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FRAMEWORK FOR NHS POLICY DEVELOPMENT

In a situation where medical advances continue to increase potential expenditure on health beyond that which most people can afford, the State is inevitably involved in deciding what level of public resources are devoted to health care and what quality of health care is provided. We can and should encourage additional expenditure on private provision; but we cannot simply leave health care to private insurance schemes - since public opinion will not accept a situation where low income families cannot afford access to quality medical services. Government must define the basic standard available to all, subsidising (through the NHS), those who could not afford these standards on their own.

If Government is permanently seen as the rationing agent, it is crucial to both be clear about, and gain public acceptance of, priorities - so as not to be judged against utopian standards. Equally if Government is ultimately the paymaster, we must ensure that the provision of health care for the resources provided is as efficient as possible - making use of the weapons of competition and customer choice, and tackling unhealthy producer power. Meanwhile we must encourage private provision to expand choice and relieve the strain on public resources.

THE FRAMEWORK

1. Setting clear priorities

Waiting lists are the most obvious symptom of health service rationing (although, of course, the need to "buffer" admission to hospital means there would be a waiting list even if funds were not a constraint.) Waiting lists are therefore bound to continue - and the number of people on

waiting lists may increase as the range of potential treatments expands.

The current waiting list initiative shows that it is possible to make some progress through emergency measures. Another approach to tackle blackspots might be to set up teams of investigators who could analyse the situation in a particular district, identify roadblocks and recommend short term solutions. This technique can be usefully employed both in an 'internal market' model and in the conventional bureaucratic one.

Such approaches will not resolve the long term problem however. To satisfy public concerns over waiting lists we need a framework that recognises explicit priorities. One possibility would be to classify treatments into three or four established priority categories (ranging from the painful/life threatening to the purely cosmetic) and publicise a guaranteed maximum waiting time to be offered a bed for the more urgent categories. Patients who reached the maximum waiting time would then be offered treatment by another consultant, another district or - if necessary - in private facilities if they could not be accommodated by the consultant on whose list they were waiting.

To maintain financial control, patients transferred to another district (or to private facilities) would be paid for by the home district - with money following the patient.

Such a system would have a number of benefits:

- it would defuse the waiting list problem by enabling the public to see explicit priorities and be reassured that they need wait no longer than the guaranteed time for any urgent operation;

- it would measure performance by the real objective of waiting time rather than the number of people on the waiting list - which is a combination of time and volume;

- it would provide a useful lever to begin to break up the consultants' monopoly control over patients on their waiting list. The patient would be free to choose to stay on the consultant's list, but there would be a clear trigger to offer the patient an alternative choice;

- the possible use of private facilities to meet the guarantee would help to win acceptance for the idea of using private health care facilities under the NHS (see below).

The key to achieving this system is to reach agreeement on the priority to be attached to different medical treatments; while contentious this should not be impossible - and it is better for it to be explicit than implicit as it is at the moment. While the medical profession might debate, a commonsense approach would probably be readily accepted by the public.

2. Increasing competition and widening choice

While accepting the need for the Government to fund the NHS, we can increase competition and widen customer choice by distinguishing public funding from public provision. Ultimately one could move to a situation where we have largely private sector facilities competing for patients under contract from the NHS. This can be achieved without radical change through a step by step approach.

i. Encourage district management to contract out operations/treatment to neighbouring authorities or private facilities where, by doing so, they can save money or improve service. (A pre-requisite

for this is a "management accounting" system to identify unit costs.)

ii. Encourage patients/GPs to choose treatment from a hospital outside their area where they are able to get faster/better treatment. (This requires accounting systems to transfer resources with the patients in order to maintain total budget control. It also requires better information on waiting lists/consultant performance on the GP's desk.)

iii. Encourage more contracting out of non-medical services - porterage and maintenance as well as cleaning and catering. This will require external auditing of tender comparisons to overcome the problem of district management unfairly favouring direct labour. We also need to encourage contracting out of all non-medical services as a single contract - allowing the removal of restrictive practices between the job definitions of porters, cleaners and other ancillary members which could achieve substantial gains in efficiency. Organisations such as Service-Master have demonstrated this capability in the US. (DHSS are considering ways of achieving this)

iv. Shift provision of <u>new</u> hospital facilities towards 'private build' contracts by allowing open tendering; and subsequently allow tendering for private building <u>and operation</u> of new hospitals under contract to the NHS.

v. Ultimately some existing public hospitals could be "privatised" with management contracts to private agencies.

The key to making this work is maintaining clear, negotiated contracts with each facility to provide specified treatment at contracted costs. The NHS remains a powerful procurement agency. Careful contracting can avoid the US problem of escalating costs in a system where insurance companies have simply underwritten the medical bill - and hospitals have competed for patients by offering increasingly expensive care.

3. Tackling producer power

To reduce costs in the NHS facilities will ultimately require bringing the producer interests, particularly doctors, under control.

i. To provide performance incentives and controls, a consultant's lifetime tenure should be replaced by a fixed term contract linked to performance. Performance would be reviewed by a mixed medical/ administrative board to which the district manager could make a report. Unlike existing reviews by the medical organisations, which focus purely on medical standards, this would also look at efficiency performance measures.

One of the mechanisms we might use to reinforce the accountability of consultants is the publication of much greater information about individual consultant performanace - at least to GPs. The wide variation in both efficiency and success rates ought to be more widely known.

ii. GP performance - particularly in the rate of referrals - can have a major impact on local costs and waiting lists. The White Paper as now drafted offers some scope for moving away from strengthened controls and incentives towards a more market

driven 'capitation' based system. Ultimately, we could make them much more free economic agents, with a per capita "budget" to spend on patient care in the most effective way. In addition we could increase the incentive for good practice by allowing allowing doctors to sell the 'goodwill' of their practice to an incoming GP.

Under an 'internal market' model, GPs could be given a financial incentive to reduce the rate of referrals as follows. A high capitation fee would be held to cover a good range of tests and minor surgery; if a GP then referred a patient to hosital to receive treatment under one of these categories, a bill would be sent to him by the hospital.

iii. Equally we need to confront the nursing interests which are pushing for ever more qualified and higher paid nursing staff. Many jobs currently performed by highly trained nurses could be transferred to less qualified auxiliary staff. We need to re-examine the whole question of task specialisation, to use expensive nurses more effectively and reduce hospital's staffing shortages and costs. Ultimately, the nursing profession may have to split into highly-qualified medical technicians and 'carers'.

4. Expanding private provision

While improving value for money within the NHS, we can also encourage expansion of private provision to reduce pressure on NHS facilities. Opinion surveys show that there is already widespread acceptance of the role of private health care, and growth in membership of private schemes will further extend public support. In addition the measures

proposed above to use private facilities for NHS treatments should blur the distinction between the two areas.

i. As additional encouragement for private funding we should consider, as a first step, providing generous tax incentives for corporate health prevention schemes. Additional expenditure on preventive health screening is in the interests of both companies and their employees, as well as ultimately reducing the call on NHS resources.

   At first glance, tax relief for employers' preventative health schemes are less likely to provoke political resistance than other forms of fiscal incentive for private health. Once widely and successfully operating, such relief could be extended - both to these not in work via individual tax relief and to cover other forms of private health provision.

ii. Residential care for the elderly is also a growing NHS cost. We could encourage private provision for such care by introducing a charging system, offset through the benefit system for those without resources to pay. The measures taken to increase the proportion of pensioners with personal and occupational pension schemes should raise pensioner income and make it increasingly feasible for many to provide for themselves through savings and pension income if they need residential care.

SHORT TERM IMPROVEMENTS

Alongside the changes necessary to move towards the framework outlined above, there are a number of areas where

action could be taken within the current framework to both improve performance and public recognition.

1 Extend best practice

Given the wide variation and performance between one district and another, we need to accelerate the transfer of best practice. We propose establishing a small review/audit team - comprising both medical and management representatives - which would examine the performance of individual districts and present management with a set of recommendations for upgrading performance.

2 Improve public facilities

Customer contact is a key part of the image for any consumer organisation. Yet NHS reception areas are typically atrocious; and hospitals are often totally lacking in "hotel-type" facilities.

We could improve the comfort of NHS hospitals and generate additional funds by allowing much greater opportunity for commercial services on site - for example, TV and video rental, bookstores, hairdressers and high class restaurants for mobile patients and visitors. Like BR stations a few years ago, hospitals have tremendous unexploited commercial potential. We might contact organisations like Trusthouse Forte with a view to renting out the entire reception/commerial space of hospitals.

Meanwhile it would be a worthwhile investment to simply smarten up reception areas, training receptionists and providing them with modern systems that would allow them to handle appointments more efficiently and courteously.

It may be possible to capture private (corporate) sponsorship to bear part of the cost.

3 Tackle specific staff shortages

The Nurses Pay Review body has so far failed to tackle the problem of specific recruitment difficulties for staff in some locations (particularly London) and some specialities. Meanwhile, the wasteful expenditure on expensive agency staff grows. We need to decide what is needed in the way of flexible pay differentials to meet local market needs, and take our approach to the review board for endorsement. (DHSS is currently considering the best way of handling this.) It may also be worth looking at the possibility of establishing a larger pool of NHS reserve staff to meet shortages - decreasing our reliance on external agencies.

4 Publicise a popular annual report

Given the amount of money that the average taxpayer is spending on the NHS, we should provide a regular vehicle for the NHS to report back on its success story. This could take the form of both a written report in advertisements/leaflets, and a more exciting, popular version presented through an annual series of TV commercials, though this might prevent legal problems.

5 Identifying NHS tax contributions

If health care is regarded as a consumer good it is perfectly healthy for individuals to wish to spend more on the health service as their incomes rise. Most, however, have relatively little idea how much of their income does currently go on health care support.

Although there are clear difficulties in going down the

route of hypothecating tax revenue to specific expenditure items, we believe the NHS costs are so large and significant that it would indeed be worth showing a separate "health insurance contribution" charge on every pay slip. This would make it possible to separate decisions on the level of health care expenditure from our general desire to reduce income tax. It might also ultimately make it possible to allow people to opt for alternative insurance.

6 Slim the management hierarchy

While we need to avoid any major new restructuring, we may need to slim down the bureaucracy at the top and clarify its role to increase the opportunity for local management initiative and enterprise. If the district is to be the front line management unit, regional staff should be only a fraction of those required at district level - with a minimal performance review and policy making group at national level.

To help implement this and restore authority at district level, we should consider gradually reconstituting regional boards to include the Chairman of the District Health Authorities in the region as vacancies occur.

A PRACTICAL ROUTE FORWARD

A programme to develop the NHS within the framework outlined above could be carried forward in an evolutionary process over the next 5 years without requiring any major discontinuities or damaging confrontations.

The short term improvements outlined in the last section could be implemented almost immediately with the exception of the NHS tax contribution - which, if considered appropriate, would obviously need structuring into longer

term tax reforms. These would help to create a better climate.

Similarly, a wider initiative on waiting lists - classifying priorities and offering guarantees of maximum waiting times could be announced early on, and implemented progressively - with one or two favourable districts taking the lead.

We would also favour an early initiative on announcing one or two private build contracts for hospitals within the NHS - at least on a pilot basis, which would make it difficult to oppose. At the same time we can encourage sympathetic districts to extend their range of sub-contracting for medical care - a practice which is already taking place in some areas. This would complement the waiting list initiative in blurring the boundaries between private and public provision within the NHS. Encouragement of private health care through the proposed tax incentives for corporate health prevention schemes could also be initiated as soon as it could be accommodated within the Chancellor's budget. All of these changes taken together would improve the service offered to patients within the NHS, build private provision of health care into the NHS framework and encourage a favourable attitude towards additional funding of private health care.

The most difficult step - but one that is nevertheless essential - is to confront consultant power and lifetime contracts. As a first step we would suggest firstly instituting a regular review of consultant performance - including both peers and administrators - and, at the same time, begin to publish (at least to GPs) more information on the performance of individual hospitals and consultants. The debate that would arise as a result of the public spotlight turning on variations in consultant performance would then create a climate in which we could more easily move to end consultants' lifetime tenure - making them more

responsive to the needs of the health service.

If we begin to go down this route now, there is every chance that by the next election we will be able to point to the reality of emerging changes in the performance of the NHS. We would also be able to clearly distinguish the framework we then present - moving ahead from a public monopoly to a system of wider choice and greater competition - from the Labour option of "more of the same".

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ROAD MAP FOR NHS POLICY DEVELOPMENT

	88	89	90	91	92	93-
Short term improvements						
- Annual Report	*					
- Clean up reception areas and exploit commercial potential		_____				
- Slim NHS structure		_____				
- Best practice reviews	*					
- Single NHS tax charge		?				
Publish performance data						
- by hospital	_____					
- by consultant		_____				
Start up audit team on waiting list blackspots	*					
Develop waiting list guarantees	----					
Develop doctor review process		_____				
New Consultant contracts					_____	
Encourage subcontract healthcare (internal and to private sector)	_____					
Encourage patient choice (with finance following patients)		_____				
Strengthen contracting out of non-medical services	_____					

	88	89	90	91	92	93-
Open tender for private build hospitals	———					
Tender for Private Operation of NHS Hospitals					———	
Privatise existing NHS facilities					———	
Tax benefits for corporate health prevention		?				