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PRIME MINISTER 22 April 1988

THE MANAGERS' VIEW OF THE NHS

The National Association of Health Authorities has produced a shrewd, comprehensive and even imaginative submission for the Health Service Review. It demonstrates the remarkable achievement of the Griffiths Report in planting a modern managerial 'culture' in the once-stony soil of the NHS. And it suggests that your reforms, when they are announced, will have widespread professional backing.

That said, the report still contains observations and proposals that are likely to irritate you. It claims that the increase in real NHS expenditure since 1980/81 has been only 3.2 per cent -- by the familiar device of treating pay rises as contributing nothing to the quality of service. (This, of course, contradicts, the pre- settlement argument that a pay rise will help to improve the NHS by improving morale and retaining experienced staff.) It seeks an annual rise in spending of 2 per cent on top of inflation merely to meet "increased pressures" on the service. And it is hostile to any substantial expansion of the private sector as likely to attract resources from the NHS and create a second class service.

These points, however, are to be expected from those who manage the status quo and who have an interest in obtaining greater resources for it. They are outweighed by NAHA's admission that the NHS in recent years has greatly improved patient care and achieved greater efficiency, and by its well-informed criticisms of bureaucratic muddle in the present structure. (See, in particular, paragraphs 84 and following which contain strong support for the Griffiths reforms and criticism of what it claims is the DHSS's creeping centralisation of power and confusing multiplicity of "priorities" since their original implementation.)



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The NAHA submission examines some of the reform proposals currently in public debate and offers some suggestions of its own. Of the former, you may want to examine in particular its strong criticism of an earmarked "National Health Tax" or social insurance (paragraphs 23 and following) where it argues that any social insurance scheme would need to be amended in such a way as to reproduce income tax "but at substantial additional cost".

Its own proposals for reform include:

1. That Health Authorities should receive additional funding in relation to their efficiency and not, as at present, to their inefficiency.

2. That there should be greater local flexibility in pay bargaining.

3. That consultants should be more involved in clinical budgeting and clinical resource management through the appointment of clinical directors with real managerial authority over their medical colleagues.

4. That there should be regional experiments in internal markets (to which NAHA is broadly favourable.)

5. That, in order to obtain better control of costs and a better integration of primary and hospital care (in particular, monitoring GP referral rates), FPCs should be absorbed by District Health Authorities.

6. That Regional Health Authorities should be slimmed down to a few strategic functions.

7. That there should be a contract between the DHA and the users of its services, specifying the level of service they could expect (including guaranteed maximum waiting

times, after which patients would be entitled to receive treatment outside the district or in a private hospital.) This would be a sort of 'core curriculum' within the NHS. (I am preparing a paper on this, in conjunction with DHSS statisticians, to reconcile this idea with cash limits through the operation of a residual category of treatments with an "indefinite" waiting time, which would lose resources to meet the guarantees in more urgent sectors.)

8. That cross-boundary flows could be facilitated (and greater efficiency introduced in general) through DRG-based costing of treatments.

9. And that the NHS should seek better marketing of amenity services and pay beds in order to raise greater resources.

It is plain that that NAHA is moving along very similar lines to the Government's own Health Review. On internal markets, DRG based costing, a smaller role for regional authorities, clinical budgeting, peer review by consultants, greater local flexibility in pay bargaining, and contract-based authorities as the basis of a new Health Service, the Association is picking up our own themes without realising it. Almost the only major idea which does not find an echo in NAHA's report is 'opting out' by hospitals -- and that is partly implied in its willingness to cooperate with the private sector.

It makes an excellent agenda for Sunday's meeting with health administrators at Chequers.

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