nearly £600m.

However, these programmes have been the subject of some criticism. There are doubts about inconsistencies and inaccuracies in recording practices. Moreover, two reports from the National Audit Office (1986; 1987a) — although supportive of the aims of the cost improvement programme — highlighted the danger of service reductions dressed up as cost improvements and the onset of diminishing returns. The latter consideration is of special relevance for the future as many contracts for ancillary services put out to tender during the first round of subcontracting are now coming up for renegotiation. It is widely expected that the less competitive conditions which now prevail — sometimes as a consequence of the tendering process itself which has eliminated the in house tenderer — will result in new contracts being agreed at prices considerably above those reached in the first round of tendering. Given the reliance placed upon the savings resulting from these programmes over the last three years, any marked reduction in this source of "extra" funding is likely to put serious strains on the system. Avoidance of these problems will depend crucially on the success of extending efficiency savings to clinical areas in ways we discuss later in this Paper.

HOW MUCH PUBLIC EXPENDITURE?

When it was established in 1948, the NHS set out to provide a comprehensive range of health services, free at the point of use to all in need. Today this remains a fundamental feature of most people's conception of the NHS. At a time when public support for many of the original welfare state institutions appears to be wavering, successive opinion polls confirm the popularity of the NHS (Jowell *et al*, 1987). It continues to command wide and deeply rooted support. To the extent that there is dissatisfaction with the Service, it does not seem to centre on the *principle* of public finance and provision but rather its inability to live up to its ideals in terms of actual performance. In many people's eyes there is a clear reason for this shortfall: underfunding.

If there is concern about funding levels — and the principle of public finance still appears to be supported by the majority of people — any consideration of policy options for the future should start with an assessment of the adequacy of current levels of public funding. Ultimately, of course, this is a political issue. The level of funding is quite properly decided upon by government which is accountable to Parliament, which, in turn, is accountable to the electorate. Within the arena of political debate, Ministers have recently challenged the assumption that health care should necessarily be financed publicly. Attention has been focused on low levels of private expenditure in the UK as the reason for its poor performance in international terms.

It is not our intention to enter the political debate. Rather our aim has been to assemble evidence which we consider of relevance to those charged with the responsibility for answering the vexed question: "how much should we spend on health care?". Four main approaches to this question may be identified:

- The economist's view;
- The needs approach;
- The GDP approach;
- The international perspective.

Each of these is reviewed briefly below.

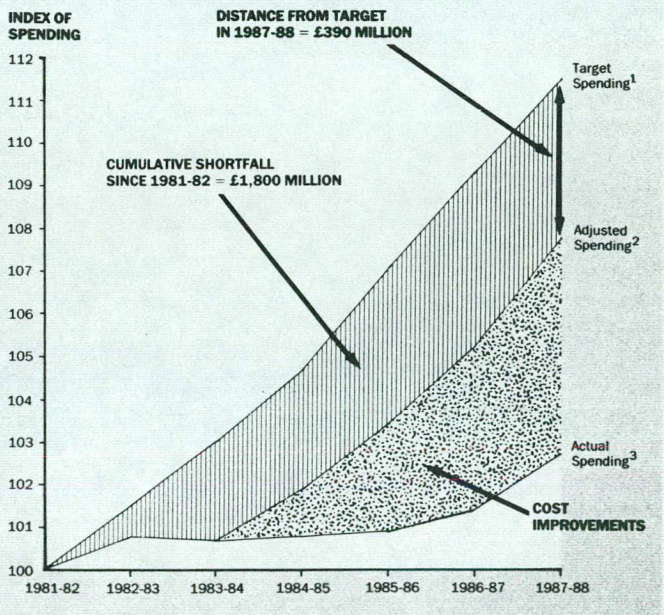
The Economist's View

The economist's view is basically that the question is at present unanswerable. Maynard (1987a) suggests that until we know the costs and (more importantly) the benefits arising from different categories of expenditure, it is impossible to say whether present levels of aggregate funding are too low, too high, or even at the optimal level. In the final analysis the logic of this argument is irrefutable. To enable rational resource allocation decisions to be made, far more information is needed about the relationship between health care inputs and health status outputs/outcomes. But this is a long term research task. Short run decisions about spending have to be made despite the considerable uncertainty surrounding the 'ideal' allocation of expenditure and, for this purpose, policy makers need as much relevant information as possible.

The Needs Approach

One way of approaching this task is to use the 'needs' approach. This method utilises the best available estimates of the growth in health care *needs* in order to determine the extra funds that the NHS will require to meet them each year. Growth of need derives from three main sources: demographic change, medical advance and nationally determined service priorities. There are considerable methodological problems associated with the way in which these estimates are produced (Harrison and Gretton, 1986), but the Department has itself accepted them as a quantified statement of what would be required to meet the additional demands being placed on the health service. In this sense they at least provide a benchmark for assessing public expenditure levels. And — although there is some dispute about the precise sums needed in earlier years (Robinson and Judge, 1987) — it is in these terms that current expenditure on the hospital and community health services (HCHS) has, since 1980/81, failed to meet the targets set for it. By 1987/88 the cumulative shortfall of HCHS purchasing power — even when supplemented by the recurrent savings from cash releasing cost improvement programmes — was approximately £1.8 billion (1987/88 prices). Within the single year, 1987/88, expenditure was over 3 per cent below its target level, bearing in mind the growth in demand since 1981/82: this represents just under £400 million (see Figure 2).

FIGURE 2 · HOSPITAL AND COMMUNITY HEALTH SERVICES. TRENDS IN SPENDING, TARGETS AND SHORTFALLS



NOTES

1. Increase over base spending necessary for demography, technology and service improvements: 1.3 to 2.3 per cent per year.
2. Actual spending plus cash releasing cost improvements at 1987-88 purchasing power prices.
3. Actual spending at 1987-88 purchasing power prices.

TABLE 4 · HEALTH EXPENDITURE PER PERSON IN 22 OECD COUNTRIES IN RELATION TO GDP AND PUBLIC EXPENDITURE REGRESSION EQUATIONS

Dependent Variables†	Independent Variables			Summary Statistics	
	Constant	GDP†	Public expenditure as a share of total expenditure	R^2	F-statistic
1. Total Expenditure on health care	–339.1	0.1	—	0.81	92.7**
t-statistic	(–2.99)**	(9.63)**	—		
2. Total Expenditure on health care	294.5	0.1	–7.25	0.86	67.56**
t-statistic	(1.11)	(9.39)**	(–2.89)**		
3. Public Expenditure on health care	–90.34	0.07	—	0.68	46.36**
t-statistic	(–0.82)	(6.81)**	—		
4. Private Expenditure on health care	–308.76	0.05	—	0.34	11.99**
t-statistic	(–2.01)*	(3.46)**	—		

** significant at 99.5% level
* significant at 95% level
† Per Capital Expenditure, $US at GDP purchasing power parity

Data Source: Schieber and Poullier (1987), 'Recent Trends in International Health Care Spending', Health Affairs, *6:3, 105-112.*

The GDP Approach

A third approach to the question of funding levels was outlined in a recent report from the Institute of Health Services Management (O'Higgins, 1987). In an attempt to depoliticise the issue, the report suggests that a minimum consensus should be sought that would provide a basis for planning the growth of health expenditure for at least the duration of the present Parliament. To achieve this aim, the report proposes moving away from the demand or needs approach to one in which the growth in health expenditure is based upon what the country can afford. Thus, the report proposes that health care spending should, as a minimum, rise in line with national income. In addition, it argues that this rate of growth will need to be augmented with separate provision for such factors as demographic change, major new service needs (eg AIDS) and any possible pay restructuring resulting from, for example, the need to attract more nurses into the NHS.

While it would be naive to suggest that the proposed formula could take the question of funding entirely outside of the political arena, it is nonetheless possible that the broad thrust of the approach does offer some potential for avoiding haphazard variations in levels of NHS funding. However, if such an approach is to receive serious attention, it requires far clearer specification. In some recent years it is quite possible that linking the growth in health spending to the rate of growth of GDP would have resulted in less health expenditure than was actually achieved. More thought needs to be given to the relative sizes of the automatic and discretionary elements which govern the necessary increases in expenditure, and the relationship between them.

For the future it has to be recognised that the NHS is a labour intensive service industry with more limited scope for productivity increases than industry generally. This means that if NHS service levels are to be maintained — and increases in health service wages and salaries are to be allowed to keep pace with those in the economy generally — the relative cost of the NHS will increase. This means that it will inevitably account for a rising share of national expenditure. Increases in productivity can ameliorate this trend but they are unlikely to be able to eliminate it completely.

International Comparisons

A final approach to funding levels involves drawing upon international evidence to see how expenditure on health care in the UK compares with other countries. Of course, there are many problems associated with international comparisons. In particular, collecting comparable data and expressing them in common monetary units involves many pitfalls. Moreover, the existence of differences in levels of expenditure can never establish that any one country should adopt expenditure practices found elsewhere. Nonetheless if one country is a noticeable "outlier" in expenditure terms this fact does merit investigation — in much the same way that, in a rather different context, performance indicators are meant to point out aspects of districts' performance that may warrant further scrutiny.

The latest data from the OECD (Schieber and Poullier, 1987) show that health care expenditure per head in the UK, at US$627, is substantially below countries such as Germany ($983), France ($1072) and, especially, the United States ($1776). However, it is well known that expenditure per head varies with the level of GDP. Consequently figure 3 shows the regression line obtained when expenditure per head is related to GDP per head in the 22 OECD countries. Significantly this shows that per capita expenditure in the UK is nearly 30 per cent below the level that would be expected in terms of the UK's GDP per head.

In seeking to understand the reasons for variations in expenditure levels, it is interesting to note the influence of public finance. Our equations suggest that, on the basis of cross country evidence, as the share of public spending in total expenditure increases, it exerts a negative effect on total expenditure. In average terms, a one per cent increase in the ratio of public to total health spending results in an almost equivalent percentage fall in total health expenditure per head. Other data suggest that the extent to which *national* governments control expenditure — as opposed to *local* governments — may also be a factor in depressing expenditure levels. Of course, it would be foolish to claim a causal link on the basis of such aggregate data. Many other factors are obviously at work. But as they stand the data do appear to be consistent with the claims currently being made by Ministers which attribute low total expenditure on health in the UK to overreliance on public expenditure and inadequate private expenditure. They are also consistent with a theory of political economy which states that individuals as consumers will tend to express preferences for higher levels of spending than they will vote for as taxpayers.

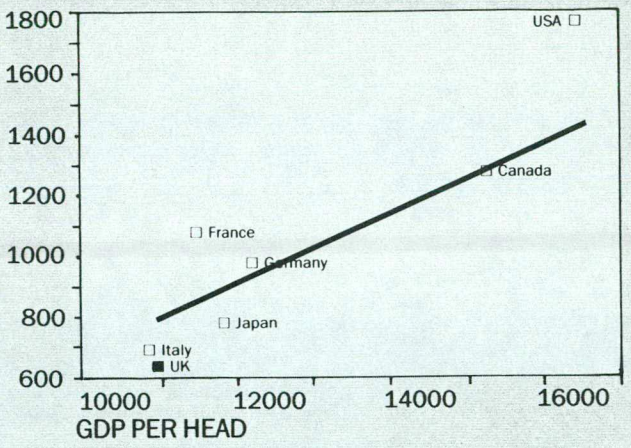
But anyone seeking to use these findings solely as support for more private expenditure should be wary. Our figures not only show that the UK spends less than expected in terms of private expenditure, but also that public expenditure is approximately 10 per cent below its expected level. Put another way: even if private funding of health care increases, international evidence still suggests that public expenditure is up to £2 billion below its expected level.

Conclusion

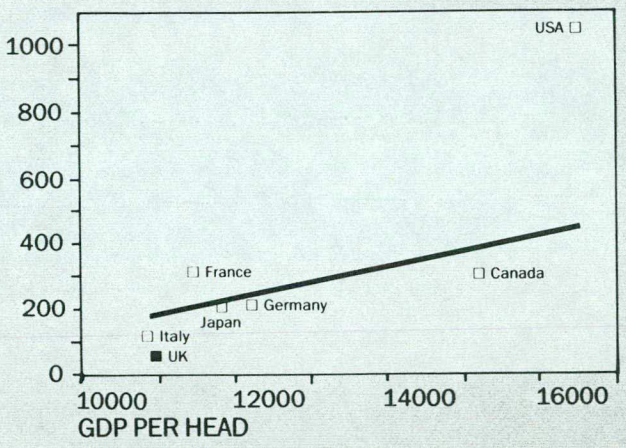
Most of the evidence we have been able to gather points to a shortfall in public spending on the hospital services. But establishing precisely the size of this shortfall is notoriously difficult. Probably the most conservative estimate is that — given the growth in resources necessary to meet the needs of increased numbers of elderly people, advances in medical technology and new service aims — expenditure would have needed to be just under £400 million higher in 1987/88 to re-establish the purchasing power spending levels of 1981/82. This judgement can be made independently of initiatives concerned with private expenditure which we discuss subsequently (see King's Fund Institute evidence to the House of Commons, Social Services Committee (House of Commons, 1988)).

FIGURE 3 · HEALTH EXPENDITURES — SELECTED OECD COUNTRIES 1985
Expenditure per head at $US purchasing power parity

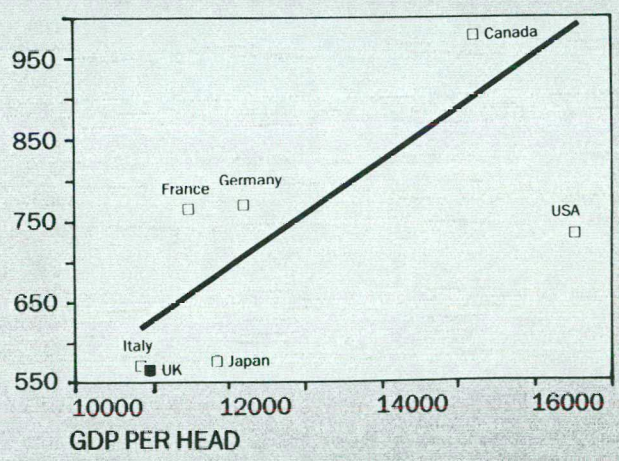
TOTAL EXPENDITURE PER HEAD



PRIVaTE EXPENDITURE PER HEAD



PUBLIC EXPENDITURE PER HEAD



Note. Based upon equations 1, 3 and 4 (see table 4)

SUPPLEMENTARY AND ALTERNATIVE SOURCES OF FINANCE

Ministers have made it clear that in future they expect to see an expansion of alternative sources of health finance as a supplement to general taxation. In the current debate surrounding the subject many suggestions have been put forward. This section of our paper describes some of these proposals and presents an assessment of their merits and demerits. It covers:

- income generation from non-clinical activities;
- income from the sale of clinical services;
- patient charges;
- private insurance schemes;
- social insurance schemes;
- health voucher schemes.

Income generation from non-clinical activities

The introduction of general management and the subsequent emphasis on cost improvements has already led to a more 'business minded' approach in many districts. One consequence of this entrepreneurial outlook has been the introduction of numerous income generation activities at the local level.

Many hospitals have developed commercial activities mainly in their concourse and waiting areas. These include: cafeteria services; newspaper and book shops; general food stores; florists; hairdressers; chemists; photography concessions in maternity hospitals; taxiphone lines; leasing advertising space; and installing video entertainment systems. In some districts more ambitious schemes are under consideration such as extending services outside the NHS (eg bidding for school catering contracts). To date the legal position concerning these activities has been an extremely grey area with some managers considering them *ultra vires*. However, the *Health and Medicines Bill* currently passing through Parliament is expected to clarify the position and open up possibilities for far greater activity in this area. Similarly, the establishment of a unit within the DHSS with special responsibility for income generation is aimed at boosting activity.

Schemes that brighten up public areas and provide convenient services for patients, visitors and staff seem to command widespread support. Moreover, there does not seem to be much objection to them being privatised if they operate more efficiently that way. The main reservations surrounding these schemes centre on two questions. Are they worthwhile given the levels of income they attract? And do they detract from management's main task of improving patient care by running mainstream health services?

On the first question it does seem to be the case that the sums which can be raised are rather small. A report by the Scottish Health Service Management Efficiency Group (1987) suggests that there is scope for raising just under £2 million per year in Scotland: this compares with a total HCHS revenue budget of £1,300 million. No published estimates are available for England, but an unpublished Rayner scrutiny commissioned by the DHSS indicated that there was rather more potential for income generation. It suggested that up to £135 million per year could be raised in the long term. But even this represents only just over one per cent of the current HCHS revenue budget. On the other hand, small savings from a variety of sources should not be dismissed too lightly in a period of very tight funding, especially if they also increase the attractiveness of the service to its staff and users. Furthermore, if the *Health and Medicines Bill* relaxes the present restrictions on income generation, this could lead to far larger sums being raised.

Ultimately, though, decisions about whether or not a particular district chooses to develop these activities should depend on a full assessment of not only the revenue gains — and benefits to patients/consumers — but also the costs in terms of management and other time. Some districts are seeking to reduce the demands on existing management through the appointment of income generation or marketing managers, often on performance related pay. However, although this should relieve managers from day to day responsibilities, they will still be required to be involved in strategic matters.

Income from the sale of clinical services

Income from the sale of clinical services offers the potential for raising far larger sums of money but it also raises far more complex issues of principle. The longest established source of income is, of course, through charges for pay beds. During the 1970s pay bed numbers were cut back dramatically: between 1975 and 1979 they fell by over 40 per cent. Since then the numbers have gradually risen again, although there were still only just under 3,000 beds in 1985 (in England) compared with over 4,000 beds in 1975. However, there are currently signs of increasing activity in this area. Since 1987 health authorities have been free to determine their own levels of charges subject to the recovery of costs. As a result, many districts are looking to this market as a source of extra revenue. At the moment though, there is some disagreement within the service about whether the NHS can compete successfully with the private sector. Some feel that the quality of pay bed accommodation and hotel services compares unfavourably with that in private hospitals and so it would be difficult to reverse the trend towards private hospital growth. (Between 1979 and 1985 the number of private hospital beds grew by 50 per cent compared with an increase of under 25 per cent in the number of pay beds.) Others point to the excellence of NHS hospitals and claim that if the NHS was free to compete on equal terms it would be highly competitive with the private sector.

Despite this uncertainty, a number of districts have plans for the expansion of their private facilities. Emphasis is often placed upon competition with private hospitals in terms of price rather than quality. In one region the districts have formed a cartel and are offering services up to 20 per cent below the rates charged by private hospitals. They are also negotiating with employers who offer private insurance as part of their conditions of service in order to try to capture this fast growing section of the market. In another district,

a private firm has been employed to market the services of a new private wing in the district general hospital.

In contrast to competition with private health care provid[redacted] NHS hospitals can also generate income through collaboration or partnerships with the private sector. The sale of support services to private hospitals — such as pharmaceuticals, pathology and x-ray services, surgical aids, etc — is an established source of income in many districts. More recently there have been a number of examples of the joint planning and financing of facilities.

In one district a new day surgery unit is planned. By entering into a partnership with a private company an enlarged scheme with additional facilities will be financed. In addition, the district has agreed a formula for revenue payments by the private company — for an initial fixed term of five years — in return for part use of the facilities by its patients. These payments will enable the unit to operate for eleven sessions per week, with the private company using two of the sessions, compared with only five sessions per week in total without the private sector involvement. Hence the district gains a contribution towards capital expenditure and three extra sessions per week.

Elsewhere another authority is investigating the possibility of a private insurance company financing a private wing in each of its two district general hospitals. These will be managed by the private company with the attached NHS hospital providing support services. Once again it was felt that the district could compete successfully with a local BUPA hospital in terms of price.

Yet another district is examining the possibility of a joint project with a private company in order to provide finance for its capital development programme. The scheme would involve the sale of land adjacent to its proposed DGH to the private company. The company would use the land to build its own private hospital and would be able to buy support services from the nearby DGH. In return for this favourable site, the district will seek a substantial capital sum as a contribution towards its planned DGH. This deal is similar to many already undertaken by Local Authorities in their dealings with private property developers. In this context, the private sector contribution to public infrastructure costs is referred to as "planning gain". Such arrangements have not to date been widely used by the NHS. However, they may well be an aspect of property management that merits closer attention as part of the programme of NHS land sales that is taking place on such a wide basis at the moment.

A slightly different source of income from the sale of clinical services occurs when districts sell specific services to the private sector, often using underutilised NHS capacity. The provision of breast screening, infertility clinics, pregnancy testing and physiotherapy services are examples of this type of arrangement. They are usually organised so that items of capital equipment are used more intensively, ie for more hours per day than they would be if confined to NHS work. Sometimes an expensive item of equipment — such as a nuclear magnetic resonance scanner or a lithotripter — is financed jointly with the private sector organisation and used on a shared basis. Also, of course, the NHS has a long history of financing items of capital equipment through charitable appeals and donations.

Because it is such a major source of confused thinking it is worth taking a little time to clarify the concept of "spare capacity" as it arises in this context. It is sometimes claimed that it is impossible to talk about spare capacity when there is already considerable excess NHS demand for many of the services provided through these arrangements. However, this is to misunderstand the sense in which the term is being used. The capacity is spare in the sense that there are no public sector funds available to finance its operation at the times when it is used for private arrangements. This does not mean that there are not NHS patients who could also benefit from the facility if the funds were made available, but that public expenditure and manpower constraints prevent them from doing so. In this situation the private patient is not displacing the NHS patient. On the other hand, when capacity is spare in the sense used above, but can only be used in conjunction with other capacity which is being used fully, there can be a conflict of interests between NHS and private patients.

Finally, on the subject of income generation, it is noticeable how the current climate of expenditure constraints, and uncertain legal controls on the ways in which money can be raised, has given rise to a number of schemes that seek to use and/or circumvent existing restrictions. These range from collaborative deals with housing associations — which seek to tap non-NHS funds to help finance care in the community programmes — to plans for setting up independent trading companies which would sell clinical services and route the profits back to the NHS through endowment funds. To the extent that these manoeuvres divert time and resources in order to circumvent existing legal restrictions, they are wasteful and run the danger of distorting patterns of service provision. The greater freedom to generate income expected to be offered through the *Health and Medicines Bill* should obviate the need for this diversionary activity.

Given the *ad hoc* way in which much of this clinical income generating activity has evolved, there is a clear need for a systematic assessment of its consequences for the NHS. A starting point is to assess such schemes in terms of their *efficiency* and *equity*.

Efficiency is essentially a management responsibility. At its most basic level it involves an evaluation of the revenue to be raised and the cost incurred through proposed income generation activities. Revenue assessments should consider the size and nature of market demand both now and in the future. Cost analysis is more problematic. Cost information within the NHS is still in a highly underdeveloped state. Attempts to improve it, following the recommendations of the Körner Steering Group, are progressing slowly and at an uneven pace. Yet accurate costings of activity — and of financial targets in terms of which performance can be assessed — are essential prerequisites for the efficient operation of income generating activity (see Grant Thornton, 1986). It may well be, though, that the development of income generation strategies provides its own impetus for collection of the relevant data. This contrasts with much current NHS data collection where the use to be made of the data is unclear to those responsible for their collection — with predictable consequences for the quality and speed of production of data bases.

Equity considerations raise far more fundamental problems. For some people the introduction of overt

commercial activities into the NHS is an anathema. For many years, health care in Britain — as embodied in the NHS — has been insulated from market processes. Income and ability to pay have not been considered appropriate for rationing health care. Equality of access has been a paramount principle. Hence the system has been largely free at the point of use and rationed through centrally determined budgets, clinical judgement and waiting lists. Selling clinical services clearly violates this principle. It enables those with ability and willingness to pay to obtain, at a minimum, quicker treatment for many non-urgent procedures. To those who have a non-negotiable attachment to the principle of equality of access, income generation through clinical activity is always likely to be unacceptable.

Other people, however, view the current choices facing the NHS more in terms of a trade-off. The provision of a service on a fee for service basis should provide revenue in excess of its cost. This extra revenue should be available to cross-subsidise, and therefore expand, NHS services. If this strategy is adopted, an improvement in the minimum standard is being achieved at the cost of some increase in inequality. If the choices facing the NHS are viewed in this way, it is crucial to know how much net income is made available to NHS patients and the nature and extent of increased inequality incurred through income generation in specific instances. Of course even accurate knowledge of these facts cannot resolve the question. For a given level of extra NHS income, some people may be prepared to countenance only a strictly limited relaxation of equality of access at the margin. Others may be willing to accept a far greater incursion of inequality for the same sum of money. The point on the trade-off anyone chooses will ultimately depend on value positions. However, while the careful collection of empirical data cannot resolve the problem, it can at least inform choices and take them beyond appeal to mere slogans.

Already there are many examples of the need for more precise information in this area. For example, one criticism levelled at the sale of clinical services is that it distorts planning priorities. It is claimed that parts of the service which are high profile and offer income generating possibilities will be expanded to the detriment of more mundane, but possibly more essential, services. It is also claimed that support staff are similarly diverted to these activities. A further argument is that the location of some services, such as breast screening or kidney dialysis units, has been affected by the need to respond to the demands of paying patients or cash donors. And on a wider scale it is pointed out that those districts located in wealthy areas would obviously benefit from the expansion of this activity far more than those in less prosperous areas. This would further increase the inequality in service provision between different parts of the country. While all of these issues represent legitimate concerns, at the moment evidence on them is highly impressionistic and/or polemical. Rational policy decisions would be assisted greatly by a cool and systematic collection of the relevant evidence.

A similar conclusion applies to another criticism levelled at income generation. Some people have questioned whether it actually constitutes a *net* addition to income. According to this view, success in income generation will simply result in the government reducing core expenditure by an off setting amount. Indeed, it is claimed that those who vigorously pursue income generation schemes are simply playing into the hands of a government that wishes to substitute private finance for public finance. Methodologically, it will always be difficult to establish whether or not this claim is correct, for to do so would require knowledge of what public expenditure levels *would* have been in the absence of successful income generation. At the moment, the best that can be done is to try to identify previous cases that might shed some light on the question. As we have seen there is now a growing catalogue of income generation schemes from which relevant information could be gleaned. But, to date, this evidence has not — to our knowledge — been exploited. Thus the substitution hypothesis remains unproven.

Patient charges

In this section our aim is not to argue for or against charges but to identify some of the relevant considerations surrounding this policy option, including the sums of revenue that would be raised under different assumptions.

In 1986/87 charges for NHS services yielded nearly £480 million or 3 per cent of total expenditure. The main sources of this income were pay beds, drug prescriptions and dental charges. At present, income from pay beds yields approximately £60 million per year. The expectation that these will be promoted more vigorously has been discussed already. Additional income could be expected from increased charges, more beds and higher bed occupancy rates. There is, however, insufficient information to put a precise figure on this sum at the moment.

The potential for increased income from drug prescriptions centres on two possibilities: higher prescription charges and/or fewer exemptions. Prescription charges have already risen steeply from 20p per item in 1979 to their present level of £2.40 per item. However, with approximately 80 per cent of people exempt from charges, and demand from non-exempt groups being largely unresponsive to price increases, there is clearly scope for raising additional revenue without having a major impact on use. Our estimates suggest that each 10p increase in the cost per item would generate approximately £7 million. Changing the conditions of exemption could potentially raise far larger sums but is likely to be considerably more controversial. In this connection, one proposal that has been floated would involve the abolition of the general old age exemption. It has been estimated that this could result in 6.5 million people of retirement age becoming eligible for charging. This group currently accounts for an estimated 110 million prescriptions per year. Assuming a 30 per cent fall in demand following the introduction of charges, the total revenue effect of charges and reduced costs resulting from fewer prescriptions has been estimated at approximately £330 million (Birch, 1988).

The White Paper on Primary Health Care (HMSO, 1987) has already proposed the introduction of charges for dental checkups and a full proportional system of charging for subsequent work. These are due to be implemented in 1988. By 1990/91 they are expected to generate about £85 million per year.

All of the above examples represent increases or modifications to existing patient charges. More radically, there have been some calls for the introduction of 'hotel' charges to contribute towards

the non-clinical costs of hospital in-patient stays.

The 1979 Royal Commission on the National Health Service undertook some illustrative calculations for 1975/76 which suggested that a £20 per week hotel charge, with 60 per cent exemptions and a resultant 10 per cent fall in the length of stay, would yield £143 million or [redacted] per cent of total service cost in Great Britain. This did not include additional administrative costs. In fact, the Commission recommended against any further charges and argued for the gradual phasing out of existing ones. However, their interest in the subject was restricted to the effect that charges would have on the way in which the NHS operates — in which light they saw them as an unnecessary rationing device — rather than as a source of additional finance.

If the Royal Commission's assumptions, ie 60 per cent exemptions and a 10 per cent reduction in the length of stay (without any compensating increase in activity resulting from this reduction), are applied to 1985 in-patient numbers in England, a rough, but more up to date, indication of the potential revenue yield from hotel charges can be obtained. This suggests that a nominal charge of £10 per day would yield up to £150 million. However it may be necessary to assume a higher rate of exemptions than applied in the mid 1970s. Moreover, administrative costs would have to be set against this revenue. They could account for up to half of the revenue gained, although — because these costs would not vary with the level of the charge — the precise proportion would depend on the size of the charge.

Private Insurance Schemes

Ministers are currently pointing to low levels of private spending on health as an explanation of low levels of total health expenditure in the UK compared with most OECD countries. And certainly at $60 per head per annum private expenditure is considerably below the OECD average level of over $200 (US dollars at purchasing power parity in 1985 (Schieber and Poullier, 1987)).

Although approximately 30 per cent of private in-patients pay for care directly, any major increase in private spending will probably depend on the growth of private health insurance. The ways in which the NHS would be able to compete for some of these funds — through, for example, pay beds — have been discussed already. But the more general consequences of the expansion of private insurance, and its implications for the NHS, are closely linked to the growth of private supply. For this reason, discussion of these issues is postponed until the final section of this paper which deals with private health care.

Social Insurance Schemes

The lack of comprehensiveness of private health insurance schemes is well known. Their failure to cover the elderly, high risk groups and the chronically sick have, in most countries, led to the growth of social insurance schemes. These usually involve risk pooling across the entire population and contributions on an ability-to-pay basis. In this sense they are equivalent to an earmarked or hypothecated tax.

Advocates favouring the introduction of such a scheme in the UK point out that it would establish a closer link between individuals' payments and what is spent on health care. This could make it easier to raise finance to fund the higher service levels which current opinion polls indicate many people want. On the other hand, it would also make people more directly aware of the costs of the health system, and so it might act to reduce demands for expenditure below the levels currently indicated by 'costless' opinion polls.

The argument for establishing a closer link between payments and levels of health expenditure is a sound one. It offers more potential for bringing service levels closer into line with what people collectively want and are willing to pay for. But the case should not be overstated. It is true that earmarked taxes establish a closer link between payments and benefits than is possible through funding from general taxation. However, they are still a long way from incorporating the "he who benefits pays" principle which is the main basis for believing that people would be willing to finance more generous levels of health expenditure by this means.

Another argument sometimes cited in support of social insurance is that revenues from this source would be more buoyant than general tax revenues. However, this is doubtful. With both systems, revenues grow with increases in taxable income; although — as an earmarked tax — the revenues from social insurance would be guaranteed for health spending and would not have to vie with other claims on public spending.

Yet another issue surrounding proposals for social insurance concerns the scope for opting or contracting out. Should those people who choose private insurance receive full, or part, exemption from social insurance payments? The main difficulty with opting out is that it would almost certainly be affluent and/or low risk groups who make few demands on health services that would opt out as they would be able to purchase private insurance more cheaply and/or easily. However, private insurance rarely offers comprehensive coverage and so some members of this group would be likely to seek the services of the NHS when not covered by private arrangements. But, more importantly, the opting out of low risk/high contribution groups would mean that high risk groups would face impossibly high premiums if they were expected to cover costs. To illustrate, the current average HCHS cost incurred by a person in the 16-64 years age group is approximately £100 per year. In contrast the average cost per person of someone over the age of 75 years is nearly £1,000. Moreover, these differences are only the beginning; there are many other determinants of relative utilisation other than age. Clearly present NHS financing arrangements involve complex cross-subsidy arrangements. To do likewise, a social insurance scheme would need a similarly large tax base incorporating higher income and low risk groups. For this reason, opting out would only be possible on the basis of nominal exemptions.

Finally, it has to be recognised that earmarked taxes have not traditionally been favoured by the Treasury because they reduce the government's flexibility over spending decisions. Whether the current debate over the state of health funding has been sufficient to establish the NHS as a special case remains to be seen.

Health Voucher Schemes

Health voucher schemes are sometimes seen as a means of attracting additional finance into health care. In fact they are more a method of deploying given

public spending allocations in a way that gives greater power to consumers. In essence such a scheme would involve allocating a voucher of a fixed nominal value to every individual with which they could buy health services of their choosing. In this way, it is argued, consumer choice would be enhanced; at least minimum standards of treatment would be guaranteed to all; and competition for business between suppliers would act as a spur to greater efficiency. On the supply side, standards of care would be regulated through managed health care systems — such as US style health maintenance organisations — in which peer group audit and utilisation reviews are important cost-containing methods (Goldsmith and Willetts, 1988). Additional finance would be forthcoming to the extent that people wished to top up their voucher with private expenditure.

But all of these expectations are highly theoretical. An NHS voucher scheme has been introduced for glasses but this is a relatively straightforward market. Elsewhere vouchers have been widely discussed in connection with education but limited demonstration schemes and feasibility studies have revealed serious difficulties with them. This does not augur well for the considerably more complex health sector. In particular there is the major problem posed by extreme variations in demand for health care. The average per capita tax payment of approximately £375 has been cited as a basis for nominal value of the voucher. Although this would be sufficient for low risk groups to purchase private health insurance, it would obviously not cover adequately actuarially-based premium payments required from high risk groups. To some extent advocates of the voucher have recognised this problem and suggested 'community rating' among various population groups, eg the young, the elderly, etc, so that voucher values compensate poor risks (Goldsmith, 1988). But even this refinement is unlikely to be able to take account of the substantial variations in demand within specific community rated groups. In short, vouchers are suited to those markets where there is relatively equal and homogenous demand from all consumers. This does not apply in health care with the result that all the well known problems of adverse selection would be likely to emerge.

Conclusion

Concerns about the feasibility of continuing to provide satisfactory levels of funding for the NHS through general taxation have led to many proposals for alternative and supplementary sources of finance. Revenue-raising activities that are presently being undertaken include: income generation from non-clinical activities; the sale of clinical support services to the private sector; the limited use of charges to NHS patients, as in the case of drug prescriptions and pay beds; and the joint finance of capital and revenue projects through partnerships with the private sector. The expansion and extension of all of these activities offers scope for raising substantial additional sums of finance, but careful consideration needs to be given to their impact on the underlying aims of efficiency and equity upon which the NHS is based.

The case for more fundamental change through the introduction of insurance based arrangements — as a substitute for general taxation — requires careful scrutiny. Private insurance is best viewed as a supplement to core public finance for certain groups of people, at certain stages of their lives, for certain procedures. Social insurance is a more feasible substitute for general taxation. As an earmarked tax, it could have many of the properties of an income tax, including universality and progressivity, while establishing a closer link between tax payments and what is actually spent on health care than is possible in the case of general taxation.

MANAGING BUDGETS MORE EFFICIENTLY

The management of the NHS has experienced some important changes since the implementation of the Griffiths Report in 1984. Management at the centre has been brought into sharper focus through the establishment of the Management Board within the DHSS; the appointment of general managers at regional, district and unit levels has resulted in clearer responsibility for decision making within health authorities; and the introduction of individual performance review for general managers, together with performance related pay and short-term contracts, has created stronger incentives for them to achieve agreed objectives. There has also been a renewed emphasis on efficiency savings through cost improvement programmes. These have involved the continuation of existing initiatives such as the Rayner scrutinies, performance indicators and competitive tendering together with new initiatives, in particular, management budgeting and its successor the resource management initiative.

As we noted earlier, cost improvement programmes have been a crucial source of development finance in recent years. However, there is uncertainty about the continuing scope for greater efficiency. An argument often heard is that health authority budgets have been squeezed to the limit and there is no fat left to cut. According to this analysis, continuing constraints on NHS spending will involve real service reductions. A counter view is that the scope for efficiency savings in administrative and support services may well be subject to diminishing returns, but that there is still considerable scope for greater efficiency in medical and nursing services. This view was a key element in evidence given by ministers and civil servants to the Social Services Committee (House of Commons, 1986). The director of health authority finance at that time told the Committee

> *in the longer term it is absolutely essential that general managers get engaged with the key professional staff, with the doctors, and the nurses, and other professional staff in the whole enterprise of using resources in the best possible way for patients, and in the long term that sort of joint working to make the best use of resources for patients is probably more important as an aspect of cost improvement* (House of Commons, 1986, p.137).

This view was echoed by the Minister of Health who argued:

> *within the area of clinical budgeting there may well be very considerable savings and cost improvements that can be made so that resources can be much better deployed* (p.153).

Similar views have been expressed recently with the government suggesting that restrictive practices, particularly among doctors, are an obstacle to the efficient use of the funds made available to the NHS.

Underlying this debate is an issue of fundamental importance: who controls the use of resources in the NHS? The Griffiths Report was in no doubt about this issue, arguing that it was doctors' decisions that dictate the use of resources. While this point is now widely acknowledged, the more important consideration is that doctors do not usually have *responsibility* for budgets in the NHS, nor are they always provided with *information* about the resource consequences of their decisions. There is a gap between clinicians whose decisions on whom and how to treat largely determines the use of resources, and managers who have overall responsibility for controlling budgets and keeping within cash limits.

The Resource Management Initiative

The traditional reluctance of many clinicians to participate in decisions about resource use derives from a very real ethical dilemma. The doctor is charged with doing the best for the individual patient and this imperative can sometimes conflict with the need to order priorities among patients for budgetary reasons. Nonetheless, in a world of scare resources, priorities have to be established. As such, there is a need to involve doctors more effectively in the management of resources, especially in the acute hospital service. It is here that the bulk of NHS spending takes place and where the harshest effects of recent expenditure constraints have been felt. In the light of Griffiths, the main mechanism for involving doctors in management has been the *resource management initiative*. The initiative has been seen by the NHS Management Board as a key element in improving the management of resources and a good deal of effort and finance has been put into the experiments now taking place at six experimental acute hospital sites. The experience gained from these experiments will play a major part in any future government policies aimed at achieving greater efficiency in the use of budget allocations.

The current resource management initiative has evolved following the lessons of two earlier experiments. First, in the 1970s and early 1980s approaches based on *clinical budgeting* were developed. These achieved significant improvements in efficiency including reductions in unnecessary x-ray and pathology tests, in length of stay, in ward stocks used by nurses and food wastage (Wickings *et al*, 1983). The second phase began, following the Griffiths Report, with the experiments in *management budgeting*. Demonstration projects were initiated in four health authorities. A report published by the DHSS in January 1985 noted that despite progress having been made on the projects some fundamental problems had not been overcome. In particular, medical staff were not always committed to the projects and this had delayed implementation. These problems continued in the second generation of demonstration projects and it became clear that it would take longer than anticipated to develop a management budgeting system that could be applied throughout the NHS. Subsequently, a Management Board review concluded that management budgeting had failed to achieve its principal objectives and it was therefore superseded in November 1986 by the *resource management initiative*.

The change in terminology from management budgeting to resource management is significant. It reflects a recognition that more efficient use of

resources cannot be achieved by introducing a budgeting system in isolation. It is crucial to the success of resource management to enlist the active involvement of doctors and nurses by providing information perceived by medical and nursing managers to be relevant to their work. To achieve this, six experimental hospital sites were chosen on the basis that doctors and nurses were already closely involved in management.

Resource management experiments incorporate the following aims:

- to provide information about the use of resources enabling clinicians, managers and others to identify the costs involved in providing services
- to establish more explicitly the resources provided for particular services (eg orthopaedics) and the uses to which these resources will be put
- to place responsibility for the control of these resources on those who determine their use
- to provide a framework within which clinicians and others have discretion within agreed budgets to use resources and redeploy savings as long as overall budgets are not exceeded
- to enable comparisons to be made of the efficiency and effectiveness with which resources are used
- to provide a means of translating district priorities into action.

A number of lessons have been learnt from experience so far. First, as mentioned above, it is clear that the support and confidence of clinicians and other staff, notably nurses, is needed if resource management is to succeed. This was pointed out by Wickings at the beginning of the management budgeting experiments and the force of his warning was borne out in practice (Wickings, 1983). Second, investment in appropriate systems for collecting and processing accurate information is an integral part of resource management, and indeed this has figured prominently in the work undertaken so far. Third, agreed rules of the game need to be established to govern, for example, how savings will be deployed and how increases in activity above agreed levels will be handled. Experience in some districts where management budgeting was seen as a way of saving money rather than achieving higher levels of efficiency reinforces the importance of this point (Devlin, 1985 and 1986). It would seem that only where real incentives exist are clinicians likely to be willing to put in the time and effort required to get resource management off the ground. Fourth, and crucially, the timetable of change is longer than envisaged. The expectation is that a decision will be taken in 1988 with a view to implementing resource management in all acute hospitals by 1992, yet even this timetable may now be optimistic.

Assuming that the resource management initiative overcomes the problems of management budgeting (and this is a large assumption), a number of areas of clinical work where improvements in efficiency are possible may be identified.

First, there may well be scope for making better use of nursing services. Nursing salaries make up 30 per cent of hospital current expenditure and even minor improvements in efficiency, for example through changes in shift arrangements and in skill mix, are likely to bring important savings. This has already been identified as an area for attention by the National Audit Office and local action seems certain to follow.

Second, it is also probable that the initiative will serve to focus more attention on areas where it has long been recognised that savings are possible, such as reductions in the use of diagnostic tests and pharmaceutical expenditures. Improvements in efficiency have already occurred in these areas but there may well be scope for further action.

Third, there is likely to be a renewed interest in comparing the efficiency with which resources are used. Performance indicators have enabled this to be done in the past and have revealed the existence of wide variations between health authorities in the number of patients treated and the efficiency with which these patients are treated as measured by length of stay and unit costs. However, performance indicators are crude tools of analysis and only permit comparisons to be made on a specialty basis. The more sophisticated information becoming available through the resource management initiative will overcome some of these problems by adjusting for case mix and by making use of diagnostic related groups. This should enable more realistic comparisons to be made between doctors and hospitals, and lead to a clearer analysis of the reasons for variations and areas of inefficiency.

As these issues are tackled, it will be particularly important to consider not just the efficiency of resource use but also its effectiveness. This means including information on the outcome of treatments alongside data on activity levels, costs, and length of stay. If this is not done, it will be impossible to evaluate whether real improvements in efficiency are being achieved or whether increased activity is at the expense of increased readmissions and complication rates. It will also be important to ensure that money is not saved simply through health authorities shifting the burden of expenditure onto other agencies through earlier discharges. Existing organisational and financial arrangements give rise to a variety of perverse incentives of this kind, and careful monitoring is needed to ensure that public expenditure as a whole is used efficiently.

As these comments suggest, the quality of care provided is just as important as the quantity of care. The recent report of the Confidential Enquiry into Perioperative Deaths (Buck *et al*, 1988) has highlighted this. This Enquiry and other data, suggest that there is room to release resources in the NHS by cutting down on unnecessary or ineffective treatments. As the DHSS itself pointed out in 1976, it may be possible to combine a high quality of care with efficient use of resources by using certain operations more selectively. The reduction in the number of tonsillectomies performed over the years is just one example of changing trends in clinical practice. A key factor here, both in explaining changes in clinical practice and in accounting for variations in admission rates between health authorities, is the uncertainty which exists in the medical profession concerning indications for treatment and the outcomes associated with treatment. This uncertainty gives clinicians wide discretion in determining whom to treat and how, and makes it possible to justify quite different treatment patterns. This suggests a need for the greater use of *protocols* to guide clinical practice in order to reduce the questionable elements which lie behind variations in admission rates. This argument applies as much to GPs, whose practice in terms of, for example, hospital

referral rates and drug prescribing habits are also highly variable, as to hospital doctors. Indeed, in the long term, tackling the major differences which exist between GPs in referrals to hospitals may be a key element in reducing the pressure on hospital services as well as seeking improvements in efficiency in hospitals themselves.

A related issue is the scope for concentrating scarce resources on those treatments which are known to be cost effective. In this context, the development of the concept of quality adjusted life years (QALYs) is of considerable importance as a tool for comparing the benefits offered by different treatment regimes. If information on costs is added to data on quality of life and survival it is possible at a crude level to construct a league table showing the costs per QALY of treatments. This in turn can help those responsible for making investment decisions. While much research work remains to be done, QALYs offer real potential to policy makers faced with the dilemma of how to achieve the best return on the resources available for health services. However, further work is necessary to improve and extend the basis on which QALYs are measured. Moreover, QALYs may have a limited application in deciding priorities *between* care groups and health care sectors.

It is a curious paradox that pursuing greater efficiency may sometimes contribute towards funding problems because improvements in clinical performance often result in an increase in total expenditure. As many health authorities have found, treating more patients by cutting lengths of stay may result in lower unit costs but the overall effect of more activity is an increase in total costs. This is because increased variable costs result from the greater use of drugs, supplies and equipment. It is also well established that changes in treatment methods, such as day surgery, result in more patients being treated and higher total expenditure. These are problems which any attempt to increase the productivity of hospital doctors will have to address. While a good deal of attention has been focussed on the problem of 'lazy' doctors, a much greater challenge is often presented by the consultant who works too hard. A possible solution to this problem might be to develop an *internal market* in the NHS. Through this arrangement there would be scope to reward efficient health authorities and clinicians.

An Internal Market

The proposal for an internal market within the NHS is based on a rather different 'model' for achieving greater efficiency, although it is not necessarily inconsistent with the resource management initiative. Instead of starting from the micro level, in an attempt to devise better management systems, an internal market concentrates on the macro, organisational environment within which health authorities operate. At this level it emphasises the importance of incentives for efficiency and, in particular, the role of *competition*.

The basic idea underlying an internal market arrangment is that there should be a separation of a district's present responsibilities for both financing and providing health care services for its resident population. Districts would continue to finance services but they could choose to buy some services from other districts if it was advantageous for them to do so. Of course, there are already substantial cross-boundary flows of patients and this is tantamount to districts buying and selling services from each other. But the system does not work well. Payments only cover in-patient — not out-patient and day case — flows; they are based on average specialty costs whereas cross boundary flows usually involve a high proportion of difficult and, therefore, more costly cases; payments are made through adjustments to RAWP targets rather than actual allocations; and they are only made after a two year time lag. In the face of these difficulties some districts are devising direct methods of charging for patient inflows. But the system is fragmented, partial and non-standardised. An internal market would seek to organise this 'trade' on a systematic basis. It would have the following features.

- Each district would receive a needs based, per capita allocation. It would be paid for services to outsiders at negotiated prices. It would also control patient referrals to providers outside the district and would pay for them at negotiated prices.
- Each DHA would have a balance sheet and an income statement. This would record all income and expenditure and would provide the basis for ensuring prompt and adequate payment and receipts. Under some variants of the internal market arrangement, DHAs would also have the freedom to raise funds on the capital market.
- Consultants contracts would be held at the district level. Family practitioners would also have contracts with DHAs.
- With DHAs buying and selling services from each other most of the trade would be internal to the NHS — hence an internal market — although trade with private health care providers could also be entered into.

Through trade, competition between districts would emerge and this — it is argued — would be the spur to greater efficiency. Recently, this proposal has received widespread attention — much of it favourable — but it has usually remained at a fairly superficial level. Like much of the political case for a market system, it has been assumed that competition is a 'good thing' without examining how exactly efficiency would be enhanced in particular circumstances. On close inspection it becomes clear that increased efficiency might be expected to arise from at least two sources:

- Reductions in slack or spare capacity.
- Lower costs from economies of scale.

The case for expecting each of these benefits to materialise is sketched out briefly below. (For a fuller discussion see Robinson (1988)).

Ensuring that optimal use is made of operating theatres, beds and staff time is a complex management task. There is little doubt that individual districts vary in the extent to which they achieve efficient levels of capacity utilisation. As a result there are degrees of slack or unused capacity (Yates, 1987; National Audit Office, 1987b). According to advocates of internal markets, competition is a way of reducing these. Just as firms compete for customers in a market system, so hospitals would compete for patients, and their revenue would depend upon their success in doing so. In this way, it is argued, competition would be a spur to greater efficiency.

However, as we have already argued previously, the main scope for future efficiency savings lies in clinical areas. As such, the link between competition and the activities of hospital doctors is crucial. At the moment, it is far from clear how exactly competition between

districts would spur consultants to work more efficiently. Holding their contracts at the district level is merely a prerequisite for integrating them within a more tightly managed organisation; this does not, in itself, provide an incentive structure for improved performance. Short term contracts and performance related pay have been proposed. But these are major changes in conditions of employment which are likely to encounter stiff opposition from the professions. Clinician involvement through resource management type initiatives offers a less threatening route, but this is still in its infancy.

Economies of scale might arise through the specialisation on certain services within a smaller number of districts, instead of the comprehensive provision of all local acute services in every district. These could result from technological economies associated with the shared use of expensive items of capital equipment and/or departments, such as pathology laboratories; or from the superior performance of larger teams of clinicians who are able to share ideas and information about best practice, support each other and develop relevant expertise.

If more specialisation were to take place through an internal market, two potential sources of cost reduction would be available to a district choosing to purchase services rather than provide them itself. First, there would be the opportunity to buy certain services at the lower average costs achieved through specialisation. Second, there may be occasions where the provider district has spare capacity and is willing to supply a service at marginal cost which will be below average cost. In fact, the rigid cash limits facing many districts at the moment are already leading them to engage in the sale of services by using capacity for which they do not have funds to use to the full.

Both of the above expectations of greater efficiency are, of course, highly speculative. There are some serious reservations about the practicality of introducing internal markets and about some of the consequences that might flow from them. Indeed, the NHS Management Board has recently dismissed the proposal as impractical. Among the obstacles it identified were the absence of accurate information on treatment costs and the incompatibility of the proposal with the GP's freedom of referral.

Obviously the lack of reliable cost information is a serious impediment to trade. Districts can hardly be expected to buy and sell services from each other without knowing the costs of the services involved. But this problem is not insuperable. Körner data is already leading to improvements in management information systems. Moreover, the growth of trade may itself act as a stimulus for the development of appropriate cost data.

The GP's freedom of referral is potentially a far larger impediment to an internal market. If districts are to buy services from each other they will have to be able to control where their patients are treated. This would only be possible if they had control over GP referrals. This would constitute a major change of practice and how it would be achieved remains to be specified. As in the case of hospital doctors, holding GPs' contracts at the district level — even if this could be achieved — would only be a first step.

Yet another reservation about an internal market concerns the fear that increased efficency may be achieved at the cost of more unequal access. If there is no longer a comprehensive range of local services available, some patients will have to travel longer distances for treatment. This may penalise low income and less mobile individuals and their families eg women and children, people with disabilities, frail elderly people, those without access to cars, etc. There would also be a greater problem of continuity of care after hospital discharge. Careful thought would need to be given to the finance and provision of transport and other support services to overcome these problems.

At the moment it is impossible to assess the relative strengths of the expectations about gains and losses because they are simply *a priori* expectations. This has led us to support calls for experimenting with an internal market — possibly within a single region — in order to collect the empirical information that would be necessary for a full evaluation to take place.

Conclusion

The need to seek maximum value-for-money from health expenditure will remain a major priority whatever the level or means of financing adopted. Already major advances have been made in improving efficiency in the management of resources. These must be built upon. The resource management initiative currently taking place at six experimental sites, by involving doctors, nurses and other professional staff in the management of resources, provides a possible model for more effective management. Accurate management information systems are crucial if it is to succeed. Moreover, information systems should extend to the evaluation of outcomes including the effectiveness of clinical procedures.

Incentives for better performance are a vital prerequisite for improvements in efficiency. Competition between health districts — as contained in proposals for an internal market — is one way in which incentive structures could be sharpened. However, at the moment, there are many uncertainties surrounding exactly how efficiency would be increased through competition within an internal market, and the effects it might have upon access to health care among different groups of people. This suggests that — as in the case of the resource management initiative — there is a case for experimenting with an internal market in order to gather information on its operation and to develop the concept.

NEW WAYS OF RATIONING SERVICES

All of the policy options discussed so far have involved obtaining additional funds for the NHS or securing more services from a given level of funding. These are all supply side responses. An alternative approach to the problem of perpetual excess demand is to take a renewed look at precisely what it is possible to offer within a universal, free-at-the-point-of-use health service. This could involve specifying the scope of NHS services more narrowly than at present. In short, it would distinguish between "legitimate" and "illegitimate" demand. Two recent pieces of work have provided a basis for thinking along these lines.

Thwaites (1987) suggests that the scope of the NHS should be defined in terms of three dimensions of case characteristics: medical condition, non-medical assessment and cost of care. As a professional mathematician and RHA Chairman, he offers a conceptual framework which seeks to combine the "scores" that different individuals with demands for health care record on each of these dimensions. This offers a way of establishing priorities and thinking about what should be within the scope of the NHS and what should be outside. His own illustrative examples suggest two cases that should be within the scope of the NHS — an average man with developing arthritis and a young wife expecting a first baby — and three cases that fall outside of its scope by differing amounts: a man with an unwanted tattoo, an unlikely survivor of heroic surgery and a woman requiring in-vitro fertilisation.

Of course it could be argued that such a ranking procedure, although implicit, is already in operation within the NHS. Someone requiring a simple tattoo removal is likely to be assigned such a low priority that their position on the waiting list may mean that they never reach the head of the queue. However, the merit of Thwaites' approach is that it seeks to make explicit the criteria which are relevant in making these assessments. This would seem to be particularly necessary if decisions are being contemplated that would redefine more tightly the boundary between those cases within the scope of the NHS and those outside of it.

The main reservation surrounding this approach concerns the danger of introducing spurious precision. The combination of Thwaites' three dimensions in individual cases will always ultimately depend on clinical decisions. And as long as there is clinical freedom the search for an objective consensus will always be problematic. Differences in individual judgements will continue to be emphasised by many clinicians and efforts to specify in precise terms what is at present implicit and impressionistic may well spark off a backlash (witness the QALY debate). For this reason the Thwaites approach is probably best viewed as a framework within which criteria for rationing may be more usefully debated.

A closely related way of looking at this problem is suggested by Maxwell (1987). He points out that health care is not a simple, homogeneous service. Rather it covers a spectrum ranging from life-saving acute interventions to minor, life-quality enhancing procedures. It is almost certain that, as a society we attach differing levels of importance to the values of efficiency, equity, freedom of choice — upon which the NHS is based — according to the point on the spectrum at which a particular service is located. The use of these value criteria in the context of different health care treatments also provides a way of thinking about possible limitations of the scope of the NHS.

But, once again, moving from the general to the particular would inevitably involve intense debate and consensus would be difficult to achieve.

The case for a more rigid delineation of NHS services already commands support from a number of NHS managers. It has been suggested that it would be far better for managers to spend their time analysing the legitimacy of current demand than seeking to find alternative sources of finance for all the demand that presents itself. This would involve careful scrutiny of waiting lists, referral rates and levels of satisfaction. Ultimately it might need to take account of evidence produced through QALY calculations. One specific issue raised in this context concerns the relative costs and benefits of some of the screening programmes that are currently being accorded high priority in service developments. Given the extremely low probability of obtaining a positive diagnosis at the frequency of screening intervals presently being recommended — and the substantial costs associated with extending the service throughout the population — doubts are sometimes expressed about the legitimacy of funding these programmes through the NHS.

Conclusion

At the moment it does not seem likely that major changes involving eligibility for NHS services will be made; nor that this will be a source of large cost savings. Efforts aimed at achieving more rational use of resources are probably best directed at establishing and disseminating clear medical protocols. These aim to identify patients likely to benefit from specific treatments. Consensus conferences provide a mechanism for taking account of a wide range of opinions — both medical and non medical — in designing protocols, and working parties established by professional associations provide another. In this context, the issues raised by Thwaites and others can be considered alongside other judgements without appearing to replace them.

PRIVATE HEALTH CARE PROVISION

When it reported less than ten years ago the Royal Commission on the NHS felt able to conlclude that:

> *it is clear that the private sector is too small to make a significant impact on the NHS, except locally and temporarily.*

Such a statement no longer reflects the position of the private health care sector.

The Growth of the Private Sector

In 1979, when the Royal Commission reported, under five per cent of the population was covered by private health insurance provided by the three principal provident associations, and the benefits paid out represented less than one per cent of NHS expenditure (Office of Health Economics, 1987). But, even then, this general picture was misleading because it masked the importance of the private sector in particular geographical areas and specialities. For example, Nicholl *et al* (1984) of the Medical Care Research Unit, University of Sheffield, showed that in 1981 the combined private sector in England and Wales accounted for 13.2 per cent of total case load in domestic, inpatient elective surgery. Within this surgical category, the private sector performed over 20 per cent of haemorrhoidectomies, hysterectomies, total hip replacements and procedures for ligation and stripping of varicose veins.

However, it is the rate of growth of private finance and provision during the 1980s that has changed the picture quite dramatically. The most rapid growth in provision has occurred in nursing and residential care homes for elderly people. In this case, much of the expansion has been fuelled by the availability of public finance through the social security system (Audit Commission, 1986; National Audit Office, 1987c). As far as the acute sector is concerned, preliminary indications from data being analysed by the Sheffield Medical Care Research Unit also suggest that there was a marked increase in activity between 1981 and 1986 (Williams, 1987). Private acute care is financed mainly (about 70 per cent) through private health insurance. Since 1979 the percentage of the population covered by some form of private health insurance has doubled: from under five per cent to ten per cent. About one-half of private insurance is paid for by companies who offer it to their employees as part of their conditions of service. Company financed insurance has grown rapidly in recent years and is expected to continue to do so in the future. Overall, Laing (1987) estimates that by 1986 expenditure on private in-patient and out-patient services (including nursing homes) accounted for just over 9 per cent of total expenditure on hospital based services in the UK. This is the changed context within which the private sector must now be examined.

The remainder of this section concentrates on the private acute sector. This comprises both for-profit hospitals and clinics and not-for-profit charitable institutions such as Nuffield hospitals. In recent years growth has been more pronounced in the for-profit than the not-for-profit sector. Clearly the marked growth in private health insurance and activity within this sector indicates that it is meeting an expanding source of consumer demand. Moreover, the government clearly favours the expansion of private expenditure on health, and partnerships between the public and private sectors. There is, therefore, support for an expanding independent health care sector in the UK. Such development offers both opportunities and disadvantages. Some of the more important of these are considered below.

Costs and Benefits

In common with other systems of market allocation, the private finance and supply of health care offers a direct link between what people are willing to pay for and the service they receive. Subject to reservations about the amount of information possessed by consumers of health care (i.e. lack of expertise on medical matters), this can be expected to produce a system that is responsive to consumer preferences. Certainly consumers of private non-urgent, acute care generally have access to services with shorter waiting times than NHS patients and, often, enjoy higher standards of hotel services. But it is still only a small minority of the population who have access to these services. Even with the continued expansion of the private sector in the future this is almost certain to remain the case. It will act as a supplement to mainstream NHS services for certain groups of people and procedures. This being so, it is important to examine some of the consequences of private sector expansion for the NHS. Chubb *et al* (1982) identify four potential sources of concern. These are:

- the possible emergence of a two tier system of health care
- the effect on planning priorities
- an increase in health care costs without a corresponding improvement in health status
- the diversion of doctors and nurses away from the NHS.

How valid are these fears?

Two Tier System. The welfare state, it is claimed, is built on the basic values of equality, community and the rights of citizenship. The NHS is probably *the* most important embodiment of these values. But clearly this is just one position on a wide spectrum of views. At the other extreme there are those who believe that questions of equality are best dealt with through the tax and benefit system, and that health care should be sold freely in the market as any other commodity. An intermediate position is that equality of access is an important and legitimate objective of the health system, *per se*, but that certain forms of private health care are acceptable in the interests of better service levels and patient choice. The task, then, is to devise a mixed system of health care that is neither socially unjust nor divisive. In this connection two issues that are often overlooked become relevant.

First, concern about a two tier system centres on the inequality such an arrangement might breed in terms of access (Mooney, 1982). But under a mixed economy of health there is no reason in principle why equality should necessarily be pursued through public *provision*. It may be more efficient to pursue it through a combination of public finance and private provision (Laing and Hunter, 1982). If confined to the role of a paymaster, the NHS would undertake the regulation of the private health sector and ensure the maintenance of standards. Health authorities already possess

extensive powers of inspection and registration through which to manage a mixed health economy even if there remains scope for modifying and strengthening present arrangements (Chubb *et al*, 1982; Day and Klein, 1985).

Second, for most people their ability to rely on private finance will follow a clear inter-temporal pattern. Demand for health care will be greatest at the beginning and at the end of their lives when they will almost certainly require some public finance (West, 1984). It is during their working age that private finance is likely to be used most frequently. Many people are therefore likely to be users of both public and private systems over their lifetime. There will not be two distinct populations served by two distinct systems. Indeed, as Klein (1987) has noted, people already commute between the two sectors. They do not exit from the NHS in favour of the private sector but use both depending on the circumstances. Increasingly, there has been a blurring of the dividing line between the public and private sectors.

Planning Priorities. The possible distortion of planning priorities has been discussed already in connection with NHS income generation activities. In that context, distortion may result if NHS services are redirected in response to income earning possibilities rather than planning priorities. But the situation concerning private hospital provision is rather different. In one sense it complements NHS provision by offering services where the NHS is unable to do so. As mentioned above, private provision has grown most rapidly in the area of cold elective surgery where NHS waiting lists are typically at their longest. On the other hand there are those who argue that the existence of private medicine can exacerbate waiting list problems. According to this view consultants have an incentive to maintain lengthy lists as these encourage patients to opt for private treatment. While there may be some substance in this claim, it cannot be the main reason for the NHS's weaknesses in this area of surgery. This is more to do with its priorities at a time of tight funding.

A more serious distortion of planning priorities may occur from private sector activity stimulating or inflating demand. It is well known that the demand for health care is supplier-induced. For the most part, doctors define what the patient needs and so the normal assumption of consumer sovereignty breaks down. If the supplier has a pecuniary interest in providing a service there are incentives for overprovision. Some of the current expansion of private screening services may fall into this category. Such imbalances have implications for both quality control and regulatory arrangements.

Clearly, the nature of the private sector and its operation, especially in the long term care residential sector, where the turnover in nursing and residential home ownership is high, and stability and consistency of provision can be uncertain, has implications for planning in the NHS. How and to what extent should the NHS take account of it in its own planning?

Some commentators argue that the RAWP formula (and its counterparts in Wales, Scotland and Northern Ireland) should take account of the levels of private provision in particular regions and districts especially as private provision remains overwhelmingly concentrated in the Thames Regions and certain other large cities (Laing, 1987; Griffith *et al*, 1985). The main problem with this suggestion is that very few people within a district would have access to private care and so inequality within the NHS would possibly increase. Nonetheless, there is a clear case for some kind planning system which seeks to take account of the private sector.

Increased Costs Without Improved Health Status. Critics of private health care point out that a growth in this sector could increase expenditure on care without any demonstrable improvement in health status. While more resources might go into health care through such means, it is not clear what proportion of this additional investment would go into direct patient care as distinct from increased administrative costs and increased incomes for service providers.

Against this view, others argue that this may have been a failing of private health care systems in the past, but that managed systems — such as US style health maintenance organisations — have successfully developed ways of containing costs and regulating quality (Green, 1986; Goldsmith and Willetts, 1988). Overall, whatever the merits of these competing claims, the dangers of cost inflation and unregulated growth are not likely to become a serious issue in the UK as long as the private sector remains small in relation to the NHS.

More generally, all health care systems display a greater concern with what goes into health services than with what comes out (Maynard, 1987b). Output continues to be measured in terms of activities. Knowledge of the impact of provision upon health status remains partial although a substantial body of evidence suggests that public health measures, nutrition, housing and so on may have a greater impact on health than the provision of more and more health services.

Diversion of Doctors and Nurses: The extent to which private provision either supplements NHS provision or substitutes for it (with different priorities and patients) depends crucially on the question of labour supply. To be specific, is the time of doctors diverted away from NHS work? Or is the time they devote to private health care a net addition to what the NHS would otherwise receive? Similarly has the opportunity for better pay and conditions of service led nurses to leave the NHS for the private sector?

In many ways alleged labour diversion among doctors is the more complex to disentangle. Since 1980, full-time NHS consultants have been permitted to earn up to 10 per cent of their gross income from private practice. Consultants on maximum part-time contracts are able to engage in private practice without restriction on their earnings by giving up payment for one NHS session per week. Prior to 1980 outside earnings were only available to consultants working for the NHS if they gave up payment for two sessions per week. Clearly the post 1980 arrangements have increased the scope for private earnings.

On *a priori* grounds there must be a strong expectation that the opportunity to engage in private work reduces both the time and commitment available for NHS work. However, this could well be a misleading, short-term view. It has been argued that without the possibility of outside earnings many consultants would leave the NHS altogether. But the number in a position to do this would seem to be rather limited. A more important but complicated question is: how does the long run supply of doctors adjust to the existence of private work? The issue arises because opportunities offered for private earnings are an

'indirect way of keeping down public sector costs. The public sector does not have to bear the full costs of doctors' earnings. Expenditure saved in this way should, in principle, be available to employ more doctors to replace the time of those engaged in private work. This raises the wider question of medical school policies and the long run supply of doctors. Clearly this is a complex issue involving a number of behavioural responses at different levels. At present there is insufficient empirical information to measure the size of these effects either in the short term or the long term.

As far as NHS nursing staff are concerned there are currently severe problems of recruitment and retention in many districts. However, data from a recent study on the movement of nursing staff between the public and private sectors (Thomas *et al*, 1988) suggest that this is more to do with overall shortages in the supply of nurses at prevailing wage rates than diversion between sectors. The study carried out in 1985 indicated that the NHS suffered a net loss of just under 1,000 nurses to the private sector in that year. Given that the NHS has a qualified nursing workforce of over 250,000 and that 30,000 leave the service for a variety of reasons each year, the relative scale of movement to the private sector is small. However, there may be points of particular pressure within this overall picture. For example, the same study indicated that private hospitals are currently recruiting approximately 200 theatre nurses per year, many with special theatre nursing qualifications, whereas in 1985 only 385 nurses in total obtained this specialist qualification.

Once again, though, the long term consequences of these movements depend upon the extent to which public sector funds released by departing nurses are used to train and employ new entrants. Leaving aside the more general question of shortages in the overall supply of suitably qualified applicants to nursing — a question that will ultimately have to be resolved by the NHS offering sufficiently attractive pay and conditions of service — there have been calls for the private sector to bear some of the training costs currently incurred by the public sector. In some senses this is a clear case of special pleading. Most people in this country have their education and training paid for by the public sector but there is no expectation that they should not work in the private sector. Moreover, the Sheffield study shows that nurses leaving established NHS posts have, on average, already given the NHS five years service.

Private Health Insurance

Recent statements from Ministers suggest that the encouragement of private expenditure on health is going to be a policy priority in the future. This will lead to greater emphasis being placed on private health insurance. How should this be viewed?

International evidence shows that where private insurance is the main form of health finance it has a number of failings. Adverse selection means that high risk groups find it difficult to obtain cover at affordable premiums. Most policies exclude cover for catastrophic and long term, chronic illness. Insufficient control over treatment levels and prices has sometimes led to serious cost inflation. Low income households can rarely afford adequate cover. To meet these failings, in all advanced countries, governments have invariably assumed major responsibilities for finance. Even in the United States, over 40 per cent of total health expenditure is publicly financed (OECD, 1987).

However, proposals for an extension of private health insurance in the UK do not usually envisage it as a replacement for public finance. Rather it is seen as a source of supplementary or top-up finance. In this connection, there is a case for examining existing private insurance arrangements to see whether there is scope for offering more varied packages that would reach a larger section of the population. These might involve the further development of limited cover insurance schemes that enable people to choose between the public and private sectors for, say, specified elective procedures. At the moment, as Laing (1987) points out, the high marginal cost of private medical care has placed a limit on its growth. Unless a person earns less than £8,500 a year, there are no tax concessions available for private insurance. In some cases it might be cost effective for the government to extend tax subsidies on private health insurance if it encouraged individuals to finance the remainder from their private incomes. However, these subsidies would need to be offered on a selective or targeted basis. There would be little point in offering subsidies to those people already subscribing to private insurance schemes.

Conclusion

There is scope for the private sector to contribute towards the improvement of the health care system alongside the NHS. Problems associated with the distortion of NHS planning priorities, cost inflation and possible adverse effects on NHS labour supply are likely to be manageable as long as the private sector remains a relatively small-scale supplement to the NHS. And despite its recent growth, it is likely to continue in a supplementary role: offering certain procedures, for certain people, at certain stages in their lives.

Even as a supplement, though, private top-ups provide access to health care on the basis of ability and willingness to pay. The NHS provides access on the basis of need as defined by clinicians. Multiple and conflicting objectives pose difficult choices. Is some sacrifice in equality of access acceptable in return for more health care and individual choice? As we stated at the outset of this report, attitudes to such matters ultimately involve value judgements. Our aim has not been to impose these judgements. Rather we have sought to clarify the nature of the trade-offs in the hope that this will lead to a more fruitful debate.

CONCLUDING COMMENT

No health care system anywhere is perfect or can meet all demands placed upon it, although some arrangements may be more successful than others. The NHS is no exception. The challenge confronting policy-makers is to seek ways of reducing imperfections. Taking the existing NHS as the starting point, our report has reviewed a range of proposals designed to do this.

Ultimately, a political choice has to be made in selecting the option, or options, most likely to secure the desired ends. Our purpose has not been to impose these judgements. Rather we have sought to clarify the nature of the trade-offs in the hope that this will lead to a more informed debate.

One thing that has become particularly apparent during our investigations is that no proposals for change can be evaluated without some reference to underlying assumptions and principles. If the Government aspires to reform health care finance and provision in the UK, rational debate following the publication of proposals would be greatly aided if they were to be accompanied by a coherent statement of goals and objectives.

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APPENDIX

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KING'S FUND INSTITUTE

The Institute is an independent centre for health policy analysis which was established by the King's Fund in 19[redacted] Its principal objective is to provide a balanced and incisive analysis of important and persistent health policy issues and to promote informed public debate about them.

Assessing the performance of health care systems is one of the Institute's central concerns. Many of its projects focus on trying to determine whether health care systems achieve their objectives. The Institute is also concerned with health policy questions which go wider than health services proper. These centre on the scope of public health policy and on social and economic determinants of health.

The Institute's approach is based on the belief that there is a gap between those who undertake research and those responsible for making policy. We aim to bridge this by establishing good relations with the scientific community, and by gearing our work towards making the most effective use of existing data. One of our key objectives is to undertake informed analyses and channel them to politicians, civil servants, health managers and professionals, authority members and community representatives.

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CC 30.

GB/fm

28th June 1988

Mr. Paul Gray,
Private Secretary to the Prime Minister,
10 Downing Street,
London, SW1.

Dear Mr. Gray,

I herein submit a report for consideration by the Prime Minister's Review Group on the NHS.

Yours sincerely,

Gordon Best.

Gordon Best
Director

REFORMING THE NHS : MANAGED EXPERIMENTATION

A Submission to the Prime Minister's Review of the NHS from the King's Fund College

E X E C U T I V E S U M M A R Y

June, 1988

REFORMING THE NHS: MANAGED EXPERIMENTATION

1. The attached paper is intended as a contribution to the Prime Minister's Review of the NHS. The paper argues that the use of incentives, competition and better management has already led to significant progress in improving efficiency, effectiveness and consumer responsiveness within the NHS. The key challenge now is to build on these beginnings in order to accelerate this process.

2. A key premise of the paper is that it is not possible to specify now, in advance, in any useful degree of detail, what the NHS should look like in four, five of ten years' time. Purposeful and beneficial change will not be achieved by prospective detailed prescription from Government. Rather, it will be far better and far more effective to:

a) concentrate government attention on a small number of key strategic themes (e.g. the use of market-led incentives to increase consumer choice);

b) translate these themes into a change agenda (e.g. to encourage greater competition);

c) create conditions within which local initiatives consistent with this are encouraged (e.g. to reward successful competition); and

d) **create a surveillance function** which (a) sanctions and establishes the ground-rules for local experimentation; (b) manages the risks invariably associated with such local initiatives (c) ensures that successful initiatives become the basis for defining good practice; and (d) allows for 'earned' local autonomy by ensuring that those responsible for successful experiments are given increasing scope to innovate.

3. It is thus a main thesis of the paper that the **Prime Minister's review should focus on the managerial process of bringing about change rather than the prospective specification of change.**

4. The paper makes a number of suggestions for promoting innovation and change in this manner. A key suggestion is that reformed Regional Health Authorities - restructured along the lines of the 'agency' model suggested in the report on improving government management by the Prime Minister's Efficiency Unit - have a key role to play in discharging the responsibilities set out above. More specifically, it is suggested that:

* **Slimmer Regional Health Authorities, freed from the many of their service provision and operational responsibilities and re-structured as agencies with a smaller board of executive and non-executive directors, could play a pivotal role in translating political priorities into successful local initiatives.**

* To achieve this, Regions would a) negotiate a change agenda with Central Government; b) take responsibility for promoting and sponsoring local initiatives consistent with this agenda and c) act in a surveillance capacity.

* Even with Regions as agencies, there is still a need for a managerially orientated Management Board (or its equivalent) at the Centre. The Board's key roles in bringing about a reformed NHS through managed experimentation, would be to a) advise Ministers and Permanent Secretaries on the management implications of policy; b) negotiate with Regional 'agencies' a change agenda reflecting ministerial priorities; c) agree a policy and resources framework with each Region; and d) challenge performance against that framework.

* Locally, the process of managed experimentation would be driven by the introduction of organisational incentives and disincentives. For example, Regions and delivery organisations such as DHAs or FPCs, should be allowed to 'earn' (or lose) revenue and/or gain the freedom to invest revenue surpluses through association with successful experiments. Success should be rewarded. Regional agencies should be rewarded for sponsoring and managing the risks associated with successful experiments; delivery agencies should be rewarded for seeing through successful experiments that advance the national change agenda.

* **Legislative and other changes are needed to make available the managerial freedom required to undertake meaningful experimentation. This freedom should, however, be held in reserve and only granted in circumstances where the Regional agency (a) can demonstrate good chances of success and (b) has credible proposals for managing the risks involved.**

5. In summary, it is suggested that a managerially-orientated NHS Management Board, Regional agencies, organisational incentives and increased statutory freedoms are the key ingredients in creating a process of managed experimentation. Building on recent NHS achievements and working to a national change agenda, such a process holds out the prospect of bringing about significant beneficial reform reasonably quickly.

King's Fund College

June 1988

REFORMING THE NHS : MANAGED EXPERIMENTATION

A Submission to the Prime Minister's Review of the NHS from the King's Fund College

June, 1988

The King's Fund College

The King's Fund College is a part of the King Edward's Hospital Fund for London which was founded in 1897 by Edward, Prince of Wales, to mark Queen Victoria's Diamond Jubilee. The King's Fund is a leading independent charity which seeks to stimulate good practice and innovation in all aspects of health care including policy, practice and management.

As a part of the Fund, the King's Fund College has constantly reflected in its activities the rapidly changing circumstances of health services management in the United Kingdom. The College played an important part in both the development of thinking about general management in the NHS and its practical implementation. Today, when reviewing progress to date, we believe that the Faculty of the College has unrivalled experience to draw upon. This is because College Fellows have been working regularly both in the classroom and in the field with a wide range of regional, district and unit general managers as well as professionals from throughout the NHS. Furthermore, the College is, by a substantial margin, the largest of the many Management Development Centres working with the NHS. In consequence, it is probably visited in total by more doctors, nurses, authority members, senior (and junior) managers and administrators, than any other comparable institution. These practitioners in the field, inform us freely about their successes and failures. The College's evidence given below draws upon this breadth of experience as well as upon that of the Faculty's individual members.

This paper reflects the contributions of a number of members of the College as well as NHS managers and others. These were co-ordinated by:

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REFORMING THE NHS: MANAGED EXPERIMENTATION

1.0 Introduction and Background

1.1 This paper is a contribution to the Prime Minister's Review of the NHS. It addresses the following questions:

> 'How can the NHS be made more competitive and innovative? Is it possible to increase its efficiency, effectiveness and consumer responsiveness without simultaneously undermining its traditional strengths?'

A key premise of the paper is that this kind of change can be achieved. More important, the process of doing so has already begun.

1.2 In some parts of the NHS, better management - especially when supported by the use of incentives - has already led to significant progress in improving efficiency, effectiveness and consumer responsiveness (see below). The opportunity exists now to build on these beginnings and accelerate the process without undermining the founding principles of the NHS (comprehensiveness, equity and access not dependent on ability to pay) which are seen internationally and at home as its greatest strengths.

1.3 This paper tries to avoid repeating arguments and proposals made elsewhere, but the proposals below owe much to Best (1987); Culyer/IHSM (1988); Efficiency Unit/Ibbs (1988); Enthoven (1986); Marinker (1987);

NAHA (1988); Parston (1988); Peet (1987); and Willetts and Goldsmith (1988). Unlike many of these publications however, this paper argues that it is not possible to specify now, in advance, the details of the issues that will be facing the NHS in three, five or ten years' time and hence what organisational arrangements will be appropriate.

1.4 Purposeful change in the NHS will not be achieved by prospective detailed prescription from government. Rather, it will be far better and far more effective to:-

a) **concentrate government attention on broad strategic themes** (e.g. the use of market-led incentives to increase consumer choice)

b) **translate these themes into a change agenda** (e.g. the encouragement of greater competition);

c) **create conditions within which local initiatives consistent with this are encouraged** (e.g. rewards for successful competition); and

d) **create a surveillance function which (a) sanctions and establishes the ground-rules for local experimentation; (b) manages the risks invariably associated with such local initiatives; (c) ensures that successful local initiatives become the basis for defining good practice;** and (d)

allows for 'earned' local autonomy by ensuring that those responsible for successful experiments are given increasing scope and encouragement to innovate.

1.5 Most suggestions for change in the NHS produce blueprints or sets of options which (presumably) Ministers are to choose between. It is important to stress at the outset therefore, that while alternative visions of the future are an important backdrop against which to set a change agenda, good management practice suggests that successful change in complex organisations cannot be pre-ordained in detail. Richard Beckhard, a respected advisor to many of the largest and most successful U.S. and U.K. corporations has put this view forcibly:

> 'The future is not the result of choices among alternative paths offered in the present - it is a place that is created - created first in the mind and will; created next in activity'. (Beckhard, 1985).

1.6 The introduction of General Management in the health service and the increasing pressures to find new and locally appropriate ways to stretch resources further, has already set in train the change in the mind to which Beckhard refers. The IHSM (1988) report, for example, represents an important statement about managers publicly committing themselves to new values, experiment

and innovation. It was a key strength of the Government's management review, chaired by Sir Roy Griffiths in 1983, that it recognised that releasing the management development process was far more important and would be far more productive than detailed prescriptions about what managers should do and how they should do it. The challenge now is to manage consciously - and thus accelerate - the process of change that has already begun.

2.0 What is there to build on?

2.1 This section addresses two questions: first, what evidence is there that the change process has already begun? and secondly, what evidence is there that incentives and better management will deliver beneficial change reasonably quickly?

2.2 The introduction of general management and the closer scrutiny of financial and other aspects of NHS performance over the past five years have been in part or in whole, responsible for a wide variety of changes within the Service. (The publications by Best (pp 1 - 10); Culyer/IHSM (sections 3.3 - 3.6); NAHA (pp 1 - 3); and Peet (Chapters 2 - 6) all document many of these changes). Some of these changes have emanated from Management Board level. These have included the introduction of Individual Performance Review and Performance Related Pay for top and senior managers; temporary contracts for top managers and the strengthening of the Performance Review process; and Resource Management as a combined national/local initiative breaking new ground in the management of clinical and nursing services and in information systems support. There have also been a number of local initiatives sometimes involving partnerships with the private sector. For example, a number of health authorities now buy and/or sell acute services, while many sub-contract long-stay services to the private and voluntary sectors. There has also been a significant

move away from bureaucratic models of management with unprecedented and widespread differences in local organisational and management arrangements. For example, performance review and income generation managers have been appointed and unit structures have been designed specifically to bring about desired change. Many of these changes can be seen as measures intended to build upon and strengthen the general management function while others make use of incentives to influence managerial and organisational performance.

2.3 There are many instances where the particular energy of District and Unit managers has produced beneficial change on an unprecedented scale. One well-documented example is that of a major London teaching hospital which (a) has used the introduction of general management to involve clinicians directly in the management of resources; (b) in so doing, has completely turned around its financial performance; and (c) is now completing the process of introducing incentives so as to improve morale and ensure that these major structural changes result in an improved service to patients. Appendix A attached describes these changes in detail.

2.4 The scale of change described in Appendix A while impressive on such a short timescale, is by no means an isolated example. Other examples include major changes in the delivery of mental health services in Exeter and Newcastle DHAs; collaboration with the private and voluntary sector in the care of the elderly; quality

assurance initiatives in Wessex RHA and Brighton DHA; and personal service initiatives in Trent and Mersey RHAs. Such examples leave little doubt that, in the favourable circumstances of proactive, confident managers and a solid coalition between managers and clinical leaders:

* **Improved management can be a key ingredient in effecting major change in an organisation as complex as the NHS in a relatively short period of time.**

* **These changes do have a major impact on the performance of the organisation, including the standards of service that it provides.**

* **Even in conditions of financial stringency it is possible to create positive incentives for change.**

* **It is possible to work with the private sector in ways that create further scope for incentives and which, as a consequence, strengthen both elements of the partnership.**

2.5 There will always be special circumstances peculiar to each local initiative. It is important not to allow this to distract attention from the fact that successful change has almost always occurred in circumstances where a) the managerial structure has both enabled and rewarded successful initiatives; b) higher levels in

the NHS hierarchy have given a clear sense of direction, but not tried to manage in detail; and c) there has been a recognition that it is important both to motivate and to control the process of experimentation.

2.6 This experience gives rise to two major practical questions: (a) can such local initiatives and experiments be encouraged and promoted more widely? and (b), if so, how should the process of experimentation be managed in order to promote beneficial change while minimising risk? The next section considers these two issues.

3.0 Managed Experimentation

3.1 If the process of introducing beneficial change in the NHS is to be accelerated, the key is to find ways of identifying, fostering, encouraging and monitoring more local initiatives and experiments. Equally, it will be necessary to ensure that only those experiments that represent reasonable risks are embarked on; that the range of experiments is broad; and that the learning from them is captured, disseminated and acted upon so as to promote change on an increasingly broad front. In short, if such a process of experimentation is to succeed, it will need to be managed. The remainder of this paper considers how this can be done.

3.2 Establishing a change agenda

3.2.1 Any agenda for change in relation to the NHS must reflect both political and managerial considerations. It is the responsibility of ministers and their advisors to agree in the light of governmental priorities what changes they would like to bring about (see below). To maximise the chances of these changes occurring and achieving what ministers intended however, local managers should be given the maximum freedom to decide how best to deliver these changes. This is an important lesson which the public sector needs to learn from industry. Indeed, the recent report by the Prime Minister's Efficiency Unit

suggested that while "... strategic control must lie with the Minister and the Permanent Secretary ... once the policy objectives and budgets ... are set, ... management ... should have as much independence as possible in deciding how those objectives are met." (Page 9).

3.2.2 The Ibbs Report suggested that political and managerial concerns within Government departments could be reconciled through the creation of 'agencies' established to carry out the executive functions of Government within a policy and resources framework set by a department:

> 'An 'agency' of this kind may be part of government and the public service, or it may be more effective outside government. We use the term 'agency' not in its technical sense but to describe any executive unit that delivers a service for government. The choice and definition of suitable agencies is primarily for Ministers and senior management in departments to decide. ...
>
> These units, large or small, need to be given a well defined framework in which to operate, which sets out the policy, the budget, specific targets and the results to be achieved. It must also specify how politically sensitive issues are to be dealt with and the extent of the delegated authority of management. The management of the agency must be held rigorously to account by their department for the results they achieve.
>
> The framework will need to be set and updated as part of a formal annual review with the responsible Minister, based on a long-term plan and an annual report. The main strategic control must lie with the Minister and Permanent Secretary. But once the policy objectives and budgets within the framework are set, the management of the agency should then have as much independence as possible in deciding how those objectives are met. A crucial element in the relationship would be a formal understanding with Ministers about the handling of sensitive issues and the lines of accountability in a crisis. The presumption must be that, provided management is

operating within the strategic direction set by Ministers, it must be left as free as possible to manage within that framework.' (Page 9).

3.2.3 It would be managerially attractive to see these recommendations as applying to the NHS Management Board. But the NHS is so large, diverse and politically sensitive that it is unlikely that a single agency could, by itself, provide an effective mechanism for managing the whole complex process. A national change agenda will need to reflect governmental priorities - for example, increasing consumer choice; fostering increased competition between providers in order to achieve a higher quality of service and better value for money; promoting increased partnerships with the private sector; and so on. In addition, criteria will need to be established against which local initiatives intended to translate these priorities into real change, can be judged. A number of the publications cited above suggest such criteria - for example, impact on access to services, contribution to service effectiveness, community acceptance, and so on. The process of moving from Government priorities to fostering and promoting local initiatives which, when judged against such criteria, stand a good chance of success, is a complex task. It will, for example, require prospective judgements to be made about the quality of local management; the scope for cross-organisational co-operation; the scope for competition between providers; the timescale within which the results of innovation can be measured; and the means of assessing

consumer satisfaction.

3.2.4 It would be impractical for a central body such as as the DHSS or the NHS Management Board to scan 190 DHAs, over 90 FPCs and a similar number of other potential public and private providers and then to identify those specific, local opportunities that offer the greatest potential for fruitful experimentation, let alone to keep in close touch with them as they progress. The DHSS and the NHS Management Board are too remote from the field to be able to exercise informed judgements about more than a handful of local management initiatives. In addition, both are too close to government to provide the necessary distancing of ministers from the risks which are inevitably associated with experiment and change.

3.2.5 By contrast, regions are relatively well-placed organisationally to negotiate a change agenda with the Centre and then to seek opportunities to translate that agenda into successful action. In particular, regions should be close enough to local service delivery to make well-informed judgements about the potential for successful experimentation, and about its progress, while also sufficiently divorced to take an overview. Slimmer Regional Health Authorities, freed from many of their service provision and operational responsibilities and re-structured as agencies with a smaller board of executive and non-executive directors, could play a key role in

translating political priorities into successful local initiatives.

3.2.6 Under such an arrangement, the role played by the Centre (i.e. the Department of Health) will also be crucial. Following the Ibbs' recommendations, the Centre would:

* advise Ministers on the management implications of policy;

* agree a policy and resources framework with each Regional agency;

* challenge performance against that framework;

However, even with the model of Regions as 'Ibbs' agencies there is still a need to retain (in close conjunction with DHSS) something like the Management Board. There are several reasons why this is so:

a) The negotiation of the change agenda, the subsequent communications and the measurement of success requires the Centre to be conversant with the values, risks, language, and tools of management. Without such knowledge and experience the Centre will not understand the perspectives of management in the field;

b) Conversely, a core of people with managerial experience at the Centre will enable the Government's political perspectives both to be absorbed by Regions and translated into managerial programmes and controls in a way more likely to create credibility and commitment in the field;

c) A managerial presence at the Centre is essential in certain key fields such as the pay and conditions of staff, policy on procurement, and the governance of national standards in data collection.

These important factors in the relationship between the Centre and the field would be lost if the Management Board were dissolved without the creation of something equivalent to take its place. Indeed it needs strengthening, not weakening, and a clearer recognition of its role.

3.2.7 The Centre is at present not internally structured in a way which reflects or can respond to the imperatives of running one of the world's largest organisations. No doubt the internal lines of command could be altered but two more fundamental issues would need to be resolved. One issue relates to the problems continually generated by the artificial separation of policy from management. A second issue concerns the sets of problems thrown up when two very different

kinds of organisation are trying to address a shared task. There is growing organisational friction as the NHS becomes increasingly a managed service while the Centre remains an administered and indiscriminately centralising undertaking.

3.2.8 Achieving the required change will require firm support of Ministers and Permanent Secretaries. It would be all too easy for Whitehall to acquiesce with the concept of the NHS Management Board as an agency, but to then stifle innovation by retaining excessive authority and continuing to involve itself in wholly unnecessary detail. The drive towards delegation and the commitment to liberate NHS managers for innovative change must be genuine and sustained.

3.3 Creating the conditions for encouraging local experimentation

3.3.1 A key reason for suggesting the creation of Regional Agencies is that they would be well-placed to establish ground-rules for local experimentation (e.g. to negotiate and monitor service standards); to identify potential risks (e.g. gaps in service coverage which might arise from competition); and to manage risk (e.g. to underwrite financial risk in part or in whole by providing a 'banking' service or, for example, ensuring that alternative provider arrangements are available in situations where an experiment may not meet the needs of all patients).

3.3.2 It is also likely that despite their relative distance from most aspects of service delivery, regions are close enough to see opportunities for experimentation within and between districts and in the private and voluntary sectors. Regions are also close enough to amplify the learning from experimentation and to take responsibility for ensuring that such learning is generalised and incorporated as a basis for good practice. This is critical if local experimentation is to be encouraged on a wide enough scale to create models for more widespread change within the NHS.

3.3.3 To discharge these responsibilities successfully, it will be necessary for Regional Agencies to encourage local initiatives which, if introduced successfully, would promote greater patient choice, a more efficient use of resources, an increase in public/private partnerships, and so on. Measures often suggested include:

* internal trading between health authorities (for example, the buying and selling of acute services between authorities)

* competition between health authorities and between health authorities and the private sector (for example, competition for the provision of pathology services on a multi-district basis)

* the separation of responsibility for finance from that for provision (for example, the creation of a special authority to purchase hospital, primary care and social services from both public and private providers)

* the strengthening of general management (for example, the introduction of general management in FPCs and/or the creation of 'units' of management incorporating primary care services within the RHA structure)

* the wider use of performance incentives (for example, the use of performance bonuses and/or the extension of the designated area allowance to modify GP referral behaviour)

3.3.4 The introduction of these kinds of initiatives presents both a number of practical problems (e.g. lack of adequate information; legislative obstacles, etc.) and certain risks (e.g. internal trading leading to greater inequalities in access to services). It is a key premise of this paper that provided these measures are introduced as a part of a carefully managed and selective process of experimentation, neither of these types of danger need delay progress.

3.3.5 In order to make significant progress in a reasonably short period of time, however, it is necessary to create enough managerial freedom for significant experimentation to take place. There is a need to remove or modify particularly significant barriers to more effective management. These include:

- over-centralisation and inflexibility in pay bargaining;

- over-elaborate and time-consuming public consultation currently applying to the smallest changes in patterns of service delivery;

- inflexibility between capital and revenue, coupled with an inability to raise capital or to account for capital depreciation in a commercial way;

- inability to develop appropriate measures of health care effectiveness and consumer satisfaction, resulting in the current preoccupation with methods and systems of measuring what is happening and how it is happening, rather than concentrating on where health care effectiveness and consumer satisfaction need to be improved;

- inability to trade between hospitals within the public and private sector because of the lack of

basic information about treatment 'tariffs' and because of professional rigidities (e.g. barriers to the transfer of patients from a consultant's waiting list to a service elsewhere);

- confusion within health authorities around the role of members as consumer representatives, staff representatives or non-executive board directors;

- **inability of managers to be directly involved in consultant appointments** or to review/reward consultant performance against contracts with a five or ten year 'break clause'.

3.3.6 Perhaps most important, there is an urgent need to introduce **organisational incentives** which would (a) **motivate DHAs, FPCs and other providers actively to seek out opportunities for experimentation** and (b) **motivate Regional Agencies to want to sponsor and facilitate successful experiments.** For example, Regional Agencies and other authorities ought to be able to 'earn' additional revenue and/or have the freedom to reinvest earned surpluses if they are a party to successful experimentation which promotes the agreed change agenda. In general, **success should be rewarded.** Similarly, agencies which do not perform well should risk losing resources (e.g. another agency taking over some of their responsibilities). **The**

agency model offers a very real prospect of removing most if not all of the worst features of 'boundaries' around Regions as well as around Districts.

3.3.7 It is important to underline the importance of such incentives. Many of the practical barriers to experimentation noted above have on occasion already been overcome within the Health Service. Districts are already trading internally and both competing with, and working in partnership with, the private sector (see Appendix A). There have also been examples where cross-organisational co-operation has been successful (for example, between FPCs and DHAs). In almost all cases, however, the prospect of reward (for example, additional income; access to earmarked joint planning monies, etc.) provided the spur for such developments. The prospect of securing additional resources and having the freedom to invest those in improving services can have a major motivating effect: it can lead for example, to an active and successful search for information which is 'good enough', even though imperfect. It is quite likely that many of the practical barriers to successful experimentation can be circumvented if the motivation is strong enough.

3.3.8 It is also important that experiments only proceed in circumstances where the chances of success are judged to be high enough and where arrangements for managing the risks involved are in place. In particular, if

the legislative and other barriers listed on pages 18 and 19 are removed, the ability to utilise these additional freedoms should have to be 'earned'. Regional Agencies and delivery bodies such as DHAs and FPCs should be required to earn additional autonomy by association with local initiatives that are likely to advance the national change agenda.

3.3.9 Finally, if Regions are to fulfil these roles successfully, there is a strong case for freeing them of some of their existing responsibilities. In particular, a combination of devolving some services to Districts for them to manage (e.g. Ambulance Services and Supplies) and contracting out (e.g. Regional Design and Project Management and Regional Computing) will free Regions to concentrate on their core agency functions, as well as their more traditional strategic roles of planning and allocating resources; stimulating a strategic vision for Districts; challenging District performance; and promoting the development of better managers and management practices.

In these circumstances, the re-structuring of Regions should almost certainly also involve the creation of smaller boards of executive and non-executive directors, chosen in part for the ability to contribute to the work of the Agency, to replace existing RHAs.

3.3.10 In summary, it is suggested that a managerially-orientated NHS Management Board (or its equivalent), Regional agencies, organisational incentives and increased statutory freedoms are the key ingredients in creating a process of managed experimentation. Building on recent NHS achievements and working to a national change agenda, such a process holds out the prospect of bringing about significant beneficial reform reasonably quickly. The idea is to create within the NHS many of the stimuli, incentives and sanctions of the market, so that innovation becomes part of everyday life rather than being imposed from above. Precisely the configuration of services and management arrangements that will result is not specified in advance, but will emerge from many competing efforts to do the job better than others, within the framework of government policy and government decisions on funding.

APPENDIX A

A SUMMARY OF RECENT CHANGES AND DEVELOPMENTS AT GUY'S HOSPITAL - 1984 - 1988

A.1 Guy's Hospital exploited the opportunity afforded by the introduction of general management to introduce a decentralised clinical management structure with each major specialty coming under the management of a senior consultant from within that specialty:

A.1.1 Each clinical firm within each Directorate has accepted **explicit responsibility for meeting prospectively negotiated caseload and financial targets.**

A.1.2 To facilitate this process, most of the support departments within the hospital (e.g. medical records) have been de-centralised with **about 70% of all staff reporting through clinical directorates.**

A.1.3 The **management of admissions and waiting lists** and authority over **ward budgets** have also been **decentralised to clinical teams** and/or directorates.

A.1.4 The **14 clinical directors** (i.e. consultants) meet as a management board on a monthly basis to **monitor expenditure, quantity and quality of**

activity and where appropriate, agree changes in policy and/or operations.

A.2 Many of these changes were introduced in part to address the severe financial difficulties facing the hospital in 1984. At that time, the hospital's annual deficit was £1.2m on a budget of just under £60m. In 1985/86 this deficit grew to £1.7m. During that year and throughout 1986/87 however, the Management Board agreed actions which effectively cleared the deficit. In 1986/7 the hospital broke even (while every other teaching hospital in London registered a significant overspend) while in 1987/88, the hospital underspent its budget. During the period 1984/85 to 1987/88, management in the hospital reduced expenditure by £7.8m per annum (15%); reduced its bed complement by 340 (28%); and its staff complement by 17%. Moreover, while the volume of patients treated fell during the early phase of these changes, they rose by about 5% in both 1986/87 and 1987/88 and are expected to reach 1982 levels (the highest year on record) during 1988/89.

As might be expected, this scale of change has had a traumatic impact on the hospital. Aware of this, the hospital's management has continually sought ways to guard against sacrifices in the quality of care and staff morale. Action has included:

A.2.1 The establishment of an observation ward associated with the accident and emergency

department to take pressure off beds, and a five-day ward and day surgery unit. (It is widely believed that these changes have been responsible for the sharp fall in waiting lists which began in mid-1987).

A.2.2 The establishment of a quality assurance committee (chaired by a consultant member of the Management Board) which, amongst other activities, monitors inpatient re-admission rates and has introduced a new system for planned discharges for the elderly or chronically disabled with a reporting system to judge inappropriate discharges to the community.

A.2.3 The establishment of a centrally-administered development fund made up in the first instance (see below) or fortuitous savings and a proportion of planned directorate savings: (this fund is held centrally against the possibility of a hospital-wide overspend; in the absence of an overspend, the Management Board invites directorates and other parts of the hospital to bid against these monies to fund new developments).

A.2.4 To increase revenue the hospital has in the past, provided acute services to other DHAs with long waiting lists for given conditions.

A.2.5 To effect further savings (and therefore increase income to the development fund) the hospital has **contracted out the management of its hotel and support services.** (Although the hospital continues to employ the staff involved (with the exception of management) the private contractors have agreed to meeting significant savings targets while adhering to explicit standards of quality, respecting existing conditions of employment and making no reductions in staff save those agreed with the Unions as a result of 'natural wastage'.)

A.2.6 Perhaps most significantly, the hospital has **raised the capital (through its Special Trustees) to open its 'own' private hospital** (to be opened in the Autumn of 1988). The **management of this hospital is contracted out to the private sector** which again, has agreed to quite rigorous conditions including quality standards, the purchasing of all medical support services from the 'parent' NHS hospital and so on. In addition, **a significant proportion of the surplus earned from the private hospital will be channelled into the parent hospital's development fund:** (these monies together with the income from the provision of medical support services will create an annual development fund in excess of £2m/annum).

A.3 Although there is no doubt much to be learned from this experience (and others), the point of covering it in detail here, is that it provides a concrete illustration of how incentives and better management can be used to bring about significant change within the NHS in a reasonably short period of time.

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NHS AUDIT

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CONFIDENTIAL

From: S D H SARGENT

Date: 28 June 1988

MR ANSON

cc PPS
PS/Chief Secretary
Mr Phillips
Mr Saunders

NHS REVIEW: AUDIT

Sir Peter Middleton spoke to Mr France on 28 June about NHS audit. Mr France said that he was concerned about two aspects of the proposal that the Audit Commission should be involved in auditing the NHS. He regarded this as separate from the wider question of whether there should be an independent audit of the NHS. His first worry was about how the Audit Commission's activities would relate to those of the NAO, and about what would be said to the PAC. There was clearly a limit to the number of auditors who could sensibly go over the same ground. His second worry was about the impact of the Audit Commission's involvement with the NHS on their main function of auditing local authorities. Clearly Mr Ridley needed to be brought into the discussions. Mr France stressed that he did not wish to sidetrack the discussions that were already going on, but he felt he should register his concern on these points. Mr Mayne's recent letter to Mr Phillips about mechanics touched on the same problems. Sir Peter Middleton said that he would think further about the issues raised by Mr France and then have another word with him.

2. Sir Peter Middleton would like to have a word with you and Mr Phillips about this.

S D H SARGENT
Private Secretary