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From the Private Secretary

27 May 1988

NHS REVIEW

I enclose, for the information of members of the NHS Review Group, a paper by Dr Clive Froggatt, one of the participants at the first Chequers Seminar, on medical audit and incentives for change in general practice.

I am copying this letter to Alex Allan and Jill Rutter (HM Treasury), Jenny Harper (Department of Health and Social Security), Sir Roy Griffiths (Department of Health and Social Security) and Richard Wilson (Cabinet Office).

PAUL GRAY

Geoffrey Podger, Esq.
Department of Health and Social Security

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NATIONAL HEALTH SERVICE REVIEW

May 1988

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NATIONAL HEALTH SERVICE REVIEW

The GROUP consists of doctors who were invited to Chequers by the Prime Minister to give opinions on the National Health Service and who, afterwards were asked to enlarge on some of their comments. They felt a coordinated input might give a better picture than individual reports.

Lord Trafford of Falmer

Professor Ian McColl

Professor Cyril Chantler

Dr Clive Froggatt

CONSTRAINTS AND CONSIDERATIONS

1. Seven hundred and fifty thousand to one million voters pass daily through the national health service system and to antagonise a large percentage of these could have a powerful propaganda effect on party fortunes.

2. At present 80 to 90% of consumers, i.e. patients, express varying degrees of satisfaction with health care and 70 to 80% specifically favour the existing NHS.

3. The OECD study on parameters of the outcome of health care systems in a nine nation survey suggested that Britain was not in any way out of line with other similar developed countries, despite the difference in the level of GDP devoted to health care. It is at present therefore relatively efficient and the tight financial control and cash limiting has been effective as a means of cost containment, compared with other systems.

4. Part of the reason for any complaint has been the very success of the health service as operated within the past decade, with increasing numbers of patients treated, operations performed, advances maintained and research carried out. Most complaints in the last nine months have arisen from a small part of the acute sector of the hospital service

only and have been mostly proven to be unjustified.

5. Finally, it is probable that the law of diminishing returns would apply to any increase in money granted to the health service as at present constituted.

REVIEW REQUIREMENTS

Throughout the development of our proposals we have kept in mind certain basic factors of which account must be taken:

1. The proposals must allow:
   (i) An increase in efficiency in the delivery of health care
   (ii) An increase in choice to the consumers of health care, i.e. the patients
   (iii) An increased quality of care with emphasis on medical audit

2. There must be gainers and losers amongst the professionals in the health care field and since the only universal incentive is money, there must be financial incentives and penalties

3. There must be increased competition both in primary care and the hospital care sections

4. There must be an increase in information technology and information systems to enable proper costs to be

evaluated and for value for money to be obtained. Comparative costs and the costs of development would also be available for the first time.

5. The creation of internal markets is essential to increase competition and choice within the framework of the health service.

6. There should be an improvement in the quality of managers and management systems with financial incentives and penalties applied to them also.

PROCEDURE

We have examined and made recommendations on the primary sector, the hospital sector, the management system, the financial system and the private sector.

PRIMARY HEALTH CARE

The gateway to demand in the national health service is largely controlled by the General Practitioners and the primary health care team which deals with approximately 90% of all episodes of illness in the first instance. We would recommend that the present functions of the Family Practitioner Committee are transferred to the District Health Authority (see later) and that the funds for primary care, which should be cash-limited, are channelled through that authority. The General Practitioner would remain an independent contractor but would have a contract as provider of health care with the District Health Authority who would, as buyer of health care, enter into that contract.

(1)

General Practitioners would compete for such contracts, laying out for inspection by the Authority and by the public, i.e. the patients, the services that they contract to provide. The provision or otherwise of their contracted services would be used as performance indicators by which to assess the results. Such information must include the rate of referrals to hospitals, the rate of referral to consultants, the rate of domiciliary visiting, the hours of service, the number of sessions available for consultation, the amount of home visiting, prescription rates, the level of screening activity, immunisation rates and the ancillary services at their disposal, e.g. their relationships with health visitors, district nurses, community nurses, psychiatric nurses

and social counsellors. A model contract could be issued by each District Health Authority as appropriate to a particular area to give a guide as to requirements. Patients would have a choice as to which general practice to attend and the payment of General Practitioners by the DHA as buyer would depend upon the results as judged by the performance indicators outlined above. Special audit procedures for quality of care, as described later, would apply to the primary care sector.

The successful primary care team would attract more finance, but failure to achieve the results as judged by the performance indicators on the contract would result in financial penalty.

General Practitioners would be able to refer patients to consultants for opinions or to hospital for admission as at present and would be entirely free to send patients wherever they felt the best service for that patient could be obtained. This would require increased information, for example with regard to the availability of services in the various surrounding districts, the length of waiting lists and the like.

This new, competitive, contractual approach to the delivery of health care with financial incentives and penalties to the provider would increase choice to the consumer; allow control of primary care costs by the buyer of services and improve the quality of service provided by the introduction of compulsory auditing processes.

THE HOSPITAL SERVICE

We believe it is advisable to devolve the responsibility for the running of each Unit as far down the ladder as possible. The District Health Authority would be the buyer of services and would contract for these with individual hospitals which would then, as providers of service, become more self-governing. In some instances, centres of clinical activity could be contractors, especially in areas where most clinical services are concentrated in one centre. In others the scale or nature of the District might dictate that the DHA itself remains the provider of services but it would nonetheless devolve, as far as possible, financial responsibility to individual cost centres.

Within this framework, however, we would strongly recommend that the Griffiths organisation is strengthened and district administration is slimmed (see next section). Each area of medical activity should be defined, brought within one section with a clinical director, and given a specific budget agreed annually with the hospital as contractor to the buyer of services (District Health Authority) or occasionally with the District Health Authority directly. District management would have the added responsibility of implementing the recommendations of an independent audit system.

A detailed survey of how clinical centre budgeting can work has already been presented from Guys Hospital and this system was first introduced there in 1985/6. Its

success is already manifest in the economies effected, the improvement in opportunity for clinicians and, paradoxically, the increased freedom within which they have found they can operate. The management board at Guys with 13 clinical directors and with a Chairman and the DGM, inherited a deficit in 1984/5 of £1.2 million and an inherent overspend in 1985/6 of £300,000 per month. In August 1985 it was apparent that the Unit was heading for an overspend of £5 million, 10% of its budget in that year. The management board tackled this problem and in fact at the end of the year the Unit was overspent by only £1.7 million. By the end of the financial year 1986/7 this deficit had been cleared and the Unit was breaking even. This position was maintained in the year 1987/8 and thus, since the beginning of 1984 the Guys Unit had lost 28% of its beds; its manpower had been reduced by 17% and expenditure by £7.8 million (14%) per annum. Inpatient activity throughout the year is, however, only 6% less than the maximum ever achieved which was in 1982. Insofar as quality control can be applied, it would seem that there has been no deterioration in quality at all.

The above example is a measure of what can be achieved by a determined management in the right context and supported by the right framework.

However, there are certain potential prerequisites:

(a) Professional health service administrators and managers tend to have mixed feelings about the involvement of clinicians in hospital management,

as indeed do clinicians themselves, but it is important to distinguish between professional accountability and management accountability. A clinician is professionally accountable to his patient, audited in various ways, some traditional and some by various professional bodies such as the Royal Colleges, and of course by law. Responsibility and authority must be coterminous and commensurate and if the responsibility to provide a clinical service is to be taken by a group of clinicians with a clinical director, then the authority commensurate with that responsibility must be transferred to this individual.

All this will require a change in the consultant contract and we would now recommend that this should be with the District Health Authority for a period of seven years (renewable) with special recognition for various duties such as those of clinical directors.

(b) The introduction of proper management budgeting throughout the service so that expenditure is under the control of named individuals who can receive their budgets and can check expenditure at regular intervals and take action where necessary, will require a considerable increase in expenditure on information technology and information systems.

(c) Districts and their component hospitals should be seen as being in competition with each other. It is essential to have an internal market operating throughout the hospital system. Thus, referrals from primary care would be to the District or hospital that provides the best service and, according to that service, finance follows. Thus, should Hospital A steadily fail to attract patients and have a low bed occupancy, low utilisation of theatres or long waiting lists, whereas Hospital B has the opposite, the money would flow to Hospital B rather than Hospital A. Since all concerned in Hospital B would then be obtaining more return than Hospital A in financial terms, it would be in the interests of Hospital A and all therein to improve their services, or should they fail to do so, ultimately to be taken out of service altogether.

(d) Financial incentives for successful results are built in both by the flow of money and the change in the consultant contract. Failure to match up to contracts or performance indicators would produce a financial penalty, whereas success would provide a financial incentive.

(e) The position of hospitals of tertiary referral, e.g. special centres for example neurosurgery, cardiac surgery, transplantation, renal dialysis and so forth would also be competitive but in their case the market would be mainly referral from other hospitals. Thus, to take a specific example,

if Guys fail to provide a service to the South East that Kings College Hospital can provide, the patients would tend to flow to Kings College Hospital and once more with them would go the finance. Kings would therefore do better than Guys unless and until Guys changed its habits and became more competitive. It would obviously be of great interest to any referring District as the buyer of health care services to take note of the cost as well as the quality of the service provided at Guys and Kings and one would expect that, in practice, various departments or units at each hospital would develop a particular pre-eminence

(f) The maintenance of requisite local health services in teaching hospitals would remain so that their educational function could continue but as largely pertains at present, finance for the teaching and payment of extra salaries for teaching purposes could come from the SIFT (Special Increment for Teaching).

(g) The position of medical research in the national health service is slightly different and the above system would not allow for research activity. In line with the House of Lords Science and Technology Committee Report on the Medical Research Council, we feel that the setting up of a National Health Service Research Authority, under the aegis of the NHS Management Board for the purposes of funding such research, again on a competitive

basis, would probably best answer this requirement and it would not preclude application to other funding bodies, e.g. Science Research Council or the MRC for further or special project funding. Essentially the National Health Service Research Authority would be concerned with clinical research and applied research, related to the quality of medical care and the delivery of health care.

Joint planning arrangements with the MRC, the charitable trusts and industry should take place to avoid duplication and waste of money or effort.

MANAGEMENT

The buyer of services in the health service should be the District Health Authority. We would see the district health authorities reporting directly to the National Health Service Management Board which would operate more as a holding company operates in a large commercial organisation. (The Department of Environment deals with over 600 councils in England and Wales and it would therefore not seem unreasonable to suggest that the Management Board could deal with less than 200 district health authorities). If devolution of finance along the lines suggested in previous sections of this paper was followed, there would be little necessity for the NHS Management Board to hold for itself large sums of money but it would be responsible for the National Health Research Authority, SIFT and no doubt it would hold a small contingency reserve.

We would see the NHS Management Board with an independent Chairman appointed by the Secretary of State, as the controlling body of the Health Service. We believe it must have the requisite powers and 'bite' but it would of course remain responsible to Ministers and Parliament.

It could decide to keep small Regional offices but we would feel it would be better to have, in its own headquarters, arrangements for a form of Regional advice or action designed to suit its own pattern of management. The NHS Management Board would receive and have to act upon the advice of the independent audit and/or health

inspectorate (see below) and could refer questions to either for examination. The Inspectorate and the Auditors would report to the Board and the Secretary of State who could also refer questions.

The inevitable corollary of the above changes would be a very much smaller Department of Health and a reduction in the existing Regional Health Authority staff numbers.

We would recommend removing from the Department of Health all responsibility for building, maintenance, capital planning and capital allocation. All funds, therefore, apart from the minor ones mentioned above, would be devolved to the District Health Authorities as a block grant which would vary depending upon the amount of services they ought to provide (see example of Hospital A and Hospital B in previous section); there would be no distinction between capital and revenue and for capital purposes the District would have to apply to the market to obtain finance, obtaining only general approval from the NHS Management Board and not the detailed option appraisals, AIP's, Capricode system that now operates and which is so enormously wasteful.

The District Health Authority itself should consist of an appointed Chairman, the Executive Officers (the DGM paralleling the Managing Director of a commercial organisation), a finance officer (Finance Director), Nursing and Personnel, District Medical Officer (responsible for primary care) and five non-executive directors appointed by the Secretary of State, one or two of whom would be from the Community Health Council

to allow for the input of local opinion. Many of the present deficiencies of District Health Authorities would disappear if their management was coordinated in this fashion and their present subjection to political whim, union pressure, local lobbyists and the like would be significantly reduced. Decisions could then be made on their merits, made quickly and put into effect. It would be incumbent on the District Health Authorities to enter into contracts with primary care teams (GP's), hospitals and in some cases clinical budget centres, and to privatise as many services as possible, e.g. hotel services, laundry services, etc. Clearly in all these quality control would be of the essence. There is no intrinsic objection to privatising radiology services, pathology services, nursing services and so forth, but these would probably be better organised as part of an internal market with the clinical services buying from these units whatever service they actually require to carry out their function.

As far as planning services and building and maintenance services are concerned, these should be abolished and private contractors used. All these functions would be subject to quality control but there is no reason why they should not be more efficient and cost-effective than at present.

There would be no specific limitation on precisely how a district health authority carried out the tendering of the above services or whether it operated them by using in-house management. The costs and efficiency

would be reflected as part of their competitive position and would soon become apparent to the authority concerned, relative to other authorities who may use different methods.

Once again, the basic principle is that the District Health Authority would be the buyer of the hospital services, operated through its various general services, e.g. nursing, pathology, portering services, etc. and also through the hospitals and/or clinical directorates and could adjust its allocations of finance accordingly. If its overall cost was much higher than that of an adjoining district, providing exactly the same services, its allocation would be adjusted accordingly by the National Health Service Management Board. It would therefore be in the interests of districts to compete and for all their services to be efficient to enable them so to do. If a district found that its services being provided were not used because of inefficiency or poor quality, and that its primary care contractors were sending their patients to other districts, once again this would become apparent to the authority who could take the appropriate remedial action. It must be recognised that the real virtue of competitive tendering or privatisation is not necessarily the direct assault on high costs but rather an attack on the factors that tend to cause them such as organisational rigidity. It makes managers in the NHS actually define the services they require and would break the local monopoly operated by the present service providers.

Competition between services, between hospitals or between districts probably would save money but certainly would improve efficiency and provide a better service.

To effect these changes it would be necessary to buy out consultant tenure and to change the consultant contract but we see little reason to continue with the concept that a consultant is appointed for life, or for that matter that every doctor should have a job which is the basis of many of the manpower problem that afflict, or are thought to afflict the National Health Service at present. Once the concept is accepted, as indeed it is in Germany, America and elsewhere, that doctors have no more right to a specific job or jobs for life than any other member of the community, manpower problems become easier. There would have to be some changes regarding the responsibility of District Health Authorities and the functions of the National Health Service Board, but essentially, all the above changes would retain the current framework but create an internally competitive and more efficient market.

Other systems have been discussed and each have their advantages and disadvantages, but in many respects it is a question of a choice of which problem one would prefer to tackle. This scheme, for example, removes the question of whether the national health service is a curing or caring service, for the DHA as buyer would make a choice of whether to provide such services

in-house at a certain cost, or to privatise them, or to put them out to tender, perhaps covered in the contract of certain primary care providers.

The financial incentive and disincentive for DHA's lies in their success or failure in buying services that attract custom. Salaried directors or members of the DHA should have a significant part of their salaries performance related so that they have a definite financial interest in the outcome of health care services for which they would be responsible.

THE PRIVATE SECTOR

Much has been made of the possibility of expansion of the private sector to absorb some of the demand on the national health service. If, however, an internally competitive service such as the above is operated, then the national health service would tend to see all patients going to the private sector as potential lost customers. Equally, if the private sector was expanded dramatically, the amount of staff it would tend to draw from the NHS, which is its main source of supply, would severely detract from the capacity of the health service to meet its commitments. The further one extends the competitive market to the health service itself, the less necessity there is, from the point of view of buyers of the service, to look to the private sector.

At the present time, however, the consumer who insures himself buys the provision of a slightly higher standard of hotel care, better manners and increased opportunity to have whatever procedures he requires to be carried out at a time convenient to him. Since this is a private contract between the consultant and the patient, the consultant is frequently content or compelled to operate in unsocial hours and to do more things himself than he would normally do at present in an NHS hospital. Introduction of more competition and the change of the consultant contract in the health service would tend to produce the same effects within

the health service and therefore once again would be more likely to equate the two. There would, however, be no reason why a district health authority should not use the private sector as at present constituted on a contractual basis for a great deal of its elective surgery (which is the main function of the private sector at present) and therefore reduce its own in-house costs. It is probably in these fields that the private sector could be most useful.

It is beyond our remit and our expertise to discuss any tax changes for private insurers and their likely effect but it is probably in the sphere of comparative practices that examination of the private sector is of most value relative to the problems of the health service.

FINANCE

Once again, it is outside our expertise to comment on financial changes that are possible and whether or not the health service should be completely funded solely from the national tax system. Our only major suggestion in this field has been that the present division between capital and revenue allocations cease and that all monies should be devolved to the District Health Authority who will then raise capital from the market to carry out its capital programme. There are many areas in the country which are firmly convinced that a larger capital programme would produce significant revenue saving. (For example SE Thames Region - see appendix 1). If this view were accurate, then clearly they should be allowed to proceed. The only limitation upon this would be that the District Health Authority would have to obtain the approval of the National Health Service Management Board for expenditures over £5 million and they themselves would probably have to obtain permission from the Treasury for anything in excess of £25 million which is roughly the current position.

All the intermediate stages of the concealed cost of planning, the huge mostly under-used departments concerning planning, building, engineering, architecture, etc. in the Department of Health, the Regions and the Districts could all be abolished.

The District Health Authority would be the same as any other customer to the architects and builders and the approval that would be obtained from the National Health Service Management Board would not need to be in the detailed form that is currently required with AIP and Capricode procedures.

We recognise that the devolution of money to Districts, the use of clinical cost centres, privatised tendering, the movement of money with the patient, either in the primary care setting or within the internal hospital setting, would all require an expansion of financial support for information systems. This would probably be necessary in any event in view of the necessity to move the whole national health service from a basis of input statistics to output statistics.

AUDIT AND HEALTH INSPECTORATE

At DHA level there should be an independent audit department that reports publicly on the performance of the DHA as buyers of services and the primary care contractors, and the hospital (and/or clinical service centres) as providers of services. This is an essential ingredient of our scheme as audit of what is performed and how effective it is remains crucial to the maintenance of quality in the service. The pattern of its function could be that of the Audit Commission which already has a proven record of success.

At national level a national audit department could provide the NHS Management Board with vital information to carry out its particular function and could correlate district auditing exercises, thus enabling direct comparisons of efficiency, quality and cost to be made all over the country. (A notional national figure for general or specific costs could then be published as a yardstick and comparisons in any district could be made with the actual charge. This is analogous to the national average and the actual community charge in the proposals relative to Local Government Finance).

Alternatively, or in addition, a health inspectorate along the lines of HM Inspectors of Education could be set up and other functions, also, if desired, such

as consultancy, comparative clinical efficiency, research auditing activity, or even local enquiries or reports, sometimes paralleling the Ombudsman could be carried out. The latter type of role may have advantages and disadvantages to Ministers responding to NHS questions.

CONCLUSION

In reviewing the existing problems in the National Health Service, we have looked at various systems and come to the conclusion that in many respects, as they all have their own virtues and drawbacks, it is largely a question of which type of problem one would wish to tackle. We have produced what we believe to be the least damaging in terms of restructuring or reorganisation and the least likely to require significant legal change. The greatest outcry would probably come from the medical profession and secondly from the unions who have always objected to any form of competitive tendering. However, we believe that a solution along the lines we have outlined by building in at all levels financial incentives and financial penalties would increase efficiency, provide a more cost-effective service, enable quality control to be carefully monitored, improve the requirements of consumer need (and up to a point consumer choice), allow for future medical developments and provide an overall system of health care that does not depart from the fundamental ethos that has served the nation well by and large for 40 years, but at the same time would carry it forward and allow change into the next century. Running through every proposal is our insistence that it is the output statistics that would be emphasised and that quality control (or medical audit) is fundamental to future development.

APPENDIX I

South East Thames Regional Health Authority

Capital for the Acute Sector

There are several major acute schemes which could take place but which are unable to proceed because of lack of capital funds. The rationale behind these schemes is a combination of the following factors:

(1) The need to replace old and obsolete stock which is unsuited to the provision of efficient or effective medical care

(2) The need to eliminate unnecessary duplication of medical and diagnostic services caused by the spread of acute specialties over a number of sites which are within relatively close geographical proximity

(3) The need to rationalise the level of land-holding and to reduce the level of fixed costs associated with state maintenance as well as providing more energy-efficient building stock.

An example of this is the proposed development in the Bromley Health Authority. Their acute services are provided at Farnborough Hospital, Orpington Hospital and Bromley Hospital. The ward sizes are inefficient, resulting in the need for higher nurse/patient ratios than would be necessary in a modern ward design. Diagnostic services

services are replicated on all three sites and the spread of specialties over the sites militates against efficient working relationships. A capital development programme has been worked out at an estimated cost of £86 million, but land sales resulting from rationalising the number of sites should produce approximately £50 million to off-set against this cost. The service benefit is that replacement equipment costs will be reduced; utilisation of equipment will be optimised and a projected increase of 4,000 cases per annum will be achieved as well as producing a revenue saving of approximately £1.2 million per annum which is 4% of current costs.

Similar examples are Camberwell, Dartford, Hastings, Tunbridge Wells, Canterbury and Thanet, and Greenwich.

Capital for Priority Care Services

There are seven major mental illness and mental handicap hospitals in the Region which have land holdings in excess of one hundred acres and a further hospital in Wandsworth of about thirty acres. The Region's problem stems from the difficulty in investing in new services in advance of cleared sites being available for sale. The pace of transition is therefore constrained by the amount of capital available from the general programme. This results in a very slow pace of change and also

increases in revenue pressures in the form of double running costs which in this Region are now estimated to run between £5 and £6 million per annum.

Capital for General Needs

The RHA is currently investing £10 million in the development of a Regional Distribution Centre which will provide a central supplies service. It is estimated that this will result in a revenue saving of £2.5 million per annum. A similar shceme concerning a cook/chill method with catering services is being planned. The capital cost would be of the order of £15 million and would produce a revenue saving of £3 million per annum.