CONFIDENTIAL

Prime Minister

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REVIEW OF THE NATIONAL HEALTH SERVICE: A SCOTTISH PERSPECTIVE

I am grateful for the invitation in your Private Secretary's letter of 21 March to offer my suggestions to the NHS Review Group.

This minute discusses operational issues of service delivery: it does not cover financial issues, including the balance between public and private funding.

Our principal objectives must be to widen patients' choice and to improve the performance of the Health Service in delivering patient care and value for money. To do this, we need to introduce competition and to foster sound management practices. An organisation of the size of the NHS cannot be reshaped or made to change direction overnight; and there are limits on what can be done even within the lifetime of a Parliament. Our strategy for change should therefore be clearly focused on creating the necessary mechanisms within the Health Service to drive it effectively to meet our objectives.

Everyone is a customer of the Health Service at various times of life; and we must recognise that the demand for health services is almost literally infinite. Increasing demand is fuelled not only by advances in medical technology and rising expectations of the appropriate quality of life at different ages, but also by the ignorance of consumers and providers alike of the costs of their choices. There are a number of themes which flow from this analysis. For convenience I group these under the headings of patients, health professionals and management.

Patients

We need to ensure that patients are treated more like customers and less like supplicants. The gap between best practice and what is tolerated in some areas remains too wide. Our White Paper "Promoting Better Health" had as one of its main themes making the primary care services more responsive to the consumer. We need to develop this theme in relation to the hospital services too, under the heading of the Patients' Charter. The NHS already ensures free access to treatment: but too many people have too little say in how, where and when that treatment is provided.

We know from our waiting list initiatives that we can make Health Boards use their resources more effectively and so reduce some of the worst delays. But we also need to stop these delays building up. This will require more and co-ordinated investment in computers to provide the information necessary as a basis for informed choice. We should recognise, however, that one of the consequences of success here will be an increased demand for resources; and this point must be addressed along with the other funding issues arising from the review.

Health Professionals

The deficiencies of the present contractual arrangements between consultants and their employing authorities are well recognised and have been the subject of comment in this year's Review Body Report. The very existence of a model contract, agreed between Health Departments and the medical profession, may act as a disincentive to employers to add to the contract to oblige consultants to take part in the evaluation of clinical methods, to participate in reviews of resources, to contribute to planning and budgeting processes, or to accept some corporate responsibility for the functions of their authority. Clearly it would be difficult to withdraw the model contract unilaterally; but we must seek agreement on the incorporation of management objectives in consultants' terms of appointment. We must also encourage management to evolve ways of engaging the co-operation of consultants in setting and achieving these objectives. Disciplinary procedures are presently under review: we must find ways to speed these up.

Management

Scotland has a single integrated tier of management in the form of 15 Health Boards (and the Common Services Agency). These Boards also cover the work of Family Practitioner Committees in England. While we could operate at least as effectively with fewer Boards, the political trauma of negotiating even a marginal adjustment in their number would be considerable and, I judge, would divert our energies and the public's attention from changes which promise more immediate benefits. I would not reconsider the pattern of Health Boards unless it makes sense to do so in the context of a fresh look at the structure of local government.

The composition of Boards needs to be revised in the aftermath of the introduction of general management. Fewer members will make them less cumbersome, though it would be difficult to avoid including certain types of member to deal at local level with service committee appeals and discipline.

The drive for efficiency in support services has already delivered significant savings. The programme of competitive tendering will continue that process and should be extended. The programme of rationalising the NHS estate must continue (though disposal receipts will inevitably decline as the historical pattern of our holdings changes to match present-day requirements).

But we can also take the idea of competition closer to the care of patients by developing the concept of an internal market for certain categories of patient care. At present the allocation of resources for Hospital and Community Health Services in Scotland is made through the SHARE formula. One of the most significant adjustments to the basic distribution reflects the treatment of patients resident in other areas - cross-boundary flow. The data base for this adjustment is presently three years old and it will never be practicable to reduce this lag to less than two years. Thus the simplicity of the present arrangement is bought at the price of delays in compensating Boards for the extra costs they incur when they open new facilities offering services for which their residents previously had to travel.

I think that there may be merit in removing the payments for cross-boundary traffic in acute and obstetric in-patients from the SHARE calculations and substituting a regime of direct payments from the exporting to the providing board for these services. Much will depend upon whether we can obtain adequate information on costs; and we will need to develop ways of helping General Practitioners to take cost-effective decisions about where to refer patients. Some progress, on an experimental basis, might be possible in 1989-90. In the longer term, the development of cost data on Diagnostic Related Groups may enable us to consider more radical changes to the SHARE allocation system for wider categories than cross-boundary flow - for example, all acute in-patients.

A regime of direct payments should promote more informed decision-making and cost-effectiveness; and through time it ought to promote the quicker development of innovative services. By contributing to a better match of supply and demand, it should also help to reduce waiting times.

Preventive Medicine

Prevention is better than cure. Yet we remain preoccupied with cure and give limited attention to prevention. Health promotion and health education are notoriously difficult areas for both policy choice and subsequent evaluation. We need to increase the importance which we give to this work. I shall seek to ensure that this area of activity is given a more positive steer at national level in Scotland

I look forward to joining in further discussions on the Review. It is important that there is adequate time to consider the implications of the emerging conclusions for the distinctive Scottish Health Service.

I am copying this minute to Nigel Lawson, John Moore, Peter Walker and Tom King.

MR

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NAT HEALTH: Expenditure

Pt II.