DH to Hall reading a 22/7

PRIME MINISTER (4) AT 27/6

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THE HEALTH SERVICE

The attached article from last week's Economist makes very interesting reading, if you have the time.

The main points are:

- We can create competitive pressures for efficiency within a universal free Health Service.

- We need to encourage experiment. Whitehall doesn't know best, so Whitehall shouldn't promulgate detailed guidance on how District Health Authorities should operate.

Not everything in the article is politically feasible. But a lot is attractive - using GPs to encourage competition between hospitals to reduce the waiting list, treating the patient like a consumer. It shows that your economic philosophy can apply to the Health Service just as much as to the rest of the British economy.

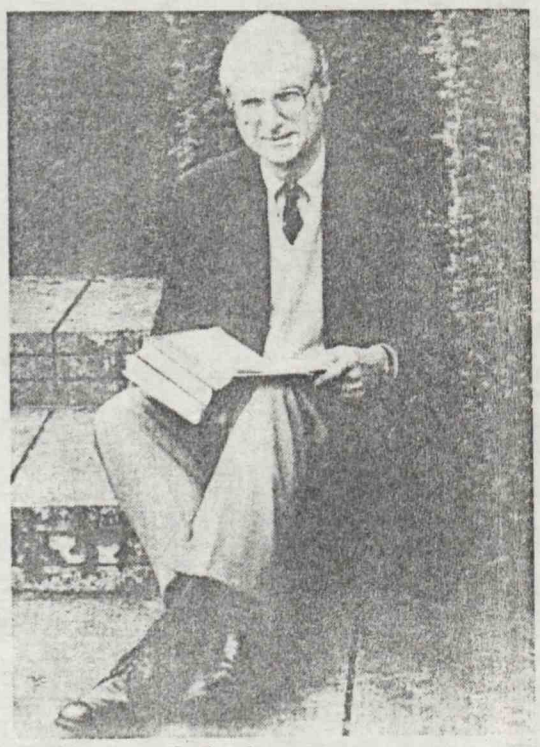
David Willetts

DAVID WILLETTS

NATIONAL HEALTH SERVICE

Some reforms that might be politically feasible

Professor Alain Enthoven of California's Stanford University is one of America's leading experts on the economics of health care. The Nuffield Provincial Hospitals Trust sponsored and organised his visit to study Britain's National Health Service. The Trust will publish his full, sympathetic and remarkable report later this summer*. *The Economist's* precis, below, concentrates on his recommendations for improvements in Britain, rather than on his descriptions of what has gone worse in the United States. We think his main proposal—for an experimental "internal market" in the NHS—could be very important.



Enthoven at Oxford

The National Health Service (NHS) is the democratic choice of the overwhelming majority of the British people. It produces a great deal of care for the money spent. Americans spend about 11% of gnp on health care, Britons only about 5.5%. But, rhetoric notwithstanding, no political party is likely to increase the proportion of gnp spent on the NHS by very much in the next decade, even though there will be more elderly patients and a lot of desirable but expensive new medical technology.

Resources will stay tight. If the NHS is to make effective new technology available to all who can benefit from it, it will need to achieve substantial continuing improvements in productivity. It will require constant innovation and a reward system that guides thousands of decisions in the direction of better-quality care at the same or reduced costs.

This is where the NHS structure is weakest. It suffers from a lack of real incentives for good performance. It relies on dedication and idealism. It is propelled by the clash of the interests of the different provider groups. But it offers few positive incentives to do a better job for patients, and some perverse ones. The four main providers, and associated problems, are:

1. Consultants and those waiting lists

Hospital consultants have accepted long-term contracts with the NHS, and limits on total expenditure, in exchange for job security and "clinical freedom". Thus NHS management has little leverage to make consultants' services responsive to patients' needs. To change the speciality mix of its medical staff, a region must wait for deaths and retirements. In the name of "clinical freedom", consultants can choose the kinds of cases they want to see, arrange their operating schedules, pursue their intellectual interests independently of patients' needs, and keep patients waiting for months. An example is the use of a waiting list for NHS surgical patients instead of a diary system. I am told most consultants say to their patients "You need the operation; it will take place some time in the next year or so, and we'll call you a week in advance to tell you when to come into hospital".

The alternative would be to say "Here is my operating schedule for the next year; pick a vacant place that suits you". That would restore the patient's sense of control over his own life. I heard excuses: there are emergencies, or the waiting list screens out unnecessary operations. Frankly, none was persuasive.

The present practice reinforces the authority and status of the consultant. Embarrassingly, a consultant's NHS waiting list creates a demand for his services from private pay patients. Thus clearing a waiting list is directly opposed to the economic interest of the consultant. Equally embarrassingly, GPs who refer patients to other districts with low waiting lists risk antagonising consultants in their own districts. GPs who want a good reception for their patients when they need it must play the referral game to the satisfaction of consultants near them. I doubt whether the present insensitivity can be corrected without some powerful change in incentives.

The powerful change I would recommend would be the development of an internal market in the NHS, initially and experimentally in a few districts. I will suggest details later, but such a system should give incentives to each District Health Authority (DHA) to seek the best care for its residents even in hospitals outside its district, and also give incentives to DHAs to provide cost-effectively the services most in demand from everybody. If this is deemed too radical, waiting lists could be cut by introducing some smaller market mechanism between districts, such as a negotiated price per other district's case treated.

Another way to reduce waiting lists would be for NHS districts to buy surgery from private-sector organisations outside the NHS when they could get it at a good price.

The numbers of British people who choose the private sector for some of their care are a performance indicator for the NHS. The main private coverage is to pay for cold surgery. Yet the NHS, which buys much long-term geriatric care from the private sector, does not systematically buy much surgery. Any it gets seems to come from targets of opportunity: suppliers with excess capacity willing to sell at marginal costs, and buyers with waiting lists to reduce. One inhibiting factor is that the NHS does not know its own costs, so management is not able to prove

*Reflections on improving efficiency in the National Health Service. A Nuffield Occasional Paper.

that what looks like a good deal is one.

It is worth paying several accounting firms to compete to develop the best cost-accounting system. Because the private sector caters to a market segment demanding a higher standard of amenity, it would often not be an effective competitor to serve NHS patients on the basis of price. But the private sector does have important advantages such as greater freedom from restrictive work practices, easier access to capital, and freedom from complex bureaucratic procedures that add to delays and costs. Our experience in the United States suggests that hospitals show wide variations in cost for apparently similar cases. Private hospitals using effective management methods might prove economic suppliers of open-heart operations, hip replacements and many other procedures on the waiting lists.

2. GPs locked into a rigid structure

General practitioners (GPs) have a proud independent status, but no incentives to reduce referrals. They have neither the incentives nor the resources to make extra efforts to keep people out of hospital, even though (eg) extra attention to ante-natal care might save some costly weeks in the neo-natal intensive care units. At present the hospitals and family practice services each have incentives to dump their problems on the other.

In America, the government sponsors several hundred research, evaluation and demonstration projects to test new ideas and see what works. In the NHS, variation is disliked; it is equated with inequality and injustice. The idea of districts trying something distinctly new and different, other than in response to orders from Whitehall, is perceived as a threat to the minister. He might have to answer for it in parliament. But Britain needs lots of experiments.

One desirable pilot experiment might probe new incentives for GPs to prescribe drugs economically; why not test a system in which GPs who prescribe economically get to share in the savings? Another might probe whether the NHS is too locked into a model with separation between GPs and hospital-based specialists; I was told they communicate with each other mostly by mail.

In the United States, we have some multi-speciality group practices in which primary-care physicians are partners in regular contact with specialists, sharing the same offices, records and equipment. Consultation is easy and quick. There is a collegial atmosphere with both formal and informal continuing education. There is some built-in quality assurance through peer interaction. In Britain it might be productive to let one or two hospitals hire GPs and enrol patients for primary care. My point here is not to convince British readers that hospitals-with-GPs are better, only to suggest that Britain should try a few pilot schemes, and let new ideas spread if they proved good.

3. Trade unions and too much politics

Trade-unionised nurses and other staff have negotiated national agreements on wages, working conditions and job security. Thus their supervisors do not have much leverage or latitude to make efficiency-improving changes in work practices or personnel assignments.

Politicisation makes this worse, and of course occurs under all parties. In 2½ weeks last year more than 350 people at one hospital were poisoned by salmonella and at least 10 of them died, because it was said "cooked beef was taken from a refrigerator and left out for 10 hours in a kitchen and a ward on a warm day". The opposition spokesman on social services promptly charged that "spending cuts imposed by the government have been a major factor".

Tragedies of this sort are avoided by the disciplined observance of carefully designed procedures. It must be difficult for managers to create and enforce them

if a leading MP, possibly the next minister, says it is the government's fault, so that sacking of the negligent worker could make him look a martyr. Somehow, amid much politicisation, the interests of the patients get lost. Political involvement can create a defensive culture, a ritual assertion that everything is just fine, a sort of perpetual cover-up.

4. Managers with wrong incentives

In a competitive industry, a manager who develops and implements efficiency-improving changes is offering solutions to the organisation's basic problem: how to meet the competition's price and quality. In the non-competitive NHS, a manager who conducts an open and honest search for deficiencies, and proceeds to try to remove them, will risk antagonising doctors and workers. He may gain a reputation for rocking the boat. Local citizens will fight to hold on to local jobs and services, blocking efficiency-improving consolidations. When any closure of an inefficient facility is sought, it may end up as a question in parliament, a weapon against the minister.

Add to this a standard problem of bureaucratic budgeting: that one strengthens one's case for more resources by doing a poor job with what one has. When I was assistant secretary of defense in the United States, I used to caricature the problem:

> General: Secretary, I am sorry to have to tell you this, but that million dollars you gave us for shoes were spent on left shoes. Now we need another million for right shoes. We will both be embarrassed if you don't give it to us.

Thus, managements and consultants in a district may risk weakening their campaign for a new hospital wing if they shorten their waiting lists.

Even if a NHS manager does seek greater efficiency, how should he measure it? Performance indicators can be political numbers games. Throughput per bed can be achieved by admitting people who don't really need to be in hospital. Cost per day can be reduced by keeping people in the hospital longer.

Among competing Health Maintenance Organisations in America (see below), a key indicator of performance is the ability to attract and retain subscribers while holding expenses below revenues. A successful HMO strives to improve care and service at the same or reduced cost. Efficiency-improving changes include scheduling clinic hours at times convenient for patients, adoption of shortened stays, efficient sequencing of diagnostic tests, balancing diagnostic capacity with bed capacity so that inpatients' stays are not prolonged by delays in diagnostic testing, more rigorous evaluation of the benefits of surgery and new technologies.

As one excellent example of an efficiency-improving change, an American orthopaedic surgeon recently explained how he and his team reduced the average length of hospital stay for total hip replacement cases from 18 days to nine while improving the outcomes. An industrial engineering analysis of the procedure enabled them to reduce the time of the operation; this reduced blood loss and the need for transfusions. The team initiated the use of a continuous passive motion machine (for flexion and extension) sooner; this reduced post-operative pain and enabled patients to regain their full range of motion sooner. They introduced autotransfusion: patients deposited their own blood in advance of surgery. This substantially reduced complications from transfusions.

The combined results were less pain and faster recovery. All these procedures

cou[illegible]ave been implemented several years earlier. The innovation came under the impetus of the Medicare Prospective Payment System which pays hospitals a fixed payment per case regardless of their actual costs, and thus makes shortened stays more lucrative for hospitals.

Who or what in the NHS keeps nagging consultants to search how to improve procedures in this way? British regional and district medical officers are drawn from community medicine. Training in community medicine is not the same as training in management, or in giving leadership to consultants.

In the United States we are now developing a new breed of board-certified specialists who take degrees in management, and who plan careers as practising doctors in leadership positions. The jobs they aspire to include chiefs of staff of hospitals and physicians-in-chief in Health Maintenance Organisations. At Stanford, we have some physicians in our management programmes. Their subjects include micro-economics (should we buy our own CT scanner or contract to use somebody else's?); accounting (a critical understanding of what financial information systems produce—our graduates should be leaders in refining Medicare's new system to pay hospitals a fixed global payment per inpatient case in each of 468 Diagnosis Related Groups); marketing (which includes measuring patient preferences, patient compliance with prescribed medications, doctor-patient communication, health education); organisational behaviour and decision sciences (how to create a productive corporate culture, decision-making under uncertainty).

I would not recommend this immersion in a management and efficiency-oriented culture for every doctor. It is something for comparatively few leaders, perhaps 200 to 400 in Britain. But education won't do much good unless these people are allowed to manage: that is, to adjust speciality mix to the needs of their population, to replace consultants, to buy services outside, to clear waiting lists, to establish medical audit and quality assurance programmes, and to take corrective action when quality is deficient.

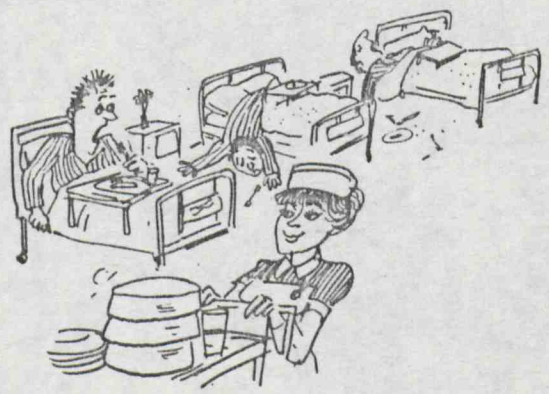
Griffiths and tendering

The Thatcher government has recently decreed acceptance of the Griffiths report and of competitive tendering for some services. Griffiths recommended that general managers (GMs) be apppointed at authority and unit levels, a sensible idea. But a decree requiring all authorities to appoint GMs is an unlikely way to bring about a real change, because the doctors and staff can defeat the GM if they want to. Market forces that make good performance in everybody's interest are a lot more fundamental than the details of organisation charts. Perhaps GMs should first have been developed and tested in a few enthusiastic pilot districts.

The same applies to the British government's recent demand that hospital managements obtain competitive tenders from commercial contractors for catering, cleaning and laundry services. This is an innovation of great potential value. The gains from it should be much greater than the early cuts in costs, though even these could look good. A 20% cut in catering costs would save the NHS £70m per year. At about £700 per acute inpatient case, that would be enough to pay for 100,000 more cases per year. It might be enough to pay for over 30,000 more hip replacements per year, more than enough to clear that waiting list.

More important, tendering introduces a whole new style of management. It requires managers to develop a precise work statement for each department. It tells in-house suppliers of services, previously in a monopoly position, that they have competition. It should hugely increase the control that management has over the quality of services. The threat of non-renewal of a contract is a lot more powerful than complaints to an in-house monopoly provider of the same services.

Unfortunately, it does not appear to me that issuing a circular asking all DHAs



to submit programmes, and then monitoring progress in a hectoring manner, is the best way forward. Most district managements apparently do not know how to do tendering, and some obviously do not want to. It is said that some DHAs have refused to follow the order, and that the government has threatened to take the refusing DHAs to court. If one wants to ensure that some DHAs do a really bad job of it and give the whole idea a bad name, I cannot think of a more effective method for achieving that result.

Another reason for a more deliberate approach is the need in many areas for development of competent private-sector suppliers of these services. In 1982-83 only 0.23% of NHS catering was contracted out, so some NHS managements may not realise that buying from the lowest bidder is not the best way to buy meals; they need to become practised at saying "in my opinion the food does not taste good, and if you do not fix it fast we will switch to another supplier at the end of this contract".

It would have made most sense to begin with a dozen pilot districts whose managements were enthusiastic about the idea, develop and test the methods, with plenty of expert advice from airlines and hotels and others who have much relevant experience, then push tendering to the maximum, display the benefits for all to see, write the manuals and the sample contracts.

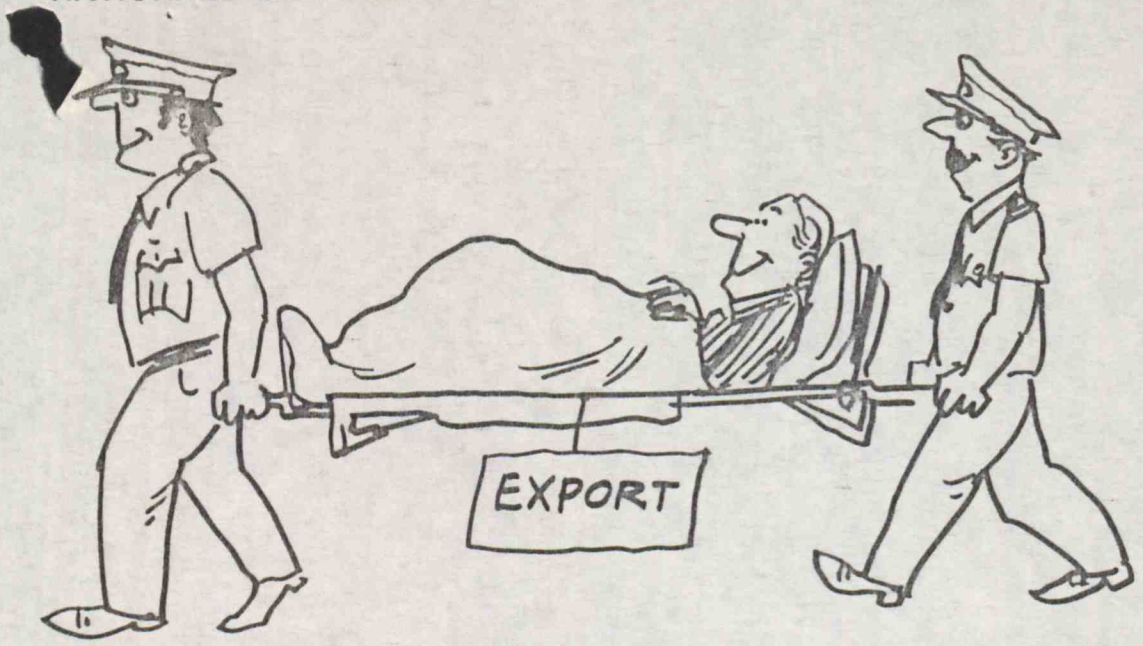
The same system of experimentation should apply to a main reform I would recommend. There should be a pilot experiment to test the idea of an "internal market model".

Internal market model

The finances of the NHS are at present distributed on lines suggested by the Resource Allocation Working Party (RAWP) in 1975. It recommended that total revenues be distributed in proportion to the weighted population of each region, with weights based on age and sex, mortality, fertility and other indicators of relative use of services. Regions would be free to use the revenues as they thought best, not constrained by the relative distribution among services on which the formulas were based.

Regions can therefore import and export patients, but there is no structure to promote trade in pursuit of economic efficiency. A district that does a poor job will export patients and have less work, but not correspondingly fewer resources, for its reward. A region that creates a "centre of excellence" in (say) hip replacement, or that shortens its waiting lists efficiently and thereby attracts patients from outside, will find itself rewarded by more work without correspondingly more resources. RAWP's compensation for cross-border flows is based on national average cost per patient in a given speciality. This is likely to be below the costs of patients who are willing to travel for speciality services (ie, those with more complex problems), and anyway will not be reflected in an increase in the RAWP target until two years from now at the earliest. Actual revenue and capital flows take even longer to catch up, if indeed they ever do.

RAWP has been interpreted in a way that implicitly equates spending in a district with spending for services for the people there. A better deal could be secured for poorer areas by appropriating funds equal to the RAWP target for each DHA, and letting the DHA use them to



buy the services its people want from the hospital offering the best combination of cost, quality and convenience, whether inside or outside the district. As 13% of inpatients account for 50% of inpatient costs, only a relatively few patients would have to travel to referral centres outside their districts to achieve equality in per capita spending.

In the model I suggest below, each District Health Authority (DHA) would be given responsibility for comprehensive care for its people—plus a budget, based on RAWP, to provide care or else buy care from other districts at negotiated prices. This system would allow poorer areas to clear their waiting lists without waiting until they had built their own facilities. The system should make it unnecessary to close or shrink some fine hospitals; the London teaching hospitals could compete for referral business from other districts, rather than be ground down by the relentless application of RAWP. The system would correct some of the disincentives described earlier. A "centre of excellence" would be rewarded. Patients it attracted would bring revenue with them. Each district management might no longer feel it was attempting to satisfy limitless demand, a feeling that must be quite discouraging.

A detailed proposal

Under my experimental proposal, each district would receive a RAWP-based per capita revenue and capital allowance. Each DHA would continue to be responsible to provide or pay for comprehensive care for its own resident population, but would get current compensation when it provided services for other districts' residents. It would be paid for emergency services to outsiders at a standard cost, and non-emergency services to outsiders at negotiated prices. It would control referrals to providers outside its district and it would pay for them at negotiated prices. In effect, each DHA would be like a Health Maintenance Organisation (see below).

Consultants would contract with districts, and districts would be free to enter into all sorts of contractual arrangements, including short-term contracts and ones with incentive payments for increased productivity. Family practitioners would also contract with districts, who would have an incentive to ask some to conduct pilot experiments that might cut costs.

Each district would have a balance sheet and income statement. It would be free to retain savings and to borrow at government long-term interest rates up to some prudent limit on debt. A district owning a valuable property could sell it, keep the proceeds and add the interest receipts to its revenues. Each district could buy and sell services and assets from other districts or the private sector. All districts would be freed from many of the present controls which are inserted to satisfy the needs of central government, the region, the medical profession, national trade unions, etc, but which don't help patients. Preferably, wages, working conditions and subcontracting would be negotiated locally.

The theory behind such a scheme—which can better be called "market socialism" than "privatisation"—is that the managers could then buy services from producers who offered the best value. They could use the possibility of buying outside as bargaining leverage to get better performance from their own providers.

Unlike in the normal bureaucratic model, they would not get more money by doing a poor job with what they have. Managers would be assured that they could retain all the savings they make, and use them on the highest priority needs in their districts. The flow of services to people could be adjusted smoothly and rapidly without the need to wait for facilities to be built or closed.

While such a change in the internal economic structure of the NHS would b fundamental, it would be almost invisib to most patients. Universal free ca would remain. Thus, from a politic point of view, this might not be a unfeasibly radical change.

As a further instalment of consum choice, some people near the borders o one district might prefer to get their ca from a neighbouring district. They cou be permitted to join it. Such a step wou move the NHS towards the competin Health Maintenance Organisation mode

HMOs as an alternative

In America I am very favourably im pressed by the performance of Healt Maintenance Organisations (HMOs). A HMO is an organised system (ie, wit internal management controls) that ac cepts responsibility for providing compre hensive health-care services to a volun tarily enrolled population for a fixe periodic payment set in advance (ie, a "capitation payment" that is independen of the number of services actually used b the person enrolled).

HMOs have shown they can do the jo for 25-30% less cost than the traditiona fee-for-service system. Under intensifie competition, they may do even better. A Stanford, the university's employees an their families have an annual choice o three HMOs or a traditional insuranc scheme. The university contributes a fixed amount, and the employees pay th rest. This makes us cost-conscious in ou choice, and puts the HMOs under con stant pressure to improve service bu keep expenses down. We get excellent competitive service.

I have based this paper on the assump tion that proposals in Britain for radica change in the NHS are unrealistic. I do not sense any demand for such a change. However, if British policy makers were to examine seriously the case for an alterna tive, I would recommend the competing HMO model as the most promising candidate.

One path from here to there would be for large employers or trade unions to sponsor HMOs, in a scheme in which each subscriber could designate that his actuarially-determined per capita cost to the NHS (considering age, sex, health status) would be paid to his HMO, and he would agree to get all his care from the HMO. If the HMO cost more, the subscriber would pay the difference. In the case of poor people, the government could subsidise part or all of the difference. If this development went well, NHS districts might be allowed or encouraged to become HMOs and to compete to keep their patients. All this would be a very long-term proposition, not something that could happen quickly.