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Mr. Paul Gray,
10, Downing Street,
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Dear Mr. Gray,

I must apologise for the slight delay in replying to your letter of the 29th March. In that letter you ask me to expand upon my comments on the development of more centrally-determined cost norms and formularies to improve NHS cost efficiency. May be I can preface my remarks by a few observations before getting down to detail.

Approximately 3 years ago when I took over the Chairmanship of our local Medical & Surgical Equipment Advisory Committee, we established a new central warehousing store for this district. An exercise was therefore undertaken to collect stocks from all the wards and determine what was obsolete, what was wanted and what was still usable. Regrettably, in that exercise, no less than £80,000 worth of redundant and obsolete equipment was discovered. This can only be described as a terrible waste and would not be allowed to occur in any rationally run private enterprise. Why did the waste occur? It has occurred because clinicians wanted, say, various forms of endotracheal tubes whereas, in fact, they only used one or two. Different consultants insisted on different types of endotracheal tubes without rationalizing why. Then as staff changed, their own preferences came in with little scientific reasoning and hence more wastage. Many forms of bladder draining bags were available. Some had previously found favour, then had been superceded, new ones brought in without old stock being used up. An array of intravenous lines, intravenous needles, cannulae, were also found sitting on shelves not being used. A whole range of various dressings for a variety of skin wounds were found. No less than 64 different types of wound dressing and skin fixatives were found in this district. I might add the list has now been pruned to only 10 with no deterioration in quality of patient care. When one looked at masks for delivering oxygen therapy, a whole range of these were found sitting on shelves which had been bought in according to the whims of individual consultants, not necessarily on the efficacy of the product. It was at that time I decided, therefore, to embark upon a system of developing a District Equipment Formulary in exactly the same way as we have District Drug Formularies which, in turn, have derived guidance from the black list of drugs.

I fully realise there must be some competition in the market to ensure that good products are being produced and no monopoly situation arises but, nevertheless, I feel there are far too many.

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In the U.K. the quality of medical practice is sufficiently standard that we do not need a wide array of different equipment for the same treatment. As one who examines at a number of Medical Schools I can say, without reservation that the students emerging from the different Medical Schools are, indeed, very similar. This cannot always be said for other European countries.

Furthermore, the Regional Authorities have the ability, after discussions with representatives from districts, to award large contracts to Companies for a given product, thereby ensuring large discounts. Therefore, it seems reasonable to me that one should be able to come to agreements at largely a national level for many items such as the following, e.g.:

1. Wound drainage systems
2. Urinary bladder drainage systems
3. Intravenous lines
4. Angio access ports
5. Syringes and needles
6. Surgical gloves
7. Various types of endoscopes, e.g., upper gastrointestinal, lower gastrointestinal, bladder, bronchoscopy, etc.,
8. Haemodialysers.
9. Artificial kidneys

The list could be exhaustive but the above are just simply some ideas. Since the practice for which these items are used does not differ widely I cannot see why a limited national formulary for such equipment cannot be agreed upon, a limited number of firms able to compete for this type of work and, therefore, ensuring standard national costs for such items which, indeed, can be passed down to regions and all districts benefit by such arrangements.

Such arrangements would not lead to stasis of thought in equipment development. Indeed, if better equipment does come to the surface, then it should be the norm for every District Hospital to use up existing stocks before new stock of a new type can be bought. This sort of thinking should be directed from central Government then all senior clinicians would understand they have a responsibility in behaving in a fairly standard manner and not continue with the present free for all approach.

Again, when talking of developments in therapeutics, stricter guidelines from Region, maybe emanating from central Government, should be enforced, otherwise we have strange situations where, for example, say, in Radiotherapy a new drug may be recommended, e.g. Carboplatin in place of Cisplatin, at what might be an extra of £40,000 - £50,000 per district but with very little improvement in quality of patient care. We see things happening with gold therapy in rheumatoid arthritis now this is becoming available as an oral preparation. In other words, what I am suggesting is that, with some of these treatments, which are not just district based but have

national application, one has to think very carefully before new treatments should be recommended or, if they are, they must be planned for in a suitable way. There is far too much adding on to Formularies with respect to drugs and not deleting old and outdated ones. In my view (I am Chairman of the local Drugs & Therapeutics Committee) every effort should be made to make sure that if clinicians want something new there is usually something that can be deleted in its place. Again, the phenomenon of something new must be better irrespective is something to be resisted and this is done more effectively in private practice, as it happens, than in the National Health Service.

Another very good example is the cost of home total parenteral nutrition, albeit this is a small field. In this sector, a number of commercial firms supply the treatment at £30,000 per year but we have shown, for example, at our hospital, that we can treat patients for around £19,000 per year and achieve exactly the same result. Therefore, it seems to me that if one had national guidelines on this type of thing then the National Health Service could benefit from those areas who can produce the treatment at a fraction of the cost of commercially available ones.

Of course, the converse can hold true and in the last one year I have, as it were, gone private on my home dialysis delivery service, saving £50,000 on my budget per annum.

There are a number of Committees that now sit with respect to drugs, i.e., A.C.D., A.C.B.S. (I am Chairman of the latter Committee) which determine what drugs and what borderline substances can be prescribed to patients. Hitherto, no such fundamental control has taken place over medical and surgical equipment which, after revenue consequences of personnel salaries, is the second biggest drain on resources. Therefore, I feel that central DHSS should take a stronger lead in defining what is available and most effective in the delivery of medical treatment. There should be a degree of discussion but after that there should be enforcement and I am sure you would be surprised that with such a firm line, often colleagues will settle down and accept what has been stated, rather than just saying 'no' for the sake of it.

Another implication in national norms concerns the cost of various treatments in different regions. Thus, if we look at such treatments as chronic ambulatory peritoneal dialysis, regular haemodialysis treatment, coronary artery by-pass grafting, hip replacements, to name but a few, there are very considerable cross-regional differences in cost of the treatment. Now, why should that be when we are concerned with a National Health Service? The doctors salaries are the same, the nurses salaries are the same, most of the supportive technical staff salaries are the same. If, then, we rationalize on the type of equipment and drugs used, there can be no reason why there can be cross-boundary differences of even up to 400% for the same treatment. That, in my mind, is not a National Health Service, it is regional service which does not always justify the big differences in cost.

Now, to make many of the things I have mentioned above possible, we need to have a good management structure. The one thing one has to admire the private sector for is their accounting system and their very limited formularies on both drugs, dressings, equipment, which many of the same medical personnel operating in the private sector would not accept (for no good reason) in the National Health sector. However, the private sector spends between 10% and 11% of its income on good administration, whereas in the National Health Service it is something around 3.7%. I am, therefore, suggesting that a little more money spent or redistributed on good management which could bring about these changes could rationalize the delivery of medical and surgical treatment and allow money left over for other development.

A lot of what I am suggesting, therefore, does away with this issue of so-called doctors clinical freedom. However, is it clinical freedom to say I must have irrespective of efficacy or of costs involved? I do not believe this is so.

I personally am a budget holder (£3.4 million per year) which covers personnel, consumables, drugs, ancillary staff, and have not found having to think about what I do is in any way curbing my clinical freedom. Indeed, by being more cost effective, because I now realise better what goes on, I have been able to develop certain things which would not have been possible in the past.

Again, the medical phenomenon of never being able to say 'no' is something we must skirt around. Never being able to say no means you are always saying 'yes', yet not always constructively measuring why the response has been given.

In conclusion, I believe by having national guidelines and formularies re drugs, borderline substances, medical and surgical equipment and cost of specific treatments standardized, much money could be saved for the National Health Service and I would not see this in any way as curbing clinical freedom. Yes, the medical profession will get up and shout, but that is no reason for not going along these particular lines. the BMA, for example, is bound to resist but I do not think that really matters for there is a lot of common sense in going along the lines I have suggested above.

In my reasoning above, I have simply given some outline ideas but if you would like me to specify more clearly, if you found this of any interest, I would be happy to do so.

Finally, I personally believe it is unwise to overfund any service but I think the National Health Service should be kept slightly hungry. By that I mean that in the so-called hungry situation, all clinicans, managers, nurse managers, will be a little sharper in deciding what priorities they give to treatment, rather than assuming everything is available for everybody. Some support for this can be seen in the supplier induced

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demand phenomenon now seen widely in the United States and some parts of Europe. Because there are many cardiac surgeons available to do coronary artery by-pass surgery in America, many operations are still being done even at a time when it is well known the coronary artery disease rate in the United States is actually falling. Likewise, more lumpectomies are done in the States than over here because there are too many surgeons waiting around to do such operations in private practice. This is something I feel we must strongly guard against in our country and a rationalization and keeping resources limited to a certain degree is important to achieve this.

With kind regards,

Yours sincerely,

H.A.Lee
Professor of Renal Medicine

NAT HEALTH: Seminars Pt 3