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NHS REVIEW

Mr Wilson's paper sketches out a plausible scenario and achievable timetable for NHS reform.

The one problem with his paper is political. Government departments have their own agendas. The Treasury is principally anxious to control costs; the DHSS to maintain the present bureaucratic hierarchy of Management Board, Regional and District Health Authorities. Both departments will attempt to defer any change which threatens these objectives into the realm of long-term reform.

In the light of this, we should consider four changes to the paper:

Defending Fiscal Stimuli

JSh is right Not the Treasury's argument can be easily addressed. But they are right to argue we must not stimulate demand before we have freed up the supply. RRC.

(1) In paragraph 6, the paper reproduces a Treasury argument which is designed to ward off tax relief [or any other fiscal stimulus to private health care]: "Moreover, the demand for health care exceeds the supply; future growth in supply needs to be based on the removal of inefficiency and restrictive practices if an explosion of costs is to be avoided."

Essentially, this is the established Treasury doctrine of 'bidding up costs' which states that an expansion of private health care will increase costs in the public sector by increasing competition for manpower and resources. Note that this argument applies whether private health is expanding because of fiscal stimulus or independently. If

the Chancellor took his own logic seriously on this, he would be seeking to halt the recent exogeneous expansion of private care. Pushed to its logical conclusion, the Treasury doctrine means that in order to control the cost of anything the Government must control the cost of everything.

[One can play logical games with these arguments. Thus: an expansion of private care pushes up NHS costs; the biggest stimulus to private health care is press reports of NHS ward closures and cancellations of operations; these are the result of strict Treasury cash control. Therefore the way to control costs in the NHS is to increase public spending on it. Q.E.D. There has to be something wrong with an argument that can lead to such conclusions.]

Factually, of course, the Treasury argument is shaky. As the Primary Care White Paper notes, we have a surplus of GPs. That is why we are compelling them to retire at 70. Consultants too are artificially restricted in number. As Roy Griffiths points out (in my opinion, rightly), spending £100m to create 200 new consultants would both relieve competitive pressures and reduce consultants' powers of obstruction and bargaining. Finally, the health market is an international one, certainly a European one. In the short-term, we can recruit doctors and nurses from Ireland, Spain, Portugal etc. as we used to import them from new Commonwealth countries. In the longer-term we could increase the output of medical schools. (Northern Ireland, indeed, wants a central grant for nurse training precisely because the English regions are 'poaching' their nurses. The province does not suffer from the demographic nurse shortage seen elsewhere.)

None of these arguments should deter us from stimulating an expansion of private health care which in the long term will lift pressure from the NHS.

Money Does Not Follow The Patient

(2) The Treasury scheme for 'top-slicing', referred to in paragraph 8.11, was originally presented as a method whereby the money would follow the patient. It does not achieve that - or anything like it. It is best seen, therefore, as a diversionary scheme to divert the Review from any serious attempt to introduce speedy and effective cross-boundary payments that would directly reward efficiency and provide incentives to doctors, nurses and hopsitals.

The scheme suffers from other serious drawbacks. It would have only marginal impact, covering a mere 2 per cent of spending. It would give hospitals not more financial autonomy, but less - since the money would be distributed by districts and/or regions in accordance with arbitrary and shifting formulae. It would not provide doctors and nurses with incentives to improve their performance. And it would require an extra layer of bureaucracy to administer it.

Above all, however, 'top-slicing' has great political dangers for the Government. Its criteria, if followed, would in some cases compel DHAs to direct extra resources to problem-free hospitals and away from hospitals where wards were closing and operations being cancelled. That is politically foolhardy and, doubtless for that reason, the Chief Secretary's original submission contained the get-out clause that funds would sometimes be directed 'in accordance with local priorities'.

In other words, resources would be allocated much as now. But when that was suggested, the Chief Secretary replied that, if so, the cumulative mechanism of top-slicing would result in the irresponsible DHA receiving fewer resources next year.

That would, of course, make matters worse. For, then, the Government would be seen as withholding resources from Districts with major resource problems in accordance with some obscure formula of public finance. Such an approach might be possible against "loony Left" local authorities. But silver-haired consultants, winsome nurses and knowledgeable DHA managers adversely affected would have a field day in the media. The hapless Minister for Health would find himself blamed directly for every nursed sacked!

The scheme is a recipe for losing elections. The only way to reward some hospitals and withdraw resources from others without outraging public opinon is to tie the movement of resources to the movement of patients. People understand that; they will never understand top-slicing. We should abandon the scheme forthwith.

Rescuing The Buyers

(3) We all accept the need for independently-run hospitals. But paragraph 11 (ii) makes plain that in the first stage of reform, districts would continue to control hospitals and only gradually devolve responsibilities to them on the basis of contracts. Hospitals would attain autonomy only in the distant future or, in the case of teaching hospitals, earlier as pilot experiments.

The problem here is a simple one. It is well expressed in the current issue of Marxism Today: "A hospital that belongs to its financing health authority does not need to demonstrate cost effectiveness or high productivity to get resources - because it has no fear that other hospitals might under-cut it".

Contracts in these circumstances are no more than an ineffective management tool because they lack an effective sanction. And even if hospitals are performing badly, DHAs will have an incentive to refer patients to them rather than to neighbouring districts or to the private sector. Evolution to autonomy will either be slow or non-existent.

This points to a separation of buyers from providers in the first stage of reform. For that to be possible, we must build upon existing institutions. Broadly speaking, there are two possibilities:

(a) We could combine the District Health Authority with the Family Practitioner Committee and make the new joint body the 'buyer'. It would lose control of hospitals to the Regional Health Authority which would itself lose most of its existing responsibilities. The new buying authority would be financed on a capitation fee basis and so its budget would be cash limited. It would purchase primary care from the GPs and hospital care from the Region. OR

(b) We might make the FPC the buyer, leave hospitals under the control of the districts and abolish the regions altogether. Under this arrangement, the FPCs would receive capitation fees, act as the budget holder for patients, and buy primary care from GPs (as a present) and hospital care from the district.

Both of these scenarios impose cash limiting of both primary and hospital care, achieve a reduction in bureaucracy [the FPC in (a) and the region in (b)], and yet bring about a separation of buyer and provider that would prepare the way for independent hospitals. Indeed, the providing authority would be given the duty of preparing hospitals for

independence. They are consistent with some of the ideas being put forward in the Community Care Interdepartmental Working Group.

Mr Wilson's timetable, which postpones a White Paper to November/December, allows us sufficient time to work out one of the above schemes in considerable detail.

Keeping GPs Free and Happy

(4) Paragraph 15 is a plain fudge. It states that GPs would have freedom to refer patients to consultants, but that "DHAs would need to set aside funds to cover special or ad hoc referrals to hospitals not covered by their main contracts". This echoes Mr Moore's assurance at our last meeting.

But what happens if the funds for special or ad hoc referrals are not enough to cover the cost of the GPs free referrals? This problem, which occurs in real life, has been assumed away in the paper. The plain fact is that GPs cannot have complete freedom to refer in a system where costs are controlled. Placing limits on the GPs freedom to refer is an essential discipline - the very basis of a system of cash limited buyers in health care.

Presumably we have not faced up to this fact because it would restrict GP and patient choice more than at present. We need to offset this restriction in some way - particularly in a system which allocates GPs and patients to the buyer on a purely geographical basis.

The obvious solution is an evolutionary one. It is to allow GPs - if they are able to convince the NHS Management Board of their fitness and administrative capacity - to "opt out" of the district and act as the budget holder for their

patients. This would achieve several objectives. It would reconcile freedom of referral with financial responsibility. It would place a competitive stimulus on the district to perform well both for GPs and patients. And since patients choose GPs, it would make choice the basis of the system.

But it would achieve these objectives without any dramatic upheaval. No GP (or, more likely, group of GPs) would be able to opt out until he had convinced the NHS that he was capable of operating independently. And consequently, any change would be gradual. It is the very model of evolutionary development as the basis for health reform.

Recommendations

We therefore suggest that:

1. You insist upon a stimulus to private health care and insurance. [My colleague, Ian Whitehead, examines the comparative advantages of different approaches in the attached appendix.]

2. You abandon the Treasury scheme for top-slicing and move instead to a DRG-based system of direct standard payments to hospitals.

3. You insist on the separation of buyers and providers as outlined in section 3 of this paper.

4. You allow GPs to opt out of their districts and act as budget holders and buyers for their patients.

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APPENDIX

FINANCING OPTIONS

In the long run, independent health care will not thrive unless individuals can make informed decisions about the relative cost and quality of service available in the market place. We must lower the costs of entry into the private markets. What is the best way to do so?

Mr Wilson's paper mentions three main points on this issue in para 8:

- Over 60s should receive tax relief for private health insurance;

- For employed people, benefits-in-kind on company health schemes should be increased;

- There is a brief reference to the possibility of "contracting out" as outlined earlier in John Moore's paper.

The main financing options are reviewed briefly below.

Contracting-Out

Mr Moore's paper develops a model to encourage a mixed economy of public and private health care, for those in work.

In summary:

- It focusses on cold elective surgery;

- It draws upon the SERPS model of contracting-out;

- Those contracting out of cold elective surgery in the NHS, would receive an age-weighted rebate on national insurance contributions. This would represent a 23-30% discount on today's BUPA premiums.

Pros:
- Private health care would be stimulated further - the DHSS estimates it might be possible for another one million people to subscribe;
- Waiting times would fall over time;
- It would offer a good starting point for the evolutionary process.

Cons:
- The rebate may not be enough to interest many additional takers. (The DHSS, however, believes that another £375 million expenditure on health could be generated independently).

Capitation Fees

Each individual would be given the right to an age-weighted capitation fee, in return for which districts (at first) and private insurance companies would accept responsibility for buying the full range of health services for policy holders. Minimum coverage would be set at a level at least equal to today's NHS provision. Individuals could then top-up the capitation fee by out-of-pocket payments for extra services. Independent health care would then have a floor to flourish on.

An alternative method, in the longer run, is that general practitioners could accept responsibility for providing or arranging all treatment for their patients.

If, over time, most care were to be purchased by either GPs or insurance companies, the aggregate annual payments by the DHSS would represent the NHS budget less administration expenses. DHAs and RHAs would then be unnecessary in their current form.

Some may criticise the option as awarding a windfall benefit to some individuals, mainly high earners, who exclusively use private health care. (i.e. deadweight cost) So perhaps some consideration could be given to a low-income weighting. This concept is administratively more complex but provides a greater incentive for low-income families to top-up their baseline insurance plan.

Pros: - Money follows the patient.

- No need for layers of bureaucracy.

- Provides an incentive for all to increase their cover above the "baseline" national health service.

Cons: - Political difficulties when fixing the scale of capitation fees, both initially and annually.

Vouchers

The voucher option has been championed by a number of health economists. Essentially, the voucher is a transferrable capitation fee with similar strengths and weaknesses. But vouchers would be an administrative complexity - and perhaps frightening to patients.

Tax Relief

More individuals would be attracted to alternative forms of health care. Some may be prepared to pay for a broad range

of insurance cover, taking pressure off the NHS. Yet the cost/benefit analysis is difficult to evaluate.

Pros: - Simple to operate

Cons: - The current drive for a neutral tax structure would be reversed.

- Open to charge of "two tier" service.

Conclusion

The paper "Contracting-Out" tackles the issue of financing reform honestly. The model may be an evolutionary first step. Yet the resulting discount of 23-30% on BUPA premiums may not be enough to stimulate any increased demand. In the short term, tax relief for the over-60s has considerable presentational attractions. Relief for employee schemes, similarly, is building upon a real movement in the workplace. But as we move towards a buyer/provider model of health care, capitation fees (transferrable, where appropriate, to private sector "buyers" like insurance companies or HMOs) fit easily into the administrative structure and run into none of the complex difficulties "Contracting Out" throws up. We believe that the "Capitation Fees" option offers the best scope for long term reform.

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