M

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Secretary of State for Social Services

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

21 April 1988

Dear Paul,

IEA SPEECH

I attach for information, in view of its references to the NHS Review, a copy of the speech my Secretary of State proposes to make to the Institute of Economic Affairs Conference on American Health Care on Monday 25 April.

I am copying this letter and the draft speech to Alex Allen in the Chancellor's Private Office and Miss Rutter in the Chief Secretary's Private Office.

Yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

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SECRETARY OF STATE FOR SOCIAL SERVICES: SPEECH ON AMERICAN HEALTH CARE - 25 APRIL 1988

Dr Green, Ladies and Gentlemen.

INTRODUCTION

1. I am very pleased to have the opportunity of opening this conference on American health care. And for two distinct reasons. First, I was of course a resident of the United States for a number of years in the 1960s and my wife was born in America. So I have close and ongoing ties with that country. Second, this conference falls very conveniently in the midst of the Government's internal review of the British Health Service.

2. I believe that no commentator or politician concerned with that most important of human commodities - namely, health care - should approach the subject with a closed mind and an open mouth. As with many other aspects of our national life, we should seek to learn from others' experience - and perhaps also teach them something from ours. In the search for better and better ways of delivering health care we should not adopt a one-eyed, Nelsonian approach and so miss the valuable lessons which others have to offer.

3. As someone who believes passionately in the value of sensible discussion, I feel this very strongly. And I have been pleased to see a number of recent articles in the national press about the problems and opportunities facing those delivering or administering health care in other countries. If I may I would single out for particular praise the series of articles by Nicholas Timmins in the Independent and by Graham Turner in the Daily Mail. Their work has helped the public to set our own review into a broader and more international context. By doing so it has undoubtedly helped to raise the overall level of the debate.

NHS REVIEW

4. The renewed media interest in other countries' approach to health care has also served to highlight an important truth, and one which lies at the heart of our own review. It is that we are not alone. Whilst the ways of delivering services may be different and the means of financing them even more so, every Western industrialised nation faces similar problems with regard to health care. And, like us, most of them are examining their own systems in the search for improvements. For example, I understand that in West Germany a new Health Expenditure Law, to be adopted later this year, will relieve the statutory insurance schemes of responsibility to provide expensive dental work and medicines, pharmaceutical placebos and inessential hospital treatment. You will not be surprised to learn that this has provoked some adverse criticism!

5. In Norway, a Government Committee has recommended, for example, contributions from patients towards hospital care, increased payments for doctors' appointments and increases in charges for medicines. Here we have an example of an advanced Western country, deeply committed to the Welfare principle and with a tax-funded health system, taking a hard look at the current realities of health care provision. And New Zealand has been examining ways of improving the efficiency of its hospitals by introducing greater competition into the buying and selling of clinical services.

6. So I welcome this conference as a further contribution to the debate and I am sure the distinguished panel of American speakers which has been assembled for it will bring a range of valuable insights to these proceedings. Unfortunately, my diary does not permit me to stay for their contribution but I shall study your conclusions carefully.

7. As for the Government's review, this is now well under way. I must stress at the outset - to no-one's surprise, I would expect - that I shall not be using this opportunity to reveal the current state of the Government's thinking. Indeed, you would be rightly concerned if I were to give the impression that we had already reached our conclusions. We have not. The issues involved, as I am sure today's discussion will testify, are highly complex. We are proceeding as quickly as we can and we shall bring forward proposals in due course. But we shall only make those proposals after very full and careful consideration.

8. Our review needs to be seen in a domestic as well as an international context. It is all too easy to forget how times have changed in the forty years since the NHS came into being. The facts and figures speak for themselves. In 1949 £433 million was spent on health services - this year the figure will be £22 billion or around four times as much at constant prices. Over the same period the number of hospital doctors and dentists has quadrupled. And, most startling of all, there are far more and better treatments available. When the NHS started, organ transplantation had not begun. Now we have more patients with successful kidney transplants than any other country in Europe and nearly 1,500 operations were carried out last year. In 1967 some 5,000 hip replacements were done each year: by 1985 the figure was 37,600. And at the other end of the spectrum, some 3,000 babies live each year who would not have survived ten years ago. These achievements have been made possible by the dedicated efforts of the doctors, nurses and other skilled staff in the Health Service, backed up by an enormous increase in resources.

9. But despite such advances the dilemma facing us and indeed all advanced nations is broadly the same. How to keep the supply of health care in step with the increasing demands from consumers who, as their societies become more affluent, themselves become more eager for the latest treatment. And how to achieve this against a background of a steadily ageing population with its enormous demands for care and the advances in medical knowledge and treatment which make possible today what was impossible yesterday.

10. That, in a nutshell, is why we have established our own wide-ranging review of the NHS, concentrating particularly on the hospital service where the greatest pressures fall.

OBJECTIVES OF REVIEW

11. The problems we face, as I have said, are broad and complex. So we have not sought to confine our thinking within narrow terms of reference. In taking the review forward we want to keep in mind a number of broad objectives, which I want to deal with in a moment. But I want to make one thing clear. We intend to retain and build on the strengths of the existing system. I do not believe that health care systems can simply be transplanted from one country to another like cuttings from a plant. They invariably mirror a whole range of social, economic and even cultural factors in the countries concerned which makes wholesale transfer across national boundaries extremely difficult, if not impossible.

12. Having said that, I do of course recognise that there are lessons to be learnt from abroad, including the United States. I mentioned our overall objectives in the review. One is concerned with comprehensiveness. We are determined to continue to ensure that no-one is denied access to medical care because they cannot afford it and that the needs of particularly vulnerable groups, such as the long-term sick and the frail elderly, will be met.

13. Indeed it is the lack of comprehensive coverage which is, to British eyes, the most strikingly negative aspect of the American health care scene. Although the survey data varies, as [your/ David Green's] fascinating monograph on US health care showed, it is reasonable to say that in any one quarter between about 20 and 33 million Americans have no insurance cover - more than a tenth of the population. Certainly we want to see an expansion in the private health sector in this country, as well as in the number of those who take out private health insurance, either as individuals or through employees schemes.

14. But I must emphasise again that access to care regardless of the ability to pay is absolutely crucial to any system of health care in this country and will not be sacrificed by this Government. We do not want a system of "credit card care" where the provision of decent treatment and the means to pay for it are inextricably linked.

OTHER LESSONS FROM THE US

15. Indeed, whilst I believe that the American system has a number of positive features, which I want to discuss in a moment, I think we ought to be aware of other weaknesses. The desperate search for ways of containing the inexorably upward pressures on costs is an obvious example. Where the producers and consumers of health care are divorced from the funding of that care, which is provided mainly by a third party - the insurer -, there is an inevitable tendency for costs to rise as more and more care is both demanded and given, and there are few incentives to seek more cost-effective ways of doing things. And, of course, the escalating costs of medical law suits tend to lead to unnecessary treatment as doctors perform "defensive" medicine.

16. These pressures have led Federal and State governments in America to use a system of prepayment for particular types of treatment, based on so-called Diagnosis Related Groups, rather than the old payment per day method which was extremely expensive. These DRGs are now an essential feature of payment under Medicare and Medicaid, the two major state schemes for care of the poor and elderly. Rising costs have also stimulated the growth of Health Maintenance Organisations, whose key feature is that for a fixed subscription they will deliver a full range of health care, both primary and specialist. Because they work on a pre-payment basis, HMOs have a powerful incentive to contain costs once patients have been admitted and an added incentive not to admit at all, unless it's really necessary.

17. I do not propose at this stage to enter the debate on the pros and cons of HMOs and I will be interested to see the conclusions of this conference. But I would just point out that our centrally-financed and cash-limited NHS does have a good track record in containing rising costs and we are obviously bearing this in mind during our review. That is not to say that the £22 billion we currently spend on the Health Service is always used as efficiently and effectively as possible. Of course there is scope for improvement and the relentless search for that improvement goes on. But any changes would have to be careful to avoid the problems which the United States has experienced with cost-control.

18. I believe our system has other advantages over that prevailing in the United States. For example, our family doctor service, which not only deals with 90 per cent of all medical episodes requiring treatment but also acts as a gatekeeper to the expensive hospital facilities, is widely admired. And where it works particularly well there are strong networks of general practitioners, nurses, health visitors and social workers providing a very effective primary care service.

19. Nor do we appear to be as prone to what might be called the mechanisation of medicine, partly caused no doubt by the epidemic of 'defensive' medicine which I have mentioned. Dr Robert Heyssel, President of a corporation which includes the world-famous Johns Hopkins Hospital in Baltimore, was recently quoted as saying "We have medical technology without parallel in the world but what has been almost entirely lost in American medicine is the ability to talk to patients."

POSITIVE FEATURES OF US HEALTH CARE

20. So there are a number of features of the American health care scene, particularly its lack of comprehensiveness, which do not commend themselves in a British context. But that does not mean we should thereby ignore - lock, stock and barrel - the whole US experience in health care. I believe there are still a number of useful lessons it can offer, lessons which chime in with several of the other objectives we have in mind during our review.

21. First, we want to increase the <u>choices</u> available to the consumers of health care. This is fundamental. It will bring obvious benefits to patients because it should generate more competition amongst suppliers and so enhance the range and quality of the services available. Our recent encouragement of factual advertising by general practitioners and dentists points the way. Indeed the relative lack of information about doctors and their services would surprise an American audience, where patients have an increasingly significant amount of freedom to choose both the doctor they want and the hospital they prefer. Similarly, American hospitals vye with one another to give people what they want, running "Guest Relations Programmes" to try to ensure that all their staff treat patients as valued customers.

22. Secondly, we want to have done with the sterile and unhelpful distinction between public and private health care. Critics of the US system often give the impression - by way of raising a spectre - that it is 100 per cent privately-funded. It is not. Nor is it sensible to suggest that all health care must be publicly-funded. And the same critics who lament our position in the European league table of health expenditure fail to point out the relatively small contribution that the private sector in this country makes to total expenditure. Indeed the United States spends around eight times as much private money on health as a proportion of GDP as the UK.

23. Thirdly, we must couple our drive for greater efficiency with a search for improved quality of care. The American system embodies the pursuit of medical quality very firmly. Indeed the statutory involvement of Professional Review Organisations or PROs in the reimbursement procedures operated by Medicare have made quality assurance an essential component of the US health care system. Peer review and medical audit - where groups of doctors look at which treatments produce the best outcomes for patients and at what costs - appear to be much more a daily fact of life for American doctors than they are in Britain, although we are beginning to move down that track. The "Quality Initiative" of our own Royal College of General Practitioners is an encouraging sign of this, as is the work - which is continuing - into the causes of peri-operative deaths.

24. But we have not yet reached the position illustrated by a London-based anaesthetist who recently returned from a year in Dallas, Texas. His view was that, despite the paperwork, the quality assurance scheme in which he participated was very worthwhile. I quote, "Each month a particular topic was selected and treatment was assessed in a non-accusatory way to try to improve standards. The result was a lot of positive feedback in looking for optimal care. It can be done in a way which doesn't apportion blame but lets you question what you are doing in terms of quality of care for the resources you have used, against the benefits for the patient."

25. This is something we take very seriously. Our Resource Management Initiative seeks to provide doctors, nurses and other professional staff with detailed information about the costs and outcomes of their treatment and should lead to a greater focussing on quality issues. Two of the acute sites involved in this initiative -Guy's and Winchester - have re-organised themselves into a number of clinical directorates, each headed by a doctor. This is a technique borrowed from the Johns Hopkins Hospital which I have already mentioned. At the moment the Initiative is still at the pilot stage but if this approach proves successful - and I very much hope that it will - we would hope to begin implementing it at all acute hospital sites from the end of next year.

CONCLUSION

26. In a relatively brief address it is of course impossible to consider all the strengths and weaknesses of the American health care system. Nevertheless, it has a number of important lessons for a British audience, both positive and negative. The commitment to quality, the treatment of the patient as a customer and the provision of choice are features which merit close scrutiny. On the debit side are the lack of comprehensive coverage, the relatively poor primary care services and the explosive growth in defensive medicine. In taking forward our review we shall bear all of these aspects in mind as we seek to bring our own Health Service up to date and able to serve the needs of our nation into the next century.