Prime Minister 2
For your health meeting, now on Tuesday.
DCW 11/12.

SECRET

PRIME MINISTER

11 December 1987

TAKING THE INITIATIVE WITH THE NHS

"In confusion there is profit."
Anon.

The Government is at present beset by two accusations over the NHS. We are seen as unwilling to fund it adequately. And we seem to be reacting to crisis after crisis without any overall game-plan. These criticisms are likely to intensify between now and the end of the financial year as districts close wards and cancel operations in an attempt to stay within their budgets. We face at best a string of embarrassments, at worst a Tory version of the Winter of Discontent, a background of parsimony contrasting very unfavourably with Mr Lawson's tax-cutting Budget.

For districts to be driven to resort to ward closures in the last few months of the financial year is in fact a damning commentary on much NHS management. But that is not how it will be generally reported. So despite the fact we know there are major opportunities for better management of existing resources, these short-term pressures will probably compel us to provide some additional cash for the Health Service to tide it over the current crisis.

That, however, will not solve the fundamental problem of an overblown and complex NHS that has slipped almost beyond management control. Indeed, it will make matters worse if it persuades people in the NHS that more money is the answer to its problems and "shroud-waving" the way to get it. Nor will we gain and keep public confidence if we seem to be just handing out money in response to public agitation without a plan to tackle the underlying problems.

We must, instead, turn the crisis to our advantage and use it to justify the case for urgent structural changes. The political environment is oddly favourable for doing so. Much newspaper comment has accepted that the NHS's current difficulties go far deeper than the need for more cash. Our recent discussions with John Moore, Tony Newton, senior DHSS officials and informed outsiders like David Willetts have led us to believe that a new consensus is rapidly developing on an agenda for change. And the next election is four years away -- long enough for the public to realise the benefits of reforms which may at first appear threatening.

All this points to developing and announcing our own proposals quickly, linking our determination to undertake major structural changes to our acceptance of the need for more short term cash to overcome current management ineffectiveness. A Royal Commission or any other major inquiry would mean delay and perhaps losing the impetus for reform provided by the current crisis. Even a sensibly chosen Commission might move in directions which we dislike or omit reforms we think essential. And it would present its (probably contentious) proposals in the run-up to the next general election. We would have wasted four years of Government only to find ourselves fighting on our enemy's natural territory. "Action this day" is an altogether better policy.

We suggest a sequence of action in two phases:

Phase 1:

- Announce a cash injection as a temporary expedient -- but only if tied to plans for fundamental reform;

- Point to the large variations in performance between district health authorities to justify demanding such major changes;

- Set up a tough-minded task force to investigate the situation in a number of particularly bad districts (focussing on those which have most overrun their budget);

- Announce the broad outlines of an agenda for structural reform:

  * Setting priorities
  * Establishing ~~a competitive market~~ patients' choice
  * Tackling producer power
  * Encouraging private provision

Phase 2:

- Publish a White Paper (early in the year) providing details of the reforms for subsequent legislation;

- Set up, in addition, two small and carefully chosen committees to deal with thorny aspects of the reforms. Namely:

  * How to establish priorities in the acute sector.

  * Drawing up new contractual arrangements for doctors.

  These could be presented as a response to the letter from the Presidents of the three Royal Colleges and, if carefully handled, might succeed in diverting medical opposition to the reform package in its early stages.

The arguments underlying this approach are set out below.

The Scope for Improved Management

Vital evidence in turning round the public debate would be the statistics we can muster on the scope for management improvements. Figures we have obtained from the NHS management system demonstrate that the variations in performance between best and worst districts are huge on almost any measure.

For example, comparing the best 10% (90th percentile value) with the worst 10% (10th percentile value):

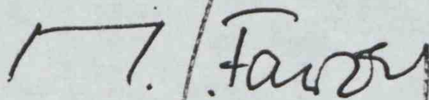
	Best 10% Better than	Worst 10% Worse than	Ratio Best/ Worst
1 Index of standardised cost per case (Cost of acute cases relative to the average, adjusted for case mix)	90	110	1.22
	Better than	Worse than	Worst
2 Index of standardised throughput (patients treated per bed relative to the average, adjusted for case mix)			
- General Medicine	118	83	1.42
- Surgery	118	83	1.42
- Trauma and Orthopaedics	128	80	1.60
- Gynaecology	122	79	1.54
- Ear/Nose/Throat	126	71	1.77
- Opthalmology	139	70	1.99

E.R.

The attached note (at Annex B) points out why figures for bed occupancy alone are not particularly useful: we are more interested in how beds are being used. It is worth pointing out that efficiency in using beds - in the sense of maximising patient throughput - need not produce savings. In a district with patients waiting for treatment improving efficiency could result in more patients being treated (which is our aim) and in higher costs. Providing patient care is more expensive than simply providing "hotel" accommodation. It is necessary to look at a range of related indicators in order to form some initial view about a district's performance. Drawing an example from the information attached, a district (for example, Huntingdon) might appear to be very efficient in terms of the way it uses its beds. At the same time that district has, not unexpectedly perhaps, a high cost per case. It would be too simplistic to attempt to criticise the district for the latter whilst praising it for the former.

One of the problems we face is that there is a certain amount of inaccuracy in the data we obtain from the NHS and use to produce the indicators. Though the data are validated as far as possible some of the values are likely to be misleading. This is particularly true of the extreme values and so we advise that these are treated with some caution. The implementation of new data collection systems from this year by the entire service will produce better, more accurate data in time.

Yours sincerely



M J Fairey

3 Waiting List (Number of days to clear waiting list at current activity levels)			
- General Surgery	48	163	3.40
- Trauma and Orthopaedics	34	203	5.97
- Gynaecology	42	189	4.50
- Ear/Nose/Threat	41	211	5.15
- Opthalmology	35	228	6.51
4 Non-medical staff cost as a percentage of total staff costs			
- Ancillary staff	10.5%	15.3%	1.46
- Building and Maintenance Staff	2.0%	3.5%	1.75
- Administrative and Clerical staff	8.8%	11.6%	1.32

See extract from letter, opposite.

The DHSS continues to urge caution in using any of this information publicly, on the grounds that the management equation is complex and districts that are bad on one measure may be good on another. In such cases, however, major variations in performance must be occurring at the level of departments - which still indicates management failure.

We believe it is time to throw caution to the winds. We do not need to prove there is a simple management solution; all we need to show is that there are huge variations in performance that translate into wastage and misuse of resources. If critics reply that this or that measure is inappropriate, they nonetheless shift the debate onto better management rather than additional funds.

The Agenda for Reform

To benefit from this situation, however, we must be be able to announce a convincing programme of reform in the next few months. While this seemed impossible earlier in the year, our recent discussions with John Moore, Tony Newton and senior DHSS officials have given us reason to believe that a new consensus is rapidly converging around the basic framework outlined in our note to you last month.

Their are four basic elements:

1 Setting Priorities: We must square up to the need to set priorities by establishing a guaranteed maximum waiting time within which a patient would be offered a bed for specified urgent treatments. This would automatically force the reallocation of resources to the specified priority treatments before money is spent on removing tattoos, providing vasectomies or expanding community care. Where necessary, districts would buy operations from other districts or private sector hospitals in order to meet their guaranteed commitments.

Any system of priorities in a context of limited resources, however, inevitably means that the lowest priority category of treatment acts as a residual sector. In effect, it would automatically lose medical resources to high priority treatments as they came under pressure.

No guaranteed waiting time could therefore be offered in the residual category and prospective patients would know from the first that their treatment was likely to be postponed in the interests of more urgent treatment. This system would have a further beneficial effect. In their advance planning, districts would find themselves allocating resources to match the hierarchy of priorities

- which would probably differ from the allocation based upon established consultant preferences.

This would, of course, provoke criticism of government interference with clinical freedom and create real problems for consultants working in this residual sector (though it would also stimulate their lists for private practice which might restrain their protests somewhat.) The committee to examine clinical priorities, on which the medical profession would be represented, is an attempt to deal with this. In general, however, we believe this system to be a commonsense and accurate reflection of consumer preferences and there is everything to gain by making such priorities quite explicit. (A more detailed note on waiting list priorities is attached as an appendix.)

2 Increasing Competition and Widening Choice: We should open up the supply of health care services within the NHS to competition more generally, rewarding efficiency and making the customer king. Two distinct ideas are here linked. First, we might introduce effective funding transfers between districts ("cross-boundary flows") to reflect patient care delivered outside the district boundary. Second, we should - and do - increasingly allow private facilities to offer NHS services where they can bid to provide the service at the contract cost. There is also scope on the non-medical side to contract out all non-medical services en bloc - for instance, the building and equipping of an entire hospital.
Taking these ideas to their logical conclusions, NHS patients would be free to take their GP's referral for an operation or other treatment to any NHS facility anywhere and, ultimately, to any approved facility, public or private. The NHS would remain a free, tax-funded health service - but ultimately need not be in the business of

managing or providing any of the health care facilities directly itself.

3 Tackling Producer Power: At some point in the reform programme, we will have to tackle the power and vested interests of NHS producer groups, in particular consultants. Some of our other proposals will provoke a clash in any event.

In an ideal world, we would simply announce our intention of ending lifetime tenure and devising more appropriate ways of linking performance to pay levels. That, however, would provoke an immediate head-on conflict with the profession at a time when we will be seeking its cooperation on other matters. We suggest a more oblique approach.

The letter from the three Royal College Presidents invited the Government to establish an inquiry into the acute sector. In the light of your broad reform programme, you might reasonably respond by agreeing to establish a committee with a narrower remit to examine, in effect, the terms and conditions of consultants' contracts. (The committee's terms of reference would need to be a work of art.) If the committee subsequently came up with the conclusions we want - and it is difficult to see how any impartial inquiry could do otherwise - that would help to marshall public opinion on our side in what is likely to be a bruising battle.

4 Expanding private provision: We should encourage additional funding through corporate health prevention schemes, the letting of commercial franchises within hospitals, patient top-up systems, etc. But coupled with the reforms above it would then be clear that encouraging private finance was not a signal that the government was washing its hands of patients who will remain dependent on free provision.

Taken together, a statement of policy intentions along these lines would signal a dramatic shake up. Management would be improved by breaking the bureaucracy up into smaller, competing units - with patients put ahead of producers. It is, in fact, a very similar framework to that which we are now pursuing in schools. Equally, however, there is still a tremendous amount of work needed to fill in the "nitty gritty" details of how such schemes might work before we can announce them with authority and credibility.

Conclusion

You will obviously need to sound out with John Moore and Tony Newton whether they are prepared to speed up policy development and nail their colours to the kind of agenda outlined above. If so, we would recommend setting work in hand to bring forward more detailed proposals on each area with the objective of announcing our broad intentions early in the New Year - with a formal White Paper following as soon as possible. As noted earlier we would also support these proposals by publicising the wide variation in performance between districts and announcing a review into the six worst districts.

If John Moore is unwilling to go along with this pace of development, we have more of a problem. In that case a carefully chosen commission of enquiry may be the only way to satisfy short term public opinion pressures to herald future policy announcements. However, the reality is that such a commission is less likely to come out with market-orientated options than policy development which we keep in our hands; it is also inevitably going to introduce several years delay. Our view is that if we act quickly and boldly, we can carry public opinion with us at this stage without the need for a commission of enquiry to provide cover.

Norman Blackwell | John O'Sullivan

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PRIVATE AND CONFIDENTIAL

DISCUSSION NOTES:

BUILDING PRIORITIES INTO WAITING LISTS

1 In a situation where medical advances continue to increase potential expenditure on health, most individuals will not be able to afford individually to buy access to all the health care that is available. Since public opinion will not accept a situation where the quality of medical service available to an individual declines with his income, Government must define the basic standard available to all through the NHS. The State is therefore inevitably involved in deciding what level of resources are devoted to health care and what quality of health care is provided. It will therefore also be seen as the rationing agent.

2 Waiting lists are the most obvious symptom of health service rationing (although, of course, the need to "buffer" admission to hospital means there would be a waiting list even if funds were not a constraint.) Waiting lists are therefore bound to continue - and the number of people on waiting lists may increase as the range of potential treatments expands.

If Government is permanently seen as the rationing agent through waiting lists, it is crucial in presenting the performance of the NHS to be both clear about, and gain public acceptance of, priorities - so as not to be judged against utopian standards.

3 In addition a more systematic method for tackling priorities could allow the extremes of long waiting times to be tackled without necessarily requiring additional resources. Long waiting times are not universal; analysis shows that waiting times vary enormously from one district

to another - and from one consultant to another. In many cases it would be feasible to tackle long waiting times by simply enabling these patients to switch to a shorter waiting list, effectively 'averaging out' waiting times.

4 The key to handling both presentation and allocation problems is to disaggregate the waiting list, establishing different targets and measures for the availability of treatment for different priority categories:

- classifying common treatments into a small number of priority categories, ranging from the painful/life threatening to the purely cosmetic;

- publicising a target performance and a guaranteed maximum waiting time to be offered a bed for the more urgent classes of treatment (a subclass of all treatments for which this guarantee can be met within available funds);

- patients who reach the maximum waiting time in these conditions would then be offered treatment by another consultant, another district or - if necessary - in private facilities if they could not be accommodated by the consultant on whose list they were waiting; those who preferred to wait for their chosen consultant would of course be free to do so - but a long waiting list would then be a healthy sign of a good doctor;

- to maintain financial control, a specified sum representing the cost of treating a patient transferred to the private sector or to another health authority would be borne by the originating health authority - who would be expected to have budgeted funds to treat the expected number of patients with this condition. Moving money with the patient maintains budget control and ensures that adequate provision is made by each

district to treat high priority cases before funds are made available for lower priority patients.

5 Such a system could have a number of benefits:

- it would defuse public conern over the waiting list problem by enabling the public to see explicit priorities and be reassured that they need wait no longer than the guaranteed time for any urgent operation;

- it would measure performance by the real objective of waiting time rather than the number of people on the waiting list - which is a combination of time and volume;

- it would provide a useful lever to begin to break up the consultants' monopoly control over patients on their waiting list. The patient would be free to choose to stay on the consultant's list, but there would be a clear trigger to offer the patient an alternative choice;

- it would discourage the practice of adding patients to the waiting list when there was no real intention of treating them in the near term. A consultant would know that once he put a name on the list he was committing resources to that operation within a fixed time limit;

- the possible use of private facilities to meet the guarantee would help gain acceptance for the idea of private provision of health care services under the NHS.

6 While this system ensures that the patient is offered treatment somewhere within the guaranteed time, the ideal

is obviously that his own district should be able to treat him rather than requiring him to travel - except for conditions where there are medical and cost advantages in focussing treatment in a few centres. The financial penalties built into the system would provide strong incentives to the district to ensure that they could meet guarantees locally wherever possible.

7 To make the system manageable only the most common conditions in each discipline need be formally classified - since a few conditions tend to account for the majority of hospital treatments. The remaining conditions would be left to the discretion of the consultant to classify the appropriate priority level.

8 The system described above would not deal with the unrecorded problem of "waiting time to see a consultant". To tackle this, similar guarantees might be provided for the maximum waiting time to see a consultant; this would require districts to organise "overload" facilities when a consultant's appointments diary became too long (although once again the patient would have the choice of waiting for his preferred consultant).

Conclusions

A system of guaranteed maximum waiting times for priority treatments could provide a useful mechanism for tackling the waiting list problem and reassuring the public about the NHS service.

However, the development of this sytem need not exclude other approaches to deal more directly with current blackspots. For example, an "audit team" or "inspectors" might be formed to investigate areas with exceptionally long waiting lists with a brief to recommend changes in working practices and

procedures, as well as 'ad-hoc' emergency solutions. This would complement the existing waiting list initiative and make it easier to introduce the system proposed above as a longer term framework.