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PRIME MINISTER

THE NHS

In his minute of 27 November Tony Newton said that I would be providing you early in the New Year with my assessment of the pressures on the health authorities. Your Private Secretary's minute of 23 December has since defined the ground which you wish to cover in this stock-taking.

2 The attached paper concentrates on the acute hospital service, because that is the heart of the problem. It briefly reviews our record since 1979 and suggests how we might build on what we have achieved. We must do this in ways which enable us to regain the initiative. I am convinced that the key is to advance the choice which the patient has over his or her access to health care. This requires more information in the hands of patients and alternative ways of paying for medical treatment. The eventual objective must be a mixed economy of care.

3 Much of the recent debate has been critical of the funding of the hospital service. But it has been helpful to us in opening up issues. I believe that options for change will now be considered by the public in a much more open and positive manner. My proposals have been framed in the light of the principles which were registered in your Private Secretary's minute. The focus should be on the improvement of the nation's health but the debate has been largely about the hospital services, which are predominantly concerned to cure illness and care for sick people. We must broaden it. We have a substantial programme for promoting health and preventing illness, and the primary care services are also vital because, among other things, they largely determine the flow in to and out of the hospital service. We have policies in place for improving the primary services, and I do not want to disrupt the very important linkage with the hospital service. But I am sure that we must sharpen people's perception of the cost of the hospital service and of the treatments it provides, and avoid the facile equation of the NHS with the acute hospital sector.

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4 The Government need not provide for the full range of medical care itself. We shall nevertheless be expected to ensure that the complete range is available to all - your first principle. That implies choice (your second principle) both between the public and private sectors and between different public sector providers. As I have said, I want to encourage choice, but that means increasing the total resources devoted to health care, including the use of alternative methods of finance such as private insurance. A major decision for us is how far to concentrate on improving a closely managed, resource efficient, single provider system or to sharpen the competitive edge and expand the options for choice.

5 As the attached paper demonstrates, there are developed plans for securing greater efficiency and cost control in the public health service. There has already been much progress, and hospital unit costs compare well with those in the private sector. There is always scope for improvement but we must not lose sight of the quality of care. Lowering unit costs usually means increasing the speed with which cases are handled. This does not always help with the public perception of a caring service, and it can stimulate demand for hospital treatment so putting up total costs. This happens because when doctors see that more efficient services offer the possibility of better treatment to more people they bring forward their patients accordingly, and the hospital case load increases. From the staff's point of view they see that as they use resources more efficiently, treating more people in fewer beds, so total costs rise to the point at which activity levels have to be curtailed to bring the books back in to balance. This is a major element in our present difficulties with those who work in the Health Service; staff at all levels are losing confidence in the capacity of the hospitals to provide essential treatments. One way to ease this would be to ensure that the full product of the cost improvement programme goes back in to improving services, not in to pay.

6 If we wish to bring supply and reasonable expectations for health care more closely into balance it will be necessary either to provide more, which will inevitably mean increasing resources (though not necessarily from the Exchequer) or take measures to reduce expectations, which, however, reflect people's need for treatment. Initiatives could range from making knowledge of the costs of treatment more readily available to patients through to a degree of charging, perhaps backed by private insurance. The paper displays some radical options of considerable political sensitivity.

7 While we consider such major changes, some of which I put forward in my Conference speech, we must regain the initiative in the health debate. We need to establish a new agenda which will shift the focus away from inputs, of beds and wards and so on, towards better health, and that is why I am developing a strategy for health which will focus on longer term objectives and indicators to measure progress towards them. I believe we should now seek to develop a programme of announcements, and that we might wish to prepare some kind of discussion document, whether or not a Green Paper, for later in the year to provide a focus for a continuing debate which we might otherwise find it hard to control. Certainly we cannot afford a false, or half-hearted, start. I welcome the opportunity to discuss these issues with you.

8 I am copying this minute and its attachments to the Chancellor of the Exchequer and the Chief Secretary , and to Sir Robin Butler.

J M

15 January 1988

THE NHS - PROGRESS, PROSPECTS AND OPTIONS

NOTE BY THE SECRETARY OF STATE FOR SOCIAL SERVICES

Health care is nearly all funded and provided by the NHS. The NHS comprises three elements:

(1) the Hospital and Community Health Services (HCHS);
(2) the Family Practitioner Services;
(3) certain centrally funded services.

There is also a small private sector, most of whose activity is funded by patients who are covered by private insurance. In this paper I concentrate on the funding and management of the HCHS.

1. PROGRESS

We have improved the management of the hospital and community health services in many ways over the last six years, including:-

(1) the structure was streamlined by abolition of Area Health Authorities in 1982;

(2) general management was successfully introduced following the Griffiths report;

(3) manpower was brought under firm control so that, for the first time since 1948, NHS employment has been falling while activity continued to rise;

(4) all health authorities have been made subject to annual accountability review;

(5) the cost improvement programme was launched, with cash savings since 1984 totalling £1.3 billion. It includes the successful introduction of competitive tendering into hospital support services;

(6) much better management information is now being collected, in the form both of Performance Indicators and of data on activity and manpower.

2. As a result of these and other factors the NHS has greatly improved its efficiency.

3. Between 1978-79 and 1986-87 spending on the HCHS rose by 136% in cash terms, and by 21% in real terms (using the GDP deflator). Because NHS costs (notably labour costs which account for 75% of total expenditure) rose more quickly than general inflation, the increase in "purchasing power" over the period was only 6%, an average of 0.7% per annum. Most of that was concentrated in the earlier part of the period. Between 1982-83 and 1986-87 the increase in purchasing power of health revenue was 0.6%, that is 0.1% per annum. The difference between this figure and the 21% increase in real terms helps to explain the different perceptions of the financial position of the NHS. Health authorities' "purchasing power" has of course been supplemented by cost improvements. Taking them into account the extra spending power over the period is 10.1% (1.2% pa) and from 1982-83 has been at an annual rate of 1.1%.

4. Activity over the period has risen more quickly than this. Between 1978 and 1986 activity levels rose by over 20% (inpatient cases up 1 million (19%); outpatient cases up 3¾ million (11%); day cases up almost ½ million (87%). Costs per case over the whole period have fallen by 16% measured against HCHS inflation, and since 1982-83 they have been falling also relative to general inflation. Unit costs compare favourably with those in the private health sector.

5. The main elements of improving efficiency are as follows:

(a) Better use of hospital beds and other clinical facilities. Throughput per bed has risen from 14.5 in 1978 to 20.3 in 1986 (up 36 per cent). This reflects closure of inefficient or wrongly sited hospitals, shorter length of stay and better management. In addition, as noted above, there has been a dramatic increase in the use of day care (up 87 per cent). There has been a marked reduction in the variation between Regions in throughput per bed and in use of day care.

(b) Better use of staff. Health care is labour intensive. Since 1983, for the first time ever, NHS employment has fallen while activity levels have risen. The fall has mostly occurred in non-clinical staff. On the clinical side, medical and nursing staff have however grown less fast than overall activity levels.

(c) More efficient support services. Support services such as catering, cleaning, laundry, portering, works and supplies have been the main contributors to the cost improvement programme. Competitive tendering has been very successful, not least by sharpening up the efficiency of the NHS's own staff, and has contributed over £100 million a year in savings. It is important to ensure that standards are maintained.

6. There is little objective data on what has happened to quality of care since 1978 - this is any case extremely difficult to measure. In some areas of the country and in some areas of medicine there have been notable improvements, but there is no doubt that in others standards are a matter for concern. Unfortunately the increases in activity have not sufficed to make any significant impact on waiting lists or times.

2. THE PROBLEM

7. It is notable that, after allowing for inflation in the HCHS, costs per case have fallen significantly. But this improved efficiency and rising activity has not been enough to satisfy the public's reasonable expectations. The main factors fuelling the rising burden of health care are the increasing numbers of elderly patients; the increasing ability of doctors to treat illness in the elderly; and medical progress generally.

8. It is a paradox of the HCHS, which causes more frustration than any other factor, that rising efficiency provides opportunities to treat more patients and so incur additional costs. As staff work more efficiently, they reduce costs per case. The surplus capacity is then used to treat more patients but each case incurs marginal costs. Alternatively the surplus capacity can be eliminated by closing beds and reducing staff - perceived as a 'cut'. Unlike a business NHS hospitals cannot increase their funding by increasing output.

That is the fault of our system.

9. It is evident that there is a need to ensure that more medical care is available for the public. The issue is how that can best be done. Part 3 of this paper explores how the present system can and should be developed to work more efficiently and effectively. Such measures will however need to be supplemented by policy changes that would both enable more resources to be brought to bear on health care, and help to meet other policy objectives such as greater choice and competition. The options are dealt with in Part 4 of this paper.

3. SCOPE FOR FURTHER IMPROVEMENTS WITHIN THE EXISTING FRAMEWORK.

10. The following paragraphs pick out the main initiatives which will contribute to raising efficiency further within the existing legislative and organisational framework.

11. The cost improvement programme will be maintained and developed. We should emphasise both the scale of the achievement so far and the need to sustain NHS management's commitment to achieving a good level of savings in future. Cash savings have totalled £1.3 billion since 1984; further they will amount to £600 million in 1987/88 compared with the 1984 base and are growing at an annual rate of £150 million. In addition, productivity savings have enabled the service to absorb a significant proportion of the growing demand which would otherwise require additional annual funding of about £400 million. On the second point it will be necessary to widen and strengthen the cost improvement programme in order to maintain a good level of savings in future. A Value For Money unit has been set up and this will be strengthened in 1988. Increasingly savings will be needed in clinical areas.

12. The resource management initiative will be crucial to achieving improved value for money and to providing a basis for establishing what given levels and mixes of care do and should cost. Under this initiative, doctors and other professionals are given detailed information on output and costs and are required to become responsible for managing the relevant resources. On the acute side, the programme involves five hospitals in different parts of the country. The new information systems and management arrangements will become fully implemented during 1988 at three of these sites and during 1989 at the

two other sites. Assuming general acceptance, they will provide information and management models for implementation at all acute sites between 1989 and 1992. A fuller note on the initiative is set out in Annex 1.

13. The income generation initiative is expected to increase health authorities' income by about £20m in 1988/9, rising to £70m in three years. Ideas range from leasing space in hospitals to retailers, through car parking charges, to better exploitation of NHS technological know-how. The NHS Management Board is setting up a unit to lead this initiative in the NHS.

14. Already dramatic results have been achieved through rationalising the NHS estate (receipts from sales of surplus land up from £9.9m in 1979 to over £200m this year). This initiative (which is now funding 20% of the hospital building programme) will be maintained and strengthened.

15. Better planning, monitoring and information systems will play their part. In 1988 Health Authorities will be given a stronger lead on the priorities they are to adopt for the development and management of services. In the annual review process in 1988 much more emphasis will be put on requiring Health Authorities to explain discrepancies in their performance, not only against their agreed plan, but also against the performance of comparable Authorities across the country. (A note on variations in performance is at Annex 2). New data flows, replacing those which had been haphazardly built up since 1948, will in 1988 allow quarterly reports on, and examination of, the number of patients treated, Authority by Authority across the country. Combined with the existing quarterly counts of hospital manpower, and the newly introduced monitoring of income and expenditure, this will enable monitoring of major aspects of NHS performance more rapidly and in greater detail than in the past.

16. The greater use of the private sector, of all sorts, will be strongly encouraged. The predominant mentality, in the past, was that the NHS provided nearly all its services in-house. That is now changing, especially as a result of the competitive tendering initiative, and the NHS now buys significant amounts of services from the private sector, mostly in support services such as cleaning and maintenance. We shall build on this by launching a major initiative in 1988 to encourage the NHS to use private

sources of services wherever it is cost effective to do so. This will clearly depend on local circumstances including the availability of private sector capacity and comparative costs.

17. Within the NHS, health authorities are not self-contained and NHS patients flow freely across NHS boundaries to receive treatment where the appropriate facilities are found. But these flows arise from clinical or patient choice, not from the operation of market forces. The institution of a true market - with health authorities buying all the services needed for their residents which they did not provide themselves, and paying for all the services their residents received from other health-care providers - is a radical option dealt with in Part 4 below. In the meantime, efforts will be directed towards:-

(a) producing better information about costs so that comparative efficiency can be examined (this will be an important product of resource management programme, para 12 above);

(b) encouraging the striking of individual trading agreements between authorities (eg for Authority A to treat defined numbers of patients from Authority B, on repayment) in order to encourage a "trading culture".

Much tauter management accounting systems are both a prerequisite of and a lead-in to this.

18. There is also the crucial question of manpower. Even with maximum use of new technology the NHS will remain labour intensive. Securing the most economical and effective use of staff is critical to obtaining maximum productivity from the system as a whole. It is also critical to continued provision of an adequate service, given the considerable contraction during the 1990s in the NHS's traditional sources of recruitment of professional staff. Competition for scarce skills is likely to mean higher pay - an effect already being seen for nurses both here and abroad. This will reinforce the need for economical use of staff, including increased devolution to cheaper non-professional staff. These changes will have to be achieved in a positive

way, designed to restore and sustain morale and to help us retain and re-attract staff. We are already working on these lines, but much more will need to be done especially on the public presentation of our aims.

19. Our efforts to improve the service vitally depend on the way in which medical staff behave, and on our ability to deploy them where they are most needed. We need in my view to pursue a major review of the contractual terms on which consultants are employed in the NHS, to increase their accountability and the effectiveness of their deployment and the part which they play in the management of available resources, and to provide a better deal for patients. We need to ensure that they make a positive contribution to our policies for reform. The time is right and we have a strong hand. I propose to start discussions as soon as possible.

20. I also wish to increase the power of patients as consumers. Within the existing financial framework the scope for doing this is limited, as hospitals are not rewarded for attracting patients (indeed, in a financial sense, they are penalised). Within the present framework, therefore, the main thrust must be the provision of better information to patients about the availability of services (already in hand so far as waiting lists are concerned) and on management action to improve "customer service" within hospitals. But it is impossible to get away from the fact that at present the public is reliant on a monopolistic system, with enormous power in the hands of the health care professions.

4. BEYOND THE PRESENT FRAME

21. The limitations of the present framework are fourfold:

first, there is no price mechanism for bridging the gap between supply and the public's reasonable expectations. In consequence, there has to be a political judgment about how far public resources should bridge the gap.

second, whilst the state remains the totally dominant provider of health care and the dominant source of health care funds, we shall not be able to develop the competition and consumer choice that our 'mixed economy' has provided in other fields.

third, the Government - and NHS management more generally - are under constant pressure to concentrate on day to day management matters rather than on long term health objectives. The horizons of political and social debate are limited in the same way.

fourth, there is only very limited scope for developing the power of patients as consumers. The public have only a 'cliff-edge' choice between the NHS and private health care. Within the NHS there is very little choice, whether or not the patient is able and willing to buy additional or better services.

22. Our starting point must be a recognition that the critical issue is our approach to the financing of health care. This section therefore concentrates on how best to overcome the limitations of the present framework and to achieve our objectives by substantially supplementing or replacing the present basis of health care finance. (The extent to which we might also help to achieve our objectives through altering the present structure for allocating health care resources is explored in Annex 3.)

23. There are two main options - to provide additional sources of funding or to replace or substantially reconstruct the present method of public funding. Additional funding could be obtained from:

charges. The scope of existing charges and exemptions could be altered or new charges could be introduced. Charges representing a proportion of costs could be made for both visits to a General Practitioner and to hospital. Such charges would have to be related to the ability to pay, so a system of rebates or exemptions would be needed. Charges have a number of advantages. Besides raising revenue they would bring home the cost of treatment and discourage unreasonable demands on the health service. They are a practical proposition but would clearly be politically controversial - particularly for visits to the General Practitioner.

private sector provision. The main element here is private health insurance, a major source of health care finance in the US. As matters now stand, any significant expansion of private health care would need a

fiscal incentive. This could be provided for example through tax relief. There would be a 'deadweight' cost to any incentive in respect of those already using private health care.

24. The second main option is to augment the current system of tax based finance by additional funds from the national insurance scheme or replace it by a social insurance scheme on the European model. The European model, which is dealt with in the annexes, would be difficult to harmonise with the way we finance and organise health care. I believe we should concentrate on the national insurance scheme. At present only a small proportion of NI contributions go towards financing the NHS. (In 1988-89, about 11% of contribution income or £3.3bn is expected to go to the NHS.) We could build on these arrangements by making a more specific link with, for example, the hospital service, taking the example further, if the cost of the hospital service were met by NI contributions this could then be shown as a separate "hospital service" contribution on pay slips. This in turn would help to bring home the actual costs of health care. I appreciate that, buoyant though the revenues of the NI fund are, any proposal to direct more (and increased) contribution income to the NHS has major implications for public expenditure, taxable capacity and the distribution of incomes, which I would need to consider with Treasury Ministers. But we would be able to turn a very important corner if we could bring clearly out into the open the costs of the hospital service by financing them in this direct way.

25. Annex 4 examines the financing of health care in more detail. More information about health care models is given in Annex 5. Annex 6 provides information about health care in the US, Canada, France, West Germany and Sweden.

PRESENTATION

26. Public acceptance of an approach based on a mix of initiatives drawn from the possibilities (some of them already under way) in paras 12-25 above will no doubt be stimulated by the breadth of the current debate. But there are three messages which must in particular be carried through to the public.

27. First, the NHS is not without cost to individual citizens. We might advance towards this by presenting costed accounts (not for payment) of treatment given in hospital, at least where major courses of treatment are concerned. This would prepare the ground for an element of charging.

28. Second, the popular equation of the NHS with the acute hospital sector must be broken. The public needs to be made aware of the cost of the hospital service, for example by increasing the national insurance charge and linking the cost to that, and by directly charging the patient with the cost of primary care (if the politics of that are acceptable).

29. Third, and in my view most importantly, we must change the terms of the health debate. I have in hand proposals for a major new initiative - the strategy for health - designed to set a new agenda for health. The terms of the debate are currently dominated by inputs, like cash, with little understanding of their relative impact or outcome in health quality terms. The absence of such output or outcome criteria also ensures that the debate is focussed on issues like beds and waiting lists, which though easy to use emotively are not necessarily germane to the real health issue. The aim is to produce a policy statement which focuses on longer term objectives for public health, not day to day issues of health care delivery. It would set the direction of health care policies for the whole health field - not just the hospital service - for the rest of this century and beyond. An integral part of this strategy is the development of a portfolio of agreed and affordable indicators of good health, which would be used to set long term goals. These indicators would provide a much better measure for the public and for the Government of the overall benefits provided by the NHS. They would also take full account of the greater acceptance of the importance of personal behaviour in underpinning good health.

ANNEX 1

NOTE ON RESOURCE MANAGEMENT INITIATIVE

As indicated in paragraph 12 of the main paper, under the resource management initiative, clinicians and other professionals are being given detailed information on output and costs and are being required to become responsible for managing the relevant resources. The overriding aim of the initiative is to enable the NHS to give a better service to its patients by helping clinicians and other managers to make better informed judgements of how the resources they control can be used to the maximum effect. The three elements of the initiative are:-

(1) the establishment of a new series of experiments at five hospital sites;

(2) setting up a limited number of second generation resource management development sites for community health services to consolidate and extend the experience built up in this field at Bromley and Worcester;

(3) promoting a regular exchange of experience between development work at the new sites and all existing sites so as to maximise the chances of achieving solutions which are workable and cost-effective and which fully reflect both the new approach and the valuable experience of the last few years.

2. As well as satisfying the basic requirement that doctors and nurses should be fully involved in management, the five hospital sites represent a balanced mix of teaching and non-teaching hospitals and a wide geographical spread. In addition they are at different stages in developing the information systems needed to support better resource management processes. As a group, therefore, they provide a cross-section with which most acute units in the country can identify at some level. The key aims in developing the programme relate to:

(1) medical and nursing "ownership" of the system. This covers both the management process and its supporting information systems;

(2) patient casemix planning and costing. There is wide agreement in the medical profession on the need to identify costs for defined groups of patients so that the actual and expected use of resources in their treatment can be compared. This is important both in monitoring clinical performance and enabling informed choices to be made about the deployment of resources within specialties and for units as a whole;

(3) accuracy of basic patient activity data. This must command medical confidence and the existing information systems are proving to need to have substantial work done on them so that this can be achieved.

3. The overall aim is to have achieved sufficient progress by 1989 to make possible a provisional evaluation of likely eventual success. Assuming that the five initial sites are successful in demonstrating the value of the approach the aim would be that implementation in all 700 acute units should be completely phased in by 1993.

4. For the five new model acute sites, experience to date suggests that the initial development will cost between £400,000 and £600,000 for each one. About 70% of these costs are being met from central funds and the balance by the RHAs and DHAs concerned. Part of the initial cost will reflect the development of the basic approach and it should cost less to introduce it in other units. Establishing realistic costings is one of the key aims of the work being undertaken currently.

5. An overall target for the new model units will be to release at least 1% of annual expenditiure for redeployment on patient services through the operation of the new resource management approach. Achievement of this target will be a key criterion for judging whether and when the approach should be extended more widely.

6. Good progress is also being made in community health services systems. The aim there is to complete systems design and implementation by 1991. The broad target of a 1% improvement in the use of resources will apply equally in this field.

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ANNEX 2

VARIATIONS IN PERFORMANCE BETWEEN HEALTH AUTHORITIES

In the Hospital and Community Health Services with 191 operational authorities, it would be remarkable if there were not some variation in performance amongst the many streams of activity for which authorities are responsible. Some of these variations stem of course from the widely diverse nature of health authorities themselves; in budget (Halton DHA £14.9m (1986/7), Leicester DHA £154.6m); in size (Rugby Health Authority (323 beds, 2 units) Leicester Health Authority (5200 beds, 26 units); in role (teaching or non-teaching, host for regional specialties or not). But, even when these important causes of difference are taken into account, there still remains amongst authorities of comparable size, and with comparable problems, a range of performance.

2. The Performance Indicator package covering 1983/4 was produced in 1985, and has been updated annually since; the pack relating to 1986/7 will be available at the end of January 1988. The pack, which covers some 450 indicators of health authority performance enables comparison between authorities and over time. It was designed primarily for district use but has also proved useful at regional and national level. The indicators demonstrate a wide range of performance between authorities. These variations have to be interpreted carefully, in the light of the tasks which particular authorities face and their circumstances. Performance indicators are however a powerful tool for investigating genuine differences in performance. Such enquiries, based inevitably on historical data, can be supplemented by the new Korner data flows which provide information on hospital (and, shortly, community) activity in a far more timely fashion than previously.

3. In previous annual rounds of reviews with Regional Health Authorities, the Management Board has used performance indicators to inform discussion on overall regional performance in the major care groups. Regions have, similarly, used performance indicators in a similar way in their reviews with District Health Authorities. In review meetings with Regional Health Authorities in the coming months, the Management Boared will specifically review with regions not only overall regional performance in key indicators, as compared with the national performance, but also the range of achievement within regions and more particularly the steps being taken by RHAs themselves to investigate these ranges and the degree to which they can either properly be explained, or should be addressed by vigorous management action.

4. This system is an essential step in the process of making health authorities more aware of their performance in the various businesses for which they are responsible, and for comparing that performance not only against their own agreed plans, but against that of comparable authorities across the country. We are also considering how best to make meaningful information about performance more widely available.

ANNEX 3

ALLOCATION OF HEALTH CARE FINANCE

The present system is that Government allocates resources to health authorities to provide services (or to buy them in from the private sector) to those patients (mostly local, but not all) referred to hospitals by GPs. Government is thus able to contol cash spending and the amount of service delivered.

Radical alternatives

2. The principal radical alternatives, each of which is a version of an internal market approach, are:

> Fund service purchasing agencies. These might be health authorities, or general practitioners who would buy health care from separate providers, who might be (other) health authorities or private hospitals.
>
> Fund individuals. This might be insurance or voucher based.

3. Funding service purchasing agencies. The principal attraction of going down one of these routes would lie in the creation of an incentive for providers to produce services as cheaply/efficiently as possible in order to secure custom. Each service purchaser would have a budget, related to population served, and would seek to make that budget stretch as far as possible. It would however be necessary for the agency to be able to control the referral of patients to hospital if it was not to lose control of its budget, and there would need to be arrangements to cope with accidents and emergencies, tourists, those without a settled home and such like.

4. The principal disadvantages are that such approaches might result in the patient having less choice than under the present arrangement, and that there would have to be surplus (and therefore wasted) capacity if the service purchasing agencies were themselves to have freedom to choose. There could be serious political problems over hospital closures, and London, where costs are higher, could be at a specific disadvantage.

5. Funding individuals. The attraction of funding the individual to purchase his or her own health care is that they would have significantly greater choice, and could thus favour better providers, who would have to compete for patients.

6. The principal disadvantages are concerned with costs. Experience in other countries has shown that it is difficult to operate effective controls on the total cost of an insurance-type system with true patient choice, while there is no incentive on providers to control their costs if the individual does not have to pay. Requiring the patient to pay in the first instance, and seek reimbursement, could have some effect, but is unlikely to help much.

7. Conclusions. In both cases the disadvantages may well significantly outweigh the attractions. The present approach gives Government control of total cost while leaving the consumer a degree of choice. Funding service providers can be done in a way which retains control of cost, albeit at the price of some surplus capacity, but diminishes consumer choice. Funding individuals increases consumer choice but loses control of cost. Neither set of alternatives is necessarily an improvement. There are, however, important lessons to be drawn for improving the existing system.

Improvements within Existing Framework

8. Assuming that the Government continue to fund health authorities as service providers there are still a number of actions in hand or in prospect to create a more market-oriented attitude.

Authorities are being encouraged to use Waiting List Funds to buy in services from elsewhere - other authorities or the private sector.

The resource management initiative by providing better information on the costs of different types of treatment will in time enable consultants (and authorities) to compare costs.

We are looking at ways of encouraging Regions to introduce cross-charging arrangements between Districts for particular services, especially new ones. One Region has volunteered to run a pilot study of cross-charging more generally.

We are determined to achieve improved information about costs and tauter accounting systems (para 17 of main paper).

I have already announced that we intend to ensure that GPs have information about comparative waiting times to inform their choice of referral.

ANNEX 4

FINANCING HEALTH CARE

Generally, health care in developed countries is paid for through:

* public finance, whether through taxation as in the UK and Canada and Sweden or social insurance as in France and West Germany; or

* private insurance, with premiums paid by employers or individuals. In the US, 60% of health care is paid for privately mostly from insurance stimulated by tax relief, 40% through public funds (I was advised in Washington that, with tax relief taken into account the publicly funded proportion rises to 75%.)

2. Supplementary finance within a broadly tax-based funding system can be raised for the NHS through:

Charges to patients Either through alterations to the existing schemes (eg reducing the exemptions from prescription charges) or by new schemes eg charges for hospital stay. Charges could be used to enhance consumer choice by levying them on optional services and amenities. The contribution that charges could make to the NHS budget would depend on their extent and level.

Income generation by health authorities. Greater resort to commercial or other fund raising activities by health authorities eg hiring out hospital premises to shops. It is likely to be only a subsidiary source of revenue.

Private sector co-operation. Joint ventures. (Bringing in private sector capital as such would not expand available resources if it substituted for public expenditure; nor would it necessarily save money.)

The current Health and Medicines Bill provides additional powers for income generation and for increased pay bed income.

3. The more that revenue is raised independently, the greater the ability to reduce direct Government involvement in managing health care. And the greater the choice of services, the easier it is for those who are financially able and willing to do so to buy better services within or outside the NHS. The ability to raise revenue will vary in different parts of the country.

4. Assuming the NHS continues to be predominantly publicly financed, there are two broad choices:

first: continuing with a tax based system but augmenting the Exchequer contribution by:

- a greater contribution from the buoyant National Insurance Fund This buoyancy is likely to continue while contributions are earnings related and benefits are increased in line with prices. There could however be adverse distributional effects.

- developing the supplementary sources of finance noted at para 2 above.

second: moving over to social insurance on the French or West German model either as a separate system or linked to the National Insurance system. Social insurance funding too could be augmented by supplementary sources of finance. It is important to recognise that social insurance remains a public finance route and therefore broadly subject to the same constraints as other sources of public finance.

Greater use of separately identified health insurance contributions would help to bring home to the public the actual costs of health care.

5. Under either alternative, more personal and occupational provision could be encouraged by greater use of charging; by developing contracting-out arrangements out of National/social insurance contributions on the model of occupational and personal pensions; or by providing tax relief for private insurance premiums or for private health expenditure. Without a financial stimulus from contracting-out or tax relief, the private sector coverage seems unlikely to expand significantly. At present, the provident associations with their charitable status dominate the market and other organisations have found it difficult to gain a foothold.

6. Greater use of the insurance model would need to take account of :

- the risk of adding unnecessarily to employers' expenses: the impact on employers costs and on wage demands is a concern in both the US and Europe.

- the risk of losing control of costs. Both private and social insurance financed systems have had greater difficulty in containing administration costs and health care costs generally.

- the need to ensure that the pattern of contributions, which under social insurance would be borne by the working population, was acceptable.

- the need to ensure that there was a minimum service for uninsured.

- the possible adverse distribution effects.

7. Timetable

Short/medium term options are:

* increased expenditure linked to reducing the surplus in the National Insurance Fund and/or increased NI contributions;

* increased receipts from supplementary finance;

* encouraging a bigger contribution from private health sector;

Longer term options (in next Parliament and beyond) are:
* as above; plus
* new funding system (eg social insurance);
* further build up of health cover through personal and occupational schemes.

ANNEX 5

ALTERNATIVE MODELS FOR THE PROVISION OF HEALTH CARE

This Annex summarises 6 possible developments from the NHS. Options 1 and 2 are concerned with organisation and management structures and options 3, 4 and 5 with financing systems. Option 6 affects both. It would be possible to conceive variants incorporating some features of 2 or more options.

1. Establish the NHS as an independent corporation.

Description. Place the Secretaryof State's duty to provide health services by statute on a new independent statutory body. RHAs and DHAs - or whatever operating units the new body chose - would be answerable to and appointed by the new body. Financing would come mainly from tax as at present, but it could be in part from increased charges, or from insurance.

2. Turn the NHS into a series of service-purchasing agencies (cf. Annex 3).

Description. This would involve health authorities, general practitioners or HMOs being publicly funded to purchase services, from private or public sector providers, for their "own" patients. Responsibility for controlling referrals would rest with the purchasing agency.

3. Move from a tax-based system to social insurance fund.

Description. A social insurance fund is an income-related insurance system which works within a contribution and benefit framework laid down by government. It can cover all the population and can allow for contracting-out eg of an industry's workforce, but might also operate alongside total state funding for those not in work. The fund meets the cost of health care, either by providing care itself or by reimbursing other providers.

4. Partial move from tax-based system to commercial insurance system.

Description. Assumes continuing state (NHS) system for non-employed population excluding children. All those in work required to enrol in private insurance schemes eg compulsory opting out of state scheme for those in work. Premiums set by market, with tax relief possible. Services bought as necessary either from state (NHS) or private sector.

5. System of Health Vouchers (cf. Annex 3).

Description. Vouchers can be a way of Government meeting the cost to an individual or family either of insurance or of care ie they might be valid for a BUPA-type subscription or alternatively entitle the holder to a set cash amount of care. Vouchers could be issued universally or selectively, eg to those not in employment. Vouchers would be accepted by providers and redeemed by Government. The consequences of vouchers for insurance or care are different - see table.

6. Replace publicly-funded health authorities by a series of HMOs funded by members' subscriptions.

Description. These HMOs would both provide care and finance it through members' subscriptions. DHAs for example could become HMOs, seeking to attract as subscribers their current population. Private hospital/health care providers could set up as HMOs. However, unless HMOs were required to accept

all comers, whatever their medical condition and unless there were some form of financial safety net for those unable to meet subscription costs, a move to HMOs might leave substantial numbers of people without health cover.

The following page summarises, in tabular form, the impact of each option.

Note Experience elsewhere in OECD highlights the difficulty of Government minimising its health care role; the Government becomes involved:

(i) as a provider of last resort;

(ii) regulating a social insurance fund, which as a part of public finance affects taxable capacity;

(iii) in response to escalating charges falling on employers and others paying premiums.

Priorities

Impact on Option	Government	Consumer	Employers	Competition/Choice	Doctors	Other Health Workers	Administration Costs
1. NHS Corporation	Pro-Reduces involvement in management. Con. strong lobby for extra cash.	No change	No change	No change	No change	No change	No change unless funding system changed also.
2. Funded service providing agency	Pro-Incentives to efficiency Con-Closures a danger	Restricted	No change	Reduced	May prompt some competition	Spur to efficiency	Added costs of payment to providers.
3. Social insurance	Pro-reduction in income tax Con-Distributional effects Some public finance still needed.	Pro-Premiums show real cost of care Con-May increase demand, thought to be a paid-for right. Some groups could pay more than under tax system.	Extra burdens if administered and part financed through employers for employees. May operate against job creation.	Can extend choice if used to support consumer freedom eg via HMOs.	Depends on methods of service delivery.	Depends on method of service delivery.	Extra costs of running fund, collecting subscriptions.
4. Compulsory insurance	As option 3 Plus:Pro Not seen as tax. Con. Needs publicly-funded safety net.	As option 3	As option 3	Can extend choice as 3. But this may be restricted by escalating costs.	American experience is of increasing medical fees	Spur to efficiency	Extra costs of running funds, collecting premiums.

Impact on Option	Government	Consumer	Employers	Competition/Choice	Doctors	Other Health Workers	Administrati[redacted] Costs
5. Vouchers							
(a) insurance	Likely to fuel demand. May need to be taxable.	Seen as free good.	As option 3 if employers have to administer scheme.	Increased choice	Depends on system of service provision	Depends on system of service provision.	Distribution system could be costly.
(b) care	Difficult to set level. Overlap with other benefits	May be inadequate in serious cases	As option 3 if employers have to administer scheme.	Increased choice subject to cost	Depends on system of service provision	Depends on system of service provision	Distribution system could be costly
6. HMOs funded by members' subscriptions	Pro-reduces involvement in management and reduces tax. Con-safety net cost and and capital finance.	Pro-Brings home costs. Con.May increase demand as option 3.	Depends on financing system	Choice widened (save areas where only one HMO viable)	May prompt greater competition but danger of excess supply.	Spur to efficiency.	Extra costs of collecting subscriptions and checking membership entitlement

ANNEX 6

HEALTH CARE IN OTHER COUNTRIES

	UK	USA	CANADA	FRANCE	FRG	SWEDEN	NOTE
FINANCE							
Total Health Expenditure as % of GDP	5.7*	10.8	8.6	9.4	8.1	9.3	(1)
Public Health Expenditure as % of GDP	5.2	4.4	6.5	6.7	6.3	8.4	(2)
Sources of Finance	Predominantly financed by Central Gov't taxation with small private sector	60% private (mix of direct and insurance). 40% public Medicare (elderly) and Medicaid (poor).	Financed largely by a mixture of Regional and Central Gov't taxation.	Predominantly financed by social insurance	Predominantly financed by social insurance	Predominantly financed by Regional taxation and Central Gov't taxation	(3)
ORGANISATION							
Ownership of Hospitals	Central Government's NHS	Over 60% of all beds are privately owned (85% are non-profit); Remainder owned by Federal State and Local Gov't.	Mostly by lay Boards of Trustees or communities	70% public owned (mainly local Gov't), the rest private	Owned by local communities, religious foundations or individuals (mostly doctors).	Local community councils.	
Balance of Markets vs Planning (Hospitals)	Mainly planning: RHAs and DHAs develop health plans	Mainly markets with some Govt regulation.	Mainly planning: Provincial Govt has full responsibility.	Heavily regulated market with central and local planning imposed.	Heavily regulated market. Capacity is controlled by State govts	Mainly planning with control at community level.	(6)

* These are OECD figures. On a National Accounts basis the percentage of UK GDP devoted to health care in 1986 was 6.2 per cent. It is not, however, possible to produce comparable figures for other OECD countries.

	UK	USA	CANADA	FRANCE	FRG	SWEDEN	NOTES
Total Health Staff per 1,000 population	21.65	24.35	21.92	17.45	-	39.49	(7)
Doctors per 1,000 population	1.35	1.94	1.96	2.17	2.37	2.41	(8)
Nurses/Midwives per 1,000 population	8.54	5.59	8.72	5.14	-	7.99	(9)
DELIVERY							
Average number of cases treated per bed per year	27	35	22	21	19	16	(10)
HEALTH OUTCOMES							
Infant mortality per 1,000 births	9.5	10.6	8.0	8.0	8.6	5.9	(11)
Perinatal mortality per 1,000 births	10.1 (E&W)	15.4	9.5	11.1	10.5	7.3	(12)
Life expectancy at age 60							
a. men	16.5	17.8	18.4	17.9	16.9	18.0	(11)
b. women	21.0	22.6	23.4	23.0	21.4	23.0	(11)

NOTES

(1) Source: Schieber and Poullier: "Recent Trends in International Health Spending" OECD 1987.

All figures are estimates for 1985.

(2) Source and dates as in (1).

(3) Sources: "Financing and Delivering Health Care" OECD 1987.

Forbes "Survey of Primary Health Care Financing, Budgeting and Payment Systems, Interim Report" WHO 1986.

(5) Source: "Financing and Delivering Health Care" OECD 1987.

(6) Source as in (5)

(7) Source: OECD: "Measuring Health Care 1960-1983". Latest date available for each country is given.

(8), (9) and (10) Source and dates as in (7).

(9) The OECD figures are not consistent between countries: the UK figures include first and second level qualified nurses, unqualified auxiliaries and learners; those for the USA are for qualified staff only; those for France include both qualified and unqualified staff but exclude learners. The WHO's figures for qualified staff only are somewhat more comparable (though only the UK has "2nd level" qualified nurses); these show around $4\frac{1}{2}$ nurses/1,000 population in both UK and USA (and of course the USA has more doctors).

(11) Source OECD paper: 1986 data not yet published.

(12) Source WHO statistics 1986.

Perinatal Mortality International Comparisons WHO Statistics

Country	Year	Rate
England and Wales	1984	10.1
USA	1981	15.4
Canada	1983	9.5
France	1984	11.1
Germany Federal	1984	10.5
Sweden	1984	7.3

NHS: Exp + dff pt 9.