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PRIME MINISTER 22 December 1987

THE PATH OF NHS REFORM

The current crisis in the NHS has had three useful effects. It has put a sense of urgency behind the idea of reforming the NHS; it has popularised certain 'radical' proposals through the leader columns of the quality press and television programmes like "This Week, Next Week"; and it has created a majority for reform among Tory backbenchers. How can we best take advantage of these (possibly transient) movements of opinion?

Three choices are open to the Government:

1. Announce major reforms of the NHS by Easter and push them through over the next two years.

2. Prepare major reforms over the next three years so that they are either ready for inclusion in the 1991 election manifesto or have just passed into law.

3. Postpone major NHS surgery until after the next election by appointing a carefully selected Royal Commission designed to report in 1992 and revive the climate for reform with its proposals.

The worst possible choice would be option 2. The NHS is Labour's only strong electoral card. We would be fighting an election on our opponents' natural territory in defence of policies which the public had not experienced and which Labour's propaganda would teach them to fear. That could be a recipe for, at worst electoral disaster, at best an undignified retreat in the heat of the campaign which would put off NHS reform indefinitely.

Option 3 is little better. No Royal Commission, however carefully selected, can be trusted to produce the right answers. And what would we do about the NHS over the next four years? Would we pumping in more money at regular intervals, gaining nothing in return and dissipating the enthusiasm of our supporters for reform? Surely not.

Our firm preference, therefore, is for option 1. As we argued in an earlier paper, reform of the NHS should be introduced well before an election so that the public's fears can be dispelled by experience.

Reforming the NHS by Stages

But if reform of the NHS is to start soon, we cannot go the conventional route of Green Paper, consultation, White Paper, and further discussion, ending eventually in comprehensive legislation. It would take at least two years before such a complex reform was ready for Parliament, and a further year would elapse before legislation reached the Statute Book. That would bring us to the eve of the election and plunge us into the murky depths of option 3. The Lords, encouraged by Labour and unrestrained by a manifesto commitment, might delay matters still further. In the process, the sense of urgency would again be dissipated and our proposals would be diluted by the professional interests and the DHSS under the 'consultative' process.

We need, instead, to strike while the iron is hot. That requires publishing a White Paper (perhaps with Green chapters) by Easter which should outline a three-stage reform over two years. The stages would be as follows.

Stage One: Supply-side Reforms.

These are reforms which the Government can implement by administrative action, by the use of existing powers or by

its power of the purse without any recourse to legislation. They are, in the main, reforms that would increase the efficiency of the medical suppliers.

For instance:

- 'buying in' medical services from the private sector;
- putting out to private contract the building and operation of new NHS hospitals;
- full publication of waiting list statistics and other information;
- setting a 'guaranteed maximum waiting time' for certain priority treatments with waiting lists;
- and establishing an 'internal market' system so that money follows the patient around (eg, from his own DHA to one where waiting lists are smaller.)

Such reforms would be introduced, step by step, in the course of the year following the White Paper.

Stage Two: Committees of Inquiry.

At least two 'supply-side' reforms, however, would require prior medical cooperation. First, if we are to lay down guaranteed maximum waiting times for certain treatments (and thus to declare, in effect, that certain conditions may meet longer and even indefinite delays), we need to establish a hierarchy of medical priorities. Second, we must draw up new terms for consultant contracts.

To carry forward these reforms, we will need to establish

two committees of enquiry, with a small but carefully chosen membership and a firm remit to report in not less than six months. Among the possible members of the Commission on Medical Priorities might be Professor Alan Maynard of York, Denis Pereira Gray, the President of the Royal College of General Practitioners, and Professor Bryan Thwaites (who raised the priorities question in a major lecture last year.) The Commission on Consultant Contracts might include, Professor Ian McColl, Sir John Butterfield, both of whom you know, John Yates of Birmingham University, who wrote a sensible book on waiting lists, and Sir Roy Griffiths.

These two sets of reforms would gradually be moving the NHS towards a 'mixed economy' in health. Step by step, the health suppliers (ie doctors and hospitals) would be privatised, while the health consumers (ie patients) would continue to be fully funded by the state. Within quite a short time, District Health Authorities would become, in effect, Health Management Organisations or HMOs for the patients in their area. They would receive per capita funding (as now) from the NHS to provide hospital care in their locality - and would either deliver the care themselves through managed hospitals or buy in from the private sector.

Stage Three: The Money Problem

That, however, lies in the future. During the first year of gradual reform, the DHSS would be examining various methods of alternative funding with a view to early legislation. Such legislation would be simpler (and therefore easier to introduce) because it would be an accompaniment to the 'supply-side' reforms already in train. It is not fanciful, therefore, to suggest that such a bill might reach the Statute Book by the end of 1989.

The 1982 working party on alternative funding suggested three basic approaches:

1. <u>A new tax-based strategy.</u>

This is essentially the present system plus some specific revenue-raising measures. Much has already been done by the 'income generation' and 'efficiency savings' programmes and inevitably the scope is limited. Among the possibilities are:

(a) 'Hotel' charges in hospitals. You were, in our view, right to rule this out on television. The political costs would far outweigh the financial gains. But certain charges are worth considering. For instance:

i. <u>allowing</u> patients to purchase "frills" like privacy, a better menu and a bedside television and telephone. This would raise revenue, humanise a hospital stay and blur the distinction between public and private provision.
ii. allowing GPs to charge for certain services that are unavailable on the NHS, such as an annual medical check up. Insofar as the community benefits from preventive health measures (which is far from clear), the recipient benefits far more by living longer.
(b) More private sector provision. This is sensible and it is already happening under joint private/public projects. We advocate more of it above under the heading of 'supply side reforms'.

(c) A Hospital Lottery. The argument that a lottery would encourage gambling is probably false. It is more likely to redistribute gambling money from football pools and bingo. And nothing should be rejected out of hand if it seems likely to raise substantial finance for the NHS painlessly. But financing health care

through such a system will strike many voters as frivolous and damage our other proposals for reform. Much depends therefore on the amount likely to be raised. If it large, we could defend a lottery with conviction. The Treasury should be asked to study this.

2. A social insurance strategy on the European model. A social insurance system does not of itself create more funds. It simply replaces a general income tax charge with a regressive flat-rate charge. We doubt that this is attractive or practicable.

3. A private-insurance strategy supported by health-vouchers. The scheme outlined in the 1982 report has many attractive features. But it would, for instance, require some people to make a financial contribution to their own health care. Nor would it remove the "rationing" problem because the Government would still need to define the basic (safety net) service level, available to all, through state contributions to the insurance premiums for those on below average incomes.

   Such a system is, in our view, inferior to the permissive encouragement of private health insurance which is the basis of the HMO-based approach we outline below. We see private insurance as remaining an important 'top-up' option rather than a root-and-branch replacement for the tax-funded system.

Developing the Internal Market

So specific reforms, such as allowing payment for 'optional extras' in hospital or a lottery, could be introduced in an early bill. In conjunction with the supply-side reforms, the measures on medical priorities and consultants

contracts, they might alleviate the immediate pressures on the hospital service over the next few years.

In the longer term, however, more will be required. We believe that this would be best accomplished by building on the new 'mixed economy' of health care with new measure to encourage competition, choice and a gradually increasing measure of private insurance on the following lines:

1. Once DHAs have effectively become HMOs, We should allow patients to switch their registration from their own DHA/HMO to either a neighbouring DHA or to a private HMO (probably run, in the first instance, by existing insurance companies.) The patient would take his captitation fee with him and, in return, would be entitled to a minimum level and standard of hospital care determined by the Government on lines similar to the minimum standard of primary care laid down by the DHSS in return for the Basic Practice Allowance.

2. This switch need not, however, be made by the patient. It could be the GP who would choose between the services of competing HMOs, taking his patients and their fees with him. The patient would, of course, continue to choose his GP, as at present, and when he did so, he would base his choice on the "mix" of services offered, including the HMO's package (which under conditions of competition would presumably be at least a slight improvement upon the DHSS minimum.)

This ingenious twist is the suggestion of the ASI's Madsen Pirie, whose note we enclose. It seems, at first glance, a minor change. In fact, it transforms the scene. It keeps all of the advantages of the HMO concept while minimising the confusion and uncertainty of asking millions of potential patients to choose between competing hospitals at a time when they are perfectly healthy.

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3. In time, however, the HMOs would be able to offer patients 'topping up' arrangements to buy packages of a superior quality. What would they be buying? There would be three advantages - to obtain "optional extras" in hospital, such as a bedside telephone, privacy, better food, etc.; to receive some treatments even sooner than the "guaranteed maximum waiting time" offered under the standard NHS care package; and to obtain treatments not available under the NHS (see 4) and such as "alternative" medicine (acupuncture, etc.), tattoo removals, etc.

4. Treatments not available under the NHS would, in effect, include those treatments which had no guaranteed maximum waiting time and were available only after an indefinite period -- what we have elsewhere called "the residual category", vasectomies, varicose veins, etc. This category will tend to expand over time as demographic changes and advances in medical technology divert resources from lower priority treatments. Patients will have an additional incentive to take out medical insurance to ensure early treatment for non-urgent conditions. Private insurance will thus tend to expand such line with increased demand, bringing more resources into health care automatically.

Conclusion

We have a major opportunity to reform the NHS. We need a forward-looking plan of this kind to give DHSS the necessary steer and stimulus.

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THE NEW SHAPE OF THE NHS

Dr. Madsen Pirie

There is an opportunity for change because health is seen to be in a similar state to that reached by education two years ago. There is a widespread feeling that the present system cannot go on. The reform of education has retained the tax-funded state service, but introduced the principle that the money must follow the child. The need in the NHS is to have choices and competitive forces within the state system, in such a way that the money can follow the patient.

Any solution must seek to retain the virtues of the NHS, notably the security which it brings and the confidence that treatment will be provided, no matter how poor the patient or how serious the illness. Incentives must be sought for cost-effective treatment, and markets introduced within the context of a tax-funded state system which is free at the point of consumption.

The proposal of the Adam Smith Institute is that Regional Health Authorities and District Health Authorities be replaced by Health Management Units. These HMUs will receive their funding from the government and disburse it to the doctors and hospitals.

General practitioners within the NHS will be required to register with an HMU, taking their patients with them. The doctors will then be paid by the HMU for treatment given to patients, rather than for having them on their roll. There will be a scale of fees to doctors for each consultation and each course of treatment. In other words, the payment of doctors will shift over to the method already used to reward dentists.

When patients are referred for hospital treatment, their HMU will select the specialists and the hospitals, and pay them for the treatment given to its patients. Hospitals will be independently managed, and will cost each service and each operation. The HMU will naturally seek to secure cost-effective treatment, and the incentive will fall upon hospital managers to make their activities efficient, and to cut wastage, administrative costs and restrictive practices.

Hospitals which fail to keep standards high and costs low will find that HMUs take their patients elsewhere, even to private hospitals and clinics if these give NHS patients better value. An important result of this competitive process will be flexible pay rates for health workers, with hospitals tending to expand those functions which they perform effectively.

The HMUs themselves will be financed directly from government on the basis of the number of patients registered with the doctors who belong to them. An Average Health Allocation (AHA) will be paid over for each patient. On present spending this would be of the order of £400 per head. Out of this funding the HMU would have to pay for all the costs of treating its patients, both by doctors and hospitals.

Just as the HMUs will be able to choose between hospitals, the patients will be able to choose between HMUs by switching to a doctor enrolled in another one. And the money will follow the patient.

The Health Management Units will have every incentive to operate efficiently. Their overall budget is limited by the AHA paid over for each patient enrolled. They will pick cost-effective hospital and specialist treatment, in order to be able to afford more and better treatment for their patients. They will act to keep their doctors and patients content with their service, just as hospitals will act to keep the HMUs content with them.

The HMUs will not be allowed to refuse patients, except on the grounds that they are at optimum numbers, and even then will have to establish a waiting list and take applicants on a first come first served basis as places become available. This will prevent HMUs seeking only low-cost patients. The AHA itself will be set annually and could be varied either by category of patient or by area in order to bring treatment, as opposed to cost, to an equal standard.

There are many advantages to such a reorganization, not the least of which is that improvement incentives are built in. Patients continue to see their doctor as at present and to be treated in hospitals as at present. The service continues to be tax funded. The difference is that the choices and competitive forces in the new system will make available more treatment than the present structure of the NHS can manage.

The ability of health managers to shop around for treatment for their patients will impose an important cost constraint on the system. Personnel from consultants to porters will be managed to give value for money, and general practitioners will be paid by results.

All of these are powerful arguments for reorganization. A further advantage of the system proposed is that it can be approached by a series of improvements all worthwhile in themselves. Hospital managers should know the cost of each activity; doctors ought to be paid for work done; managers should be able to select the best value for patients.

Individually they bring improvement. Together they constitute a system which will set markets to work within the NHS. All of the groups involved in health care stand to gain from these changes, especially the patients. The changes which together constitute a new system can be championed individually, each one as a definite improvement to the NHS.

The effect, as in education, will be to blur the distinction between private and public. The state sector will have choice and competition, and resources will be redirected as a result of the decisions made. A new partnership between private and public sector will emerge, and the groundwork laid for later changes.