b.c. J. O'S.

VC

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

6 April 1988

Dear Geoffrey,

NHS REVIEW

I enclose an advance copy of a pamphlet on the NHS which John Redwood, MP, will shortly be bringing out and which he has sent to the Prime Minister. Your Secretary of State and other members of the NHS Review Group may wish to glance at it.

I am sending copies of this letter and the enclosure to Moira Wallace (HM Treasury), Jill Rutter (Chief Secretary's Office), Jenny Harper (Minister for Health's Office), Sir Roy Griffiths and Sir Robin Butler.

Yours,
Paul

(PAUL GRAY)

Geoffrey Podger, Esq.,
Department of Health and Social Security.

IN SICKNESS AND IN HEALTH

The Marriage of Public and Private money in a National Health Service

It seems longer than two months ago that Oliver Letwin and I first wrote about the health problem. We attracted considerable public attention to the problems facing health policy and the difficulties of running a monopoly health service in the United Kingdom. We are delighted that the government has responded in setting up a high level inquiry under the chairmanship of the Prime Minister.

Further enquiry has convinced me that the extra money being committed to the Health Service needs to be committed on new terms. There need to be major changes to guarantee that it will be spent in the interests of the patients to improve the level of health care in this country. There will still need to be substantial regular increases in public funding for the health system.

There also needs to be extra cash from private sources to supplement this public funding. **Money is not a substitute for change but it will be needed to buy the changes required. The essential principle of care, free at the point of use, whatever people's income, should be protected and access to that care improved.**

The government in its defence of the Health Service in recent years has pointed to many successes. It is true that a large number of extra

patients are now being treated. It is true that many health staff are much better paid in real terms than they were in 1979 and it is true that many extra people have been recruited. It is true that new types of treatment are now generally available that either were strictly rationed or had not been dreamed of some ten years earlier. The average age of the population is growing older, people are living longer and the general standard of health of the country is improving. Many babies survive their early days where before they would have died at birth. Many elderly people not only have a longer but a much better life because of a wide variety of new operations.

Nonetheless, there remains considerable public agitation about the state of the Health Service and not all of it is opposition propaganda. There are genuine difficulties of access, quality and demand. **The most serious problem that has emerged is the difficulty that some patients have in gaining access to the care they require.** Limited access is not a new problem as Oliver and I pointed out in our first pamphlet. The Health Service has survived on rationing ever since its first foundation after the war. Waiting lists have always been long and for certain kinds of surgery or treatment the Health Service has effectively prevented individuals from obtaining it at all. There is a system of concealed rationing carried out by general practitioners deciding not to refer people to consultants for particular types of operations. There is also a form of open rationing which is becoming more obvious where people are referred but where there is no realistic chance of them getting the treatment or the operation they require within a few weeks or months. Many of the most heated debates in the House of Commons have

been where the opposition has identified groups of patients in particular health districts requiring treatments who have been denied access. The most dramatic of these are the cases of the Birmingham heart babies needing acute coronary treatment where it was alleged that treatment was not available when the patients needed it. In some cases this was genuine.

The second related problem concerns the quality of care. Most people are full of praise for the Health Service for the quality of treatment it gives. However, there are a growing number of complaints about the standards of service in related areas. For example, many patients are treated badly over the question of outpatients clinics. They are given a common appointment time only to turn up to discover they may have to wait for hours before they see the consultant. Once in hospital awaiting surgery there are some criticisms in some hospitals of the standard of food and the quality of the hotel services. Some grumbles are inevitable given institutional catering and given the pressures patients are under. Whilst most patients are careful to say how good the nurses are, often working in difficult circumstances, there is nonetheless some disillusion with the standards of hotel accommodation and care.

Unlike the US, the question of success rates and the quality of surgery has not become an issue in the United Kingdom and there is a general feeling that the quality is high. There is little evidence on which to base a judgment as to whether this is true or not. The Health Service never publishes statistics by district or hospital for the relative

success or failure of different types of operation. National figures suggest that whilst hundreds of people die each year as a result of operations or following operations, it is a tiny proportion of those undergoing surgery.

The third general issue of concern is how the Service can cope with the growing pressures of demand. There is both the problem caused by the relative ageing of the population and those pressures caused by the development of new types of surgery and treatment.

The average cost to the Health Service of looking after someone over the age of 75 is over £1500 per annum. This compares with some £200 per annum for someone of adult working age. As the population grows older these pressures will become more and more intense. At the same time improved surgery and other techniques enable more and more conditions to be tackled at ever more advancing years. More surgery is undertaken for the ageing population as well as the additional courses of drug treatment and more frequent domiciliary visits or hospital stays. There are those who are asking whether any system of health care can keep pace with this type of demand explosion and certainly whether it is feasible for a publicly funded system to keep pace. I believe that it can do providing that some greater element of private choice and private partnership is introduced.

Level of Public Funding

The level of public funding needs to keep pace with demand and costs, after allowing for some offsetting improvements in efficiency. At the moment there is no way of telling what is an adequate level of public funding given the style of management and the lack of reliable information. **Growth of real resources of around 2% per annum would be a suitable target, to be achieved unless general economic growth falls below such a level. This should meet the rising demand from the changing age structure of the population and technical improvements, after allowing for modest efficiency gains of around 1% per annum, which should be a substantial underestimate.**

Employees

At the core of many of the difficulties of the Health Service lie a series of management and union issues. It is doubtful whether a large organisation employing around 1 million people can ever be run as a successful unified whole. **There is growing evidence to suppose that running very large units with very large numbers of people and trying to run them systematically over the whole diversified nation is an impossible management task.** The evidence of the Health Service would certainly bear out this contention. Whilst the National Health Service implies through its name that it should provide comprehensive care to all the nation on a consistent basis the evidence abounds that there are huge differences in quality of care and access to care within the different districts and hospital units of the country. The effort to address this in purely financial terms by the much disliked RAWP formula

does not seem to have done a great deal to even out the standard. It has created acute difficulties for some of the hospitals in the hard pressed South East area experiencing population and demand growth in London trying to maintain high quality research based and teaching hospitals against the background of dwindling resources and declining population.

There are huge variations in costs and efficiencies around the country. Staff usage varies five fold betwen different districts. The cost of keeping medical records is five times higher at Charing Cross than in West Cheshire. The cost of building maintenance at West Birmingham is five times North Hertfordshire. There is no great evidence of national management grip on the Service.

The union problems are becoming serious. The Conservative government's union legislation has made great strides in turning the industrial minefield of Britain into a much more amicable place. There is a much greater degree of co-operation between managers and workforce in many companies. There is now a virtuous circle in many sectors of the economy with rising productivity leading to rising real wages without the need for huge and damaging industrial disputes.

There has been no such advance in the public sector services. These retain the difficulties of British unionism experienced throughout the economy in the 1970s. In the Health Service they are now at their most difficult because of a damaging battle for membership and support between three competing unions. Both NUPE and COHSE are actively trying to recruit nurses and others away from the Royal College of Nursing

which bases its activity on the laudable premise that nurses should not resort to industrial action as this could damage patients. NUPE and COHSE have wrestled with this problem along with their friends and colleagues in the Labour Party and have tried to characterise their strikes as being days of action or protest. They have also attempted to dress them up as being about the level of funding and the national interest rather than being simply about pay and conditions. This in many ways makes them more damaging and difficult.

The unionisation has been parallelled by the growth of an ever larger bureaucracy of middle and junior administration and clerks. There are now so many layers of management within the Health Service that it is extremely difficult for central management to communicate a message down the line and hope to see it implemented and enacted in the spirit in which it was intended. Total administrative costs are in excess of 10% of the total expenditure on the hospital services. There are deliberate efforts to decentralise the Service within the regional and district structure. At the same time there is a general wish to see it centralised as everyone looks to the centre for funding and is always prepared to argue that the only thing that is wrong with the whole system is the particular choice of funding level. Whenever an organisation always blames an external force or cause for whatever is going on within it we should be extremely sceptical.

The Health Service has a similar mentality to that of the British car industry in the 1970s when the only thing that was meant to be wrong with the British motor industry related to government policy towards it

- either the tax level was wrong or the exchange rate and interest rates were wrong or simply the government did not spend enough on the motor industry. The 1980s has seen a major rebuilding of the British motor industry. This has taken place because managers from within the industry have begun to understand that what matters more than all these external circumstances are basic things like the design of car, the productivity of the manufacturing unit, the way in which the cars are marketed and sold and the advantages of the product. This kind of attitudinal change has not occurred in the Health Service. Tt would not be right to replicate in the Health Service a profit seeking mentality. **However the NHS does need a management style which understands that the patients come first, and a sense that managers in the Health Service endowed with substantial resources have the opportunities to solve many of the problems themselves. Good hospital and District General Managers need to be encouraged and best practise spread more widely.**

There are too many managers, too much badly presented information and a strange style of management. It is now commonly argued that the British Health Service is a miracle of low administrative costs because the seeming administrative cost as measured by the administration at district and regional level at only 4% to 5% is quite modest compared with some overseas systems. This cost leaves out money spent within the hospitals themselves on administration. There are too many statistics, never used to manage the Service, whilst essential figures like the cost of an operation are not available. Overseas systems often have to include the cost of insurance and insurance claims which means that they are raising money as well as spending it. To be comparable the British

figures should include the costs of the Inland Revenue: over half all the income tax collected is needed to meet the costs of the NHS.

Staff morale is low in mmany NHS hospitals. The common explanation for this is that pay is not adequate. Why then when the rates of pay in some private hospitals are similar or the same as the rates of pay in NHS hospitals is morale usually much higher? There are no cases of private medical staff going on strike or indulging in days of protest. In private units the attitudes of the staff and the good relationships between managers and staff immediately strikes the visitor. Conversely, in the National Health Service there is now evidence that the lower levels of administration are becoming themselves heavily influenced by union campaigns. Some see themselves not as managers but as instigators of action and protest against the health authority or against the government on the grounds that the easy way out for any problem is to say there is not enough money.

Property

The NHS is one of the biggest landlords in the country. The estate is undergoing rapid change. Huge capital programmes expended in recent years have built a new group of mega district general hospitals. The results have been the closure of a whole series of smaller hospitals in the communitie that were often much prized and the concentration of staff in very big units where management problems are accentuated and unionisation is made that much more intense.

Much can be done in terms of estate management and husbandry. Mercifully, there are still a lot of small hospitals left and the public mood would favour their rehabilitation and use whether as GP surgery units or as small residedential hospitals catering for geriatric services, maternity services or a basic range of surgical treatments. Considerable work remains to be done in rationalising the large estate - there are still too many units and plots of land and inadequate use of some ofthe better sites. Management is becoming aware of the opportunities here as can be seen in the large increase in sale proceeds from land and buildings in recent years. Until recently there was little interest in doing this. The accounting system still does not regard land and buildings as a true cost as there is no depreciation. The Health Service got by on a wing and prayer hoping that some day somewhere money would be available for necesasry refurbishment. The Health Service faces the additional problem that many of the buildings built in the 1960s and 1970s were not built to last. Their flat roofs and concrete structures and cladding has aged very rapidly and is now superimposing on the task of updating Victorian and Edwardian institutions the task of rebuilding or renovating comparatively modern institutions.

The main outlines of the problem are becoming clearer. The inquiry needs to address itself to the issues of access, quality of care and growing demand. It also needs to address itself to the management issues of staff morale, management style and the use of people and property within our health Service. There are then the broader issues which have tended to hog the limelight about the future financing of

the Service. Should we continue with the pay as you go tax based system? Should we instead move towards some kind of private or public insurance scheme or a mixture of the two? Should we move to a system of financing within the tax based system that turns general practitioners or districts into health management units buying surgery and treatment from a variety of providers? These are now firmly on the agenda and the correct answer to these wider issues will have a substantial bearing upon the prime question of how we get high quality patient care.

Access to care

The alluring opposition response to problems of access is to assert that everyone can have access to everything if only the government loosened the purse strings a little. The opposition conjures out of the air the spectre that just for that elusive extra £300 or £400 million or (if it is a union representative speaking) the elusive extra £1 or £2 billion the public could have all the health it wanted and more besides. There is little evidence to support this contention. The last £14 billion extra put in since 1979 has not had that desired effect of giving everybody access immediately to that which they seek. Indeed, if you asked the DHSS how much it would cost to clear the waiting lists, they cannot tell you because they do not have the information and because the question is not that simple. In Scotland where spending per head is materially higher than in England waiting lists are high.

When the Birmingham children were at the centre of the political debate it emerged that it was not merely a question of money. If an extra

£1million would have sorted the thing out the government should have given them the money. But further probing demonstrated that the problem lay in a shortage of intensive care nurses and that no amount of money in the world could suddenly produce those intensive care nurses in Birmingham without taking them away from some other hospital where they were already carrying out some other important work.

The Birmingham experience showed that the problems lay deeper in training and other decisions taken over a number of years. They were exacerbated by the difficulty within the Health Service for patients to move around. Glasgow has a successful child coronary unit with a very short waiting list but it was not thought possible that some of the less severe cases from Birmingham who could travel might move to Glasgow in order to free beds in Birmingham. Not was it thought possible to transfer nursing and other resources from less acute specialities in Birmingham to the acute heart care centre. There are tight union and medical guidelines over training standards and over levels of staffing needed to carry out certain types of operation. The Inquiry should ask whether all these rules are necessary for safety or whether some manning levels and training levels are set unrealistically high to the detriment of patients wanting care.

In order to tackle waiting list problems a number of management decisions have to be taken and put into place rapidly. The first point is that cutting waiting lists has to be made an urgent priority. The Health Service needs to compile accurate figures and information on who is waiting where. It also needs accurate information on which hospitals

have spare capacity to tackle which kinds of treatment or problem and it then has to marry the two together. A simple computer programme would enable the longest wait to be reduced by offering people the opportunity to go to a shorter waiting hospital and consultant even if this does mean travel. Experience in Scotland shows that people will travel quite considerable distances in order to get out of pain more quickly without anybody forcing them to do so.

Breaking down the impenetrable district boundaries would be an important advance for evening out the standards of health care around the country and for dealing with the most acute waiting list problems. As managers became motivated to reduce waiting lists making sure they were accurate and giving people choice they would also be able to see from their computer screens where the shoe was pinching and where it was not. Then they would be able to start to take decisions which might shift resources from types of surgery and treatment which were relatively over provided or not so important into the urgent kinds of surgery where the waiting times were unacceptable.

Simply pouring more money in in the short term may do little other than increase the costs of the system. It takes time for people to respond, to go through the very long training necessary and to become nurses and doctors. It will need changes of attitude and staff use before extra money can immediately ensure more are cured. As the output of the system is determined by an amalgam of the number of nurses and doctors on the one hand and by the use of their time on the other, extra money may in the short term merely increase the costs. This may include giving

nurses and doctors a well deserved pay rise but does not do anything to improve patient throughput. In the medium term higher pay can act as a signal to the marketplace and attract more people into the profession. There also needs to be a willingness particularly on the part of some consultants and hospitals to see more consultants appointed. **Given the hierarchical structure of medical care in this country the only way long waiting lists are going to be cured is by allowing more consultants to be put into place or by allowing the new level of staff doctor down beneath the consultant the right to carry out his own operation without the supervision of a consultant.**

A simple solution to the most pressing problem of waiting lists is a national referral system where a GP can see a list of consultants and waiting times around the country and can book his patient in. GPs will have to be prepared to refer patients to consultants they do not know if the patient regards time as being crucial. The patient should expect to be given a choice ranging from the consultant the doctor knows well through to a consultant he does not know (but who must be up to general NHS standards otherwise he would not be on the system) but who can do the operation as soon as possible. The same information system would allow data to be retrieved at the centre to look at the allocation of staff and monies between specialities and districts to tackle the problems where they are most acute.

The quality of service

The problem of outpatients clinics could be tackled quite simply by the NHS Management Board insisting that every outpatient clinic be based on an appointment system where each patient was given a different appointment time. In all reasonable circumstances consultants should turn up to do the clinic or some locum would be appointed. This would have no resource cost as people are already given appointment times but they are ones that do not work.

Casualty wards need careful study. People are often sitting around for hours in considerable pain and part of the problem lies in the way in which their cases are organised. They are moved from pillar to post between nurse, consultant, doctor, X ray department, consultant and nurse. **It should be possible for a casualty department manager or general hospital manager to streamline the system with doctors making more on the spot decisions about the kind of information that the nurses, X ray departments and labs should collect before the patient sees the consultant or senior doctor for the decision on treatment.** There should be an aim to complete these tests rapidly once the patient has arrived in the hospital.

The hotel services of the hospital are much easier to tackle. Clause 4 of the Health & Medicines Bill makes a substantial advance giving hospitals powers to introduce private enterprise in the provision of non medical services on a wideranging basis. It is to be hoped that they will welcome this not only as a source of additional revenue but also as a positive means of raising the standards of hotel service within the hospital.

It is dubious whether hospitals have to organise their day in such a way that all patients have to be woken up at some extremely early hour in the morning. Part of recuperation or preparation for an operation can involve having a decent night's sleep. Being rudely awakened by neon lights and noise at 6 in the morning is not always conducive to this. **It might be possible to allow private caterers to offer an a la carte menu to those who did not like the look of the standard table d'hote offered by the NHS.** Subject to any dietary restraints that might be imposed on certain patients, it might be found that a large number of patients and their visitors took advantage of the trolley and kitchen service from the private caterer and were quite happy to pay for something different. **The private sector could certainly take care of the need for televisions, newspapers, hairdressing, telephones and other facilities that could improve the patient's stay in hospital. At the same time, this could make a modest contribution to funding the total cost of the hospital service. Private/public partnership might extend further, with private monies building new amenity bed wings, perhaps in conjunction with good hoteliers.**

Competing pressures on the NHS

The largest increase in costs is occurring because of the ageing of the population and the large number of treatments that are now offered to elderly people. The principal cost of taking care of elderly people in residential permanent care falls on the taxpayer but is not by and large carried out in NHS hospitals. A large number of private residential homes have grown up but it remains a problem meeting the costs of these for some

of the patients. This matter has been studied recently by Roy Griffiths. He recommends centralising the whole Service on the local authorities. This could place the government in future difficulties over the level of cost and the control of this programme, whilst it will remain a programme paid for out of central taxation. The government would be better advised to consider a voucher scheme where elderly people in certain categories qualified for a voucher from the national taxpayer. This could be encashed in a variety of hospitals and homes that could take care of the elderly people at the relevant level of care. At the moment provision is patchy and in some districts insufficient homes have been registered.

The second main pressure of technology does produce its own problems. However, it also presents opportunities. Given that most of the 192 districts are now moving to a system where they will have one major hospital within their district boundaries in each case this can become a centre for high tech medicine. If the districts are sensible enough to allow the growth of their community hospitals for the less serious types of treatement, the District General hospital can then get fairly intensive use out of those items of high tech equipment that are thought necessary. **In order to intensify the use still further to get the full benefits of it and to get an additional source of income to the NHS, these high tech specialities could take place on a partnership basis with the private sector.** Either the NHS hospital could buy the equipment and then sell time on it to the private sector in order to get revenue, or there could be joint funding arrangments to help carry the initial capital cost. There are examples of this now working in practice but the principle could be extended much more widely. For the most exotic treatments and machinery

there need to be regional centres of excellence. Some services like Pathology Laboratories might be better separated and run as free standing businesses on a district or regional basis. Mobile equipment of a specialist kind could be provided to a number of hospitals by a single company or provider.

The union problem

The government has to make it quite clear throughout the current troubles that it responds favourably to the arguments and the recent submissions of the Royal College of Nursing but it does not respond at all favourably to the unhelpful orchestration of NUPE and COHSE. The government should think through how any structural reorganisation of the Service could break down the large NHS labour monolith so that managers can have more direct contact with their employees and some of the tensions can be averted at the bedside or in the kitchens and elsewhere before it blows up into a major national problem. The government should not doubt that it is facing a serious challenge in the form of NUPE and COHSE's recruitment programme. Some of them closely with vocal opposition in Parliament to try and develop an atmosphere of crisis within the Health Service.

In the ancilliary services it is quite possible to bring in help from outside should the unions decide to suspend their work and their co-operation within the hospital. It would be very easy to find other ways of feeding hospital patients, cleaning the hospitals or carrying out the other manual tasks where they have not been contracted out. The same is not true with the medical profession where it is in the interests of both sides

to proceed by agreement and where the balance is much more delicate. The public might blame the medical profession for precipitating a crisis or the government for getting in the position where disruption occurred.

Some wish to develop a new form of contract for Consultants, stressing the extent of their commitment to the NHS and limiting their powers. At the moment the balance is weighted in favour of the Consultants, as they have tenure and the managers are often on relatively short contracts. It may be that this imbalance has to be redressed, or that the system at Guy's has to be followed where Consultants themselves are given service and financial responsibility. It would be unwise to tamper with GP arrangements, especially at a time of change in Consultants' conditions of employment.

It would doubtless be better for both managers and employees to reduce the extent of the management hierarchy, to concentrate on good local management and to have units where managers know all the employees by name and where there is a good working relationship between them. An example of the difference in styles between a small private hospital and an NHS hospital lies in the treatment of staff and the attitude towards the return of married women to work. In the NHS hospital there are fairly inflexible rosters and there can be antagonism towards part time people, particularly if those part time women need some flexibility over when they put in the hours they have to work because of school and home arrangements. Conversely, in a good private hospital there is an encouragement to part time work related to the schedules of the individual consultants who may

only be working one or two days themselves in that particular hospital. Good managers are willing to allow a given nurse to miss a Tuesday afternoon if in return she will do an extra Thursday evening or whatever. This kind of flexibility is appreciated and when combined with a pleasant working atmosphere in general can make all the difference between high and low morale. **There needs to be exchanges of patients between public and private hospitals. The private sector needs the back-up provided by the high technology medicine of the NHS whilst the NHS needs private hospitals to shorten waiting lists in some other areas.**

Management issues

The hierarchy of the NHS is both too big and too impotent. Following enquiries, I conclude that the best way of running it is through a centralised National Health Service Management Board which should be the principal adviser to the minsister and the main means of communicating messages around the country, improving management styles and service quality. The regions are well defended by the DHSS and by others. There is a feeling that you need regional units to make consistent plans on a regional basis for capital spending, for money and for employment. Yet it is also the case that if you want to find out what is going on in the Health Service it is better to ring up the local hospital or health unit where they know what is happening. The confusion between the responsibilities of the central NHS, the regions and the districts is quite substantial. The Regions should be abolished.

There is a rationale in having district boundaries so that each district has one major hospital and a group of smaller facilities and hospitals clustered around it. There then needs to be clear flows of patients and information across district boundaries and centrally determined decisions on resources based upon a simple management information system illustrating patient need, GP demand, waiting lists and other pressures. Most powers for day to day running should rest with hospital managers at each location.

One most sensitive issue which has emerged is that of nurse management. Many nurses and sisters have written in to say that they do not like the current system of nurse managers placed over their heads and would prefer to go back to the system where the sister was in charge of the ward and reported only to the matron. Hospitals need a good general manager and a good matron in charge of the nurses. They do not necessarily need a whole range of other managers such as has been introduced in the wake of the Griffiths' reforms and they certainly do not need a lot of junior managers intermediating between the man at the top and the sisters and nurses on the wards. **More good nurses need to be retained as nurses and paid for their skills and experience, rather than being promoted into an administrative job.**

It could be argued that the case of the large 1500 to 2000 bed hospital, presents a different problem of scale. It may well be that here we need smaller management groupings within the hospital. Under this model there would still be a general manager of the whole hospital but there might be four or five other senior managers responsible for individual blocks within the hospital, perhaps with their own separate matrons.

The NHS Management Board should collect and use simple information by hospital and speciality about cost, quality of service and access for patients and use this to manage the service as a whole and to direct new resources.

Property management

The opportunities in property management are legion. Some major hospitals are old fashioned units in the centres of towns where the site is too constrained but extremely valuable for an alternative use like retail. There may well be a case in these examples for building a unit partly out of the proceeds of property transactions which can result once the new unit is constructed. Other properties are simply redundant. An example in the West Berkshire Health District shows the scale of some of the opportunities. A small unit for dealing with autistic adolescents called Smiths Hospital near Henley currently looks after 12 young people. The total cost is £800,000 per annum or a cost of around of £70,000 per patient. Only five of these patients come from the West Berkshire District Health district itself which is a relevant matter given the budgetary constraints and the clear boundaries in health care at the moment. These children could be relocated at other sites and a major asset freed which could not only save substantial running costs but raise an additional sum for an alternative use. Similarly, in the West Berkshire District, the relatively expensive but not very satisfactory office accommodation at Great Western House could be sold for the District has a perfectly good

site at Peppard which is no longer needed for medical purposes which can be converted into an office block.

There are occasions when thoughtful health districts like West Berkshire wishing to make the most of their property encounter extreme difficulties with local authorities. The government should consider issuing a further planning circular guideline saying that where there are buildings on an NHS site there should be a presumption in favour of change of use and redevelopment in view of the Health Service's need for funds. **This money should be additional to existing health budgets.** The government could then exercise its discretion on appeal in those cases where the local authority was not persuaded.

The aim of the property redevelopment programme is threefold. Firstly, and primarily, it should be concerned to make sure that we have a pattern of modern or renovated buildings that match patient needs and include a good range of high tech regional and district centres of excellence and of community hospitals providing more basic care. Secondly, the property management should make sure that office accommodation is kept to a minimum and is not a relatively high cost element in the total property portfolio. Thirdly, property management should ensure that sensible developments are proposed and development value gained for the older buildings and land that the hospital service no longer requires. This could include symbiotic development like sheltered homes or day care centres.

Financing the Health Service - should we move to an insurance system?

Much has been made in recent months of comparisons between the proportion of GDPs spent on health in the United Kingdom and the proportions spent elsewhere. These figures do reveal that the United Kingdom is at the bottom end of the scale but they also reveal that the main divergence lies not in the costs of the public system but the amount of money contributed freely by individuals. **In the United Kingdom we have the lowest percentage of any advanced country of 0.6% in addition to the 5.6% spent through the public sector. A realistic target would be to expand the private provision fourfold from 0.6% to 2½%.** There are two ways that have been suggested of doing this.

The first is to draw an analogy between health and housing. Just as the growth of private housing was greatly stimulated by mortgage interest relief so, it is argued, the growth of private health insurance above and beyond the National Health provision could be stimulated by tax breaks to either or both employees and employers taking out private health insurance. The Treasury's main argument against this is that there would be a "deadweight" cost resulting from the grant of tax relief to the 8% of the population who have already made private insurance arrangements without any such inducement. This might be a price worth paying to stimulate more private health care plans.

An alternative version could be more accurately targeted and could be cheaper. **That would be to convert a sizeable proportion of the income tax - a little over half - into a National Health tax. This would be progressive and income related: the more money you earned the more you would pay. Then, modelled on the contracting out from the SERPS scheme,**

individuals and/or companies could be offered rebates if they were prepared to contract out all or part of their risks to a private insurance scheme. The government would have to monitor the quality of these schemes so that no one was ever in the position where they were uninsured for a major risk. The individual would only get a modest rebate as he would still have to make a substantial contribution to the pay as you go health system in the country to help pay for all those on lower income and the elderly who did not have the means to pay for their own health costs.

It might be possible with a 3 or 4% rebate to quite rapidly reach the point where 20 million people were contracted out and where the proportion of private finance to GDP had risen from 0.6 to around 2½%. There would still be a deadweight cost in this scheme but it might be less than in private tax relief depending upon the level of rebate chosen. It would have the added advantage of making the total cost of health care absolutely explicit to all those in employment paying the tax. People would see it now costs £30 a week for the average family to keep the NHS going.

Health management units

There has been considerable interest in the concept of an enlarged health maintenance organisation. Either GPs or Districts would receive capitation fees in respect of all their patients or resident population and would then spend this money with a variety of hospitals and health providers to buy the range of care their population needed. The advantage of such a scheme lies in the cost control it might exert. The health maintenance unit or groups of GPs would be cost conscious because their capitation fee for a

given range of patient would not vary; they would have an interest in keeping people healthy and in keeping the cost of care down. The scheme could introduce substantial competition into the hospital and treatment services as GPs or Districts would compete actively to find least cost, high quality systems. It would be best if it were done on a GP basis rather than a district wide basis: this protects genuine choice for individual patients as to which group of GPs they went to. This might prevent health management units becoming too mean, interested only in balancing the books or having higher remuneration at the expense of patient care.

There are drawbacks. The level of capitation fee would remain a highly charged political debate and there would be a temptation for HMOs to argue that problems lay in the inadequate level of the capitation fee rather than elsewhere in the health system. The Treasury would use the fee scale as a means of spending control. This would certainly be the case if the Districts were chosen as the unit for the HMO as these would be too large to offer people any effective choice and so people would still have to accept whatever care was dished out by the District. It would be easier if the GP unit was accepted, but this may encounter GP resistance and the whole system would depend upon the GPs liking it and welcoming it and wanting to make it work. **The system might be resource constrained whilst the doctors might not like it. With an expanding private sector, if the insurance option were adopted, HMOs will probably emerge of their own in the private sector where they would not encounter the same problems. Public sector HMOs are not recommended.**

Towards an internal market

There nonetheless remains considerable interest in how an internal health market in health care might work. The essence of it is patient choice. Money must move with the patient when the patient wishes to change. The beginnings of internal market do not have to rely upon the establishment of HMUs or HMOs. They could depend upon the following simple precepts.

1. Patients have a right to change doctor whenever they wish.

2. Doctors have a right to tell patients of the range of service their practice offers and the style of medicine they believe in.

3. The patient has a right to a choice of consultant when he needs referring to a hospital.

4. District General Managers manage the costs and quality of care provided to prevent the costs getting out of control.

5. District boundaries cease to matter. Patients and GPs between them choose where they will go to get treatment and the money will follow the patient.

6 The money following the patient should be the amount of cost actually incurred in carrying out that operation or treatment in that hospital, subject to maxima laid down by the District and the NHS management board based on a figure related to average costs.

7. The NHS Management Board should monitor unit costs of operations and treatments very carefully hospital by hospital and should call in the worst performing 10% every year to investigate and if necessary to change management styles or managers themselves for persistent failure to perform.

8. Hospitals should be allowed to opt out and establish themselves as non profit making trusts.

9. Hospitals should be encouraged to enter partnerships with the private sector, and Treasury rules should be amended to encourage such developments.

Conclusion

This pamphlet recommends some major changes in health care provision. Firstly, it recommends a major increase in resources for total health care by a major expansion of privately financed care through a contracting out insurance scheme. Secondly, it preserves the important principle of the NHS that all should have access to high quality care whatever their means and whatever their circumstances. The NHS will actually be strengthened by more partnership ventures between the public and private sector and by the breaking down of boundaries not only between NHS districts but also between the public and private sectors so that operations can be carried out wherever they can best be performed. Thirdly, it will prevent the system being totally resource constrained as money will move with the patient and will reflect the actual costs of the treatment delivered. Fourthly, it will prevent the system becoming massively expensive with a runaway inflation of costs because it will introduce new elements of competition between hospitals and other health providers and there will be the overall supervision of a strong National Health Service Management Board designed to change practices or managers in those units where costs are persistently high. Fifthly, it will make high quality patient care a prime aim and will put at the top of the management's agenda the reduction of waiting lists through a combination of good management information systems and the

targeting of resource on those areas where they are most needed. Sixthly, it offers a better deal for National Health Service Management staff by breaking down units into more manageable groupings and by reducing the huge management overhead which is as much a burden on staff morale as it is on the financing of the Health Service. Finally, it will generate substantial new revenues and savings from a bold programme of property renewal and disposal, from the additional resources coming in from private sector providers of hotel related services and from the administrative savings achieved by sweeping away the regions and some of the central overhead.