SECRET 3 Mr ~~Gray~~ RA

But no copy of the speech.

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DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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Telephone 01-210 3000

From the Secretary of State for Social Services

N L Wicks Esq CBE
Principal Private Secretary
10 Downing Street
LONDON
SW1A 2AA

2 March 1988

Dear Nigel,

HEALTH INDICATORS

Further to our discussion this morning, I thought it might just be helpful for ease of reference if I recirculated my Secretary of State's paper and covering minute of 15 January to the Prime Minister on the NHS. Paragraph 29 of the paper set out my Secretary of State's position on health indicators. I am also enclosing a copy of my Secretary of State's reference to this question in the House during the NHS Debate on 19 January.

/at flap A9

I am copying this letter to Alex Alan.

yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

PRIME MINISTER

THE NHS

In his minute of 27 November Tony Newton said that I would be providing you early in the New Year with my assessment of the pressures on the health authorities. Your Private Secretary's minute of 23 December has since defined the ground which you wish to cover in this stock-taking.

2 The attached paper concentrates on the acute hospital service, because that is the heart of the problem. It briefly reviews our record since 1979 and suggests how we might build on what we have achieved. We must do this in ways which enable us to regain the initiative. I am convinced that the key is to advance the choice which the patient has over his or her access to health care. This requires more information in the hands of patients and alternative ways of paying for medical treatment. The eventual objective must be a mixed economy of care.

3 Much of the recent debate has been critical of the funding of the hospital service. But it has been helpful to us in opening up issues. I believe that options for change will now be considered by the public in a much more open and positive manner. My proposals have been framed in the light of the principles which were registered in your Private Secretary's minute. The focus should be on the improvement of the nation's health but the debate has been largely about the hospital services, which are predominantly concerned to cure illness and care for sick people. We must broaden it. We have a substantial programme for promoting health and preventing illness, and the primary care services are also vital because, among other things, they largely determine the flow in to and out of the hospital service. We have policies in place for improving the primary services, and I do not want to disrupt the very important linkage with the hospital service. But I am sure that we must sharpen people's perception of the cost of the hospital service and of the treatments it provides, and avoid the facile equation of the NHS with the acute hospital sector.

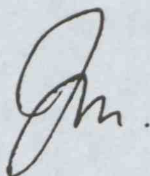
4 The Government need not provide for the full range of medical care itself. We shall nevertheless be expected to ensure that the complete range is available to all - your first principle. That implies choice (your second principle) both between the public and private sectors and between different public sector providers. As I have said, I want to encourage choice, but that means increasing the total resources devoted to health care, including the use of alternative methods of finance such as private insurance. A major decision for us is how far to concentrate on improving a closely managed, resource efficient, single provider system or to sharpen the competitive edge and expand the options for choice.

5 As the attached paper demonstrates, there are developed plans for securing greater efficiency and cost control in the public health service. There has already been much progress, and hospital unit costs compare well with those in the private sector. There is always scope for improvement but we must not lose sight of the quality of care. Lowering unit costs usually means increasing the speed with which cases are handled. This does not always help with the public perception of a caring service, and it can stimulate demand for hospital treatment so putting up total costs. This happens because when doctors see that more efficient services offer the possibility of better treatment to more people they bring forward their patients accordingly, and the hospital case load increases. From the staff's point of view they see that as they use resources more efficiently, treating more people in fewer beds, so total costs rise to the point at which activity levels have to be curtailed to bring the books back in to balance. This is a major element in our present difficulties with those who work in the Health Service; staff at all levels are losing confidence in the capacity of the hospitals to provide essential treatments. One way to ease this would be to ensure that the full product of the cost improvement programme goes back in to improving services, not in to pay.

6 If we wish to bring supply and reasonable expectations for health care more closely into balance it will be necessary either to provide more, which will inevitably mean increasing resources (though not necessarily from the Exchequer) or take measures to reduce expectations, which, however, reflect people's need for treatment. Initiatives could range from making knowledge of the costs of treatment more readily available to patients through to a degree of charging, perhaps backed by private insurance. The paper displays some radical options of considerable political sensitivity.

7 While we consider such major changes, some of which I put forward in my Conference speech, we must regain the initiative in the health debate. We need to establish a new agenda which will shift the focus away from inputs, of beds and wards and so on, towards better health, and that is why I am developing a strategy for health which will focus on longer term objectives and indicators to measure progress towards them. I believe we should now seek to develop a programme of announcements, and that we might wish to prepare some kind of discussion document, whether or not a Green Paper, for later in the year to provide a focus for a continuing debate which we might otherwise find it hard to control. Certainly we cannot afford a false, or half-hearted, start. I welcome the opportunity to discuss these issues with you.

8 I am copying this minute and its attachments to the Chancellor of the Exchequer and the Chief Secretary , and to Sir Robin Butler.



J M

15 January 1988

THE NHS - PROGRESS, PROSPECTS AND OPTIONS

NOTE BY THE SECRETARY OF STATE FOR SOCIAL SERVICES

Health care is nearly all funded and provided by the NHS. The NHS comprises three elements:

(1) the Hospital and Community Health Services (HCHS);

(2) the Family Practitioner Services;

(3) certain centrally funded services.

There is also a small private sector, most of whose activity is funded by patients who are covered by private insurance. In this paper I concentrate on the funding and management of the HCHS.

1. PROGRESS

We have improved the management of the hospital and community health services in many ways over the last six years, including:-

(1) the structure was streamlined by abolition of Area Health Authorities in 1982;

(2) general management was successfully introduced following the Griffiths report;

(3) manpower was brought under firm control so that, for the first time since 1948, NHS employment has been falling while activity continued to rise;

(4) all health authorities have been made subject to annual accountability review;

(5) the cost improvement programme was launched, with cash savings since 1984 totalling £1.3 billion. It includes the successful introduction of competitive tendering into hospital support services;

(6) much better management information is now being collected, in the form both of Performance Indicators and of data on activity and manpower.

2. As a result of these and other factors the NHS has greatly improved its efficiency.

3. Between 1978-79 and 1986-87 spending on the HCHS rose by 136% in cash terms, and by 21% in real terms (using the GDP deflator). Because NHS costs (notably labour costs which account for 75% of total expenditure) rose more quickly than general inflation, the increase in "purchasing power" over the period was only 6%, an average of 0.7% per annum. Most of that was concentrated in the earlier part of the period. Between 1982-83 and 1986-87 the increase in purchasing power of health revenue was 0.6%, that is 0.1% per annum. The difference between this figure and the 21% increase in real terms helps to explain the different perceptions of the financial position of the NHS. Health authorities' "purchasing power" has of course been supplemented by cost improvements. Taking them into account the extra spending power over the period is 10.1% (1.2% pa) and from 1982-83 has been at an annual rate of 1.1%.

4. Activity over the period has risen more quickly than this. Between 1978 and 1986 activity levels rose by over 20% (inpatient cases up 1 million (19%); outpatient cases up 3¾ million (11%); day cases up almost ½ million (87%). Costs per case over the whole period have fallen by 16% measured against HCHS inflation, and since 1982-83 they have been falling also relative to general inflation. Unit costs compare favourably with those in the private health sector.

5. The main elements of improving efficiency are as follows:

(a) Better use of hospital beds and other clinical facilities. Throughput per bed has risen from 14.5 in 1978 to 20.3 in 1986 (up 36 per cent). This reflects closure of inefficient or wrongly sited hospitals, shorter length of stay and better management. In addition, as noted above, there has been a dramatic increase in the use of day care (up 87 per cent). There has been a marked reduction in the variation between Regions in throughput per bed and in use of day care.

(b) Better use of staff. Health care is labour intensive. Since 1983, for the first time ever, NHS employment has fallen while activity levels have risen. The fall has mostly occurred in non-clinical staff. On the clinical side, medical and nursing staff have however grown less fast than overall activity levels.

(c) More efficient support services. Support services such as catering, cleaning, laundry, portering, works and supplies have been the main contributors to the cost improvement programme. Competitive tendering has been very successful, not least by sharpening up the efficiency of the NHS's own staff, and has contributed over £100 million a year in savings. It is important to ensure that standards are maintained.

6. There is little objective data on what has happened to quality of care since 1978 - this is any case extremely difficult to measure. In some areas of the country and in some areas of medicine there have been notable improvements, but there is no doubt that in others standards are a matter for concern. Unfortunately the increases in activity have not sufficed to make any significant impact on waiting lists or times.

2. THE PROBLEM

7. It is notable that, after allowing for inflation in the HCHS, costs per case have fallen significantly. But this improved efficiency and rising activity has not been enough to satisfy the public's reasonable expectations. The main factors fuelling the rising burden of health care are the increasing numbers of elderly patients; the increasing ability of doctors to treat illness in the elderly; and medical progress generally.

8. It is a paradox of the HCHS, which causes more frustration than any other factor, that rising efficiency provides opportunities to treat more patients and so incur additional costs. As staff work more efficiently, they reduce costs per case. The surplus capacity is then used to treat more patients but each case incurs marginal costs. Alternatively the surplus capacity can be eliminated by closing beds and reducing staff - perceived as a 'cut'. Unlike a business NHS hospitals cannot increase their funding by increasing output.

9. It is evident that there is a need to ensure that more medical care is available for the public. The issue is how that can best be done. Part 3 of this paper explores how the present system can and should be developed to work more efficiently and effectively. Such measures will however need to be supplemented by policy changes that would both enable more resources to be brought to bear on health care, and help to meet other policy objectives such as greater choice and competition. The options are dealt with in Part 4 of this paper.

3. SCOPE FOR FURTHER IMPROVEMENTS WITHIN THE EXISTING FRAMEWORK.

10. The following paragraphs pick out the main initiatives which will contribute to raising efficiency further within the existing legislative and organisational framework.

11. The cost improvement programme will be maintained and developed. We should emphasise both the scale of the achievement so far and the need to sustain NHS management's commitment to achieving a good level of savings in future. Cash savings have totalled £1.3 billion since 1984; further they will amount to £600 million in 1987/88 compared with the 1984 base and are growing at an annual rate of £150 million. In addition, productivity savings have enabled the service to absorb a significant proportion of the growing demand which would otherwise require additional annual funding of about £400 million. On the second point it will be necessary to widen and strengthen the cost improvement programme in order to maintain a good level of savings in future. A Value For Money unit has been set up and this will be strengthened in 1988. Increasingly savings will be needed in clinical areas.

12. The resource management initiative will be crucial to achieving improved value for money and to providing a basis for establishing what given levels and mixes of care do and should cost. Under this initiative, doctors and other professionals are given detailed information on output and costs and are required to become responsible for managing the relevant resources. On the acute side, the programme involves five hospitals in different parts of the country. The new information systems and management arrangements will become fully implemented during 1988 at three of these sites and during 1989 at the

two other sites. Assuming general acceptance, they will provide information and management models for implementation at all acute sites between 1989 and 1992. A fuller note on the initiative is set out in Annex 1.

13. The income generation initiative is expected to increase health authorities' income by about £20m in 1988/9, rising to £70m in three years. Ideas range from leasing space in hospitals to retailers, through car parking charges, to better exploitation of NHS technological know-how. The NHS Management Board is setting up a unit to lead this initiative in the NHS.

14. Already dramatic results have been achieved through rationalising the NHS estate (receipts from sales of surplus land up from £9.9m in 1979 to over £200m this year). This initiative (which is now funding 20% of the hospital building programme) will be maintained and strengthened.

15. Better planning, monitoring and information systems will play their part. In 1988 Health Authorities will be given a stronger lead on the priorities they are to adopt for the development and management of services. In the annual review process in 1988 much more emphasis will be put on requiring Health Authorities to explain discrepancies in their performance, not only against their agreed plan, but also against the performance of comparable Authorities across the country. (A note on variations in performance is at Annex 2). New data flows, replacing those which had been haphazardly built up since 1948, will in 1988 allow quarterly reports on, and examination of, the number of patients treated, Authority by Authority across the country. Combined with the existing quarterly counts of hospital manpower, and the newly introduced monitoring of income and expenditure, this will enable monitoring of major aspects of NHS performance more rapidly and in greater detail than in the past.

16. The greater use of the private sector, of all sorts, will be strongly encouraged. The predominant mentality, in the past, was that the NHS provided nearly all its services in-house. That is now changing, especially as a result of the competitive tendering initiative, and the NHS now buys significant amounts of services from the private sector, mostly in support services such as cleaning and maintenance. We shall build on this by launching a major initiative in 1988 to encourage the NHS to use private

sources of services wherever it is cost effective to do so. This will clearly depend on local circumstances including the availability of private sector capacity and comparative costs.

17. Within the NHS, health authorities are not self-contained and NHS patients flow freely across NHS boundaries to receive treatment where the appropriate facilities are found. But these flows arise from clinical or patient choice, not from the operation of market forces. The institution of a true market - with health authorities buying all the services needed for their residents which they did not provide themselves, and paying for all the services their residents received from other health-care providers - is a radical option dealt with in Part 4 below. In the meantime, efforts will be directed towards:-

(a) producing better information about costs so that comparative efficiency can be examined (this will be an important product of resource management programme, para 12 above);

(b) encouraging the striking of individual trading agreements between authorities (eg for Authority A to treat defined numbers of patients from Authority B, on repayment) in order to encourage a "trading culture".

Much tauter management accounting systems are both a prerequisite of and a lead-in to this.

18. There is also the crucial question of manpower. Even with maximum use of new technology the NHS will remain labour intensive. Securing the most economical and effective use of staff is critical to obtaining maximum productivity from the system as a whole. It is also critical to continued provision of an adequate service, given the considerable contraction during the 1990s in the NHS's traditional sources of recruitment of professional staff. Competition for scarce skills is likely to mean higher pay - an effect already being seen for nurses both here and abroad. This will reinforce the need for economical use of staff, including increased devolution to cheaper non-professional staff. These changes will have to be achieved in a positive

way, designed to restore and sustain morale and to help us retain and re-attract staff. We are already working on these lines, but much more will need to be done especially on the public presentation of our aims.

19. Our efforts to improve the service vitally depend on the way in which medical staff behave, and on our ability to deploy them where they are most needed. We need in my view to pursue a major review of the contractual terms on which consultants are employed in the NHS, to increase their accountability and the effectiveness of their deployment and the part which they play in the management of available resources, and to provide a better deal for patients. We need to ensure that they make a positive contribution to our policies for reform. The time is right and we have a strong hand. I propose to start discussions as soon as possible.

20. I also wish to increase the power of patients as consumers. Within the existing financial framework the scope for doing this is limited, as hospitals are not rewarded for attracting patients (indeed, in a financial sense, they are penalised). Within the present framework, therefore, the main thrust must be the provision of better information to patients about the availability of services (already in hand so far as waiting lists are concerned) and on management action to improve "customer service" within hospitals. But it is impossible to get away from the fact that at present the public is reliant on a monopolistic system, with enormous power in the hands of the health care professions.

4. BEYOND THE PRESENT FRAME

21. The limitations of the present framework are fourfold:

first, there is no price mechanism for bridging the gap between supply and the public's reasonable expectations. In consequence, there has to be a political judgment about how far public resources should bridge the gap.

second, whilst the state remains the totally dominant provider of health care and the dominant source of health care funds, we shall not be able to develop the competition and consumer choice that our 'mixed economy' has provided in other fields.

<u>third</u>, the Government - and NHS management more generally - are under constant pressure to concentrate on day to day management matters rather than on long term health objectives. The horizons of political and social debate are limited in the same way.

<u>fourth</u>, there is only very limited scope for developing the power of patients as consumers. The public have only a 'cliff-edge' choice between the NHS and private health care. Within the NHS there is very little choice, whether or not the patient is able and willing to buy additional or better services.

22. Our starting point must be a recognition that the critical issue is our approach to the financing of health care. This section therefore concentrates on how best to overcome the limitations of the present framework and to achieve our objectives by substantially supplementing or replacing the present basis of health care finance. (The extent to which we might also help to achieve our objectives through altering the present structure for allocating health care resources is explored in Annex 3.)

23. There are two main options - to provide additional sources of funding or to replace or substantially reconstruct the present method of public funding. Additional funding could be obtained from:

<u>charges</u>. The scope of existing charges and exemptions could be altered or new charges could be introduced. Charges representing a proportion of costs could be made for both visits to a General Practitioner and to hospital. Such charges would have to be related to the ability to pay, so a system of rebates or exemptions would be needed. Charges have a number of advantages. Besides raising revenue they would bring home the cost of treatment and discourage unreasonable demands on the health service. They are a practical proposition but would clearly be politically controversial - particularly for visits to the General Practitioner.

<u>private sector provision</u>. The main element here is private health insurance, a major source of health care finance in the US. As matters now stand, any significant expansion of private health care would need a

fiscal incentive. This could be provided for example through tax relief. There would be a 'deadweight' cost to any incentive in respect of those already using private health care.

24. The second main option is to augment the current system of tax based finance by additional funds from the national insurance scheme or replace it by a social insurance scheme on the European model. The European model, which is dealt with in the annexes, would be difficult to harmonise with the way we finance and organise health care. I believe we should concentrate on the national insurance scheme. At present only a small proportion of NI contributions go towards financing the NHS. (In 1988-89, about 11% of contribution income or £3.3bn is expected to go to the NHS.) We could build on these arrangements by making a more specific link with, for example, the hospital service, taking the example further, if the cost of the hospital service were met by NI contributions this could then be shown as a separate "hospital service" contribution on pay slips. This in turn would help to bring home the actual costs of health care. I appreciate that, buoyant though the revenues of the NI fund are, any proposal to direct more (and increased) contribution income to the NHS has major implications for public expenditure, taxable capacity and the distribution of incomes, which I would need to consider with Treasury Ministers. But we would be able to turn a very important corner if we could bring clearly out into the open the costs of the hospital service by financing them in this direct way.

25. Annex 4 examines the financing of health care in more detail. More information about health care models is given in Annex 5. Annex 6 provides information about health care in the US, Canada, France, West Germany and Sweden.

PRESENTATION

26. Public acceptance of an approach based on a mix of initiatives drawn from the possibilities (some of them already under way) in paras 12-25 above will no doubt be stimulated by the breadth of the current debate. But there are three messages which must in particular be carried through to the public.

27. First, the NHS is not without cost to individual citizens. We might advance towards this by presenting costed accounts (not for payment) of treatment given in hospital, at least where major courses of treatment are concerned. This would prepare the ground for an element of charging.

28. Second, the popular equation of the NHS with the acute hospital sector must be broken. The public needs to be made aware of the cost of the hospital service, for example by increasing the national insurance charge and linking the cost to that, and by directly charging the patient with the cost of primary care (if the politics of that are acceptable).

29. Third, and in my view most importantly, we must change the terms of the health debate. I have in hand proposals for a major new initiative - the strategy for health - designed to set a new agenda for health. The terms of the debate are currently dominated by inputs, like cash, with little understanding of their relative impact or outcome in health quality terms. The absence of such output or outcome criteria also ensures that the debate is focussed on issues like beds and waiting lists, which though easy to use emotively are not necessarily germane to the real health issue. The aim is to produce a policy statement which focuses on longer term objectives for public health, not day to day issues of health care delivery. It would set the direction of health care policies for the whole health field - not just the hospital service - for the rest of this century and beyond. An integral part of this strategy is the development of a portfolio of agreed and affordable indicators of good health, which would be used to set long term goals. These indicators would provide a much better measure for the public and for the Government of the overall benefits provided by the NHS. They would also take full account of the greater acceptance of the importance of personal behaviour in underpinning good health.

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Motion to approve order—[Mr. Lang]—o

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Debate on motion for Adjournment

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Oral Answers to Questions [Col. 803]
Secretary of State for Education and Scie
Prime Minister

Underground Fires (Research and Control) a
Motion for leave to introduce Bill—[Mr.
Bill presented, and read the First time

Opposition Day [7th Allotted Day] [Col. 824
National Health Service [Col. 824]
Motion—[Mr. Robin Cook]—on a Divisi
Amendment—[Mr. Moore]—agreed to
Motion, as amended, agreed to

Written Answers to Questions [Col. 529]

[Mr. Moore]

powers contained in the Health and Medicines Bill which is now being discussed in Committee. Those are not insignificant amounts of money. At least £70 million a year could be generated and my Department will shortly set up a special unit to encourage and help health authorities to pursue this initiative.

Thirdly, I want to encourage health authorities to use — this is critical and I know that many of my hon. Friends share our view — spare capacity in other authorities whenever it is sensible and cost-effective to do so. That is already happening in part under the waiting list initiative. I want to encourage it, to improve the accounting information systems and to give patients a better knowledge of the system through giving better information to general practitioners.

Mr. Barron *rose*——

Mr. Moore: I have given way frequently and I think that it would assist the House if I were to move forward.

Fourthly — this is important — I want to seek to increase the total resources going into health care by encouraging further co-operation with the private sector. I shall not allow narow-minded dogma to stop resources being used for patient care. One of the great weaknesses of Britain's Health Service is the small contribution made by the private sector compared with that in other countries.

Mr. Barron *rose*——

Mr. Moore: In France, 2·7 per cent. of GDP goes into health care from the private sector; in Germany, 1·8 per cent.; in Canada 2·1 per cent. and in Holland 1·9 per cent., compared with only 0·5 per cent. in the United Kingdom. There is a clear gap there. We must seek to encourage such contributions.

Mr. Barron *rose*——

Mr. Moore: Fifthly, we shall improve the primary care services. The hon. Member for Livingston has recognised the major increases in real resources in those in the past eight years. They are critical to our acute care hospital service because they are the gateway to the expensive hospital sector. The announcements in our White Paper about the way in which we are seeking to amend general practitioners' terms of service to clarify their role in the provision of health promotion services and the prevention of ill health are critical. Equally, we want to introduce a range of incentives through general practitioners' pay to encourage them to carry out specific activities such as attaining target levels of vaccination and screening. That has been welcomed by most hon. Members.

Sixthly — this is also important and surrounds the debate outside as well as inside the House—I want us to focus much more on the overall objective of our health care policies. Our aim is clear — better health for the nation. So much of today's debate has been trapped on inputs—money, staff and beds. I accept that those are important, but we look too little at the outcome or the outputs. We need better indicators and targets to help us to judge good health against which we can judge our inputs and objectives.

Dr. David Owen (Plymouth, Devonport): I, like other hon. Members, have listened for a sign of any new policy or hope. Will the Secretary of State at least say that, if the

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