PRIME MINISTER

YOUNG MOORE'S ALMANACK: SECOND THOUGHTS ON THE DHSS PAPER

I have now had time to consider the DHSS paper at greater leisure and in more detail. It combines a general review of proposed solutions to the NHS's difficulties with a set of favoured policy prescriptions. This format goes a long way to explaining why it lacks a sharp sense of direction, and my criticism of it on these grounds may therefore have been overly harsh. Otherwise, I don't think I need retract or substantially amend my very rushed reflections of last Friday evening.

The leitmotif of the document is the need fror more resources to be devoted to health care. This need can be acknowledged. But the uncomfortable fact is that there is no right level of health spending in a tax-based, centralised system that offers treatment free at the point of consumption. The only way to establish a right level is to allow people to decide how much they want to spend from their limited resources. Since decent people also want the poor to receive treatment they could not otherwise afford and the Government to provide a "safety level" level of health funding, most Western nations, starting from different philosophies and practices, have blundered into a state of affairs in which Governments spend approximately six per cent of GNP on health and private citizens add on another 3 per cent.

We must now plan our way into the same state of affairs. The DHSS document acknowledges the need for injections of private money for which Mr. Moore deserves real congratulations. But are the specific proposals to raise the level of private finance convincing and practicable? If they are not, the document becomes, in effect, a call for increased public spending on health. Let us therefore look at the document's ideas.

They come in three categories:

(i) Developments of existing supply-side initiatives
This covers the cost-improvement programme, the income generation initiative, better information and monitoring, and more "buying-in". These are all worthwhile and can be expected to produce more savings and/or revenue and to produce greater efficiency over time. But two caveats must be entered. The scope for such gains is limited. There is an irreducible amount of inefficiency in all organisations and the NHS holds down costs better than health systems elsewhere. Secondly, in a "free" system, demand will always rise to exceed supply. Such initiatives can - on their own - never gain more than a breathing space.

The section on the internal market in particular on page 6 is too glib and too timid. In a system without prices, market forces are the movement of people from areas where resources are in short supply to where they are more abundant in response to information signals on this score. Flows in response to patient and/or clinical choice are market forces which the document doubts. They can be supplemented by average costing of particular treatments on the basis of Diagnostic Related Groups (DRGs) which provide DHAs with the incentive to sell treatments if, through efficiency, they have cut costs below the national average.

The two suggestions that the document makes for encouraging the internal market - better information, and striking "bargains" between different DHAs to shift patients around - are welcome but inadequate. We should aim for a patient-driven internal market, not a management-driven one. What we need instead, therefore, is something like:

(a) A system in which GPs write a "prescription" for an oepration and can send their patients to any hospital in the country. This situation exists today legally but, under the pressure of cash limits, is disappearing in practice as DHSS refuse outsiders.

(b) Readily available information on waiting lists, waiting times and differential costs that would guide the GP and the patient in making choices.

(c) An urgent introduction of better accounting techniques so that DHAs receive accurate "bills" for patients who have gone elsehwere within a few weeks. The policy outlined in Annex 3, page 2, is inadequate.

Such a system would not only be an improvement in itself, it would also lay the groundwork for more radical market systems of health provision. For instance, the "prescription" for operations described above would need only minor amendment to become a part-cost voucher cashable in both public and private sectors.

(ii) Intermediate reforms

These are measures which, in line with Mr. Moore's argument, aim to attract extra funds into the existing system by charges and tax changes and to expand private insurance by fiscal incentives. I dealt with these measures in the two papers submitted on Friday. Here I would only reiterate that they seem likely to bring modest financial benefits at heavy political cost. And insofar as large sums are sought from obtaining more NHS finance from the National Insurance Fund, this

implies - other things being equal - an increase in taxation. Similarly, a continuation of higher National Insurance contributions, plus contracting out on the pension model, would pose especially severe political difficulties in the present condition of the NHS. The Secretary of State's desire to set a new agenda by developing "a portfolio of affordable indicators of good health" is fine as far as it goes. But it will fail unless it has a real, credible and substantial central idea. Health promotion, in my view, will not do that service - if that is what the Secretary of State intends. Insofar as health promotion actually produces better health and longer lives, it benefits the individual coverd for more than it does society whihc may then face a bigger bill in geriatric care than it saves in lower acute costs. It is therefore an ideal candidate for private health provision.

To make it the centre of a new NHS initiative in present straitened circumstances risks a backlash effect and invites the criticism of irrelevance. At the risk of sounding obsessive, I would suggest that the DHSS looks at the question of priorities which has the great merit of addressing both real problems and people's current pre-occupations.

(iii) Fundamental reforms

The lesson so far is contained in the remark quoted in an earlier paper: "When the low-risk options won't work, the high-risk option is the low-risk option." More fundamental approaches are required.

There are to be found in annexes 3, 4 and 5 which offer a generally clear and useful guide. It is a real gain that the DHSS is seriously examining wider solutions. As the paper admits, however, it does not cover combinations of the different systems. Yet that is the form any fundamental re-organisation

of the NHS is likely to take. For instance:
health vouchers to ensure free and equal access;
competing HMOs to ensure control of costs and producer monopolies; and
"Topping-up" insurance to ensure an expansion of private finance.

Recommendations

(i) Make clear that substantial extra finance will only be provided in the context of major NHS reform. This implies it will be provided
(ii) Do not rule out any options at this stage, BUT
(iii) Commission urgent studies of the fiscal contribution that charging, higher national insurance and other DHSS options are likely to make;
(iv) Set in train the accounting and other changes needed to extend the internal market;
(v) Ask the DHSS to prepare studies of combinations of various radical ideas, including explicit NHS priorities.
(vi) Consider urgently the establishment of:

EITHER a Committee of Ministers under your chairmanship,
OR a Cabinet Office/Policy Unit/DHSS inter-departmental committee,
OR a Commission of Inquiry on the NHS, headed by John Moore, on the lines of the Commission or Social Security headed by Norman Fowler,
(and preferably the first) to give urgency and direction to NHS reform.

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17.1.88