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RGM/BM

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Dear John,

It was good to bump into you again and chat about the NHS and the future of health care in this country. Resulting from this you asked me to put on paper the crucial issues as I see them which need to be tackled if health care is to be delivered more efficiently and effectively with competition and choice as key elements.

As I mentioned to you there is, quite naturally, a lot of discussion amongst managers in the NHS about the issues which might be encompassed by the NHS Review and although what follows here are personal views I would expect them to have broad support.

Let me say straight away that I believe that change in how health care is delivered is essential; tinkering at the edge will not do, if we are going to be more consumer responsive and create a stronger competitive environment. This is not to say that considerable improvements have not been made in the past few years, particularly since the introduction of general management with its emphasis on personal accountability for achieving agreed objectives. However the time has come where some fundamental changes are required if recent successes are going to be built upon.

The assumptions I am working to are a future health care system which is funded mainly through taxation with a stronger and more formal partnership between public and private provision; universal, and basically free at the point of delivery, ie does not depend upon ability to pay.

My analysis highlights the following issues as being constraints on the effectiveness of present services and resource use;

* Fragmentation of services and resources; particularly the management separation of FPCs from health authority services.

* Ineffectiveness of central NHS management and lack of leadership.

* Confusion between the service provider and service purchaser roles.

* Constraint of present DHA boundaries and bureaucracies on effective service provision and the promotion of consumer choice.

* Role and attitudes of professionals within the NHS.

Service Fragmentation

Fragmentation of service-giving responsibilities and lack of overall management direction has bedevilled effective health care for too long. Griffiths has already examined the interface with local authorities, but the management separation of primary care services continues to represent a major weakness.

As you know, much of the activity undertaken in the hospital service is a result of referral from family practitioners. Referral patterns are often historical and inflexible and GPs exert a significant influence on demand for hospital service. Health Authorities have no direct influence on this pattern of demand.

The continued management separation of these two major elements of service will constrain the development of what, from the public viewpoint, should be an integrated continuum of service. Opportunities for more effective use of combined resources, such as more local treatment in GP surgeries, will be lost. As the emphasis on community care increases, the effective integration of primary and secondary care becomes more urgent.

DHSS/Central Tier

This fragmentation is also reflected within the DHSS, in that those activities which directly concern, or impact upon, the Hospital and Community Health Services, are not under one command. Indeed all the resources required for the management of HCHS are not under the control of the NHS Management Board and it is therefore possible for initiative to be stifled if management resources are controlled elsewhere.

Primary care and HCHS are only co-ordinated nationally at a level of organisation outside and above the NHSMB. This tenuous linkage has involved the establishment of duplicate management systems at all levels. To be more specific about the arrangements inside DHSS, the Deputy Secretary with responsibility for primary care and control of medicines is accountable to a Permanent Secretary who is not even a member of the NHSMB. A similar line of command applies to the Deputy Secretary who heads up the Health and Personal Social Services Policy Group.

And where does the Health Service Supervisory Board fit into all this? This is a frequently asked question at any gathering of NHS Chairmen and managers to which a satisfactory answer has never been given, and yet the NHSMB is subordinate to it. It is certainly not visible and as far as one can see has never made any impact on the NHS.

In short, unlike the management arrangements introduced into the NHS, there is no organisational coherence within the DHSS, resulting in a lack of central direction. Of course, I am aware of the necessary political dimension in the workings of a Government Department but if we are going to see sharper managerial performance in our health care system, however it is funded, then somehow the political and managerial functions need to be distinguished whilst still maintaining overall accountability to Parliament.

What changes then are needed within the DHSS?

- a clearer line of management between Ministers and health authorities which allows NHSMB to manage and HSSB to exercise its function;

- Ministers need to clarify for the NHS what are the long term objectives so that corporate management can be exercised within DHSS;

- the resources managed by the NHSMB within the DHSS need to be reviewed so that they are more clearly aligned to the management task;

- the model of organisation within the DHSS should be reviewed to ensure that it reflects the general management culture of the NHS and that it meets the current need for management action.

Regional Tier and the Service Providers

I know that some commentators, the latest being John Redwood MP in CPS Policy Study No 95, suggest the abolition of the Regional tier, but in my view they fail to understand current and potential functions of both District and Regional health authorities as we move towards an arrangement which separates the provision from the purchase of services.

The DHSS currently finds it impossible to relate effectively to 14 RHAs and so the task of relating sensitively and managerially to approximately 200 District health units would be out of the question, (this should not be taken as personal criticism of senior officers in the DHSS but of the environment in which they work). If the Regional tier was abolished health care would suffer even more than it does now from rigidity and inflexibility which inhibits personal initiative and risk taking.

There are persuasive arguments for regarding hospitals as the service providers and not the DHA level. Indeed, it would have the following immediate and significant advantages:-

* administrative boundaries, many meaningless in social and geographic terms, would be removed;

* further flexibility would be introduced into resource allocation : there would be no need to fund a district to provide a whole range of services merely because of its 'sovereignty';

* patient choice and movement free from geographical boundaries would be encouraged;

* The Consultant manpower would be able to be developed flexibly, adapting to changing service needs, and not as at present where an individual, although appointed to a District, sees this in effect as an appointment to an individual hospital or department for a lifetime

One could see a 'Regional' tier being responsible for assessing the needs of the different communities within its population and drawing up a specification of service required. If this tier were also to take a responsibility for acquiring those services; a given quantity at a given cost (and some day at a defined quality), it could negotiate contracts for, say, three years at a time with either NHS hospitals (ie the present units), or private hospitals. It would be impossible for districts to undertake this role, not only because of their size, but because they are intertwined too closely, often by misplaced loyalty, to their own hospital units with the consequent danger of lack of commercial objectivity. However a Regional tier with a defined population of 3-4 million is ideally suited to this purpose and would have the right range of public and private provision to trade effectively on behalf of its communities.

However, whilst I believe that a Regional tier of management could undertake this role extremely effectively, I believe that the RHAs as presently constituted could not. A reconstituted Regional tier would be responsible for:-

* Assessing health needs of its community;

* Acquiring a quantity of service at a specified quality at the best cost from NHS or private sector providers;

* Formulating strategic policy and priorities for health service development and implementing change;

* Ensure that within a competitive environment services for the more dependant members of society are not prejudiced.

* To lead and mobilise action and deployment of resources across major Regional public and private bodies towards reduction of mortality and ill health arising from preventable factors;

* Allocate resources and monitor effective resource use; this raises the whole question of the provision of soundly-based information in which managers and clinicians have confidence. We are some way yet from achieving this, although the Resource Management Project at the Freeman Hospital in this Region is beginning to bear fruit.

* Establishing the medical, nursing and other manpower needs and redeploying staff to meet changing service demand;

* Monitoring performance of providers and rewarding 'good' performance and penalising 'bad' performance; a key link in the

accountability chain to the Secretary of State;

* Setting standards and enforcing them through a Regional Inspectorate;

* Commissioning market research to directly gather information about consumer perceptions of the service;

* Ensure the continued coherent development of medical advances and new technologies;

* Plan and control capital building and replacement programmes; setting aside present restrictive financing arrangements which result in ineffective use of operational services.

The Professions

My next point concerns the role and attitudes of the professions, for without their whole-hearted support and commitment the benefits of widening the funding base and changes in management style and function will not be fully realised. The restrictive practices, and in some cases the contractual arrangements which have evolved over many years, can be barriers to change and must be removed if significant progress is to be made.

Somehow they, (in particular the medical profession), need to see that "freedom" is relative and that by being more cost conscious and competitive it is possible to envisage a situation where more resources are available for developing services which at present cannot be achieved. The professions should also be heavily involved in the setting of standards of care, (something which is almost totally absent at present), for without agreed standards it is not going to be possible to measure performance properly, which in turn will mean that choice, whoever makes it, between one service and another will be made on very limited information.

Finally there is an issue about **'democracy'** in our health care system. I know only too well from 27 years in the NHS, the first 10 at Guy's Hospital after a 3 year graduate training scheme, and the other 14 as a chief officer, just how much people value membership of health authorities. And yet they can become a restriction on good management or simply concentrate on trivial issues because they cannot grasp the size or complexity of some of the matters we deal with. Assuming authorities are going to remain in some form or other I would strongly suggest that at Region what is needed is a strong non-executive Board of say 5 members, one of whom would have to be a doctor to get the support of the medical profession, who could think and act strategically and would challenge officers' recommendations. The role set out above for the Regional tier would require a new and sharper direction from members. In my view with this different and sharper Regional role there is little or no benefit in retaining DHAs as such. However if statutory bodies are retained at the service provider level then members will need to understand more clearly than some do at

present that their task is to implement policy and to ensure that all services are run efficiently and effectively within cash limits; there can be no ducking of issues because of political distaste.

I hope that this brief analysis brings together the main themes of our discussion, but if you feel there would be value in developing them more fully with you I would be very happy to do so.

Kind regards

Yours sincerely,

Douglas

J D HAGUE
Regional General Manager

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SECRETARY OF STATE FOR SOCIAL SERVICES : SPEECH TO THE CENTRE FOR POLICY STUDIES/MSD FOUNDATION CONFERENCE - 17 MAY 1988

Mr Chairman, Ladies and Gentlemen.

INTRODUCTION

1. If I were to begin by saying how delighted I am to have the opportunity to open your conference today, you would probably take it as a conventional courtesy - the sort of thing Ministers usually say when opening conferences. You would be wrong. What this conference - and indeed a number of others recently - shows is that a great many people have a genuine and intense interest in the issues of health care which face us. The helpful and thoughtful contributions to the debate recently published by this Centre and other organisations such as the Institute of Economic Affairs and the Adam Smith Institute, not to mention bodies within the NHS itself, have all served to stimulate this interest further.

2. How refreshing this is by contrast with the diet fed to us daily by certain sections of the media! I believe it was the late Dr Erhard, the pioneer of the German economic miracle, who used to say "My room resounds with catastrophe from morn to night". But Dr Erhard did not entertain the prophets of gloom and doom. Sensibly, he turned his attention to addressing the issues intelligently rather than sensationally; an exact analogy, I am sure, with what is happening here today.

THE ECONOMY AND THE HEALTH SERVICE

3. A good deal of the political debate about the Health Service inevitably focusses on the level of resources being put in. On that basis the Government's record is second to none. By generating a flourishing economy we have been able to increase spending on the NHS by nearly 40 per cent in real terms. That is more than double the increase in public spending overall since 1979 - a clear demonstration of our continuing commitment to the Health Service.

4. But it does the NHS no good to suggest that if only the £23 1/2 billion we will be spending this year could be £24 or £25 or £26 billion then everything would be well. The appeal of such siren calls lies, of course, in their obvious simplicity. But to pose such an easy solution to the complex difficulties we all face is not only to mislead but also, more worryingly perhaps, to frustrate the search for sensible solutions by closing off avenues of debate.

5. For what this approach suggests is that the problems of providing health care now and into the next century are basically fairly straight-forward and can be solved by equally clear-cut means. They cannot. In my view the only certain thing about the future of health care is that we cannot predict it with any certainty. This is not hyperbole. It reflects what has happened since the NHS was established. Who in 1949 would have predicted that the £433 million then being spent on the health service would have increased to £23 1/2 billion this year - around a four-fold increase at constant prices? Who in 1949 could have foreseen that the number of in-patient cases treated would have more than doubled from 2.8 million a year to nearly 6.5 million? And who would have put money on the routine availability of life-enhancing treatments such as coronary artery by-pass grafts, of which something like 12,000 are now performed annually but which did not exist in the late 1940s. Or hip replacements, again unavailable in the 1940s but nearly 40,000 are carried out annually now. And futuristic techniques like ultra-sonic imaging, laser surgery and radio-diagnosis were scarcely known or used one decade ago, never mind four.

6. So we must eschew the superficial and the simplistic. We need to ensure that the Health Service is flexible and adaptable enough to meet the needs of the 21st century so that changes and developments in medical practice can be harnessed to beneficial effect. Similarly, we need to think hard about how best to direct all the resources available towards the provision of modern health care. And we need to shape our services to meet the growing expectations of an increasingly sophisticated and knowledgable public - and, of course, an increasingly long-lived one as well. On top of all this we need to press on with our efforts to encourage people to take more responsibility for keeping themselves fit and well rather than damaging their health through such things as poor diet, smoking and the abuse of drugs and alcohol.

NHS REVIEW

7. These in brief are the reasons why I believe it is entirely appropriate that in this 40th anniversary year of the NHS we should step back and review the situation. I believe we need to look at three main areas - what it is that the Health Service currently does well, what it could do better and what it must do if it is to satisfy reasonable public expectations for health care now and into the future.

8. Our internal review is now well under way. As you know, we are concentrating on the acute hospital services because this is where the greatest pressures exist, but we will of course be examining the crucial relationships between hospitals and the primary care and community services. I am sure you will not be surprised in the least to hear that I cannot reveal the current state of the Government's thinking this morning. Indeed to do so would pre-empt the whole purpose of this conference which is, as I understand it, to discuss and consider "ideas for reforming the NHS".

9. Nevertheless we do of course want to see certain basic principles enshrined in any reformed system and I will talk about these in a moment. But there are many ways of achieving those aims and some way yet to go before we shall bring forward our proposals. What is very clear as our review progresses is that there are no easy answers to the health care dilemma. We need to find an acceptable balance between a variety of different concerns: between good public provision for all and a better basis for people to put more of their own money into health care; between a national framework for health care and the capacity for local response to local needs and preferences; between care in hospitals and care outside them. And we need to strike a balance between individual choice and the efficient delivery of services and between those financing health care and those providing it.

10. What I would emphasise is that, as we have made clear from the outset of the review, we are approaching our task with an open mind and in a positive and constructive spirit. We have been reading and listening carefully to all the points and submissions made to us and it is refreshing to see just how much original thinking is going on and how many constructive and detailed proposals are beginning to come forward. What is also encouraging is that these ideas are not just confined to the "think tanks" and research bodies whose job it is to produce challenging new thoughts. Many of those who work in the Service, or their representatives, are increasingly coming to accept the need for change. For example a working party of the Institute of Health Services Management recently reported that "the NHS, though successful in many ways, is displaying a number of tensions which cannot be solved simply by injections of additional funds." And the National Association of Health Authorities made a point of saying in its submission to the review that it was not complacent and that "there are a number of problems and important issues ... which need to be tackled."

11. So the review is very timely. But I would particularly stress once again that everyone must beware of superficially appealing pronouncements which will not in practice solve the basic problems. There are no magic wands in health care; no "single bullet" solutions.

INTERNATIONAL CONTEXT

12. The review also needs to be set into a proper international context. Far from being alone in reassessing how our health services should be organised and financed, we are very much in line with virtually every other Western industrialised nation. Countries as widely varying in their systems of health care - and their political complexions - as Norway, West Germany, France, the Netherlands and New Zealand - amongst others - have all embarked on reviews of various aspects of their health systems. For example, a recent report commissioned by the French Government proposed that the basic state health insurance should cover only "high risks" while "lower risks" would be covered by private medical insurance run from friendly societies or insurance companies.

13. And in Holland a report commissioned by the Dutch Government has just proposed the introduction of a two-tier system. This would consist of compulsory basic insurance covering about 85 per cent of the total cost of health care together with voluntary additional insurance covering the remaining 15 per cent. Both schemes would be run by private insurance companies. I could quote other examples: from Socialist and non-Socialist countries; from mainly privately-financed health systems and from those receiving the bulk of their resources from public funds. The essential point is that the search for more efficient means of organising and delivering health care is a very widespread phenomenon at present. Many other countries recognise, as we do, that their current health care arrangements do not provide a satisfactory response to the dilemmas I have outlined; and that the solutions of yesterday do not meet the needs of today, still less those of tomorrow.

PRINCIPLES

14. There is no universal or simple solution to the dilemmas we and many other nations face. But nor are we approaching the review without any set of guiding principles by which to judge the relative advantages and disadvantages of various proposals. Let me re-emphasise today a point I have made a number of times recently. This review is not about change for change's sake. That would be a nonsense. What we want to do is build on the strengths of the existing system so as to improve it still further. We will not shy away from radical ideas where they contribute to this aim but our journey will be an evolutionary one. There will be no "Big Bang" in the NHS. And in seeking to preserve a number of clear guiding principles we must be clear in our thinking. We must separate in our minds the means - by which I mean essentially the financing and delivery of health care - from the ends, that is, the result as seen from the patient's point of view.

15. What does this mean in practice? It means that we will not make access to decent health care dependent upon the ability to pay for it. And we want to retain the comprehensive coverage provided by the NHS, so that the old and the sick are relieved from anxiety about obtaining the care and treatment they need. These principles lie at the heart of the Health Service. We will not sacrifice them.

16. But what we will do is face up to the future. We want to widen the choices available to patients and to encourage much greater flexibility in the delivery of services. Instead of "supplier-induced demand" where services are tailored more by those who supply them than by those who receive them, we want more power in the hands of consumers to help them to ask for and to get what they want.

17. Secondly, we want to continue to move away from the sterile distinction between the public and private health care sectors. What we want is to maximise the amount and quality of health care available, not to indulge in barren and ultimately futile squabbles about whether the providers of that care are in the public or private sectors.

18. And thirdly we want to make yet further improvements in the efficiency, effectiveness and quality of health care delivery. It would be a very brave Secretary of State who would argue that an organisation employing well over a million people and spending nearly £1/2 billion a week was doing everything so efficiently that improvement was impossible. Over recent years a great deal has been achieved in making the enormous resources provided for the NHS go further and further. But in an enterprise as big as that there will always be room for even greater efficiency. The need is to supply managers, clinicians and nurses with the right information and incentives to question their working practices, to review their ways of doing things, and, above all, to instil in the basic culture of the NHS an eagerness to make the best possible use of the resources available.

19. Many initiatives are already underway to this end. For example, our Resource Management Initiative seeks to provide doctors, nurses and other professional staff with relevant and timely data about the costs of the treatments they prescribe. This is a crucial step in enabling people to assess how well or badly they are performing and how they might improve matters. Many other developments are in train. They include the production and vigorous analysis of over 450 indicators of health authority performance - and the continuation of our successful cost improvement programme.

CONCLUSION

20. So I am sure our review will in many instances build on initiatives already underway. I do not know what the outcome will be, although I can guarantee that I will study the contributions to this conference very carefully. What I can say is that our proposals will be true to our commitment to improving the health and well-being of all the people of this country. We will continue to take pride in the achievements of the National Health Service and go on building on those achievements. And we will seek to fashion a Service which, by being able to respond to changing needs and expectations, will stand us in good stead for many years to come. Above all we will bear in mind that our paramount concern is and always will be the interest of the individual patient. For we must never forget that health care, no matter how imposing a structure is needed to deliver it, will always have as its bottom line the needs of the individual man or woman who turns to it. We must not and we will not lose sight of this crucial fact.