cc BWP

HC 13

SECRET

REVIEW OF THE NATIONAL HEALTH SERVICE

ISSUES FOR MEETING ON 29 FEBRUARY

Note by the Cabinet Office

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

What the papers show

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

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

For instance:

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

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

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

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

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

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

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

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

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

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

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

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

Options for longer-term change

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

Conclusion

6. The Group is invited:

i. to note the background papers attached, and to commission any further work on them which it may wish to have;

ii. to commission a paper on the options for longer-term change on the lines of the Annex attached.

Cabinet Office

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OPTIONS FOR THE NHS

Outline of official paper

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

Changes within the existing NHS

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

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

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

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

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

New Structures

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

Changes in methods of Finance

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

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

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

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

Conclusion

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