To: The Prime Minister

From: John Redwood

24th December 1987

H E A L T H

The latest row over the adequacy of health funding has served to highlight the difficulty of pressing on with our current health policy. There may never be a level of funding which is welcomed by the medical profession and thought to be adequate for the purpose. Whenever a tragedy strikes in a hospital the reflex reaction of all those responsible is to blame the government and to put it down to lack of money. Following baby Barber there could be a whole spate of these incidents: in the last week the Royal Berkshire Hospital reported the death of a baby and the staff immediately blamed it on the government.

The ills of the Health Service are becoming clear. There are the following problems:

(1) Over-administration and under management

The endless tiers of administration often get in the way of clear responsibility and spend money unnecessarily. It should not require DHSS permanent officials, a NHS management board, the inter-regional co-ordination machinery, regions, districts, and unit management. Not only does this cost time and resource, it also means that many people down at the hospital level, as well as throughout the administrative chain, are involved in writing memos to each other and in setting out an argument why there isn't enough money. Few make the tough choices necessary in running a hospital to a defined budget.

(2) Griffiths was never given a chance

The Griffiths reforms were effectively sidelined in many parts of the NHS and the experience around the country is very patchy. In many cases unsuitable individuals were appointed and they never really meant to manage because they did not have the courage to stand up to the medical vested interests involved. The easy way out for all managers under pressure is to blame the government and demand more money.

(3) Heavy Unionisation

Union activity is clear in many of the problems the Health Service faces. It lies behind the difficulty in setting out clear contractual terms for those in hospital employment. It lies behind the hostility towards regional pay differentiation which could do a great deal to help recruitment in the hard-pressed South East without costing a fortune on the national wage bill. It lies behind the move towards turning the nurse into a paramedic, therefore requiring a very high level of qualification which makes recruitment that much more difficult and justifies higher pay.

(4) Lack of consistency in management across the NHS

The NHS management board is not bringing enough pressure to bear to ensure that there is some similarity of treatment and cost throughout the Service. The disparities in the quality of care and its cost of delivery are still enormous between different hospitals in the same district and between districts and regions. There is little management pressure to see that this is improved.

(5) Consultants' practices

In some hospitals, consultants artificially limit the number of consultancy appointments that can be made which therefore guarantees long waiting lists and patient discontent. Some consultants use their NHS position in order to build a large private practice. You are well aware of the problems of the so-called "merit awards". Some consultants resent management control and fail to provide a service to the patient which the patient can understand and which is delivered on time in a reasonable way.

(6) Medical Problems

There is a high rate of secondary infection in hospitals. Some modern hospital buildings have themselves created favourable environments for disease. A recent study reported in The Independent newspaper shows that almost a thousand people die each year as a result of operations. Even more startling was the statistic that over six percent of these deaths occurred as a result of operations which were not necessary.

The Independent did not reveal how many of these people would have died anyway but it is a matter of grave public concern that ought to be investigated. It is well known within the medical profession that the death rates vary enormously between different consultants carrying out the same operation but this is the kind of management information that is again supressed.

Many people are now in the business of offering solutions to this problem. There are three broad categories of solution:

(i) Many of our colleagues wish to see a faster move towards privately financed healthcare. They see in this an answer to the problems of cost, as people would then dig deeper into their own pockets to pay for their own health provision. It would have some impact upon the quality and range of care provided, both by bringing in additional money and by making patients demand better standards once they could clearly connect the money they were spending with the healthcare they were receiving.

(ii) The second type of solution rests upon breaking up the NHS direct labour organisation itself without attacking the principle of free healthcare to all. Under this system the money would move with the patient wherever he wished to go to get his treatment. A voucher would be made out from the NHS to a private hospital if it could do a better job.

(iii) The third type of solution is a tentative version of both models, the evolutionary rather than the revolutionary approach. This builds upon examples of public-private partnership and might encourage some modest increase in private health insurance without making it mandatory.

(i) Changing the funding system

This is likely to be the most bitterly contested route. What people most admire in the NHS is the principle that whatever your means you have access to the healthcare you require when you need it. What most disturbs them about the modern NHS is, as they see it, the failure to meet this requirement with some very long waiting lists for non-acute surgery, and now some celebrated cases of acute surgery going wrong or being delayed.

In order to break down this resistance, it would be necessary first of all to get across to people just how much they are currently paying through their taxes for the NHS. The figure you are using of around £1000 per family each year is beginning to go

home but it is still not well or widely understood. It may also be useful to tell people the startling facts that: (a) no money from the national insurance fund now pays for the NHS given the enormous cost of pensions and, (b) that the NHS itself absorbs half of all the income tax revenues collected. Once people understood that, say, 14 pence in £1, or half their income tax, was going straight to the NHS they might then wake up and ask some questions about whether all that money was being well spent and whether they were getting the quality of service they should expect from that amount of money.

Once progress is made in that argument, then it is possible to investigate alternative funding. There are three main models:

(A) Extending the principle of charging ever more widely. This might include hotel charges for hospital stays, more charges for non-acute surgery, building on a base in, say, cosmetic surgery.

(B) Extending tax relief to insurance schemes thereby hoping that there would be a large increase in the number of people taking up private insurance.

(C) Making some form of private or public insurance compulsory and converting the current tax bills for the NHS into a proper insurance payment. This could be modelled upon the payments for the State earnings related pension scheme, with rebates for those opting out of the scheme. They would not be able to get a rebate for the full amount because there would still have to be a redistributional element in their payments to cover the cost of insurance for those who were too poor to pay for themselves or those in old age who were bad risks.

All three of these options are politically hazardous. Simply extending charges is the most dangerous of all. It attacks the principle of free health provision and requires a very large number of exemptions to deal with the problem of those on low incomes or in difficult circumstances. This then immediately intensifies the poverty and unemployment traps whilst failing to convince many people that it is just.

Extending tax relief to private insurance schemes has a large deadweight cost as those already taking up private health insurance would enjoy the tax relief.

The third system is the most far reaching. If, instead of paying 14p. in the pound income tax, people paid a percentage rate national health insurance charge based on their income, the cost of the Health Service would immediately become visible. It would then be possible to tailor a rebate scheme to encourage more private schemes with people opting out for all or part of the risk as defined under government rules. The successful privatisation of the second pension would be a model for such a scheme. This is the least objectionable of all the schemes: it could be cheaper than extending tax relief to private insurance schemes depending on the level of rebate.

(ii) Attacking the direct labour organisation

This is more likely to be productive in improving the quality of care and in cutting costs. It goes to the heart of the problem which is a problem of over-administration and heavy unionisation. It introduces competition into the production side, but can be done using the language of improved patient care. People do not like the language of competition and profit intruding into health provision. It will be fiercely contested by existing producer vested interests but it should be possible to get the public on the side of sensible reform.

Tackling the consultants' contracts first may be taking on the most difficult case. They may well carry out their threat and demonstrate that a large number of consultants do do more than the contractural minimum already: it may turn out to be a policy which has costs as the consultants insist upon higher pay to take account of their so-called overtime. It is easier to establish more partnership schemes between the public and private sectors on NHS territory and to establish the principle of the internal market in healthcare. Hospitals and districts should buy operating space and treatment from outside their frontiers where they themselves are under pressure or where they cannot do it so effectively. Patients should be given a genuine choice with a voucher to take to the private sector if they choose to do so. This could produce a favourable response from the private sector healthcare producers who may well then come into the market and build more hospitals and offer more facilities. "The money moving with the patient" is a good slogan which shows the government is on the side of the patient whilst, at the same time, having some interesting implications for the least efficient and least satisfactory hospitals within the public healthcare system.

(iii) The evolutionary approach

The evolutionary approach would not immediately introduce a patient voucher. It would build on the current experiments and upon the current level of private health insurance. We are lucky that we already have private health insurance because it means that we have some established practitioners in the private healthcare field who provide us with a base which could expand. Whilst there have been recent setbacks in establishing one or two of the joint ventures, it is important to press ahead with more joint development on hospital sites incorporating public and private elements. It would also be possible to have more joint developments between hospital managements in the NHS and other private sector businesses. Why not, for example, on one or two prime hospital sites, allow a hotel to be built nearby so that people could choose to live in private comfort. They would get access to their free NHS entitlement for surgery but would choose to take some of the strain off the NHS hotel services which they would otherwise be using. It should also be possible as more retail and service activity is brought into the hospitals under the excellent Clause 4 of the Health and Medicines Bill to attract private donation and funding for other purposes which would cheer the hospitals up and create a better impression for the patient and the visitor.

Conclusion

Having watched the Health Debate closely in recent months and talked to many people within the Health Service, I am persuaded that the existing policy of paying more money to run the existing system is not going to work and will not last us through this Parliament. A large number of health workers are now writing to me about waste and maladministration. There is a well-spring of resentment throughout the Service in the junior and middle ranks about the way in which the Service is mismanaged and maladministered.

The political trick is to unleash those forces from within the NHS at the same time as championing patient rights from without. The government can then develop a pincer movement upon the top administrators, managers and those bad consultants who are, between them, briefing the press and fuelling the opposition in Parliament with all the stories about the bad NHS let down by a mean government.

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would be complementary to the Clause 4 provision of the Health and Medicines Bill and to the evolving pattern of health insurance.

If you did wish to go the compulsory health insurance route, which in its turn would have an impact upon the direct labour organisation, I would recommend looking at a scheme based on SERPS. It would have compulsory national insurance similar in some ways to income tax but clearly identified with a rebate scheme for those who opted out. This would give you much more flexibility than tax relief in deciding how much revenue you wished to forego for those who have already made the decision to opt out of the State system.

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