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PRIME MINISTER

NHS REVIEW

FLG (PT13) ON B/UP. (w/flag)

My minute of 28 June about the supply and demand for health care concluded that we need to concentrate on improving the supply side. I should like to develop that thought further in this note.

Too much of the public debate has been about <u>inputs</u> - in particular the proportion of GDP devoted to health care, but also such statistics as the numbers of doctors and nurses, etc. What really matters, however, is health <u>outcomes.</u> The following table is interesting in this context.

Country	Health expenditure as % of GDP (1985)		Life expectancy (latest available year)		Infant mortality (1986)
	Public	Total	Male	Female	Per 100 live births
UK	5.2	5.7	71.4	77.2	0.95
USA	4.4	10.7	70.5	78.2	1.06
Australia	5.4	7.3	72.0	78.9	0.99
France	6.8	8.6	70.4	78.5	0.80
Germany	6.4	8.2	70.2	76.8	0.86
Italy	5.4	6.7	69.7	75.9	1.01
Sweden	8.5	9.4	73.0	79.1	0.59

<u>Source</u> : OECD

It is clear that there is little relationship between the amount of health spending and performance as measured by these indicators. Although the UK spends less of its GDP on health than the rest, we are comfortably in the middle of the range of the indicators. The USA spends more than all the rest, but has the highest infant mortality. In short, other countries do not seem to be getting good value for money from their higher expenditures.

This is less surprising when one recalls the great difficulty most other countries are experiencing in getting the costs of health care under control in either the public or the private sector. Indeed, they envy our ability to keep costs down. It is clearly important that we do nothing to erode our advantage: indeed, we should be seeking ways of getting even better value for money.

One reason for this loss of cost control in other countries is the practice of payment per item of service, which among other things leads to considerable numbers of unnecessary operations. There are surprisingly very large variations in the amount of treatment given, for example up to four-fold differences in some operations (eg Caesarean sections, appendectomy, tonsillectomy and hysterectomy). All in all, it is evident that there is no validity in arguments based on the proportion of GDP spent on health care.

This leads to a more general point. We know far too little about the effectiveness of different forms of treatment. We are in no position to say which represent the best value for money and so are most deserving of extra resources. There have been major success stories, such as the immunisation programmes, kidney transplants, and hip replacement operations, which have had a dramatic effect on either mortality rates or the relief of pain. But there is equally evidence of money being spent to little effect, and of extra spending yielding diminishing or even negative returns:

- some past studies in this country showed that then long standing and costly types of treatment - coronary care units, freezing of duodenal ulcers and hormone treatment of viral hepatitis - did little to increase survival rates, and even sometimes decreased them.

- Studies in the USA and Germany have shown that, even though prevalence of the disease is much the same, those areas with the highest rates of appendectomy operations also have the higest rates of death from appendicitis, no doubt as a result of the risks attached to operating on patients.

- One of the top ten causes of hospitalisation in the USA is adverse reactions to drugs administered for medical reasons.

Other countries now recognise the need to tackle these problems. For example, in the USA, the Health Care Financing Administration, which is responsible for federal expenditure on Medicare and Medicaid,is about to start a programme of assessing the effectiveness of particular types of treatment.

We too need to tackle these problems. While we have a system which successfully controls hospital expenditure, thus helping to keep costs down, we have not yet got the incentives right at the clinical levels. We can start with a number of supply-side measures which are already in prospect, like improving the information available to doctors and managers and encouraging medical audit. We can go further by new measures, some of which we have already discussed, like involving doctors more closely in

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management and improving value for money audit. And we most certainly need to take further steps to improve the supply-side by far greater private sector provision of health care. But this is quite different from seeking to expand private sector finance, which risks the damaging consequences I outlined in my earlier note.

While there are detailed elements which we shall need to discuss, I commend the approach in the Cabinet Office note on the overall package. Taken with the action we need to take on consultants' contracts and restrictive practices in the medical profession, I believe that this provides us with the outline of a coherent set of proposals which can be put into effect quickly and would not rule out more radical change in the longer term.

I am copying this minute to John Moore, John Major, Tony Newton, Malcolm Rifkind, Tom King, Peter Walker, Sir Roy Griffiths, Sir Robin Butler, Richard Wilson and John O'Sullivan.

A C S Allan

pp N.L.
6 July 1988

[approved by the Chancellor and signed in his absence]

NAT HEALTH: Expenditure PT14.