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PRIME MINISTER 29 April 1988

MR WHITNEY'S SEMINAR

Ray Whitney held a seminar on health care at the Commons this week. Its participants included representatives of some of the major public and private health bodies and specialist correspondents. (A list of names is attached).

I could not be present but I obtained reports from several who were. From the Government's standpoint, it is encouraging that there was general agreement on the following necessary/desirable features of a modern health service:

1. Comprehensiveness - good quality care accessible to all.

2. Better costing and incentive mechanisms to improve the use of resources. Better measurement of outcomes.

3. Increased and steadily growing funding - to meet rising demand.

4. A much greater role for private funding to provide the growth in resources which will be needed - an end to "the sterile and unhelpful distinction between public and private health care" (John Moore, 25th April 1988).

5. Better incentives for preventive medicine and modification of life styles.

6. Improvement in informed consumer choice and in the quality of care.

7. Separation in the public sector of the funding and the provision of health services.

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8. A distancing of health care from the centre of the political battlefield.

9. A greater degree of consumer responsibility and control.

(These objectives were proposed to the seminar, and the passages underlined are those which the participants added.)

When it came to practical proposals for reform, there was a good deal of agreement on the benefits to be obtained by "floating free" NHS hospitals. (This is also advocated by the first leader in this week's Economist.) It is plainly an idea which is gaining ground.

The major dispute at the seminar was on the question of how much we need to spend on health. Those who believe that future demand for health will increase markedly tend to favour financing reforms like health credits and/or contracting out in order to meet it from private spending; those who think present spending levels will prove adequate merely want to improve the efficiency of the present system.

That led directly onto proposals for financing reforms. Discussion centred mainly around the proposal (in Mr Whitney's book) for health credits. In his view, they give choice to the consumer and create incentives for doctors to achieve the optimum use of resources and to practice "managed care" and preventive medicine. He also argues that credits offer an easy and uncomplicated route to a widespread and buoyant topping-up system which would help to meet future demand from non-public sources.

Interestingly, this was apparently more attractive to the representatives US private health insurance present who

talked of a steady real terms growth in demand of 6%. BUPA and PPP were apparently much more cautious both about future demand and reform proposals.

In general, however, at this seminar and in the NAHA report, the debate is taking place on broad conservative terrain.

John O'Sullivan

JOHN O'SULLIVAN

SEMINAR ON HEALTH CARE HELD ON WEDNESDAY, 27TH APRIL 1988, JUBILEE ROOM, HOUSE OF COMMONS.

PARTICIPANTS

Dr.Digby Anderson	Social Affairs Unit
David Boddy	Market Access International
Keith Cuninghame	Research Division, House of Commons Library
Marian Downey	Medeconomics
Laurie Edmans	AMI Health Care
Richard Efler	Western Provident Association
Hugh Elwell	AMI Health Care
William Fitzhugh	GN Health Management
John Ford	British Medical Association
Roy Forman	Private Patients Plan
Paul Gardner	Conservative Research Dept.
Dr.Michael Goldsmith	Medisure
Kenneth Groom	International Federation of Voluntary Health Service Funds
Geoffrey Hulme	Public Finance Foundation
William Laing	Laing and Buisson
Dr.James Le Fanu	Sunday Telegraph
Sue Marks	British Medical Association
Alan Martin	Shepheard-Walwyn
Professor Ian McColl	Guy's Hospital
Andrew Mitchell MP	
Humphrey Nicholls	Murchison Associates
John Peet	The Economist
Edgar Price	Hospital Consultants & Specialists Association
Michael Prowse	Financial Times
Dr.Geoffrey Rivett	DHSS
John Sellars	Medisure
Jill Sherman	The Times
Julian Stainton	Western Provident Association
Prof.George Teeling Smith	Office of Health Economics
Ray Whitney,MP	

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OPTIONS FOR CHANGE HC 15

A range of options

1. Models of health care delivery need to cover:

   i. the buying of services. This may be undertaken by a public monopoly or near-monopoly (as now, by health authorities), by a private sector intermediary, or by the individual consumer.

   ii. the provision of services. This may again be either mainly in the public sector or mainly in the private sector.

   iii. the method of financing services. The three main possibilities are:

   - predominantly tax, as now.

   - some form of social insurance, perhaps with provision for people to opt out - either partly or fully - in favour of private insurance.

   - predominantly private insurance, with some form of state support for the poor and uninsurable.

2. The various possibilities for buying, providing and financing health care - ranging in each case from radical to no change - can be combined in different ways, including radical solutions in any one or two of the three dimensions coupled with less fundamental changes in the others. This paper discusses five broad models, chosen to illustrate, not exhaust, the range:

   i. Patient as Buyer: the most radical option overall, maximising individual responsibility and a market-based approach.

   ii. Local Health Funds: also involving major change, but using mechanisms akin to US-style Health Maintenance Organisations.

   iii. Independent Hospitals: major transformation in the provision of services, coupled with relatively modest changes in buying and financing.

   iv. Opting Out: a significant change in the method of financing, with some related changes in buying and provision.

   v. The NHS Refurbished: essentially the present model, but with scope for significant improvements.

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3. The following paragraphs describe each of the models and outline some of their advantages and disadvantages. The issues raised would need to be explored more fully if the Group wished to pursue further any particular option, or any of the many possible variants.

Patient as Buyer

4. The central feature of the "patient as buyer" would be that of giving people responsibility for arranging their own health care and the maximum scope for choice between competing providers. Government would have only a limited role in buying or providing services, but would regulate the market and give financial support to those who could not look after themselves. This is the most radical model.

5. Among its key characteristics would be:

i. a range of free-standing suppliers of services. As with the "independent hospitals" model (see below), hospitals could become public trading bodies, in competition with the profit and non-profit hospitals currently in the private sector. There would be a need for supervision of hospital standards, including a licensing system.

ii. as many people as possible would buy services themselves on a fee paying basis, using private health insurance cover or out-of-pocket payment. Bills would be paid either directly by the insurer or by the patient subject to reimbursement. Many would probably look to employers, trade unions and so on either for information or to negotiate with insurers and suppliers on their behalf. Insurance cover might be on either a group or an individual basis.

iii. Government would need to finance - but not necessarily to buy or provide - a substantial body of provision for the old, the poor, the chronically sick and perhaps others, possibly using vouchers or credits to maximise choice.

iv. hospital doctors could be free to work independently if they wished, although some might choose to be employed by suppliers. GPs would no longer necessarily be the "gatekeepers" to hospital services. Government would probably need to regulate the professional market, in order to prevent restrictive practices and facilitate competition.

6. The main advantages of this model are maximum choice for the consumer and maximum competition among both insurers and suppliers of medical care. It would introduce dynamic market mechanisms into health provision, with in theory large potential gains in efficiency and in consumer responsiveness to patients.

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7. On the other hand, control of costs would in practice tend to pass to the suppliers, with competition on quality of service rather than price. Overseas experience has shown that this can result in an expensive system, but also that the market is capable of generating its own mechanisms for containing costs. The most notable of these mechanisms - HMOs in the USA - would tend to transform this model into something closer to a "local health fund" approach (see below).

8. The "patient as buyer" model would also incur social costs. It would be difficult to enforce compulsory insurance (would treatment be refused to those to who had not insured themselves and did not have the means to pay the full cost of treatment?), and to ensure a full range of services. There would be risks of a "two-tier service". Insurance premia would not be related to income, and this would bear heavily on low to middle income families who were not poor enough to qualify for government finance. Careful consideration would need to be given to ways of mitigating these disadvantages.

Local Health Funds

9. The "local health fund" (LHF) model would also give people responsibility for arranging their own health care and provide for competition between providers. Its main distinguishing feature would be the existence of free-standing bodies (LHFs) which would be responsible for securing health services for their subscribers. People would be free to decide to which LHF they subscribed, and then, once enrolled, would be effectively committed to choices made by the LHF on their behalf. To stay in business each LHF would have both to attract customers and to contain the costs of providing them with services.

10. Among the key characteristics of this model would be:

i. everyone would be expected to subscribe to an LHF (with sensible provision for those who did not do so). LHFs would compete for subscriptions.

ii. LHFs might be all publicly owned, or in a mixture of private and public ownership, or might evolve from public to private.

iii. each LHF would have to offer comprehensive health care services for its subscribers, whether provided by the LHF itself, purchased from other LHFs, or purchased from independent suppliers.

iv. the subscription would be set in advance, unaffected by the actual service consumption subsequently.

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v. there would be various structural alternatives: GPs and hospitals might contract with LHFs; groups of GPs and paramedical staff might form themselves into LHFs and contract with hospitals; GPs might combine with particular hospitals to form an LHF; and so on.

vi. the method of financing could be from general taxation as at present, or might move towards social or private insurance. With both tax and social insurance, payment could be made either through vouchers to individuals themselves, or direct to LHFs on a capitation basis. The value of vouchers or capitation payments could reflect the individual's likely consumption of health services, for example by being made age-related. People would be free to top up these payments if they wished, to pay for additional benefits.

vii. Government would need to regulate private sector LHFs, both to ensure that they offered the required level of service and to prevent them from creaming off people with higher incomes and low health risks.

11. This approach would have a number of advantages by comparison with the "patient as buyer" model. It would offer greater incentives to efficiency, cost-effectiveness and good preventive care, together with potentially better access to health care and less risk of a "two-tier service". On the other hand, whilst there would still be an element of choice, at least in those areas covered by more than one LHF, patients would be committed to the terms of, say, annual contracts; this could limit their options at the time when care or treatment was sought.

12. Relative to the NHS in its present form, the advantages of the LHF model in terms of efficiency and effectiveness are less clear. It might mean an increase in costs overall, and, if publicly financed or subsidised, there would be an initial "deadweight" cost to the Exchequer in that some privately financed treatment would in future be funded publicly. The value of capitation payments or vouchers would be subject to considerable political pressure if financed by government. On the other hand there would be a bigger private sector, and perhaps scope for people to spend more on their own health. Public funding through vouchers or capitation payments would be consistent with LHFs themselves being partly or wholly in the private sector; and, whether publicly or privately owned, an LHF would be free to offer additional benefits in return for "topping up" private insurance.

Independent Hospitals

13. The central features of an "independent hospitals" model would be twofold. First, public bodies - possibly based on present health authorities - would be retained as the buyers of services on behalf of their resident populations, funded either from tax or through social

insurance; and would be responsible and accountable for ensuring that the health care needs of their resident populations were adequately met. Secondly, such health authorities would not normally provide services themselves but would contract with competing, independent suppliers. In short, the buying of services would be kept broadly as now, unlike the position with the first two models; but the provision of services would be opened up to competition. The financing could remain tax-based, or could be changed to some form of social insurance.

14. Among the key characteristics of this model would be:

i. hospitals and other facilities currently run by health authorities would (perhaps with limited exceptions) be contracted out through charities, privatisation or management buyouts, or perhaps leased to operating companies formed by staff. They would then be in competition with each other and with existing private sector facilities. There might be a mixture of public and private sector contractors, with new suppliers emerging over time.

ii. health authorities would monitor the performance of their contractors.

iii. the present management structure could be streamlined. For example, separate Family Practitioner Committees might disappear, with GPs on contract to or employed by health authorities.

iv. GPs would remain the "gatekeepers" to hospital services. Their freedom to refer might be constrained by an authority's decision on who should supply particular services, but they might also be given a major role in taking those decisions. Little change would be noticeable by patients in the short term.

v. hospital doctors might be either employed by suppliers, or under contract with them, or both.

vi. Government would continue to hold health authorities directly to account for the exercise of their buying powers, and would have a substantial interest in ensuring that contracts with providers were consistent with national policies for health.

15. This approach should widen the options available to health authorities. It would provide incentives to increase both cost-effectiveness and customer satisfaction, and competition between suppliers might encourage more "topping-up". On the other hand, this same competition might lead to increases in pay rates for scarce, skilled manpower, and would depend on a degree of surplus capacity. Also, consumer choice - at least as exercised through GP referrals -

might be reduced, and access to local services could deteriorate if particular facilities or services failed to survive in the face of market pressures.

Opting Out

16. The central feature of this model, unlike the others, is a change in the method of financing. The publicly financed element of health care provision would be funded from hypothecated NI contributions, with individuals or groups free to opt out of part of their contribution in favour of private insurance for, say, elective surgery or other readily insurable risks. This approach would need to be combined with the organisational features of one of the other models.

17. The freedom to opt out would inject a significant element of choice, more private money, "added value" for those opting out (as with pensions), and - relative to "NHS refurbished" (see below) - a substantial encouragement to private sector growth; in short, more scope for people to invest in their own health. On the other hand, the costs of this approach would need to be addressed. There would be a "deadweight" cost in giving a contributions rebate in respect of treatment previously financed privately. It would also be necessary to consider how far those who opt out would tend to be lower risk people from higher social classes; how far this would tend to push up the cost per head of providing services for those who remained; and what the impact would be on public expenditure, and on total Exchequer costs including the contributions rebate.

18. A switch to an NI-based financing system also needs further thought. The financing base would be much narrower than the present system, with the biggest users - the elderly - paying nothing. Moreover, Government would still have to take separate decisions on both the level of expenditure and the rate of contributions. An alternative - although one with its own complexities - would be a separate health insurance system.

NHS Refurbished

19. The "NHS refurbished" model is fundamentally the present one: health authorities plan services for their populations and continue to provide directly a substantial proportion of these services. But there is considerable scope for improvement. This would need to be fully exploited in the interests of, for example, better health outcomes, more consumer choice and greater efficiency. "Refurbished" in this way, the present system could be considered either as an option in its own right, or as a staging post from which more radical change could be implemented or might evolve.

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20. The main advantages of retaining the present model are accessibility, comprehensiveness and strong central control over overall, if not particular, costs. Also, improvements can be sought by building on demonstrable successes within a system which is understood by those who work in it. The main disadvantages, by comparison with more radical models, are that the scope for increasing consumer choice and expanding the private sector is relatively limited; that Government, and not the market, would still be responsible for allocating money; that services would still be rationed by queues, and not by price; and that there could be only limited market-type incentives to increase efficiency and improve customer satisfaction.

21. Some of these weaknesses might be tackled in part by means of major organisational changes within essentially the same model. Two possibilities, which could be pursued either individually or in combination, are:

i. decentralised budgeting: pushing budgets down to the lowest possible operational level, and holding budget-holders accountable for delivering the required outputs within those budgets. This should sharpen decision-taking on priorities and cost-effectiveness, and act as a further stimulus to greater efficiency. But it depends on having enough people with the ability to exercise such responsibilities, and on adequate mechanisms for avoiding disabling conflicts between budget-holders.

ii. more "trading" between health authorities, and between health authorities and the private sector. This might include ways of ensuring that the money follows the patient where, for example, temporarily excess capacity can be used, and might also encompass some competitive tendering for clinical services. The effect on consumer choice could be mixed: potentially improved for those able and prepared to travel further, but reduced if inter-authority "deals" were effectively to constrain referrals. Trading should encourage more cost effective patterns of service provision by stimulating authorities to turn to more economic providers.

All these possibilities depend in part on improved costing information. But that is needed anyway.

Conclusion

22. This paper is not intended to point to particular conclusions - except perhaps that, under any conceivable model, government retains a major role of some kind and cannot entirely divest itself of financing

responsibilities. The five models discussed do not exhaust the options, nor do they necessarily exclude each other. There could, for example, be different solutions for different categories of treatment; or various combinations of features from different models.

23. Subject to supply side constraints (including medical and other skilled manpower), there may also be scope for moving from less radical to more radical solutions over time, either as part of explicit plan or through a process of evolution, provided that shorter term developments are carefully chosen for consistency with longer term objectives. For example, it might be possible to develop trading between health authorities under an "NHS refurbished" approach (paragraph 21(ii)) in a way which helped a subsequent transition either to "independent hospitals" or to "local health funds"; and "independent hospitals" might itself be a useful stepping stone to "consumer as buyer" - "freeing" the provision of services first, and then moving on to open up the buying of services too.

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NAT HEALTH Expenditure pt 11

(Attached R Wilson to PM 18.5.88)