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PG on.
I have not made any arrangements.
PG 3/6

PRIME MINISTER

REVIEW OF RAWP

The DHSS letter of 26 May (Flag A) returns to the charge on their wish to announce that the Government accepts the recommendations of the RAWP Review at the time the report is published. You resisted this in the earlier round of correspondence, as recorded in my letter of 23 May (Flag B). The earlier papers are:

Flag C - my minute of 20 May

Flag D - DHSS letter of 19 May

Flag E - John Moore's minute of 10 May.

The latest DHSS letter does not add any major new points, although it places more emphasis on the argument that an early statement of acceptance of the recommendations might make it easier to deal with the 'losers'.

Are you content to agree that the recommendations should be accepted, or do you still wish to see the Report published without an indication of the Government's view on the recommendations?

Perhaps John or Tony would come and have a word with me.

PG

I think it unwise automatically to accept that distribution.

M

pp PAUL GRAY

2 June 1988

SLHAWU

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FINAL REVISE

EMBARGOED: NOT FOR PUBLICATION, BROADCAST OR TRANSMISSION BEFORE 1300 HOURS, THURSDAY 2ND JUNE 1988

ALTERNATIVE DELIVERY AND FUNDING OF HEALTH SERVICES

FINAL REPORT

THE INSTITUTE OF HEALTH SERVICES MANAGEMENT

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PREFACE

The Institute of Health Services Management decided in 1987 that the future of the delivery and funding of health services must be a crucial topic during the fortieth year of the National Health Service.

The Institute represents health services managers working in both the public and private sectors and the report proposes practical and achievable options for the future.

This final report, together with the seven working papers already published, lays forth the thinking of the Institute's Working Party as a contribution to the current debate. Throughout its work, the Working Party has aimed to produce thoughtful insights and analysis based on available and commissioned research where possible. It has shunned dogma and been prepared to consider all the options. Indeed the very composition of the Working Party and its external panel of commentators has ensured a broad balance of views.

Although members of the Working Party had differing views on specific issues, they all endorse the recommendations in this final report.

I would like to thank members of the Working Party for their expertise, time and enthusiasm. We owe special gratitude to Professor Tony Culyer who, in addition to making a significant contribution as a member of the Working Party, was responsible

for the invaluable research contained in Working Papers 2, 3, 4 and 5. I would also like to thank the members of the External Panel for their helpful advice and the staff at the Institute for their hard work in support of the project.

The Institute is proud to have been associated with the successes of health service provision in Britain over the last forty years. I hope this contribution to the debate will help to ensure another forty glorious years.

BARBARA S YOUNG

CHAIRMAN OF THE ALTERNATIVE DELIVERY AND FUNDING WORKING PARTY

June 1988

ACKNOWLEDGEMENTS

Grateful acknowledgement is due to the King Edward's Hospital Fund for London for funding in support of Working Papers 2, 3, 4 and 5 and to the Russell Charitable Trust for additional financial support.

We are indebted to George Orros of the Institute of Actuaries and to Graham Lister and Malcolm Prowle of Coopers and Lybrand for producing Working Papers 6 and 7 respectively. We would also like to thank the numerous individuals and organisations who contributed ideas and information to the study.

SUMMARY AND CONCLUSIONS

Chapter 1: Identifying the need for review

1 The NHS in its present form will not be able to meet the rising demands and expectations for health services in the future (1.1). In spite of the need for change, however, much of the criticism of the NHS is unjustified and does not recognise the contribution it has made to the health care of the nation over the last forty years (1.4).

Chapter 2: Current strengths and weaknesses of the NHS

2 The debate about the future of the NHS is hampered by disagreement over its current strengths and weaknesses. As experienced by practising managers the problems of the NHS fall into several groupings (2.1-2).

3 **Financial issues** There is a legacy of underinvestment in the NHS. These cut across such diverse areas as buildings, equipment, management technology and clinical research (2.3).

4 The use of cash limits has meant that health authorities have had to constrain levels of output and the system of funding the NHS creates a climate of uncertainty. The NHS does not have recourse to the same range of solutions as the private sector when confronted with these problems (2.4-7).

5 **Service issues** Some of the most pressing current inadequacies in the provision of services by the NHS include lack of adequate amenities and privacy for patients; concern over waiting lists and waiting times; too little systematic attention given to the quality of services; too little knowledge about the outcomes of health care; relatively slow development of new services and application of new technology; inadequate services for the priority care groups; and a limited impact of health promotion policies (2.7).

6 **Staff and organisational issues** Pay levels in the NHS are too low and there are insufficient rewards. This has resulted in low morale and has made it increasingly difficult to recruit and retain staff (2.8).

7 The NHS still does not possess the information systems necessary to support a more rigorous approach approach to assessing its efficiency and effectiveness (2.9).

8 The problems of the NHS should not be allowed, however, to conceal major strengths which should be preserved in the future. These include the fact that it is comparatively comprehensive, equitable and accessible, irrespective of ability to pay. It is remarkably cost-containing in national economic terms and it still provides relatively good standards of care by international comparison. It has

a personalised family doctor system and lastly, it entails a comparatively low management and administrative cost (2.10).

Chapter 3: Establishing the criteria

9 The current debate about health services lacks a framework of criteria against which options can be judged and the inevitable trade-offs between options made explicit. These criteria fall into three broad groupings (3.1).

10 The **founding principles** are those associated with the foundation of the NHS in 1948. These are comprehensiveness, equity, and services free at the point of delivery. It would be foolish to jettison these objectives in any attempt to move towards fundamental change in the existing system of funding and delivery of health care (3.2)

11 The **emergent values** have arisen naturally out of the development of the service, a higher managerial profile and the emergence of new political values. These include effectiveness, efficiency, quality, choice and consumerism (3.3).

12 The **pragmatic principles** are concerned with the realities of implementing change in the system. They include the impact of change on society at large in terms of economic viability, political feasibility and social acceptability. They also relate to the impact of change within the health service itself. This raises criteria such as smoothness of transition, professional acceptability, and managerial technology and capacity (3.4).

13 Much recent debate has also focussed on the level of resources and level of health care provided. This raises the question of adequacy or whether services and resources are sufficient both in terms of international spending and individual provision of care (3.5-8).

14 These different sets of criteria are used to test out various delivery and funding options. Alternative systems should only be adopted if they: address real current problems; achieve the most effective balance tested against the criteria; and do not produce a new range of problems which may have greater disadvantages than the current system (3.9-10).

15 This explicit presentation of criteria and assumptions is vital to the debate, if it is not to be superficial (3.11).

Chapter 4: The sources of funding health services

16 Previous work commissioned by the IHSM, the RCN and the BMA, proposed that the growth in NHS funding be linked to the growth in the gross domestic product. Should the growth of health care funding not keep pace with GDP, then the gap between spending on health and public expectation will

quickly widen (4.1-3).

17 The Working Party has no objection in principle to additional funding coming from private sector expenditure provided the criteria are met. It is, however, unrealistic to expect voluntary private health spending by itself to compensate the shortfall in overall spending created by political restraint (4.4).

18 Although this country might spend too little on health care, it is doubtful that an increase in the level of resources would alone solve the perceived problems of the NHS (4.5).

19 The **major options for health care funding** are considered in terms of the criteria. These are general taxation; public health insurance/hypothecated taxation; private health insurance; and direct user charges (4.6).

20 **General taxation** The current system of funding health services is largely based on general taxation with some user charges and a relatively small private sector. It is considered still to adhere closely to the original founding principles despite certain shortcomings. However, it is also thought to offer too little choice and inadequately satisfies consumer need. The Working Party strongly supports the retention of the option of general taxation as the major source of funding (4.8-13).

21 **Public insurance/hypothecated taxation** This would still be dominantly publicly funded with services free at the point of delivery and therefore would perform in a similar fashion to general taxation. It is however argued that the advantages of public insurance or hypothecated taxation are that they more easily allow the public to identify with the cost of health care. It might also be cushioned, but not immune, from general public expenditure policy. Much would depend on the system of collection. It is possible that some forms of collection public insurance would result in a regressive distribution and would therefore affect equity. The conclusion is that not enough is known about the precise effects of a shift away from general taxation. The potential problems associated with public insurance should not preclude it from being considered as an option. The Working Party believes that hypothecated taxation as the major source of funding for health services is a sustainable option and should be taken forward for further discussion (4.14-23).

22 **Private health insurance** As the major source of funding, private health insurance would threaten the founding principles of the NHS, in particular equity, equality of access and comprehensiveness. It is possible that it would offer a higher quality of service and more choice but it is unlikely that these benefits would be bestowed on the whole population. Private health insurance as the major source of funding is ruled out on these grounds (4.15-26).

23 **Direct user charges** This system would probably ultimately

imply private health insurance for those who could afford it, with the associated problem of premiums based on health status. Those who could not pay would probably get some sort of state support. Even if those groups had only to make small payments themselves, the evidence indicates that this would deter them from making use of health services. Therefore direct user charges are ruled out as a major source of health service funding (4.27-28).

24 **The public/private mix** The debate is about which major source of public funding should be made available for health care and how that source should relate to the various private sources of health funding. Private expenditure takes two major forms: topping up (whereby people pay for additional services whether through the NHS or the private sector) and opting out (whereby people leave the major health care system and receive some form of rebate (4.29-30).

25 The Working Party has no objection to topping up provision in the NHS, but only for non-clinical services. The purchase of additional clinical services is likely to increase, however, and the NHS should be able to offer private facilities to compete for this growing market; the NHS should not deny itself the benefit of the additional potential income from this expanding market. If it were to ignore this source of income, then this would accelerate the development of a two tier health care system and institutionalise it in separate sectors (4.31-34).

26 There was little support, however, for opting out schemes which would offer rebates to leave the system. The majority of the Working Pary took the view that opting out schemes were not practical and could deprive the main system of resources. A minority view thought that these problems were not insurmountable and might be worth the additional consumer choice (4.35-37).

27 **Supplementary sources of income** These include private health insurance, where there is some room for expansion as a supplementary source of income. Direct user charges do not perform well against the criteria, however; the evidence indicates they affect the take up of services by the poor and by children in general. The Working Party is opposed to further extension of this form of funding. Income generation is supported and should be pursued energetically provided it is cost-effective in the use of management resources. But national lotteries are thought to be a nuisance and a distraction from the central funding issues. They might also jeopardise local fund raising schemes (4.38-44).

28 The Working Party therefore concludes that (i) general taxation and (ii) public insurance/hypothecated taxation should be discussed further. It also concludes that whatever the major source of public funding, it will go hand in hand with supplementary sources of income which should include private insurance, topping-up schemes and income generation (4.46-47).

Chapter 5: Options for delivery

29 The available evidence on delivery options is too insubstantial to make hard choices. Decisions over delivery options will therefore be somewhat tentative if they are not too involve a leap in the dark (5.2).

30 The **options for delivery** are considered against the criteria. These options are the NHS at present; retrospective reimbursement at full cost; prospective payment by item of service; provider markets; health maintenance organisations (HMOs); and reimbursing primary care providers (5.3).

31 **The current NHS** suffers from inbuilt inefficiency because there is no direct link between funding and workload. Consequently health districts might be discouraged from increasing their output and could therefore be operating at an inefficient level of capacity. In the primary sector there are perverse incentives for GPs to offload their costs onto the hospital sector. It is difficult to verify whether inefficiency exists in practice by looking at international comparisons. However, wide variations in resource use within the UK are prima facie evidence that inefficiency exists. This indicates that the current delivery system does not encourage the optimum use of resources (5.4-11).

32 **Retrospective reimbursement at full cost** has an inbuilt bias towards inflation and its general lack of cost-containment rule it out as an option on the grounds of cost-effectiveness alone (5.12-14).

33 **Prospective payment by item of service** has certain advantages in that providers receive a fixed amount for a specific item of workload. It therefore constrains costs and when introduced in the United States resulted in reduced length of stay. It is, however, by no means certain these improvements would be repeated if prospective payment were introduced into the NHS. The lack of evidence means that it is difficult to assess prospective payment as an alternative to the current system (5.15-19).

34 **Provider markets** The separation of the purchasing of health care from its provision creates the possibility of a market for providing services among health authorities and also among organisations outside the NHS. The implications are that health authorities might be able to increase their workloads because they would be able to sell their services to other authorities or they might have to reduce their facilities because they can purchase services elsewhere cheaper than they can provide them themselves. The term provider market is used because it implies the involvement of all the providers of care, whether from the NHS, voluntary agencies, the non-profit private sector or the for-profit private sector (5.20-22).

35 A more radical version of the provider market would be for this separation to take place organisationally. The health authority would only purchase care for its population, it would not provide it. The acute hospital sector could become a separate organisation or hospitals could become independent institutions. Regulations might be necessary to protect policy principles or to retain some control over the pattern of provision (5.23).

36 In the light of the recent report on community care by Sir Roy Griffiths, one further option might be for the purchasing agency to take over the complete spectrum of care to include acute services, primary care and the priority groups. This might be thought to cover too great a range of services but the organisation would be purchasing care only. It has been argued that the organisational complexity and variety across the spectrum of care is, in itself, a reason for bringing the responsibility for its purchasing into one distinct agency (5.24).

37 The advantage of both versions of provider markets would be that competition and possible efficiency gains would be combined with the intrinsic equity of a central allocation system (5.25).

38 Despite the advantages of a provider market, smoothness of transition needs to be carefully considered as there is a danger that the running down of provider facilities could have hidden costs (5.27).

39 The Working Party advocates the introduction of experiments to test out provider markets. Experiments are not an easy option since they would require detailed and meticulous work to sort out all the problems of implementation (5.30).

40 The Working Party also considers that more than one experiment should be set up. At least one of these should be concerned with the more radical version outlined earlier (5.31).

41 **Health maintenance organisations** The recent evidence from the US indicates that the early benefits from HMOs are not being sustained. The intense competition is producing severe financial problems and doubts are being cast over the quality of services (5.32-35).

42 **Reimbursing primary care providers.** The present system of rewarding GPs is largely by capitation with elements of other methods added. On the basis of the available evidence, we consider that the present system should not be largely altered. We also strongly support GPs maintaining their role as the 'gatekeepers' to the system.(5.36-37)

43 **Conclusions** There is a lack of firm evidence that overwhelmingly argues the case for any of the alternative options discussed (5.38).

44 Provider markets appear to be a major alternative to the

present system. They address some of the current problems such as the poor linkage between funding and workload, large variations in efficiency and over and under capacity of facilities (5.39).

45 Because provider markets are such an unknown quantity and so little evidence exists about their likely effect, we propose they are approached on an experimental or 'demonstration project 'basis (5.40).

Chapter 6: Organisational and managerial issues

46 If the NHS is to thrive in a competitive environment, it needs certain freedoms in responding to market forces. It needs to be able to change its product range and the cost structure of items within it. It needs to be able to change the 'packaging' of the product and make any of these sorts of changes quickly (6.2)

47 Local flexibility in managing the relationship with clinical staff will be crucial in changing the pattern of resource use and delivery of services. Local health care organisations must be able to manage doctors' contracts and the work that doctors do (6.5).

48 In a market where there is an increased public/private mix, local flexibility in pay and conditions must be possible (6.6).

49 Similarly, if services are to be provided in an efficient and competitive way, then it will be necessary to loosen up the availability of capital for health services to enable providers to develop adequate standards of accomodation and cost-effective patterns of capital stock. Serious consideration should be given to the proposal that health authorities should be permitted to borrow funds (6.7-9).

50 The drive for improved efficiency and the need to compete in a mixed environment mean that each health district must be able to invest adequately in information systems. It will also be necessary to compensate those bearing the costs for teaching and research. Recruitment, training and retention of the most able managerial talent will also be fundamental to the successful implementation of plans for reform (6.10-12).

51 The move towards a mixed economy implies that a central organisation will be required for setting and monitoring essential standards in both public and private health care (6.13).

52 **Organisational implications** Major clarifications of roles and responsibilities are needed at the centre and at regional and district level within the NHS (6.15).

53 Considerable confusion has developed in recent years about accountability at the centre in relation to Parliament,

Government, and the DHSS. Despite earlier intentions, the Health Services Supervisory Board is not seen as the strategic central force for health services. While the achievements of the Management Board in certain areas have been considerable, its membership and role have become increasingly multi-faceted: part-political, part-executive and part civil service. If public accountability is to be served in the future, it will be important as a first step to separate out these legitimate but totally different functions, since merging them in one single body means that none is satisfactorily achieved. There is also concern about the separation of the management responsibility of the Management Board from the policy development responsibility within the DHSS (6.16-21).

54 A common focus of accountability and strategic direction for both the hospital and family pracitioner services would greatly enhance the possibility of innovative, consumer-sensitive delivery systems at local level (6.22).

55 It is our view that the limits of improvement within the current central management arrangements have been reached. The Working Party recommends that a realignment of the central organisation should be undertaken based on the following principles:

- Reaffirmation of the accountability of the NHS to Parliament through the Secretary of State and Ministers.

- Creation of a separate management board with no 'ex-officio' political or civil service members. The board would be accountable to the Secretary of State, either through a chief executive or corporately depending on the preferred model.

- The management board should be in direct managerial or executive relationship to the NHS and should be held responsible for advising ministers on the development of health services policy, and the implementation of policy, as well as for the performance of the system.

- The necessary civil service support for the Secretary of State and Minister should be organised separately from the management board (6.24).

56 Concerning roles and responsibilities at local level, the Working Party is of the view that local health authorities should be unequivocally established as the local board of management of health services, with individuals selected for their personal capacity and relevant knowledge and experience (6.28).

57 It would also be essential, therefore, to place truly powerful local bodies alongside the local boards for the purposes of representing consumers and allowing groups in the community to affect the health system as it operates in their locality (6.29).

58 There are powerful arguments for retaining a regional level in the English system. But any such regional level of authority should be clearly and exclusively managerial in focus, with a regional management board or group accountable to the central management board (6.30).

WORKING PAPERS

Working Paper No 1:	The search for a system - establishing the criteria. Price £1.95
Working Paper No 2:	Alternatives for funding health services in the UK. By A J Culyer, Cam Donaldson and Karen Gerard. Price £2.50
Working Paper No 3:	Financial aspects of health services: drawing on experience. By A J Culyer, Cam Donaldson and Karen Gerard. Price £2.95
Working Paper No 4:	Alternatives for organising the provision of health services in the UK. By A J Culyer and J E Brazier. Price £2.75
Working Paper No 5:	Organising health service provision: drawing on experience. By A J Culyer, J E Brazier and Owen O'Donnell. Price £2.95
Working Paper No 6:	The potential role of private health insurance. By George C Orros. Price £2.95
Working Paper No 7	Capital in the NHS. By Malcolm Prowle and Graham Lister. Price £1.95

Copies of the working papers are available from:

IHSM
75 Portland Place
London W1N 4AN

Tel: 01-580 5041

CHAPTER 1. IDENTIFICATION OF THE NEED FOR REVIEW

1.1 The debate about reviewing the NHS began in the Institute as early as April 1987. The Institute's Council considered that **the NHS in its present form would not be able to meet the rising demands and expectations for health services in the future.**

1.2 The Institute's decision to launch a major study was not taken lightly. It was taken in full awareness that many would see the study as opening Pandora's Box. Critics claimed that it would encourage a government, perceived as being hostile to the NHS, to make radical and substantial changes while others speculated that the study was never intended to be radical or fundamental and was simply a gambit to preserve the status quo.

1.3 The study is, in fact, a genuine attempt to discover the best directions in which health services could move. We invited people of different political views and from different backgrounds to become members of our Working Party. These differences were also reflected in our choice of advisers for an External Panel. We have attempted to cut through the ideological undergrowth and find our way to discover the most appropriate forms of health service delivery and funding for the future. As part of this process, we commissioned several Working Papers to make the latest research available for the current debate (see page 13).

1.4 Since the decision was taken to carry out the study, much has happened. During the second half of 1987, many health authorities found themselves in increasing financial difficulty. The subsequent political crisis culminated in the Government launching its own review headed by the Prime Minister. The whole debate and controversy has produced a great increase of interest in a fundamental re-appraisal of the NHS. Many proposals and suggestions have been made within the last few months and there has been a sharpening of ideas about health care. Consequently, the NHS has been subjected to a great deal of criticism, much of which, we feel, is unjustified. **The NHS has served the country reasonably well for the last forty years, providing comparatively comprehensive care in a cost-effective manner.**

1.5 The recommendations of this report have been made with a view to their **practicability**. This report is essentially based on the views of practising managers who are able to offer a unique perspective. The members of the Institute of Health Services Management have a particular responsibility for the management of the service. **Whatever system of health care is developed, members of the Institute, both in the NHS and in the independent sector, will have to manage the process of transition and the new services as they are established.**

CHAPTER 2. CURRENT STRENGTHS AND WEAKNESSES OF THE NHS

2.1 The NHS is now generally depicted as being in crisis. But judgements about the condition of the NHS are essentially subjective. **There is a lack of consensus about whether the NHS is efficient and effective.** It has been demonstrated that the health service delivers an increasing number of treatments to many apparently satisfied patients at a cost which stands comparison with any other health care system in the world. It has also been argued that our health care fails to command its appropriate share of the country's wealth and delivers inadequate care in inadequate conditions to patients who have inadequate choice. These contrasting views are a problem in themselves because they provide so slender a foundation upon which to conduct a well-informed debate.

WEAKNESSES OF THE NHS

2.2 The Working Party felt it necessary to review in an objective fashion the current problems of the NHS, as experienced by practising managers. These problems fall into several groupings.

Financial issues

2.3 There is a worrying **legacy of underinvestment in the NHS.**

- The cumulative maintenance bill of the NHS has been estimated to run into hundreds of millions of pounds. Old buildings and plant receive inadequate refurbishment and replacement and even new hospital stock sometimes suffers from inadequate expenditure on maintenance.

- Managers and clinicians see a similar lack of expenditure on the purchase and replacement of medical equipment.

- The evidence for the declining investment in clinical research and development has been strongly presented in recent months.

- Inadequate capital is available to equip all health authorities with the information technology required for effective decision making (see 6.10).

2.4 Very significant savings have been achieved in non-clinical support services in the last few years. Although more can be achieved in such services, the days of large financial returns on a relatively modest investment of management time within short time scales will not be seen again. The NHS is now confronted with the reality that increases in

clinical output, involving extra expenditure on drugs, medical and surgical implants and consumables, cannot be contained within the authorities' cash limits. In this sense, **increased output becomes something to be constrained rather than encouraged.**

2.5 Despite the Government's intention to bring forward the date for deciding upon the funding of pay review body recommendations, there will still be much uncertainty during the financial year for health authorities. Other elements such as price inflation, the non-review body awards and the possibility of sudden government intervention combine to produce a **climate of financial uncertainty.**

2.6 Financial uncertainty exists both in the NHS and in the private sector. But **the NHS does not have recourse to private sector solutions** such as changing volume and pricing in order to overcome the effect of changes in cost, or taking advantage of productivity gains.

Service issues

2.7 **Some of the most pressing current inadequacies in the provision of services by the NHS** include:

- lack of provision of adequate standards for patient privacy and amenity;

- widespread public concern about waiting times for out-patient and in-patient and day case appointments;

- too little systematic attention given to the quality of services;

- too slow a response to the increasing expectations regarding individual choice, dignity and consumerism;

- too little knowledge about the outcomes of health care;

- low rates of development of new services and the application of new technology compared with other Western economies;

- inadequate services for people with mental illness and mental handicap and the elderly, both in institutions and society at large;

- the relatively limited impact of generally agreed policies in health promotion.

Staff and organisational issues

2.8 There is ample evidence that **pay levels in the NHS are too low** and that there are **insufficient rewards**. These pay levels have resulted in **low morale** within the Service and have made it **increasingly difficult to recruit and retain staff.** There are also central problems with

long-term manpower planning, the most vivid current example of which is the predicted shortage of trained nursing staff.

2.9 Although progress has been made, **the NHS still does not possess the information systems necessary to support a more rigorous approach to assessing its efficiency and effectiveness**, particularly in clinical services.

STRENGTHS OF THE NHS

2.10 These problems should not conceal the fact that **the current National Health Service has some major strengths which we should preserve in the future.**

- It is comparatively comprehensive, equitable and accessible, irrespective of ability to pay.

- It is remarkably cost-containing in national economic terms.

- It still provides relatively good standards of care and treatment by international comparison.

- It has a personalised primary care doctor system.

- It entails a comparatively low management and administrative overhead cost.

CHAPTER 3. ESTABLISHING THE CRITERIA

3.1 The current debate about alternatives for funding and delivery of health services lacks one key feature - a **framework of criteria by which options may be judged and the inevitable trade-offs between options made more explicit.** Such criteria might be seen as falling into three groups.

THE FOUNDING PRINCIPLES

3.2 The NHS was founded in 1948 on the basis of satisfying certain criteria such as **equality of access, equity, comprehensiveness and free services at the point of delivery.** No one would claim that all or indeed any of these criteria are fully satisfied by the NHS as it stands forty years later. However, they are all strong features of the present system and appear to be highly valued by the general public. **It would be foolish to jettison these objectives in any attempt to move towards fundamental change im the existing system of funding and delivery of health care.**

Comprehensiveness: Under the National Health Service Act of 1946, the duty of the Minister is laid down as follows:

> "It shall be the duty of the Minister of Health to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with the following provisions of the Act."

What actually comprises "a comprehensive health service" has been the subject of debate ever since. Nonetheless, the notion of providing appropriate care for most presenting conditions is still generally assumed.

Equality of Access: Equal access to services according to need only.

Equity: Equal services for equal need; unequal service for unequal need.

Services free at the point of delivery: Everyone is eligible to use the service, simply by being a citizen. Charges for certain services were introduced early in the life of the NHS but the criterion still applied

today is that inability to pay should not prevent access to services.

THE EMERGENT VALUES

3.3 The development of the Service, the introduction of a higher managerial profile and the emergence of new political values have seen the development of other criteria. Broadly speaking these include **effectiveness, efficiency, quality, choice** and **consumerism.**

Effectiveness: The assessment as to whether the intended objectives are achieved, at both an individual and societal level.

Efficiency: The maximisation of output in relation to cost or, more simply, making the optimum use of resources.

Quality: The capacity of the Service to perform to a predetermined set of standards.

Choice: The ability of the individual to select the time and place of treatment, the personnel providing that treatment and possibly even choice over the treatment itself.

Consumerism: The ability of consumers or their

representative organisations to influence the way in which services are provided.

PRAGMATIC PRINCIPLES

3.4 The third set of criteria is concerned with the pragmatic realities of implementing change in the system. These criteria include **economic viability, political feasibility, social acceptability, smoothness of transition, professional acceptability,** and **practicability in terms of managerial technology and capacity.**

Economic viability: Any proposal must be affordable in terms of the national wealth and compatible with the economic structure.

Political feasibility: The acknowledgement that any proposal must broadly relate to the social policy aspirations of the government of the day. This does not mean that any solution has to be in direct agreement with the government view, but attempts to influence and change that view must at least take account of the policies on which the government was elected.

Social acceptability: The extent to which the public is prepared and is able to use a given system of delivery. In particular, any system must be analysed

for its likely effect on specific groups such as the elderly who might hold very different attitudes from the general population.

Smoothness of transition: The ability to demonstrate that the negative effects of disruption are outweighed by the benefits to be achieved.

Professional acceptability: Does the solution offer a rewarding environment for the professions and staff and encourage them to work with, rather than against, the system?

Managerial technology and capacity: Is an option practical in terms of operation and management? Are the information and technology available and appropriate? Can the degree of change proposed be accommodated by the organisational system?

THE QUESTION OF ADEQUACY

3.5 The notion of adequacy is often used as an all-embracing criterion when assessing alternative models. The Working Party recognises the power of the adequacy concept, but found it difficult to apply. For instance, one could argue that it is impossible to assess whether a given country's level of health care is adequate because there will always be unmet need.

3.6 On an individual basis, consumers make subjective judgements about the adequacy of services. On a macro-economic level, adequacy is often interpreted as some kind of optimum level of spending. There are international comparisons available of the proportion of GDP spent on health care according to the wealth of the country (or the per capita GDP) which could imply an appropriate level of health care spending. The latest OECD figures (Financing and delivering health care [1987]) show UK health care spending to be 5.9 per cent of GDP; other similar economies spend between 7 and 8 per cent of GDP.

3.7 This leads on to the question whether there is an optimum level for a nation's health care spending. There is work which suggests this may be the case (Robert Maxwell [1981], Health and Wealth - an international study of health care spending). It is clear, however, that levels of health spending are determined by factors other than purely economic ones. For example, different forms of organisation might have varying levels of constraint on health spending.

3.8 Furthermore, levels of spending do not directly relate to the volume and effectiveness of health care provided. Countries will have varying degrees of efficiency in their use of resources and offer different rates of real pay to the staff. So levels of spending could well be a misleading indicator of the real volume of services to consumers.

CONCLUSIONS

3.9 This chapter has attempted to present a set of criteria against which alternative models of delivery and funding can be tested. These criteria will be used in subsequent chapters to test the various funding and delivery options.

3.10 **Alternative systems should be adopted only if they:**

- **address real current problems;**
- **achieve the most effective balance tested against explicit criteria;**
- **do not in turn produce a new range of problems which may have greater disadvantages than the current system.**

3.11 **The Working Party is clear that this explicit presentation of criteria and assumptions is vital to the debate, if it is not to be superficial.** The trade-offs between criteria will be difficult but nevertheless will bring to the surface the values being adopted in fashioning an alternative to the National Health Service which has served us well for forty years.

CHAPTER 4 - THE SOURCES OF FUNDING HEALTH SERVICES

THE GENERAL LEVEL OF HEALTH CARE FUNDING

4.1 The question of whether the country devotes sufficient resources to the provision of health care has recently been the subject of much debate. In a report published last year (Michael O'Higgins [1987], Health spending - a way to sustainable growth), the Institute together with the British Medical Association and the Royal College of Nursing proposed that in future **the growth in health care funding should be linked to growth in the gross domestic product (GDP).** This proposal was described as "modest" because the evidence suggests that as per capita GDP increases, the proportion of GDP spent on health rises. This is now a widely accepted principle and was conceded by the DHSS in their recent evidence to the Social Services Committee (DHSS [1988], Evidence to the Social Services Committee inquiry into resourcing the NHS).

4.2 The international tendency for the proportion of GDP spent on health care to rise in this way has become a source of conflict and lies at the heart of much of the recent controversy over the level of health care spending. As discussed in 3.7, it is difficult to make precise calculations about the optimum level of a country's health care spending. Many factors might be involved in that calculation and, in any event, health spending does not

necessarily relate to the volume of health care provided. However, there are symptoms which indicate that spending is sub-optimal (See Chapter 2). One of these is certainly an increased public perception that health care spending and provision are inadequate. Other symptoms could be said to be the physical appearance of public hospitals and the length of waiting lists.

4.3 Furthermore, international evidence shows that for most countries health spending does not merely rise in line with the growth of GDP but rises at a greater rate. **If, because of organisational constraints, health spending does not consistently increase in relation with the growth in GDP, then the gap between spending on health and public expectation will quickly widen.**

4.4 Government ministers have recently indicated that additional resources for health care should be found from private expenditure. **The Working Party has no objection to an expansion of this form of funding provided the criteria are met.** However, the latest evidence suggests that the major determinant of the level of health care spending is income (A J Culyer, Cam Donaldson and Karen Gerard (1988), Financial aspects of health services: drawing on experience, Chapter 2, Working Paper 3). Although this is not the only factor to affect the level of spending, it is far more significant than, for example, whether the source of funding comes from the public or the private sector. A recent study of the potential expansion

of private sector insurance (G C Orros [1988], The potential role of private health insurance, Working Paper 6) indicates that this could make a helpful but relatively small contribution to the overall level of resources. **Therefore it is unrealistic to expect voluntary private health spending by itself to compensate for the shortfall in overall spending created by political restraint.**

4.5 **Although this country might spend too little on health care, it is doubtful that an increase in the level of resources would alone solve the perceived problems of the NHS.** If the system has failed to deliver an optimal level of funding then it is possible that it has also failed in other ways. We return to this theme in Chapter 6 on managerial and organisational issues.

THE MAJOR OPTIONS FOR FUNDING HEALTH CARE

4.6 The source of funding is one of the major components of any health care system. However, **methods of funding are not in themselves health care systems and therefore they cannot be properly evaluated in isolation.** This section tests the major funding options against the criteria. It will then be possible to see which options can be taken forward into the subsequent discussion of delivery and organisation. **These options, which are more fully discussed in Working Papers 2 and 3, are:-**

- **general taxation**
- **hypothecated taxation/public health insurance**
- **private health insurance**
- **direct user charges.**

4.7 The initial discussion will examine each of the various options as the major source of funding. In practice, it is extremely unlikely that the health care system would have a single source of funding, so there is also a discussion of some of the main components of a mixed funding system.

General taxation - the current system

4.8 The existing major source of health care funding is general taxation. The NHS is funded from part of the total taxation collected by the Treasury. In relative international terms, the system is perceived as providing a highly cost-effective service. Theoretically people pay for the Service based on their incomes and people receive services based on their need. The present system is a mixed system and, apart from general taxation, health care is funded by limited direct user charges and a private health care sector.

4.9 Despite some erosion of the principle of free care at the point of delivery, the current system still remains close to Bevan's original concept. The criteria of

comprehensiveness, equity, and equality of access are still largely satisfied by the current system.

4.10 Although the emergent values of effectiveness and quality are potentially compatible with a system of general taxation, there is some doubt as to whether these criteria are being fully met (see Chapter 2). Can an almost totally publicly funded health care system without any form of significant competition be highly efficient? It will be argued in Chapter 5 that health care can involve types of competition which are not uniquely associated with particular methods of finance.

4.11 The present system of general taxation is also said to provide too little choice for the consumer and too little expression of consumerism. Patients have choice in the family practitioner services over GPs and dentists but in practice a patient might find it difficult to be treated by the hospital doctor or at the hospital of their choice. Community Health Councils exist to act on behalf of patients but this mechanism only empowers consumers to a limited degree. Although this points to shortcomings in the present system, they relate more to the consumer's relationship with providers than to the methods of funding.

4.12 Looking at the pragmatic principles, general taxation as the status quo would obviously cause no problems in terms of smoothness of transition. Moreover it would meet the principles of economic viability and social and

professional acceptability.

4.13 **The Working Party strongly supports the retention of the option of general taxation as the major source of funding for the health service.**

Public health insurance/Hypothecated taxation

4.14 Public health insurance and hypothecated taxation can be seen as synonymous, the former being a variant of the latter.

4.15 Under a system of hypothecated taxation, health care would, as with general taxation, be funded through the Treasury. However, instead of the cost of health care being paid for from the general exchequer fund, it would be paid for by a hypothecated tax - that is an amount levied and earmarked specifically for the funding of health services.

4.16 The most common argument in favour of hypothecated taxation is that it would enable the public to more closely identify the cost of health care. Indeed, there is evidence to suggest that many people already think that their national insurance contributions directly pay for the NHS (DHSS [June 1985], Reform of Social Security, Background Paper, Cmd 9519). Another possible advantage of hypothecated taxation is that it might be more cushioned from general public expenditure policy even though it could not be wholly immune from government and political intervention.

It is possible that a much stronger central management of the NHS would come about if it were separately financed. This leads on to the question of whether the health care system would be better off centrally managed by an organisation separate from the Department of Health (See Chapter 6 on organisational and managerial issues).

4.17 Hypothecated taxation would perform against the founding principles and emergent values in a similar fashion to general taxation. In terms of equity, much would depend on whether the tax were related to income.

4.18 Recent work discusses the likely economic effects of a public insurance system (Anne Ludbrook and Alan Maynard [1988], The funding of the National Health Service. What is the problem and is social insurance the answer?). Based on the assumption that the NHS would be funded by the new insurance system without a contribution from the central government consolidated fund, it is concluded that there would be a regressive redistribution of income from low to higher income earners, an increase in the supply of labour from low income groups, a fall in the demand for labour, a rise in unemployment and a rise in inflation. These conclusions depend, however, on a particular set of assumptions which, while plausible, are not known to be valid. **We simply do not know enough about the parameters of the system to forecast the consequences of shifting in any major way from general taxation to public insurance.**

4.19 It could be argued that in order to soften these effects of insurance funding it would be necessary to set up a system of public insurance that begins to mirror the existing method of collecting direct taxation. So that if, for example, it were collected via the national insurance stamp then it could incorporate various allowances to reduce the regressive effect. However, this solution would seem to be pointless as it would replicate the system it had replaced.

4.20 Unlike private health insurance which sets its rates on the basis of experience, one likely characteristic of public health insurance is that the premium would be community rated, meaning that different levels of payment do not depend on income. While this means that people who are more likely to be ill or the elderly do not pay more for their health care for these reasons, it also means that families of similar size will pay the same regardless of income. Community rating is more equitable than experience rating but less equitable than payment according to ability to pay, whether proportionate or progressive.

4.21 In terms of political feasibility, public health insurance could run into some objections. If there were, for example, to be a public health insurance fund, this would start to become quite separate from the general public expenditure programme. Would the government want to have less control over what could be a major part of public expenditure?

4.22 There is also a problem in terms of the potential 'domino effect'. If health funding were to be either hypothecated in general terms or supplied by public health insurance then people might well campaign for other areas of public expenditure to be similarly removed from Treasury control. **However, in the view of the Working Party, this potential problem is not sufficient in itself to preclude hypothecated taxation.** If the case for hypothecating a tax on health is justified in its own right, then it would appear unconvincing to dismiss it simply on the possibility that a similar case might be made in another area of government expenditure.

4.23 **The Working Party therefore believes that hypothecated taxation is a sustainable option as the major source of funding for health services and should be taken forward for further discussion.**

Private health insurance

4.24 It is estimated that around 11 per cent of the UK population have taken out some form of medical expenses insurance. The uptake of private insurance has been limited to certain sections of the population (G C Orros [1988], The potential role of private health insurance, Working Paper 6).

4.25 The evidence from our working papers on funding and

delivery suggest that under private insurance people would begin to pay for their health care on an experience basis. In other words, what people would pay would depend on their health status. It is possible that subsidies or regulation could attempt to prohibit experience rating but it is likely to be difficult to enforce (Working Paper 3, Chapter 4). Although insurance companies might not actually refuse to take on people who had a high health risk, they would most certainly attempt to 'skim off' people who were very good health risks. This drift towards risk discrimination would mean that the elderly, the chronically sick or those who had a high health risk would have more difficulty in obtaining coverage.

4.26 A private health insurance system performs well against some of the emergent values. It certainly offers choice for some and it would probably create an environment of consumerism, particularly if companies were to take out insurance on behalf of their employees. It might produce competition and efficiency among providers but this would depend critically on the particular system of delivery and the method of payment. It is unlikely to perform well on the founding principles. There could be negative effects on equity, equality of access and comprehensiveness. The pragmatic principles against which such a system would not perform well are, arguably, economic viability, social acceptability and smoothness of transition. **For these reasons, the Working Party rules out private health insurance as a possible option for the major source of**

health care funding.

Direct user charges

4.27 If direct user charges were extensively used as a supplementary form of funding then theoretically services would not be free at the point of delivery. In practice, it is likely that people would take out voluntary private insurance in order to hedge against having to pay very large bills. It is probable that those who were unable to pay would receive some kind of support from central or local government, as is the case in the United States. **However, the evidence from the US indicates that direct user charges in the form of co-payments do have a deterrent effect, particularly on adults in low income groups and children of all income groups** (Working Paper 3, Chapter 3).

4.28 It is likely that such a system would result in a two-tier service, with lack of equity and lack of equality of access. Health services might be effective and efficient for the patients who received them but they are unlikely to be provided on a comprehensive basis. It is probable that a system of direct user charges would bring with it widespread voluntary insurance usage. Large numbers of people would be uninsured and therefore not eligible for health care. A further threat to equity would come from the likelihood that insurance companies would charge people according to their health status. Companies would charge

on the basis of experience rating rather than community rating. There could be significant gains in consumer choice and quality of care but only for a certain proportion of the population. Nor is it likely that such a system would be socially, professionally and politically acceptable. **The Working Party therefore rules out direct user charges as the major source of health care funding.**

THE PUBLIC/PRIVATE MIX

4.29 None of the previously discussed options would exist as a sole source of funding. **In reality, the debate is about which major source of public funding should be made available for health care and how that source should relate to the various private sources of health funding.**

Topping-up and opting-out

4.30 The role of private expenditure is likely to take two main forms, namely topping-up and opting-out. Topping-up is when people can obtain extra services from either the public or private sector by making additional payments. Opting-out is when people leave the system, either for all of their health care or for 'one off' treatments or procedures and receive some form of financial rebate.

4.31 Topping-up options already exist within the NHS - for example, amenity beds. However, amenity beds have not been viewed as a serious source of income and their potential has not been exploited. There is a view that topping-up is not acceptable because it implies that the NHS no longer provides services on an equitable basis. Another view is that purchasing extra services is acceptable as long as it is restricted to non-clinical services such as hiring colour televisions or being served more expensive meals. **The view of the Working Party is that the purchase of additional non-clinical services is not at the expense of equity and should be encouraged, provided the basic level of provision is perceived as adequate.**

4.32 Under the current system it is possible for people to purchase additional clinical services within the NHS and the private sector. This is due to factors such as higher levels of disposable income, the desire to be treated more quickly and in more pleasant surroundings, and the marketing of schemes specifically designed to meet these needs by private insurance companies.

4.33 If topping up of clinical services were acceptable, then the NHS could itself expand still further to compete for the private health market. Just to clarify the distinction, the NHS would provide additional non-clinical facilities for people having NHS treatment and at the same time compete for the custom of people who demanded private health care through private insurance. The former would be

on the normal NHS waiting list but pay for better hotel facilities when they received treatment. The latter would pay for all aspects of their care, both clinical and non-clinical. In other words, NHS hospitals could expand their private facilities and cater for people who wanted private health care in a more comprehensive fashion than they do at present.

4.34 **The view of the Working Party is that the purchase of additional clinical services is likely to increase. The NHS should upgrade its private facilities to ensure that patients opt for private care within the NHS. Private patients would not be obtaining health care at the expense of NHS patients. They would, in fact, be creating additional health care provision and the income derived from this activity would be used for the benefit of all patients. The consequence of the NHS isolating itself from this trend would be to deny itself access to the increased funding of health care ensuing from the growth in topping up. This would accelerate the development of a two tier health care system and institutionalise it in separate sectors.**

4.35 Opting-out is when people decide to leave the major health care system altogether with the benefit of various incentives such as tax rebates. There are difficulties with providing financial incentives for people to opt out of the system. Tax incentives have no real effect on

delivery of care. They would simply bring about a relatively small reduction in the tax bill and in practice would end up as a regressive financial reward for people who have taken out private health insurance. A further major disadvantage of offering incentives to opt out is the cost of administration. There would also be the complex task of having to check on whether patients were eligible for NHS treatment.

4.36 Under the present pattern of providing health care in the UK, it is difficult to see how complete opting out would work since any opting-out scheme would involve some form of re-purchasing services (for example, accident and emergency services) back from the NHS. There has been some discussion about partial opting-out schemes under which people would forego the right to certain categories of treatment. A number of technical difficulties implied by such schemes should be emphasised:

4.36.1 People who opted out would still be entitled to a core of treatment on the NHS. The task of deciding precisely what care would continue to be made available by the NHS would be immensely difficult, if not impossible. There would be the added task of monitoring the system and a general increase in bureaucracy and administrative costs.

4.36.2 On what basis is the rebate to be calculated? Would it be based on the cost savings to the NHS by those opting out or would it be based on the costs they face

obtaining the equivalent treatment elsewhere?

4.36.3 What would prevent adverse selection, as those opting out would be of higher health status than the average NHS patient? The average cost per case in the NHS would rise as the healthier people left the system. In addition, what would be done to prevent the inevitable drift towards experience rating in the opting-out sector?

4.36.4 What is partial opting-out trying to achieve? Is it really a supplementary form of income or is it a potential alternative form of income?

4.37 **The majority of the Working Party took the view that opting-out systems were not practical and could potentially deprive the main system of resources. There was a minority view that these difficulties were not insurmountable and might be a price worth paying for additional consumer choice.**

Supplementary sources of funding

4.38 We consider below some of the major sources of supplementary funding in mixing public and private sources of finance for health care.

Partial private insurance

4.39 Although private insurance has been ruled out as a sole source of funding, we have acknowledged that it could still have a important role as a source of supplementary funding. Indeed, it is largely through private health insurance that the private health sector has grown over the past few years.

4.40 We have already referred to the analysis in Working Paper 6 which investigates the potential role of private health insurance under a number of hypothetical scenarios. This is one attempt to predict the growth of the private sector via private health insurance. Whatever the proportion of health care that is eventually provided from the private sector, public finance will always be the main source of funding. **Private health care expenditure via private insurance is likely to expand in addition to and not at the expense of the NHS and is therefore an acceptable source of supplementary funding.**

Supplementary direct user charges

4.41 In many health care systems, nominal user charges have been used in an attempt to restrain utilisation. Such charges already exist in the NHS and in fact now raise a considerable amount of income, although it is small in proportion to the total level of expenditure. These charges raise certain issues. In particular, there is the question of to what extent such charges are nominal and to what extent utilisation is unnecessary or frivolous. The

use of co-payments in America for various forms of health care appears to show that the poor and children in general will begin to suffer under a system of even nominal charges (See 4.27). Recent evidence in this country indicates that the use of dental services has declined among low income groups since the imposition of higher levels of charges (National Consumer Council [1987], Dental patients' rights, The NCC's position). Similar evidence is coming forward in connection with increased charges for pharmaceutical prescriptions. There is also the cost of operating a system of nominal charges. **The problem with charges appears to be that the ability to pay them is inversely correlated to the need for health care. Consequently, supplementary user charges do not perform well against the criteria.**

4.42 **While it would not be practical or politically feasible to abolish all existing direct user charges, the Working Party is opposed to further extending this source of funding.**

Income generation

4.43 The present Government has now enabled and encouraged NHS managers to provide services from hospital sites which aim to generate income. These include both clinical and non-clinical services. Although this is a source of income which would only produce a relatively small proportionate increase in overall funding levels, it does not appear to

be at the expense of any of the criteria. **This source of income should be pursued energetically provided it is cost-effective in the use of managerial time.**

Lotteries and fund raising from voluntary sources

4.44 Much publicity has recently been given to the notion that the financial problems of the NHS might be eased by the introduction of lotteries and other voluntary sources of income. On a local level, the NHS has always benefitted from local fund raising. This has the advantage of not only providing additional income but also is a way of involving the community in the work of the hospitals. However, on a national level, fund raising from lotteries is both a nuisance and a distraction. It would make little real contribution to the total level of resources. Evidence from Ireland suggests that government run schemes adversely affect other voluntary initiatives on a national basis. There is also the possibility that they would jeopardise local fund raising schemes.

CONCLUSIONS

4.45 It is possible to rule out certain major funding options against our criteria before moving on to examine delivery and organisational and managerial issues. As main sources of funds both private insurance and direct user charges would jeopardise equity and would cause major disruption.

We consider that the possible advantages of consumer choice are not sufficient to compensate for these shortcomings.

4.46 **The major options which the Working Party will take forward are:**

(i) general taxation

(ii) hypothecated taxation and compulsory public insurance.

It appears that both options go at least some way to satisfying the founding principles. Obviously, retaining general taxation as the major funding source would create least disruption. However, if public insurance were ultimately to appear more effective in obtaining higher levels of funding, and could be designed in an equitable fashion or were a better match for a delivery system that offered a higher quality of care, then it might be worth paying the price of disruption.

4.47 **We can also conclude that whatever the source of public funding, it will go hand in hand with other supplementary sources of income which should include private health insurance, topping-up schemes and income generation. These supplementary sources are not a substitute for adequate government finance but they are a welcome contribution to funding health services provided they meet our criteria.**

CHAPTER 5. OPTIONS FOR DELIVERY

INTRODUCTION

5.1 The previous chapter dealt with the potential sources of funding. This chapter discusses the disbursement of that funding and the ways in which health care is provided. There are a great variety of possible options for providing health care but we will limit the discussion to the current system and those options most likely to be considered as alternatives.

5.2 **The evidence concerning the various options is too insubstantial to make hard choices. We have sought to build upon what evidence there is but decisions over delivery options must necessarily be somewhat tentative if they are not to involve 'a leap in the dark'.** Our conclusions are based on the evidence offered in Working Paper 5 which provides an extensive examination of the available evidence on the various options for the delivery of health care.

OPTIONS FOR DELIVERY

5.3 The options we consider are:

- the NHS at present
- retrospective reimbursement at full cost
- prospective payment by item of service

- provider markets
- health maintenance organisations (HMOs)
- reimbursing primary care providers.

The NHS at present

5.4 Under the current system, various statutory authorities - regional and district health authorities and family practitioner committees (FPCs) - provide health care for a given population. The health authority in the hospital sector acts both as the purchaser of health care and the provider of health care for its population. These roles are separated in the Family Practitioner Services (FPS) sector. The FPC purchases general medical services from General Practitioners (GPs) who are independent contractors.

5.5 Both sectors are essentially funded by central government. Health authority funding is cash-limited and is distributed according to a formula based on population and adjusted for factors such as age and mortality rates (DHSS [1976], Sharing resources for health in England, Report of the Resource Allocation Working Party, HMSO). The FPS contractual services are administered by FPCs. GPs are paid on the basis of the number of patients that are registered with them with some adjustment for factors such as the proportion of elderly patients and allowances and fees for certain services. There is no financial link between GP services and the hospital sector.

5.6 Apart from emergency treatment, patients can only enter the hospital sector if they are referred by their GP. This 'gatekeeper' role of the GP is considered to be an important and desirable feature of the NHS. Theoretically, a GP can refer a patient to any doctor in any hospital in the country. In practice, the patient is likely to be referred to the nearest acute hospital that can offer suitable treatment. In many cases, a patient who resides in one health authority might be treated in a hospital in a neighbouring health authority. These cross-boundary flows, as they are called, are estimated to account for 20-30 per cent of the total workload in the hospital sector (Working Paper No 5, Section 2.3).

5.7 One of the major criticisms made of the NHS is that it is inefficient. For example, because districts are cash limited, they are not rewarded for becoming more productive and increasing their workloads. Instead they are likely to overspend their budgets. However, one additional source of income within the NHS is for treating patients from outside the district. But this notional adjustment is made on a two year time lag and is based on crude average case costs which might well be less than the cost of the treatment provided. There is no compensation for treating outpatient and day cases which come from outside the district boundary. **Consequently, districts might be discouraged from increasing their output and therefore could be operating at an inefficient level of capacity** (Working

Paper No 5, Section 2.9).

5.8 In the FPS, payment to GPs is mainly based on the number of patients on their list. Therefore, their remuneration is not linked directly to the size of their workload. In fact, **there is a perverse incentive for GPs to offload their costs and workload.**

5.9 The evidence about whether such potential sources of inefficiency exist in practice is difficult to verify by looking at international comparisons (Working Paper No 5, Section 2.15). However, internal comparisons within the UK show wide variations in resource use that is prima facie evidence of inefficiency. This indicates that **the delivery system does not encourage the optimum use of resources.**

5.10 The current system attempts to satisfy the principle of equity but in practice there are some shortcomings. One source of inequity is geographical. The Resource Allocation Working Party (RAWP) devised a formula for distributing funds across the country based on population factors. It replaced a system which was based on historical workload and therefore favoured parts of the country such as London which had a relatively high level of facilities. The system was phased in over a long period of time as it would have caused too much disruption had the imbalances been adjusted immediately. Although most of the historical inequity has now been removed, there is still

some progress to be made before full equity is reached. The inadequate funding for cross-boundary flows referred to in 5.6 could be construed as an opposing source of inequity. **On the one hand parts of the country fail to receive the appropriate funding for their population while on the other hand other parts of the country might claim that they fail to receive the appropriate funding for their workloads.**

5.11 Another criticism made of the NHS is that it contains inadequate choice. In theory, patients can choose their GP and, as we noted earlier, the GP can, on the patient's behalf, choose any clinician in any hospital in the country. Both these elements of choice are limited in practice (Working Paper No 5, Section 2.26). Patients can choose to be treated in the private sector but obviously this depends on their ability to pay.

Retrospective reimbursement at full cost

5.12 Under a system of retrospective reimbursement at full cost, the government or other funding agency pays hospitals a sum which covers all expenses incurred in the previous year. The obvious consequence is that hospitals will treat as many patients and provide as much medrrical care as possible in order to maximise their income. Under this method, doctors are usually paid on a fee-for-service basis. All these factors imply a high level of spending on medical facilities, high use of clinical tests and

procedures and would have an in-built inflationary bias.

5.13 It could be argued that such a system would offer a high quality of care. However, there is no guarantee that high quantity of care translates into high quality. Indeed, patients might well be subjected to unnecessary treatments and tests.

5.14 It is possible to offset some of these disadvantages by use of appropriate regulation but in practice this would not be likely to attain efficiency. **Although this system could satisfy the founding principles, it can be ruled out as an option.** Its bias towards inflation and its general lack of cost-containment dismiss it on the grounds of cost-effectiveness alone. It would also be politically unacceptable for similar reasons. Irt is a method that was widely used in North America in the past but which is now being increasingly abandoned.

Prospective payment by item of service

5.15 Prospective payment by item of service (payments for service) is reimbursement at a pre-determined price for a defined unit of 'work-load', or 'item of service'. The item of service relates to a particular procedure (a day in hospital, a diagnostic test). The funding agency decides on an appropriate price for a particular operation or course of treatment, and then reimburses the provider of that service with that sum of money - irrespective of

whether the service was provided for less cost (in which case the provider makes a profit) or at a greater cost (in which case the provider makes a loss).

5.16 Payments for specific services would need the kind of detailed costing information common in the manufacturing industry, and which might be provided by, for example, the development of Diagnosis Related Groups (DRGs) or by the resource management initiative currently under way. There is some question about whether the development of these kinds of delivery systems need to await the arrival of sophisticated costing technology.

5.17 This system would need to have overall cash limits or control on resources. There is a possibility of adverse selection of patients, by the provider choosing to attract patients to whom services could be provided at a below average cost. This would threaten the equitable provision of services. The criterion of efficiency could be satisfied within such a system, as reimbursement rates would be set at an average or efficient cost. However, there would be a need to ensure that hospitals were not offering inferior quality of care to save costs and under this system it would be important to monitor standards.

5.18 The prospective payment system would fit in well with the current NHS. Much of the non-capitation element of the GP service is already determined in this way. The US experience of using a prospective payment system is

inconclusive. There has been evidence to show that the average patient length of stay in hospital has been reduced. Although this has achieved substantial cost savings, this reduction in length of stay might be at the expense of quality of care or standard of treatment, shifting costs to other agencies, or a rise in readmission rates. There is also little evidence on outcome. Nor is it clear whether the claimed US improvements in length of stay would be repeated in this country. These improvements were made because prospective payment replaced the very expensive retrospective reimbursement system referred to in 5.11-13. **It is by no means certain that these improvements would be repeated if prospective payment were introduced into the NHS.**

5.19 **The lack of evidence means that it is difficult to assess prospective payment as an alternative to the current system.** The major advantage of the system is that it links workload to payment and at the same time restrains costs.

Provider markets

5.20 **One of the features of the present system of delivering care in the NHS is that health authorities are responsible for different functions which could be separated.** At present, their responsibilities include the purchasing, provision and, to some extent, monitoring of health care. In particular, the separation of the

financing from the provision of care implies a different type of health service delivery. It means, for example, that a health authority would be responsible for obtaining care for its surrounding population without necessarily having to provide that care itself. **This distinction creates the possibility of a market for providing services among different health authorities and also among non-NHS organisations.**

5.21 This could have profound implications for health authorities. **Health authorities might increase their workloads because they can sell their services to others or they might reduce their own facilities because they can purchase services elsewhere cheaper than they can provide them themselves.**

5.22 There are numerous ways in which this market could be created. However, there are two broad options. The first is the partial version in which health authorities receive finance (quite possibly under a similar formula to the present one) and then have the task of obtaining care from any source they choose. Much of this provision would possibly be provided by the health authorities themselves but they could also purchase care on behalf of their population from other health authorities, other public sector organisations or indeed from the private sector. Such a system was initially proposed by Enthoven (A Enthoven [1985], Reflections on the management of the NHS) and has been called the **internal market**. **However, the**

Working Party prefers to use the term provider market as the competition and market need not be restricted to NHS institutions but could include voluntary agencies, the non-profit private sector and, still further, the for-profit private sector (Working Paper No 5, Section 3).

5.23 A more radical version of the provider market would be to separate organisationally the financing and provision of health care. Health authorities or a variation of them would again receive money under a number of possible systems. They would then buy care from one or more of a number of sources but would not provide care themselves. Under this system, radical structural changes would need to take place within the NHS. Management arrangements for the acute hospital sector would need to be agreed. Possible options might include the acute hospital sector becoming a separate set of authorities or alternatively hospitals could become independent public or private institutions which had to earn their own funding. In practice, it is likely that the local funding agency would, in most cases, award or purchase much of its hospital care from what was the local district general hospital. There might also be regulations to protect any particular policy principles that were thought to be at risk. In particular this would refer to the extent to which the market was allowed to determine the distribution of facilities. For example, it might be decided that some types of hospital facility should be retained locally even though the services they

offer could be provided more cheaply elsewhere.

5.24 In the light of recent policy proposals in the area of community care (Sir Roy Griffiths [1988], Community care: agenda for action) **one option might be for the funding agency to take over the purchase of care for the various priority groups too - something along the lines of a health and welfare agency.** This could also include primary care and therefore the agency would be responsible for purchasing care across the whole spectrum of health and welfare need. The obvious argument against this proposal is that the range of activities would be too wide and diverse to be contained in one organisation (see 5.32). This objection might well be valid if applied to an organisation which both purchased and provided care. It has less force when applied to an organisation that functions only as a purchasing agent. **Indeed, one might go further and argue that the organisational complexity and variety across the spectrum of care is in itself a reason for bringing the responsibility for its purchasing into one distinct agency.** The provider market would provide a powerful mechanism for the integration of services and their provision in the packaging of care to individuals.

5.25 **The advantage of both versions of provider markets would be that competition and possibly efficiency gains would be created combined with the intrinsic equity of a central allocation system.** In addition,

the facility to buy and sell services would mean that authorities with an increased workload would also receive more resources, something that does not necessarily happen at present.

5.26 As we discussed in 5.6, there are already within the existing system considerable cross-boundary flows of patients between districts. Further development of markets might mean that patients are required to travel longer distances for treatment which may be a threat to the criteria of equality of access but this would be a matter for the district to weigh in its contracting arrangements. Careful monitoring would be essential to ensure that quality did not suffer although this safeguard might also be applied to the existing system. There would be a larger number of options available to purchasing agencies or health authorities than at present. But under some of these options there would be less choice for individual GPs or consumers as in the search for the best deal the purchasing authority might well limit the number of providers it uses for a given procedure or treatment. This would need to be considered in experiments.

5.27 On the pragmatic principles, there is no doubt that the widespread introduction of provider markets would result in significant change to the organisation of health care services. It could be a potentially destabilising series of changes - as some hospitals expand services and others are forced to cut back. **Smoothness of transition needs**

to be carefully considered as there is a danger that the running down of provider facilities could have hidden costs, such as long term redundancy payments. There is also the question of the extent to which services are amenable to provider markets. For instance, there will always be a need to provide a local accident and emergency department and this needs to be properly supported by a whole range of back-up specialties.

5.28 However, **the principle of freedom of entry into the market, so making such a market readily 'contestable' (Working Paper No.5, 3.34), may be as important an agent for change as the actual transfer of services itself.** Therefore the actual change in the introduction of such markets may not be as great as the psychological effect of operating in a competitive environment. There is obviously the potential option of evolving towards a radical provider market via the modified version.

5.29 **The ability to influence and control the nature and volume of service provision would be a prerequisite of a provider market.** The capacity to provide a quote for, say, a contract for 200 hip operations, may become a common and necessary practice. As in any market undergoing major change, management control of the potential redeployment of both staff and equipment needs to be clear and firm to minimise harmful effects. The discipline (or realities) of the marketplace may lead to a better service in the long run, but without careful planning it may simply lead to an

unwanted concentration of services in specialist centres at the expense of a reduction of local choice.

5.30 **The introduction of experiments referred to earlier to try out a variety of alternative provider markets is not an easy option. It would require detailed and meticulous work to sort out all the problems of implementation to make the experiment work satisfactorily - as detailed as if it were to be introduced nationally. It would also require monitoring against clear criteria, a careful examination of costs, and patience to allow for a proper evaluation before conclusions are drawn.**

5.31 **We have taken the view that more than one experiment should be set up.** We also favour at least one of these being concerned with the more radical type of market which we outlined earlier. It is beyond the scope of this report to make a detailed proposal but we would suggest that the radical option in which the purchasing agency took responsibility for the whole spectrum of care has much to commend it. This would mesh in with the major principle and recommendation of the recent Griffiths report on community care, that a single agency should be responsible for obtaining - but not providing - the care for the priority groups. At the same time, it would offer a solution to some of the delivery problems which we discussed earlier, especially in relating funding to workload.

Health maintenance organisations (HMOs)

5.32 One of the major criticisms of the NHS is that it is monopolistic, both vertically and geographically. Firstly, the NHS does not separate out various parts of the process of providing health care. In addition, there is no local geographical competition. Provider markets offer a solution to the vertical monopoly by separating out the process of health care. A solution to the problem of the geographical monopoly is the health maintenance organisation (HMO). Although this system integrates finance and provision, competition comes from having more than one system available geographically.

5.33 There are several varieties of HMO but for the purposes of this discussion they are characterised by some common features:

- HMOs contract to provide care to a defined population;
- the choice of HMO is made by consumers;
- HMOs bear the financial risk;
- they compete for their funding by marketing packages of care in return for annual 'subscriptions' from consumers.[Working Papers 3 and 5)

5.34 Health maintenance organisations have expanded rapidly in the US because of their apparent ability to reduce costs

and the absence of a comprehensive family doctor service (Working Papers 3 and 5). However, this reduction was from a very expensive delivery system and there is no real evidence that it would produce similar savings from the current NHS system. HMOs can be provided in many different ways and therefore their performance against the criteria would depend on the particular system being used. Variants of the HMO model including Health Management Units (HMUs) and Managed Health Care Organisations (MHCOs) have been proposed recently in the UK (Working Paper 4).

5.35 In terms of the criteria, the major gain comes from the creation of choice, efficiency and competition. However, the system threatens to jeopardise other criteria. The climate of competition and the drive to contain costs could adversely affect quality of care. There could be variants of HMOs where the basic health service provision was topped-up by private payment. People could choose to join 'up-market' HMOs by paying additional amounts to get a higher level of service. Loss of equity and equality of access would be the price paid for improved quality of care for part of the population. **The recent evidence from the US indicates that the early benefits from HMOs are not being sustained. The intense competition is producing severe financial problems, some evidence of adverse selection and experience rating and doubts are also being cast on the quality of services (Working Paper 3, Paragraph 4.7).**

Reimbursing primary care providers

5.36 The basic options for reimbursing primary care providers are payment by salary, capitation payments for offering care to a fixed number of people, and fee for service. The present system of rewarding GPs is largely by capitation with elements of other methods added. **On the basis of the available evidence, we consider that the present system should not be largely altered.** There is a case for improving incentives for GPs to carry out good practice and in this connection we commend many of the recommendations in the Government's recent White Paper on Primary Health Care together with the work of the Royal College of General Practitioners. **We strongly support GPs maintaining their role as the 'gatekeepers' to the system.**

5.37 Some of the proposals for HMO-type delivery systems imply a greater management involvement on the part of the GP. There is some doubt about the appropriateness of GPs taking on a more central and complex managerial role until there is some indication of how GPs themselves would regard an increased role in management.

CONCLUSIONS

5.38 **It is clear that there is a lack of firm evidence that overwhelmingly argues the case for any of the**

alternative options discussed. It is largely a matter of judgement about the theoretical attractions of individual options.

5.39 Provider markets appear to be a major alternative to the present system. They address some of the current problems such as the poor linkage between funding and workload, large variations in efficiency and over and under capacity of facilities. The effect of transition could be lessened by ensuring that the change would be gradual - it would not occur on one appointed day. In addition they would create a climate of 'contestability' because of competition between providers and could therefore improve efficiency. At the same time they would appear to minimise changes in the way the average consumer uses the NHS although little is known about what effects they would have in practice.

5.40 Because provider markets are such an unknown quantity in the UK and so little evidence exists about their likely effect (Working Paper 5, 3.67), we propose they must be approached on an experimental or "demonstration project" basis. The experiments must address the practical issues of implementing provider markets, such as the allocation of resources to ensure equity of service across the country; the cost and effect of redundancy; the effect on the freedom of general practitioner referral to consultants; and the terms of employment of medical staff in such a system.

CHAPTER SIX: ORGANISATIONAL AND MANAGERIAL ISSUES

INTRODUCTION

6.1 This study of alternative funding and delivery of health services in the UK would be incomplete without some examination of the organisational and managerial consequences of the options for change. Organisational models and their managerial implications should however flow from the preferred funding and delivery options rather than be the starting point for the analysis. If health care delivery is going to evolve into the more competitive environment of a mixed economy - which is essential if there is to be a mixed economy in funding without eventually a two-tier service - then certain organisational and managerial issues follow.

MANAGEMENT OF RESOURCES

6.2 **For an organisation to survive and thrive in a competitive environment, it needs certain freedoms in responding to market forces: freedom to change the product range, to change the cost structure of items in the product range, to change the design and 'packaging' of the product and to make any of these sorts of changes quickly.**

6.3 In the context of the health care industry, these somewhat abstract expressions of freedom imply that those managing health care provision will almost certainly want

to do things that currently cannot be done very effectively, if at all, in the NHS.

6.3.1 Managers will want to determine with doctors the target case mix that will meet the work programme intended by the organisation and the materials that will be used.

6.3.2 Managers will need to decide what permutations of staffing numbers, rostering arrangements, skill mix and pay provide the best chance of maintaining competitive edge in providing a service at the required level of quality.

6.3.3 They will need to move quickly to improve the physical environment of hospitals and the adequacy of their equipment. NHS hospitals will need to upgrade their plant dramatically if they are to compete in that part of the market that would otherwise gravitate to the private sector. If NHS hospitals cannot do that and if private funding of health care increases, we will see a drift towards a two-tier service. The same effect will occur if NHS hospitals are priced out of the market as a result of their being unable to invest capital in order to achieve cost savings.

6.3.4 Finally, managers will want to take advantage of the ability to distinguish between cost and

price in order to accumulate surpluses with which to improve and extend the business.

6.4 It is also inevitable that a mixed economy in health care delivery will be characterised by local variation. There are already great differences in the amount of private sector provision from one part of the country to another and expansion of the scope for private sector provision will magnify the degree of local variation.

Managing medical resources

6.5 **Local flexibility in managing the relationship with clinical medical staff will be crucial in changing the pattern of resource use and delivery of services. Local health care organisations must be able to manage doctors' contracts and the work that doctors do.** This will entail periodic change and renegotiation in response to changes in planned programmes of work. Without infringing clinical freedom relating to individual patients, local health authorities or providers must be able to determine the level and nature of the clinical services so contracted, and be able to renegotiate contracts as health needs in the community change.

Local pay flexibility

6.6 **If health authorities or providers are going to compete in a market where there is increased public-private mix and competition from other providers, local flexibility in pay and conditions**

must be possible; without it NHS authorities will be unable to recruit and retain the scarce staff they need, finding themselves locked into grading structures and restrictive practices that prevent them from achieving efficiency and effectiveness. The role of the Whitley Councils and the Review Bodies must be fundamentally assessed if such flexibility is to be achieved.

Investment in capital

6.7 At present, many health services in the NHS are provided in inadequate accommodation and in buildings which are not as cost-effective as they might be. **If services are to be provided in a competitive and efficient way, it will be necessary to loosen up the availability of capital for health services to enable providers to develop adequate standards of accommodation and cost-effective patterns of capital stock.** This would also entail shedding capital stock that is surplus to requirements.

6.8 We accept the analysis made in Working Paper 7 about the current state of capital finance in the NHS. Capital in the NHS is perceived as a free good under the present system. Health authorities should be able to build up their capital funds on a yearly basis and should be able to borrow funds for capital purposes. Ultimately, capital financing should come from a combination of savings and borrowings. A more rational and efficient use of capital could bring about some improvement in its utilisation - better harmonisation of capital-to-service

objectives and a more systematic follow-up of capital spending. The future nature of capital finance in the NHS will obviously depend on the system of funding and delivery, but we believe that it is essential in a competitive situation to have a more flexible and commercially disciplined approach to capital finance.

6.9 **The suggested option that health authorities should be permitted to borrow funds should, we believe, be given serious consideration.** This would address the free good problem as health authorities would pay for capital via interest rates. This might, for instance, involve permitting health authorities to have access to capital markets or to public sector capital finance. We would welcome a general endorsement from central government for this type of development.

Information systems for management

6.10 The ability to manage cost-effectiveness within specific clinical procedures and in whole-hospital organisation, and the ability to achieve a sufficient margin between cost and price to finance future service development, require a greater sophistication in management information systems. At present, few local health authorities have the information systems to ensure effective decisions in the managerial and organisational areas, far less in clinical decision making where outcome evaluation and effectiveness will become increasingly important. **The drive for improved efficiency and the need to compete in a mixed environment mean that**

each health district or provider must be able to invest adequately in information systems.

Teaching and Research

6.11 **If health service providers are to compete on equal terms, it will be necessary to compensate those organisations involved in substantial teaching and research for the costs of these activities.** At the moment the vast majority of staff for the health services are trained in the NHS, including nursing, medical, paramedical and a wide variety of other staff. If the NHS continues to be the major provider of such training, a contribution to the costs should be made by non-NHS provider organisations. Alternatively, teaching and research could be extended into the private sector in a mixed public-private provision system, or be centrally funded for the system as a whole.

The resource of management

6.12 Much progress has been made in recent years in improving managerial effectiveness. Nonetheless, there are signs that the relatively small investment in management training and development in the NHS is getting even smaller. **The potential changes outlined in this report will create new demands for management, both in terms of a greater proportionate investment in management overall and a greater sophistication of managers in the system.** Recruitment, training and retention of the most able managerial talent will be fundamental to the successful implementation of plans for reform.

Quality

6.13 New arrangements for delivery will make it more important than ever that there is explicit measurement of both the quality of medical care and the quality of management. Experience elsewhere suggests that competition in health care provision can lead to cost-cutting compromises in the quality of service and in the availability of a comprehensive range of services. The potential role of health service 'accreditation' in the quality assurance process is currently being examined by the King's Fund and other commentators. **If we move towards a more mixed economy, it is likely that a central organisation will be required for setting and monitoring essential standards in both public and private health care. It also seems inevitable that a co-ordinated planning function will be needed to guarantee reasonably accessible and comprehensive services.**

ORGANISATIONAL IMPLICATIONS

6.14 In considering the organisational implications of changes in funding and delivery of health services, the Working Party was well aware that even in a mixed economy, the bulk of the funding of health care will come from or via the Exchequer; accountability to Parliament will therefore continue to be central in the way the system is

organised and managed. Furthermore, health care is both a personal and a local service. Individual and local opinions about the adequacy of health services matter. Just as it is not right for doctors alone to determine the pattern and style of local health care, so it is not right for managers to have discretion without accountability.

6.15 Against this background, the Working Party took account of the organisational tensions that have developed within the NHS as a whole in recent years and came to the view that **major clarifications of role and responsibilities are needed at the centre and at regional and district level within the NHS.** Without such clarifications, health services locally will be handicapped in their response to a competitive environment and it will be extremely difficult to experiment with innovative models of funding and delivery and to evaluate their effectiveness.

Roles and responsibilities at the centre

6.16 A continuing theme in the Working Party's work has been the need to increase the extent to which the NHS in particular and health services in general can be held accountable. **Considerable confusion has developed in recent years about the accountability at the centre in relation to Parliament, Government and the DHSS.**

6.17 The NHS Management Inquiry in 1983 laid out clear roles and responsibilities at the centre for the Health

Services Supervisory Board and the NHS Management Board. The Supervisory Board was conceived as the strategic body, determining the purposes, objectives and direction for the NHS. The Management Board's role was seen essentially as an executive, managerial one, concerned with implementation of policies and 'general management' of the NHS.

6.18 **Since 1984, the clarity of these central arrangements has been eroded with consequent confusion in the NHS itself about accountability. The Supervisory Board has become largely an unknown quantity for the NHS and is not seen as the strategic central force for health services. The achievements of the Management Board in the personnel field and resource management initiatives have been considerable. But the Management Board role and membership have become increasingly multi-faceted: part-political, part-executive and part-civil service. If public accountability is to be served in the future, it will be important as a first step to separate out these three legitimate but totally different functions, since merging them in one single body means that none is satisfactorily achieved.**

6.19 It is absolutely right that in a system substantially funded through the Exchequer the Secretary of State must be able to review the state of the nation's health and the epidemiological patterns of ill-health and disease

and must be able to formulate national priorities and national expectations about the philosophy, style and shape of services. Similarly, the Secretary of State has a duty to monitor issues of equity of access to services and to initiate change to remedy inequities. He must also be able to demonstrate to Parliament that public money is being spent properly and effectively. In carrying out these crucial political functions, the Secretary of State must, of course, have appropriate advice in assessing and monitoring the service. This is the role of the civil service.

6.20 The merging of the civil service with the executive management of the health care system within the Management Board does, however, cause profound difficulties. Managerial requirements in terms of planning and running services are flexibility and verve, often involving risk-taking. These are not characteristics of the civil service which are, quite properly, disposed to caution rather than enterprise. An example is the way in which the whole public service ethos in this country is more concerned with prospective accountability than with retrospective accountability. Too much time is spent on producing highly detailed plans, both strategic and short-term, and too little on scrutiny of outputs and the effectiveness and efficiency of what was actually achieved. Overall the effect is too great a concern with detail, too little concern with direction and not a little confusion on how to distinguish good performance from bad.

6.21 **There is also increasing concern about the separation of the management responsibility of the Management Board from the policy development responsibility within the DHSS.** Health services policy must, of course, rest firmly with the elected politicians but its detailed interpretation and implementation must be woven into the managerial and executive process. Otherwise, policy can become isolated from the day-to-day operational considerations and operational management cluttered and inhibited by lack of delegation from the centre.

6.22 Although the reasons are well understood, it is also unfortunate that the Management Board does not "cover all NHS management responsibilities within the DHSS" as the Griffiths Report in 1983 recommended it should. The exclusion of the Family Practitioner Services from the purview of the Board has increased the local problems of co-ordinating the Hospital and Community Health Services with the Family Practitioner Services. The General Medical Practitioners in particular are crucial to many of the possible delivery systems being publicly discussed and their role and relationship to the 'provider' system is also a critical aspect of Sir Roy Griffiths' recent proposals on community care. **A common focus of accountability and strategic direction at the centre for the Hospital and Community Health Services and the Family Practitioner Services would greatly enhance the possibility of innovative,**

consumer-sensitive delivery systems at local level.

6.23 Over the years, there has been recurring consideration of a central corporation or commission model for the NHS. It was discussed prior to the 1974 reorganisation and the 1979 Royal Commission found the arguments for the model attractive, but rejected them at the time because it felt that improvements were possible within the existing framework without the need for major structural change. But the Royal Commission also said that ministers should keep a watching brief to see whether suitable improvement could be made without major change.

6.24 In the ten years since the Royal Commission reported, the demands on management have increased beyond recognition. It is our view that the limits of improvement within the current central management arrangements have been reached. As the foregoing diagnosis indicates, **the Working Party recommends that a realignment of the central organisation should be undertaken based on the following principles:**

6.24.1 **Reaffirmation of the accountability of the NHS to Parliament through the Secretary of State and Ministers.**

6.24.2 **Creation of a separate management board with no "ex-officio" political or civil service members. The board would be accountable to the Secretary of State,**

either through a chief executive or corporately depending on the preferred model.

6.24.3 **The management board should be in direct managerial or executive relationship to the NHS and should be held responsible for advising ministers on the development of health services policy, and the implementation of policy, as well as for the performance of the system.**

6.24.4 **The necessary civil service support for the Secretary of State and Ministers should be organised separately from the Management Board.**

Roles and responsibilities at local level

6.25 Clarification of the accountability of health authorities would also be necessary, particularly if some form of a provider market is to be established. In common with many other public sector bodies in this country and overseas, health authorities have an equivocal role. On the one hand, local health authorities are seen as executive bodies, corporately accountable within the NHS and sanctionable within the system. Hence, health authority members are enjoined to be impartial; no member is appointed to represent sectional (or personal) interests. On the other hand, there is an implicit expectation that members will in some sense 'represent'

the local community - that is, be publicly accountable - and the seeking of nominations from local government, professional organisations, interest groups and so on, underlines this expectation.

6.26 So local health authorities can find themselves expected to carry out national policies as agents of the Secretary of State, while at the same time acting as advocates for health needs in their communities. We have seen instances where this tension has rendered health authorities quite ineffective as corporate bodies, achieving neither managerial control nor the representation of public interests.

6.27 It has been argued that the way out of this dilemma which achieves greatest public accountability is to elect local health authorities. Then the members would be truly accountable to, and sanctionable by, their local community. But it is the Working Party's view that such a solution is unlikely to meet the pragmatic principles of political feasibility and professional acceptability outlined in Chapter 3.

6.28 **The Working Party is therefore of the view that local health authorities should be unequivocally established as the local board of management of health services, with individuals selected for their personal capacity and relevant knowledge and experience.** Ideally, these local authorities or boards would be smaller than the present authorities.

6.29 Such local boards would have delegated authority to regulate their internal affairs and external relations. **It would also be essential, therefore, to place truly powerful local bodies alongside the local boards for the purposes of representing consumers and allowing groups in the community to affect the health system as it operates in their locality.** The community health councils (or local health councils in Scotland) have the foundation for such a significant 'counter-bureaucracy' but at present have neither the constitutional nor the financial base to serve this function.

Regional organisation

6.30 Continuing the theme of public accountability, the organisational changes outlined above highlight the question of the need for a public authority at an intervening regional level. Like local health authorities, regional health authorities in England retain the representational basis for their membership even though there is no equivalent political community to which they relate. **There are powerful arguments for retaining a regional level in the English system to do with issues of the planning and distribution of services, economies of scale and the impracticality of two hundred local health authorities relating directly to the centre.** The future role and shape of regions will, of course, depend on the new central NHS

management. But any such regional level of authority should be clearly and exclusively managerial in focus, with a regional management board or group accountable to the central management board.

APPENDIX 1

MEMBERS OF THE WORKING PARTY

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