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MEETING WITH NHS AND PRIVATE SECTOR ADMINISTRATORS: CHEQUERS: 24 APRIL

Sir Donald Wilson opened the discussion. He saw two main strands to the exercise. First long-term issues, involving financing and structure, which would take time to have effect and might require pilot schemes and legislation. But second there was a range of action it would be possible to take in the short-term, within a period of months, which could be implemented by management action. The main aspects were:

- The essential starting point was the provision of more cost information. It would be possible to have a system up and running by the summer of next year. This would open up a range of opportunities, eg developments towards an internal market, with districts bidding to provide services; the possibility of privatising some activities such as radiology where the private sector could do them better and more efficiently; and patients being made aware of the costs of their treatment. It would also make possible the principle of money following the patient (at present reimbursement could take two years).

- Raising customer/patient awareness of the quantity and quality of services. GPs were the key to this.

- Tackling the entrenched areas of professional and trade union privilege. This needed vigorous action from the centre to tackle a wide range of unacceptable working practices, many of which were so far untouched. Junior doctors were likely to welcome this process.

- A clearer distinction between the funding of health care and its delivery in the NHS.

Mr. M. Smith raised a number of general points about the independent sector. He stressed that the sector was not anti-NHS, and recognised there were benefits from

specialisation between the public and private sectors. The independent sector was not looking for special treatment, but would resist what it saw as competition from a subsidised public sector. The private sector did now make a substantial contribution to the overall level of health provision, and research showed that the public welcomed this trend.

He went on to identify two barriers to improving efficiency in the NHS:

- The lack of cost information. This was something the private sector already had to have; the NHS must follow.

- The present rigid demarcation in the controls over revenue and capital funding.

Mr. Smith also saw considerable scope for further expanding the role of the independent sector. The key requirement was that it should be offered an adequate return. Within this framework, the private sector was very good at performing elective surgery; it currently had a market share of 25 per cent in some specialities and this could be increased. There was also a role for the private sector in primary care services; changes in the contract arrangements for GPs, as well as consultants, and the drugs bill could increase patient choice and reduce costs. Some private sector operators were now able to offer turnkey contracts to build hospitals. And the sector could also play an important role in ensuring the willingness of the general public to take prevention seriously.

Mr Doughty said that progress had been made since the introduction of the Griffiths reforms. Although it inevitably took time, management grip was accelerating. Amongst the priorities he saw were:

- The need for accounting changes to ensure the availability of clean and timely data;

- The regions were the best vehicle for radical change, and they might take on more functions from the centre. There would be advantage in the RHAs including private sector representatives; and that principle might later be extended to the DHAs.

- Performance review was progressing, but he agreed with previous speakers there was scope for more privatisation, e.g. in pharmacy.

- Consultants' contracts must be looked at. But it was also important to offer help to consultants; many of them were children in the arts of management.

Mr Byrne wondered why the NHS did not have adequate cost information: the most likely explanation was that earlier management structures had not produced a need for it. They had got by each year by asking for their present level of expenditure plus inflation plus a little bit more.

He was keen to see the independent sector integrated with the NHS in the sense of two sectors actively competing for contracts for publicly funded health care. This could bring in a lot more private capital, for instance for the building of hospitals. He also saw scope for the independent sector to compete for primary care services, particularly in the inner cities; and to expand from its existing 50 per cent market share in the long stay care market.

Mr Tiley stressed two points:

- It was essential to change the nature of RHAs from predominately political and administrative to predominately hard-nosed business. The RHAs should bid for resources in return for a given output of health care; and they should then sub-contract the provision of this health care to districts.

- Problems over NHS costs arose not just from operations and treatments that were carried out but from the major difficulties when patients did not turn up as scheduled. This imposed a heavy cost burden, about which the public needed to be made aware.

Mr. West thought one reason for the paucity of information of NHS costs was because of past under-investment in management resources. He was also concerned about the possibility of any further major structural management changes in the NHS; this could easily lead to a further period of management paralysis.

He said that a major problem over consultants contracts was that these were held by the NHS regions. This meant it was all too easy for the BMA to obstruct progress. Although the majority of consultants honoured the spirit of their contracts major problems arose from those who actively sought to exploit the system. The solution was for contracts to be held at district level, and for appointments to be made by the managers with the medical profession acting only as observers. Management must also be able to demand that consultants answer questions about the implementation of individual contracts and work programmes.

A related point was the importance of focussing on the quality of consultants work. Under present arrangements it took many years to sort out cases of individual incompetence. This had to be resolved by the introduction of local management sanctions, based on a system having fixed term contracts, annual performance bonuses rather than merit awards, annual work programmes, and reconstituting appointments bodies so that they were not dominated by the medical professions. It was also important to end the system of special payments for domicilary visits.

Commenting on these points, Mr. Tiley suggested that:

- The RHAs might be reconstituted to comprise the DHA chairman.

- Some consultants might have contracts involving a 100 per cent commitment to the NHS, but this would require adequate remuneration.

Commenting on the second point, the Prime Minister said she thought it better to allow consultants to work both in the NHS and the independent sectors, but the key requirement was to specify precisely their responsibilities to the NHS.

Mr. Carter raised the following points:

- He agreed with earlier speakers about the importance of changes in consultants' contracts.

- The Griffiths reforms were working well in some places. But some authorities had not sought to implement them seriously, and had just bolted on minor changes to their existing systems. As previous speakers had said, some DHAs spent too much time playing politics.

- It was important to have the private sector more in competition with the NHS , and to avoid the private sector simply creaming off the easy and profitable elements of treatment.

- Initiatives in which sums of money were targetted on particular problems, such as waiting lists, had been very effective. The NHS was clogged up in some areas; DHAs should be encouraged to turn to the private sector for health care which it could provide efficiently.

Mr I. N. Smith described arrangements in Somerset where the DHA had resisted pressures to spend all their revenue

provision in servicing old facilities, and had set aside a reserve which allowed them to finance investment in new facilities including the one-off costs of re-equipment.

Although he saw advantages in the development of the internal market, it was important to remember that only 25 per cent of total NHS treatment was elective; the other 75 per cent was acute and emergency work where it was essential for the NHS to respond quickly. He also questioned whether in areas of dispersed population it would be as easy to operate an internal market as it was in large population centres. If the internal market was to operate effectively it would be necessary to increase labour flexibility, e.g. by relaxing manpower control and other ceilings.

Mr. Nichol welcomed the scope for health authorities to use the private sector to provide additional services. In the Mersey area, the total acute budget came to £250 million, not all of which was well managed. They believed that £10 million could be placed in contracts for hi-tech operations by the private sector, and another £20 million could be held back from allocated budgets, with the DHAs being invited by the RHA to bid competitively with proposals for contracting work out to the private sector. Patients did not mind whether something was done by the private sector or the public sector. He also saw scope for an increased role for the private sector in residential care for long-term and mentally ill patients.

Mr. Nichol also thought there was scope for a substantial increase in the number of minor operations carried out directly by GPs. At present most GPs instinctively referred far too many cases, e.g. minor head wounds, to the hospital sector.

He agreed with other speakers on the need to develop cost information. He saw the particular requirement as the identification of treatment costs for different conditions.

Mrs. Quinn said that the private sector was keen to cooperate with the NHS, rather than compete. She was currently involved in a joint venture with the NHS in the area of psychiatric work and the mentally ill. It was right for the private sector to continue to focus on those tasks they were good at; this could include the development of new approaches, such as the initial planning of the total resources for health care in new towns.

Having worked in both the NHS and the private sectors, she had asked herself why it was that doctors and other staff behaved differently (and better) in the private sector. An important factor was that private sector clinical staff felt they had a say at all stages in what happened to patients, and this added to productivity. It was crucial that staff at all levels should be given more training so that they were more productive and could make an active contribution to management.

Mrs. Quinn also saw the need for education of patients. She agreed with previous speakers about the cost problems when NHS patients did not turn up to appointments, and wondered whether some system of fines could be introduced. More generally it was important to tell the patients what they should expect from the health care services and what this cost.

Mr. Stokoe felt it was important to have active competition between the NHS and the private sector. Management reforms in the NHS still had a long way to go. In his area he had been conscious of business being lost to the private sector and had set out actively to compete with BUPA by developing a private wing in Hemel Hempstead Hospital. This had been very successful, and plans for a further wing were under consideration. It meant that the private sector were setting standards for the public sector. This process would be helped if general managers in the NHS had more freedom, e.g. over the raising of private finance. (The Prime

Minister pointed out that this would only be feasible if it could be made clear that no form of public guarantee was available for the borrowing.)

Mr. Weaver thought it was necessary to consider structural changes, and he saw considerable attractions in health management units. By contrast he thought a number of difficulties with the idea of a contract between a DHA and the users of its services had been understated; would this help reduce costs or improve the status or patients? how far was it reasonable to expect patients to travel? Would it be possible adequately to define waiting times? He thought that such a "contract" would be cosmetic.

Mr. Burgess explained that the Shanning Group was involved in a wide range of independent provisions. He thought that the NHS presented a paradox: it was simultaneously one of the best and one of the most inefficient health services in the world. Maybe by attempting to be all things to all people it was trying to do too much. He also thought that patients did not realise key aspects of the nature of NHS arrangements; for example, did they appreciate that GPs were members of a subsidised health club and not directly employed by the NHS?

He was distressed by the resistance within the UK to proposals by his company to sell turnkey hospital contracts. RHAs were not interested in fixed price total contracts, and their resistance was strengthened by a range of Treasury and DHSS controls. The result was the UK had persisted with NHS planning of new hospitals which was amateurish and high cost. He was also concerned about the lack of willingness by the authorities to deal with abuses and wastage in the NHS.

Sir Donald Wilson pointed to the benefits of delegated budgets. These worked extremely well as long as clinical staff were able to keep some of the financial savings they made. That was the key to improved motivation.

The Prime Minister asked for ideas on how to improve the

utilisation of nurses' time. Mr. I. Smith said that in Somerset he was undertaking a study of the required standards for types of nurses' work; this was involving work study, which was as essential to breaking down professional restrictive practices. Mrs. Quinn said that nurses' perception of their role was largely determined by their initial training. It was necessary to change those perceptions, and for all concerned to recognise that many of the services patients needed did not require nurses; standards of care could be improved at lower cost by using new types of staff for non-clinical services.

Mr. West argued that one of the difficulties over training was that the bodies concerned with accreditation, notably the English National Board for Nursing, were outside the main management chain. A related feature was that the faculties of the Royal Colleges set unreasonably high standards. These were not problems faced to the same degree by private hospitals. Mr. Byrne commented that the private hospitals found it difficult to obtain training courses from the ENB because of political opposition; Mrs. Quinn reported that she was now after a long period beginning to break through this problem. But she did not believe it right for independent hospitals to get involved in the basic training requirements for registered nurses. Mr. Burgess said that nurses recruited by his organisation from the NHS frequently had no perception of costs and standards of services; there was a requirement for increased training in these aspects for all levels of staff.

Sir Roy Griffiths commented on the difficulties of dealing with the professional unions in the health service. It was important to remember that for the first 35 years of its existence the whole of the running and management of the NHS was in the hands of the professions. They were very tough bodies who had been determined to create artificial shortages for example through their training standards; the ENB's Project 2000 was a classic example of this. (Mr. I. Smith agreed and said that this was in practice an academic

education programme not a training programme.) Sir Roy also pointed to the reduction in managers' freedom of manoeuvre flowing from the decision to hand over responsibility for pay to the Review Bodies. After the large increases now agreed following the 1988 reports it was essential for management to tackle restrictive practices with the unions forcefully.

Mr. Tiley returned to the treatment of revenue and capital expenditure in the NHS. He hoped that these could in future be treated differently along normal business lines. It was essential to introduce commercial accounting for capital expenditure. The Prime Minister commented that one of the difficulties with present capital allocations to health authorities was that managers automatically assumed they had a right to spend up to those limits rather than searching for cost-effective expenditure projects.

(PAUL GRAY)
25 April 1988
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