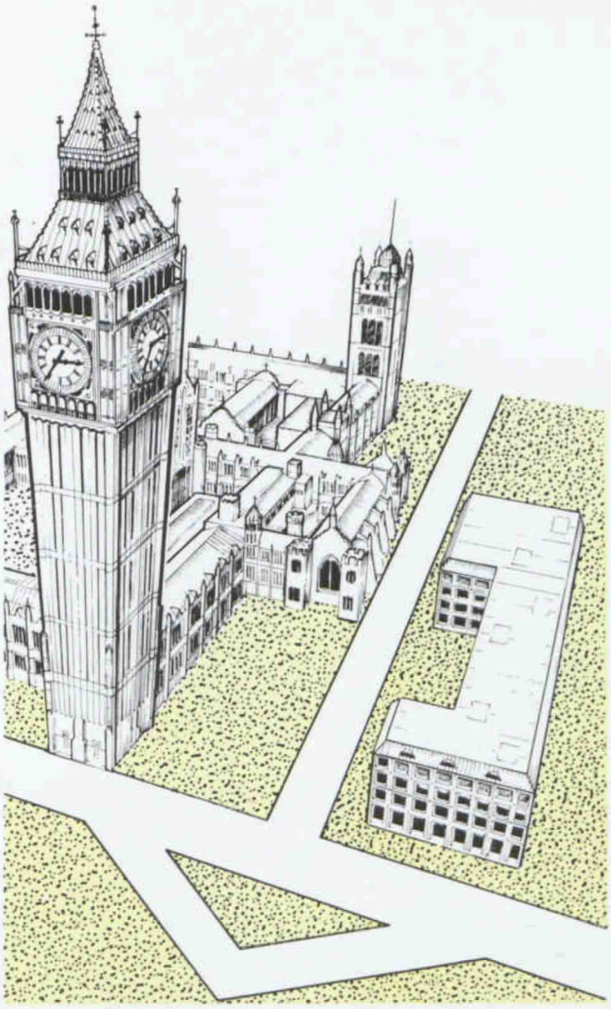

THE NATION'S HEALTH

-A way forward

NAHA'S EVIDENCE TO
THE PRIME MINISTER'S REVIEW OF THE NHS 1988

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NAHA'S EVIDENCE TO THE PRIME MINISTER'S

REVIEW OF THE NHS

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THE NATION'S HEALTH

- A WAY FORWARD

CONTENTS

KEY POINTS

(i) In this paper, the Association gives a wide-ranging assessment of the achievements and performance of the NHS.

In particular, it stresses that:

* The provision of equal access to health care irrespective of means, free at the point of delivery, has relieved people from worry about the personal costs of being ill.

* The effectiveness of the NHS planning system has avoided wasteful duplication of facilities.

* Polls show a high degree of satisfaction amongst those who have either received treatment recently or have had a close member of their family receive treatment.

* In the 1980s the NHS has increased the number of in-patients, out-patients and day cases treated, as well as developing community care, achieving substantial savings and introducing general management.

GOOD FOUNDATIONS MUST NOT BE UNDERMINED

(ii) Whilst acknowledging that the NHS is facing several difficult challenges, the Association argues that they do not amount to a justification for undermining the good foundations which have been laid by the NHS over the last forty years. These challenges do, however provide an exciting agenda for the NHS in improving the nation's health in the years leading up to the end of the century.

NO ADVANTAGE IN SWITCHING TO ANOTHER FUNDING SYSTEM

(iii) NAHA believes that, measured against objective criteria, there is very little advantage in moving to an alternative to the current system of funding. However, in arguing for the continuation of general taxation as the primary source of funding, the Association also believes it to be essential that:

* the NHS is allocated sufficient funds to meet inflation and legitimate patient demand and other agreed developments; this amounts to some 2% real growth in funding per year;

* there should be sufficient buoyancy to provide incentives for efficient health authorities.

ACTION ON 'EFFICIENCY' INCENTIVES

(iv) NAHA has called for the rectification of what it calls 'perverse incentives' to greater efficiency. It draws attention to the fact that, by an efficient use of resources health authorities have reduced the average costs per case - by treating more patients in fewer beds - yet have increased total expenditure by overall expansion of services. Cash limiting of budgets then penalises those who have improved their performance in this way.

OTHER FACTORS

(v) Among the other factors NAHA has highlighted:

* the need to reverse the recent abolition of the facility by which health authorities can carry over a proportion of their budgets from one year to the next;

* the possibility of a system under which a pre-set, percentage bonus could be given to districts over-achieving agreed activity levels within agreed budgets;

* the desirability of trials of 'internal markets' to work out problems before the concept is widely adopted within the NHS.

THE ROLE OF THE PRIVATE SECTOR

(vi) Any expansion of the private sector will, the Association believes, have consequences for the NHS. It could, for example:

* increase NHS costs by introducing competition for the recruitment of doctors, nurses and other professions;

* exacerbate the nurse shortage problem already being experienced by the NHS;

* lead to the NHS becoming a 'second class service' as a result of the private sector taking on much more of the acute health care.

(vii) In view of these potential problems the Association believes that it will be very important to ensure that an expansion of the private sector does not lead to a lowering of standards of provision in the NHS.

THE ROLE OF TEACHING AND RESEARCH

(viii) The Association believes the NHS crucially depends for the quality of its care on the high standards and excellence of basic and clinical research and training.

Therefore NAHA call for:

* reversal of the increasing reliance by universities on 'soft money' for academic medical posts, following the reductions in UGC grants;

* formal compensation by the private sector for the benefits it receives from the teaching and research activities carried out in the NHS.

AN NHS FOR THE 1990's

(ix) NAHA sees the necessity for organisational and attitudinal changes if the NHS is to cope with the challenges it faces ahead in the 1990's. It sets out a number of ideas in the paper.

CONTRACTS WITH THE CUSTOMERS

(x) Such a contract between a DHA and the users of its services would specify:

* the kind of service people could expect;

* the maximum periods people could expect to wait for treatment for a particular condition, either within the district or in a private hospital or another district depending on agreements reached through an internal market trading mechanism.

NATIONAL HEALTH ACCREDITATION AGENCY

(xi) This would assess the standard of service being provided by DHAs and might follow the model of the Joint Commission on the Accreditation of Hospitals in the United States, which sets standards for:

* medical staff organisation and functioning;
* nursing;
* anaesthesia;
* out-patients;
* medical records;
* laboratories;
* physical plant design, structure and functioning;
* quality assurance;
* outcome measurements.

THE DISTRICT HEALTH AUTHORITY

(xii) DHAs, as the 'pivotal tier' of NHS management, will need to ensure that clinicans are brought into the mainstream of resource management. A number of other important steps should be taken:

* consultants to be employed by DHAs;

* district general managers to take part in the interview and appointment of consultants in order to assess managerial performance;

* consultants to undergo peer-group reviews of clinical performance.

LOCAL PAY DETERMINATION

(xiii) The present centralised system of pay determination is largely outdated and should be replaced by a much more flexible one. The problem of 'leapfrogging' is exaggerated - the regional review system and cash limits will provide sufficient controls.

PRIMARY CARE SERVICES

(xiv) The division of responsibility between FPCs and health authorities is illogical. All primary health care services should be brought within the jurisdication of DHAs.

(xv) GPs should be brought more into the managerial and planning process. New contracts should be drawn up which set the objectives of a practice for a specified term and detail the obligations of both sides to that contract.

NHS MANAGEMENT AGENCY

(xvi) A radical shake up is needed at the centre. Looking back at the NHS over the last 40 years, NAHA concludes that the relationship between Ministers and their agents - the health authorities - has been one of confusion with too much interference and wasteful energy devoted to bureaucratic procedures governing that relationship. This has, in turn, undermined the confidence of local managers to be dynamic, thrusting and entrepreneurial.

(xvii) Establishing the NHS Management Board as an agency outside the structure of the DHSS would provide enormous benefits in improved management, effectiveness and efficiency, and in producing the permanent and easily identifiable leadership which the Service at present lacks.

(xviii) Such an agency would contract with health authorities for districts to deliver on a number of key policy objectives - a contrast to the present situation in which health authorities face an enormous number of competing health policy priorities.

Section I

AN ASSESSMENT OF THE NHS

1. It would be wrong and misleading to allow the present financial crisis and uncertainty facing the NHS to understate the achievements of the Service. During the lifetime of the NHS, there have been significant improvements in the health of the population. The provision of equal access to health care irrespective of means, free at the point of delivery, has relieved people from worry about the personal costs of being ill. The effectiveness of the NHS planning system has avoided wasteful duplication of facilities and the comprehensiveness of the service covering long-term ill, elderly, people with mental illness and people with mental handicap, as well as acute care, are notable features.

2. A particular strength of the NHS is the primary care system dealing as it does with 90% of medical episodes. General Practitioners effectively act as 'gatekeepers', ensuring that patients do not enter the more expensive hospital system unnecessarily and they provide a very good level of health care in conjunction with the community health services.

3. The standing of British medicine is high and the NHS has been able to provide comprehensive district services whilst maintaining high quality teaching and research. This has been achieved despite the relatively low level of resources devoted to the NHS as compared to health care systems in other countries, thus testifying to its efficiency and tight cost control.

4. The NHS is an extremely popular institution. Opinion polls in the last few months have confirmed the findings of previous polls conducted by Marplan for NAHA and the Health Services Journal. These show a high degree of satisfaction amongst those who have either received treatment recently or who have had a close member of their family receive treatment. The bond of loyalty

which exists between the NHS and its staff and customers is one not to be lightly tossed aside.

RECENT ACHIEVEMENTS

5. In the 1980s, the NHS has a number of achievements to its credit including the following:

* In terms of hospital services, between 1980 and 1986, in-patients cases increased by 17%, day cases increased by 57%, regular day attendances increased by 15% and out-patient cases increased by 7%.

* Both the community based services and the hospital sector have responded to the significant increase in the proportion of elderly people in the population.

* The imbalance in resources between regional health authorities has been substantially redressed.

* Large savings on revenue budgets have been generated by health authorities and capital expenditure has been enhanced through sales of land and buildings no longer required by the Service.

* In collaboration with local authorities and voluntary agencies, health authorities have worked to expand the provision of care within the community rather than in large unsuitable institutional settings.

* General management has been introduced and this has led to a much more efficient management system.

* Management costs have been rigorously controlled and as a percentage of revenue expenditure are now down to below 4.5%.

ISSUES TO BE TACKLED

6. The Association is not, however, complacent. There are a number of problems and important issues, set out below, which need to be tackled:

i) The present system of funding is outside the control of the NHS and is determined by competing national political priorities rather than by the legitimate requirements of the service. Thus health authorities are now having to restrict the level of work they can do.

ii) Within the NHS, there is a very definite feeling of frustration, along with loss of confidence, over the ability of the service to match reasonable public expectations. Furthermore, in addition to the service pressures which are being recognised (eg through lengthy waiting lists) and in many cases inadequately met, there is evidence of further unmet needs in the community.

iii) The relationship between government and health authorities is unsatisfactory. Too many bureaucratic controls, financial restrictions and unfocussed priorities have served to undermine the confidence and ability of health authorities to act in a dynamic, innovative and effective way.

iv) The present system of allocating resources to health authorities from the Government is not sufficiently related to the relative effectiveness and efficiency of each authority.

v) The NHS needs to become more responsive to patients' needs and feelings and to provide a greater element of choice. At the same time, medical peer group review along with general standard setting and monitoring of the quality of services needs greater emphasis and development.

vi) Performance in both clinical (including waiting lists) and non-clinical areas is variable between health authorities and this cannot always be explained satisfactorily by local conditions and circumstances.

vii) Financial and other information systems need further development in order that the fullest information can be made available to clinicians and managers to help them make effective decisions.

viii) Health authorities need greater freedom to negotiate on pay and conditions with their staff in order to compete in local labour markets.

ix) Improvements in health care are likely to depend considerably on changes in personal behaviour and in the social and economic environment. The NHS needs to give greater emphasis to the promotion of health, the prevention of disease and co-operation with other sectors to improve the general environment.

7. These issues which we have identified do not amount to a justification for undermining the good foundations which have been laid by the NHS over the last forty years. They do, however, provide an exciting agenda for the NHS in improving the nation's health in the years leading up to the end of the century.

Section II

THE NHS IN CRISIS?

8. One of the major causes of stress and serious concern facing the NHS centres around the Service's financial state. It is clear that - for health authorities - this issue has not been unexpected: the funding 'crisis' has been building up over a number of years. Whilst the NHS has benefitted from a relatively high rate of increase in expenditure in comparison with many areas of the public sector, a number of growing pressures on this expenditure can be identified.

INFLATION

9. When set against the rises in pay and prices experienced by the hospital and community health services (HCHS), the 49% cash increase between 1980/81 and 1986/87 falls to a real rise of just 3.2%, or just over one half of one percent per year. The table overleaf shows how the level of expenditure in cash and real terms has changed from year to year.

10. The difference in expenditure changes between the cash-limited hospital and community health services and the largely demand led family practitioner services (FPS) is quite marked. Indeed, had the 80% cash growth experienced by the FPS applied to the HCHS then HCHS cash limits would have been £12,598m in 1986/87 - 20% more than it actually received.

11. In recent years, the underfunding by the Government of pay awards has had serious effects on the careful and finely balanced financial planning undertaken by health authorities. Government underestimates of the pay inflation element of authorities' cash limits has reduced the effects that cash-releasing cost improvements have had on service development. NAHA's Autumn 1987 financial survey of health authorities revealed that the full year

costs of the 1986 pay awards in 1987/8 plus the 1987/8 awards resulted in a shortfall of about 1.21% of the total revenue cash limit for 1987/8. This is almost exactly the amount that new cash-relating cost improvements programmes are estimated to realise in 1987/8.

Table: Resources available to the NHS 1980/81 to 1987/88

ENGLAND	1980/81	1981/82	1982/83	1983/84	1984/85	1985/86	1986/87	1987/88 Estimates)
HCHS Current								
Total Spending (£m)	6,999	7,720	8,284	8,709	9,205	9,699	10,421	11,427 b
Cash Increase (%)	-	10.3	7.3	5.1	5.7	5.4	7.4	9.7
Inflation Rate (%)	-	8.2	6.5	5.1	5.8	5.2	6.9	8.3 a
Purchasing Power (%)	-	2.0	0.8	0.0	- 0.1	0.2	0.5	1.4
FPS Current								
Total Spending (£m)	2,173	2,504	2,894	3,110	3,419	3,600	3,908	4,269
Cash Increase (%)	-	15.2	15.6	7.5	9.9	5.3	8.5	9.2
Inflation Rate (%)	-	12.9	11.6	5.4	6.9	6.1	6.0	7.2 c
Purchasing Power (%)	-	2.0	3.6	2.0	2.8	- 0.7	2.4	2.0
NHS Total								
Total Spending (£m)	9,971	11,182	12,195	12,919	13,870	14,675	15,811	17,208
Cash Increase (%)	-	12.1	9.1	5.9	7.4	5.8	7.7	8.8
Inflation Rate (%)	-	9.0	7.4	5.0	5.9	5.4	6.5	7.7 c
Purchasing Power (%)	-	2.9	1.5	0.9	1.3	0.3	1.1	1.1

Note: the figures for NHS total spending include both capital and central health and miscellaneous service expenditure, therefore these figures will not equal the sum of HCHS and FPS expenditure.

(a) Estimated (b) Public Expenditure White Paper Allocation plus £75m; less £30m transfer to capital
(c) NAHA estimates

Source: Social Services Committee, session 1985/86 Public Expenditure on the Social Services HC 387 and DHSS memorandum to Social Services Committee, session 1986/7 Public Expenditure on the Social Services HC 413.

DEMAND

12. Although the cumulative real increase in resources between 1980/81 - 1986/87 for the NHS as a whole (+8%) and its two components, the HCHS (+3.2%) and the FPS (+12.7%), suggest that the Service had room for expansion and/or improvement in service quality, these resource rises should be compared with the change in demand placed upon the NHS. These particular pressures on resources have been identified by NAHA and others as follows:

* Demography
* Medical Technology
* Government Policies/Priorities

13. The table below shows the estimated percentage increases in funding over and above inflation - required to respond to these pressures.

Table: Demand pressures on HCHS: 1980/81 - 1987/88

%	1980/81	1981/82	1982/83	1983/84	1984/85	1985/86	1986/87	1987/88
Demography 1	1.1	0.4	0.4	0.5	0.6	1.3	1.0	1.0
Medical Technology 2	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Policies/Priorities2	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Total	2.1	1.4	1.4	1.5	1.6	2.3	2.0	2.0

1 Source: King's Fund Institutes Briefing Paper 4 1988
2 'Best Guess' Estimates

14. In no year, from 1980 onwards, were the real increases in HCHS expenditure high enough to cover the combined effects of a population which is growing older, of medical advances increasing the range of conditions that can be treated as well as the need to fulfil important central government policies.

15. As the figures used here are national averages, it must be remembered that they can disguise considerable variations between authorities. The growth in the elderly population is not uniform across the country

nor are advances in medical technology immediately available to all health authorities. Together with the effects of RAWP at a time of virtually static increases in real resources, these differences have lead to differing experiences of the past six years' financial situation. For those authorities 'over target' the combination of increased health care demands together with a budget falling in real terms has produced exceptional difficulties and serious implications for existing services, let alone new developments.

16. If health authorities had been fully funded for inflation and had been allocated a 2% development addition per year, the NHS would not be in its current financial crisis. There is, therefore, very little evidence that the current method of funding the health service is in some way fatally flawed and that the NHS as a whole is in need of a complete change, for example along the lines of the US system of health care. This conclusion is lent credence by the experience of other western countries operating largely private and/or insurance based health care services. Additional expenditure on health care within these types of systems has not automatically secured a proportionate level of improved health care, although waiting lists are less of a problem.

17. For example, the USA spends about twice as much on health care as the U.K. Yet its state of health is not significantly better. It fails to provide adequate health care to some of the most needy people in US society, although it isarguably over-provided with hospitals and has levels of medical staffing and sophistication in medical equipment which far outreach those in the UK. In West Germany, where higher proportion of GDP is spent on health care, there is great concern about expenditure rising out of control. In fact experience in the USA, West Germany and in other countries suggests that extra spending by society on these other systems of health care sometimes results in a disproportionate rise in the income of health care providers, or in the provision of underused or inefficient facilities and services.

18. The experience of other western countries in providing health care does not suggest that a perfect model exists which can simply be taken off the shelf and applied to

the UK. Unquestionably extra funding for health is required, and the NHS has a sufficient track record to suggest that it is the most appropriate vehicle for ensuring that it is spent effectively; provides value for money and can be successfully integrated into an overall strategy for improving the nation's health.

Section III

FUTURE FUNDING/PROVISION OPTIONS

19. NAHA believes that one principle should be cardinal: a high standard of health care should continue to be available to all, free at the point of delivery. This has been a tenet of the NHS since its formation and is a major factor in the continued public esteem in which the NHS is held. In addition to this, any future options for funding need to be judged against the following criteria:-

* Total Resources:	Generate sufficient resources to meet public expectations on services.
* Effectiveness:	Produce positive benefits in terms of improving the health of the nation.
* Efficiency:	Provide health care in an efficient way.
* Consumer Choice:	Be responsive to the needs of patients in their role as consumers of health care; respecting their dignity, personal freedom (including GP advice and referral functions) and choice.
* Economy:	Minimise administrative and clerical bureaucracy.
* Geographical Equity:	Ensure equality of access and care in different parts of the country.

* Equity of Medical and Social Need:	Ensure comprehensive and good quality care to people with a mental and/or physical handicap, people who are old and other groups at special risk or socially deprived.
* Equity between Generations:	Ensure proper and adequate care for the old and the young.
* Financial Equity:	Provide care and treatment unrelated to a person's ability to pay.
* Community and Family Practitioner Services:	Ensure a close relationship between the hospital services and primary health services.
* Teaching and Research:	Ensure that the long-term requirements for a well-trained medical workforce, together with appropriate and high quality research facilities and opportunities, are maintained.
* Public Commitment:	Ensure that it is held in high esteem by the public.
* NHS Morale:	Ensure that the morale of staff is high.
* Health Promotion:	Provide comprehensive health promotion services to the entire population.

20. In addition to these criteria, the recommendations of the recent Acheson Inquiry into public health raises important issues with respect to the vital role any health care system must play in terms of:

* Population medicine (ie epidemiological studies, health monitoring/target setting);

* Prevention, health surveillance and control of communicable disease and infection;

* Inter-authority and inter-agency co-operation on health promotion.

21. Furthermore, the need to pursue the World Health Organisation's goals of Health for All by the Year 2000, and in particular the 38 regional targets adopted by the member states of the European region of WHO, must be recognised.

THE ALTERNATIVES

PRIMARY SOURCES OF FUNDING

22. Three major alternatives for raising funds are considered below. Many variations on these alternatives have been put forward but in essence they tend to fall in one of three categories: an earmarked national health tax; a social insurance scheme; private health insurance.

Earmarked National Health Tax

23. Increases in income tax rates, or taxes such as VAT or National Insurance could be 'earmarked' for the exclusive use of the NHS. For example, a very substantial increase in VAT (presumably roughly matched by some reduction in income tax) might cover the cost of the NHS together with

providing some margin for NHS growth and a linking with both inflation and general growth in the economy. NHS funding from taxation would thereby be protected from the competition for funds from other Government departments.

24. However, the earmarking of taxes for specific uses runs contrary to British political traditions because it removes public spending decisions from the arena of Government and Parliament. It is unlikely that any Government would guarantee funding for the NHS from an earmarked tax without intervening to set the tax to produce a particular level of total funding which, in the Government's judgement, the NHS should receive. Therefore if an earmarked tax was introduced for NHS funding the rate applied would probably be a matter for annual political review. Moreover few, if any, forms of earmarked tax could produce a predictable level of income. For example, a tax set as a particular percentage of VAT would yield an income variable plus or minus some million pounds depending on the performance of the economy in a particular year; this could destabilise firm resource allocation and budgeting much more than the present system of funding.

25. Although it is argued that such a tax would strengthen the relationship between the payment for, and cost of, health care, any earmarked tax would only do this in a very general way; the actual costs of care received by any particular individual would rarely, if ever, reflect that person's 'earmarked tax' contributions. Furthermore, the promotion of health care cost awareness amongst <u>patients</u> misses those groups who actually <u>demand</u> care on behalf of patients and who have some <u>control</u> over costs - e.g. GPs, nurses, clinicians and managers.

<u>Social Insurance</u>

26. Such a scheme would probably be part of the national insurance system and would provide funding for health care to contributors on an income-related basis within a scheme established by Government. The cost of contributions would be shared between employer and employee and would probably be limited to funding

services for the working population. The non-working population would need to be covered by the Government, probably through tax funding.

27. The main disadvantages include increased cost of collection and unpredictability of year to year income. If national insurance is used in its present form (but increased to meet funding of the NHS), then this would be a regressive step in taxation terms. Also, as employers currently contribute to employees NI, increasing NI would increase employers on-costs. To get round this (and the regressive taxation problem) national insurance would have to be restructured, along the lines of income tax with the NHS part of the tax paid solely by employees. The effects of such changes would be merely to duplicate income tax, but at considerable additional cost. Major organisational problems would be encountered in relation to people who contracted out of the social insurance system and opted for a private insurance scheme and then needed to switch back to state support if they became unemployed or suffered long term illness.

Private Health Insurance

28. Private Health Insurance (PHI) as here defined is a wider concept than existing UK PHI schemes. With the exception of those groups of people who qualify for free health care (eg children, the elderly, people with handicaps and the chronic sick) everyone could be required by law to insure themselves and any family members not covered by free health care, by paying premiums to PHI.

29. Persons insured under PHI would have access to private hospitals as well as the NHS. Organisations providing PHI cover would negotiate prices for their members direct with the NHS and with private hospital chains.

The main advantages include: greater choice, sensitivity and closer relationships between service provision and demand (albeit demand based on ability to pay). Main disadvantages include: an inequitable, 'two tier' health care system would inevitably result with a large increase in indirect (ie non treatment) costs to administer private health insurance schemes; 'opting out' could become a serious problem for the NHS as it is likely that those choosing to opt out would be the relatively affluent, relatively healthy middle classes, leading to a reduction in income for the NHS while not reducing NHS workload commensurately. 'Opting out' also raises problems of subsequent 'opting in': if 'opting in' is to be allowed then the NHS could face very serious, if not insurmountable, problems of trying to maintain a high quality, comprehensive service on funding reduced due to people initially 'opting out'.

Major Funding Alternatives Versus General Taxation

30. NAHA believes that, measured against the guidelines criteria outlined in paragraph 19, there is very little advantage in moving to an alternative from the current system of funding health care. Private health insurance systems are inevitably partial in their coverage. For access to health care to be rationed on the grounds of ability to pay contravenes one of the central criteria by which any health care system should be judged. Social insurance would not offer any advantages over funding by general taxation, indeed it would have to closely resemble the current form of funding (but at additional cost) if the problems of unequal access and unequal quality of care were to be avoided. Although earmarking a tax for specific use by the NHS could theoretically protect NHS funding from other public spending, in practice the level at which the tax would be set would be determined annually, by government - not unlike the current way of funding the NHS, but with little discernable additional benefits.

31. Having evaluated the present system of funding and the various well-publicised alternatives against the identified essential criteria, NAHA is strongly of the opinion that the present system of funding by general taxation is the most appropriate, the most cost effective and the most socially acceptable and should not be abandoned.

32. However, as was intimated earlier in the paper, it needs to be recognised that one major disadvantage of general taxation is that the amount of funding is wholly outside the control of the NHS and is not directly related to the volume of patient demand on the NHS. Instead the level of funding is determined by competing national political priorities, including policies on the reduction of public expenditure and taxation. In arguing for the continuation of general taxation as the primary source of funding we believe it to be essential that the NHS is allocated sufficient funds to meet inflation, legitimate patient demand and other agreed developments and has sufficient buoyancy to provide incentives for efficient health authorities.

SECONDARY SOURCES OF FUNDING

33. In addition to the above 'primary' sources of funding, 'secondary' sources have also been considered by the Association.

Part-Pay and Hotel Charges

34. 'Part-pay' charges could be used to raise a portion of revenue from patients treated, and also to bring home to patients and the public that health care is not a 'free good'. Charges can be at a minimum flat rate, a flat rate per day, or a percentage of estimated total cost of treatment. Persons excused from prescription charges could also be excused from these hospital charges. 'Hotel' charges are a variant on the foregoing where the charge rate is linked to the cost of non-clinical services provided during care.

35. Major problems are envisaged in operating such a system. If such charges are set too low, the costs of collection will outweigh revenue; if they are set too high they could deter the less well off from seeking care, ultimately to the detriment of their health. In addition, scarce and valuable managerial time and effort could be diverted from the main task of organising and providing health care to operating a costly bureaucratic system with all the administrative problems of billing and exemptions etc.

Amenity Charges

36. There is a long tradition in the NHS of providing amenity beds. Often these do not appear to have been actively developed or promoted to earn extra NHS income. Many NHS hospitals would have to raise the standards of patient amenity in order to compete with private hospitals. However, it is possible that significant income could be gained from increased amenity charges even after paying back the interest and principal on additional capital obtained by external borrowing or internal brokerage loan funds provided from within the NHS.

Paybeds

37. Beds for private patients could bring health authorities a small sum of additional funds although it is likely that there is a considerable geographical variation in the level of demand. During the last ten years the number of paybeds has declined and there has been a large expansion of private hospitals; it is therefore difficult to assess how well NHS hospitals would fare if they attempted to increase their funds by encouraging the development of paybeds.

Sponsorship

38. The NHS, by comparison with the Arts, Sport or even the Universities, has not done as much as it could do, to

involve industry and commerce in the funding, or part-funding, of new developments, new buildings etc. Of course, it is important that sponsorship funding should cover all or part of the running costs of new developments for a period of years and not just the initial capital cost of some headline-grabbing new development such as a scanner.

Sale of Surplus Land and Buildings

39. Selling surplus land and buildings has now become normal practice in most health authorities, subject to delays over planning permissions and the transfer of long-stay patients into community care. These sales release capital funds for better re-investment, but they do not normally do anything to enlarge revenue funding because the NHS is not allowed to invest funds for future income.

Income Generation

40. Over and above those mentioned above, the NHS has embarked upon an income generation initiative with schemes expected to raise £20m in 1988/89 rising to £70m in 1991/92. This can range from the letting of shop outlets in hospitals to selling services to the private sector.

Secondary Funding - A Limited Resource

41. Many of the secondary sources of funding are in fact already being used by health authorities. However, the scope for providing any more than a small supplement to authorities' main incomes is limited. It would be unwise to rely too heavily on this source.

42. One income generation scheme which many health authorities feel should be considered is the ability for authorities to borrow on the money market. Obviously such a new possibility needs careful checks and balances to ensure that health authorities avoid getting into a downward 'creative accounting' spiral. However, the possibility exists for the NHS collectively to negotiate favourable loan terms, enabling it to pursue particular, targetted, developments requiring pump-priming revenue funds. Furthermore, the possibilities of lease-back, whereby surplus land/buildings are used as collateral to secure loans, should be investigated.

DISTRIBUTION OF FINANCE

43. Whatever method is used to fund the NHS, the distribution of finance is just as important an issue. Three distributional methods have been considered by NAHA in relation to the current method of allocation to health authorities.

* RAWP

  These are the current population, SMR based formulae for redistributing finance between health regions. The logic and equity of the current formulae at sub-regional level is doubtful, however, especially at a time of stagnation of resources.

* Central Regional Funding of Agreed Services Plans

  The RAWP system implies the distribution of available funding according to notional needs of the local population. This in turn implies endorsement of local self-sufficiency in health care delivery, other than for the specialised and often expensive treatments which must be concentrated in a few regional or national centres. An alternative policy

for sub-regional funding (and which is in partial use in some regions) is to agree that the full implementation of RAWP must be deferred until some future time of more rapid resource growth. Instead, priority should be given to requiring health districts and units to plan resource use and care delivery to maximise the outputs of existing facilities in a manner to share their resources and strengths to compensate for shortages and weaknesses in neighbouring or nearby localities. This is the principle of maximising the output at the margin of all existing resources. One way to seek to achieve this is by determining funding allocations to districts only after agreeing that their service plans allow for maximum patient access to all specialties, inclusive of cross-boundary admissions from other districts.

In theory, this approach should bring into use all spare capacity within the NHS acute services and provide equality of access (though not necessarily 'local access') for all patients. A practical problem, however, is that under current arrangements financial compensation to districts receiving patients from other districts is dealt with by funding adjustments to RAWP for cross-boundary flows, which are typically more than a year in arrears. This does not provide a great financial inducement to seeking out, or even welcoming, inflows of patients from other districts to fill any spare capacity available from time to time in particular specialties.

* Central or Regional Funding of 'Costed Workloads'

For the funds distribution method described in the preceding paragraph, there is no real need for detailed knowledge of the unit costs of hospital treatment, or 'workloads', since the system involves working from existing total costs to make adjustments at the margin (upwards or downwards) to reflect the relative merit of different districts'/hospitals'

agreed annual service plans. However, the introduction of DRGs (Diagnosis Related Groups - classifications of patient conditions and relative costliness) offers the ability within two or three years to have fairly accurately estimated national standard average costs of treatment for acute hospital patients. This opens the possibility of constructing the acute care component of district funding allocations by costing the workloads. The use of costed-DRGs for funding would increase the pressure on acute hospitals to be efficient and to maximise the use of any spare capacity. Funding allocations could be based on agreed plans for the coming year's DRG casemix and volume. It should be possible to determine provisional hospital funding allocations on the above basis, and then to adjust the actual final funding allocation up or down by quarterly monitoring of the actual DRG workload provided by each hospital.

44. NAHA supports the idea that a RAWP-type system of finance distribution (that is, one based on population size and the need for health care) is the best way of allocating money to different areas of the country. The problems associated with RAWP and low or no real resource growth, are best solved by ensuring adequate resourcing for the NHS. However, the Association does recognise particular difficulties and problems with the current RAWP formulae which need adjustment to allow for:

* Speedier reimbursement for cross boundary flows.

* More accurate approximations for or direct measurement of, morbidity.

* An efficiency incentive mechanism.

45. The trade-offs and conflict of objectives between the efficiency incentive mechanism and the equity thrust of RAWP/population/needs - based allocation system obviously needs careful balancing. Whilst the Association notes much valuable work in this area within the NHS; for example, performance related pay and especially the refinement of objectives/outcomes, without which measuring efficiency is problematic, it is still the case that, at the minimum, perverse incentives to greater efficiency should be rectified.

46. The drive for efficiency in the acute sector has been responsible, in part, for the financial problems of health authorites. The average length of time patients stay in hospital as inpatients has decreased by nearly 21% and the number of inpatient cases per available bed has increased by 24% during the 1980s. Therefore by an efficient use of resources, health authorities have reduced the average cost per case yet increased total expenditure by the overall expansion of services.

47. For example, the growing trend amongst health authorites (in the face of cash limited budgets) to restrict catchment areas can lead to the unnecessary duplication of services: districts outside redrawn catchment areas have to develop their own services to meet needs traditionally met by neighbouring authorities. The recent abolition of the facility to allow health authorities to carry over a proportion of their budgets from one year to the next should be reversed. Furthermore, an increase in the proportion of their budgets which authorities are allowed to carry forward should be introduced. This would help reduce poorly planned and inefficient year-end spending. Consideration should also be given to positive incentives for greater efficiency. For example, within the district/region contractual arrangement noted elsewhere in this paper, provision could be made for a pre-set, percentage bonus to districts overachieving agreed activity levels within agreed budget levels.

48. OTHER MAJOR FUNDING/PROVISION OPTIONS

The categorisation we have used to group alternative funding methods ('primary', 'secondary', 'distribution' etc) has tended to cut across some types of funding/provision systems. In particular, the generic 'internal market', health maintenance organisations (HMOs) and health care vouchers are three related ideas which have received much attention recently and which are commented on below.

Internal Markets

49. The NHS currently operates as a co-operative confederation of districts, with both formal and informal cross boundary flows of patients and services. Proponents of 'internal markets' suggest that great benefits, as they see it, in terms of efficiency gains, from the use of 'spare' capacity, could be realised through a greater formalization of this inter-district co-operation with intensive buying and selling between districts and the private sector.

50. NAHA is in general sympathetic to the aims of internal markets but would strongly emphasise the practical and theoretical problems associated with the implementation of a formal or compulsory market for health care within the overall structure of the NHS. The onus is on the proponents of this system to firstly demonstrate rather than simply assert the merits of the internal market, and secondly to explicitly state the probable ramifications of internal markets:

For example, will they:

* Result simply in a transfer of the burden of some health care costs to patients in terms of increased travel time, loss of earnings etc?

* Reduce consumer choice by transferring a greater proportion of health care supply decisions up the line from GPs to district health authorities (a reduction in the freedom to refer)?

* Lead to a distortion in management priorities as districts seek to compete for patients and hence survival?

* Reduce wages for NHS employees - many of whom are already low paid relative to the private sector?

* Require complex cost recording and billing systems and increase administrative bureaucracy?

* Mean the end to equalisation of access to services through the incremental RAWP procedure?

51. The Association welcomes the proposal for a regional trial to see how exactly these problems work out before the concept is widely adopted within the NHS. This would be particularly relevent in relation to regional specialities.

Health Care Vouchers

52. Under this system funding travels with the patient. Health care vouchers (HCVs) would be issued to every member of the population to be exchanged for NHS (or private) health care. Although the idea behind HCVs is to provide a degree of consumer power over the providers of health care, there are considerable problems associated with such a system. Not least is the problem of deciding what value of HCV to issue to each individual given the age, sex, geographical, social class and other factors influencing the amount of health care each person consumes. The problem of what to do when a patient uses up his/her voucher is very substantial.

53. If HCVs are to be used in a more indirect way, with districts receiving funding according to the number of patients/vouchers they attract, then this is in essence no different from the current RAWP cross boundary flow compensation and, as such, would suffer from the same technical problems of tardiness and inaccurate costing data, both of which, in the view of the Association, could and should be improved within the RAWP formulae.

54. It is highly unlikely that HCVs would extend the patient's choice of health care any further than currently exists with the freedom of GPs to refer their patients to any consultant or service willing to accept them.

Health Maintenance Organisations

55. Health Maintenance Organisations (HMOs) have been in existence in the USA for nearly forty years and much of the evidence for their success at reducing costs of care, while still providing a quality service, comes from their comparison with the US fee-per-item of service system. Although different forms of HMOs exist, all retain essential characteristics. For a standard fee, a person can become a subscriber to an HMO (a health business), which will provide a set package of care which may include major surgical procedures. An HMO may well sub-contract work to specialist organisations/hospitals - for example pathology services or hi-tech medical treatment.

56. As with internal markets, the onus is on the proponents of HMOs as a substitutue/complement to the NHS to provide hard empirical evidence for their worth in a British setting. To date, one of the striking aspects of the arguments put forward in favour of HMOs is the similarity between HMOs and the NHS which could be described as a co-operative confederation of HMOs. At present there is little to stop private health providers or groups of doctors setting up their own HMOs, attracting flat-rate paying subscribers and offering high quality

comprehensive health care to their members. The sole experiment in HMOs in the UK so far has been the Harrow Health Care Centre. Although its supporters claim it as a medical success, nonetheless it has suffered financially due to its inability to attract the 'critical mass' of subscribers which would enable it to spread its risk (as do insurance companies). (For further information on the Harrow Health Care Centre see Michael Goldsmith and David Willetts, 'Managed Health Care: A New System for a Better Health Service'; Centre for Policy Studies, February 1988).

57. The common characteristic linking the many variants of HMOs (eg health management units (HMUs) managed health care organisations (MHCOs)) is the conjunction of financial and health care provision responsibilities. However, NAHA would point to the considerable amount of work that has already been carried out in the NHS, from resource management to DRGs, which is likely to produce the effect of health care provision linked to financial responsibility that characterise HMOs - but without recourse to overhauling the entire structure of the NHS.

58. The ability of general practitioners to refer freely on behalf of the patient may be severely curtailed by the introduction of HMOs. Serious consideration should be given to the restrictive consequences HMOs will have on this most basic of clinical and indeed patient freedoms.

59. Geographical and demographic differences (eg rural/urban, elderly/young populations) will necessarily lead to differences in premiums for different HMOs reflecting different demand for health services, but which will not be related to ability to pay. This is a very serious criticism of HMOs and one which could only be avoided by a complicated and costly 'topping up' or national

redistribution of HMO premiums to even out health care costs to patients. A further possibility would be for the state to provide a health care service for all those unable to pay HMO subscriptions. Such a two-tier health care system would, in the view of NAHA, be unjustified and unnecessarily divisive.

60. The Association believes, therefore, that whether HMOs are organised around GPs or DHAs, their introduction as a substitute for the NHS is unwarranted and inconsistent with the basic evaluation criteria set out earlier in this paper.

61. ALTERNATIVE FUNDING: CONCLUSION

The NHS has achieved much in the last few years. However, the demographic inflationary and development pressures it has had to face have been a considerable additional burden for which health authorities have not been adequately compensated. There should be little mystery about our present problems. If, during the 1980s, the NHS had been fully financed for inflation and given sufficient additional funding for demographic change, medical advances and government priorities, health authorities would now be financially robust.

62. In the view of the Association, the funding of the health service from general taxation is both efficient in tax collection terms and is seen by the public as one of the most equitable ways of financing a free at the time of need health service. Although the formalising of the present co-operative provision of health care by many health authorities (internal markets) may bring some additional benefits hard evidence is needed before embarking on major reorganisation. The immediate need is for the NHS to be funded for inflation and specified developments.

Section IV

ROLE OF THE PRIVATE SECTOR

63. A comparatively low proportion of British GDP is devoted to private health care spending. However, the private sector of the UK health care industry has been expanding for some years and this trend is likely to continue. Whilst this may lead to more resources being spent on health care in the UK, there are some by-products and consequences of such an increased take-up for the NHS.

64. The first point to be made is that the private hospital sector, whilst relieving some burden on the NHS, does not in any sense provide a comprehensive service. Rather it is to be seen as providing a 'topping up' service, mainly in relation to routine surgical procedures in the acute sector. It is noticeable that whilst some of the prominent private sector insurance organisations have now developed plans for elderly people, the scope of their cover is inevitably limited.

65. Secondly, as the private sector grows, it will be competing with the NHS for scarce staff resources. This is likely to be exacerbated by demographic changes in the 1990s reducing the supply of potential nurses. So one of the unintended consequences of a greatly expanded private sector, could be additional costs for the NHS if the private sector becomes the market leader in the pay field. If the NHS is not able to compete effectively with the private sector on pay it would then be weakened by a diversion of staff from NHS to private hospitals. Private hospitals would utilise staff and provide equipment for the more routine procedures, but highly complex procedures would still be referred to NHS hospitals. However, the absence of experience and staff in providing total care would ill-equip NHS hospitals for carrying out this function.

66. Thirdly, the prospect of the NHS becoming a 'second class service' is one which is viewed with considerable apprehension. This arises from the consequences of the private sector taking on a considerable proportion of the acute health care for the middle classes and the more wealthy members of society.

67. The Association believes that in these circumstances, it will be essentail that the NHS continues to provide services of the highest quality and is funded appropriately in order to do this. Equally, it is accepted that as the private sector expands, close co-operation and collaboration with the NHS is desirable and that in the planning of services health authorities need to take account of present and potential private sector provision. However, public and professional acceptance of a mixed health economy would be more easily maintained on the basis of a genuine partnership which can demonstrate direct benefits to NHS patients. As the private sector expands, it must be expected to play its part in contributing to the essential health care infra-structure and in relation to the training of professional staff, make appropriate contributions towards the cost.

Section V

THE ROLE OF TEACHING AND RESEARCH

68. The NHS, indeed any health care system, depends crucially for the quality of its care on high standards and excellence in basic and clinical research and training. Nursing and medical training and research provide one of the key investments in health care. They provide the route to increasing medical knowledge as well as ensuring wide dissemination of new forms of care and new methods of treatment, apart from training new generations of health workers.

69. The NHS provides mainly, though not exclusively, through Teaching Authorities and the London SHAs an invaluable environment in which to conduct medical research and training. Whilst not without its faults the opportunities afforded by the NHS for doctors to observe and practice on a wide range of patients and illnesses are second to none. The Association sees a number of problems, however, if the current symbiotic relationship between academic medicine and training on the one hand and NHS health care provision on the other, is changed too much.

70. It should be recognised that training and research in health care requires both long term commitment as well as adequate financial resources. For these reasons, teaching districts/hospitals are inevitably more expensive in financial terms (eg cost per case) as well as in terms of patient activity (eg average length of stay, throughput per bed). Alternative funding systems such as health care vouchers or the internal market would have to recognise these essential differences between teaching and non-teaching districts. However, such recognition would come at a cost in terms of additional complications and bureaucracy for these two systems of funding.

71. It is the view of the Association that, given the central, long term role played by medical training and research to the success of the NHS, this area of health service work should be retained and developed within the public sector. In terms of financing teaching and research, NAHA believes that the increasing reliance by universities on 'soft money' for academic medical posts, following the reductions in UGC grants, is detrimental in the long term to the quality of medical teaching and research and hence the NHS, and should be reversed. This would restore some of the balance of priorities in teaching, and especially in research - which can all too easily be diverted to more commercial ends to the possible detriment of the ethos of NHS health care. Given the private health care sector's use of and benefits from, the teaching and research activities carried out in the NHS, arising from the long term investment by the taxpayer in NHS buildings, equipment and staff, the Association believes that some formal compensation would not be inappropriate. This particular issue would become especially crucial if the level of competition between the private and public health care sectors were to increase.

72. However, the Association recognises that the current structure of teaching and research, involving many different groups (NHS regions & districts, DES, UGC, MRC etc) funded in different ways, with often conflicting objectives, pressures and planning horizons, needs to be carefully examined.

Section VI

AN NHS FOR THE 1990's

73. If the NHS is to meet the challenges identified in paragraph (6) and to cope effectivly with many of the issues already raised in this paper, a number of changes need to be made to the way it operates. Firstly, we deal with the NHS's relationships with the general public. It is here that the most crucial challenge of all is to be faced and it is upon our success in this area that the future well-being of the NHS rests.

CONTRACT WITH THE CUSTOMER

74. The whole endeavour of the NHS must be directed towards the end product: good quality service to members of the public. Since the publication of the NHS Management Inquiry Report, health authorities have developed a number of techniques for improving the sensitivity of their services. These have included:

* Surveys of patient attitudes and opinions.

* Development of quality assessment and quality circle programmes.

* Establishment of consumer panels.

* Literature and information for patients and visitors have been made user friendly.

* Staff training programmes for dealing with the public have been established.

* Health Authority newspapers are delivered regularly to people living in a number of districts.

75. The Association believes that we need to build upon this by the establishment of a contract between district health authorities and the users of their services. Such a contract would specify the level of service people could expect and the maximum periods they might have to wait for treatment for a particular condition, either within the district or in a private hospital or another district depending on agreements reached through an internal market trading mechanism. The contract would be readily available to members of the public and widely publicised. We have noted suggestions that if a health authority fails to deliver on such a contract, patients would themselves have the right to shop around for a specified treatment and expect their local health authority to pick up the bill. There is clearly some attraction in such a concept but the Government would need to recognise that this would inevitably require more exchequer support for the NHS and be very expensive to administer.

76. Complementing the contract, would be a package of measures to make services more user orientated. These would include:

i) All staff, including clinicians, to receive training on good practice in dealing with the public.

ii) The public must be more involved in their own treatment and this means that professionals must be more ready to share information with them and discuss options available.

iii) A more speedy, sensitive and responsive complaints system should be established.

iv) Performance review systems must provide more emphasis on the quality of service provided and should involve the public in this assessment. Regular and systematic peer-group review by clinicians of their clinical performance would be a major element in this process as a mechanism for quality control.

ACCREDITATION

77. In order that a reliable audit of the quality of service is maintained, the Association proposes that a National Health Accreditation Agency should be established. This would ensure that a good standard of service was being provided by district health authorities. Hospitals are already inspected by the Health and Safety Executive, fire officers, environmental health officers and professional bodies including the Royal Colleges and national nursing boards. However, the efforts of these bodies are un-coordinated and take in a narrow range of activity such as physical standards and the professional training of staff.

78. We think that the USA model of accreditation is one which could well be looked at. The Joint Commission on the Accreditation of Hospitals sets various standards to be achieved by a hospital's governing body and management: for medical staff organisation and functioning; for various hospital services - nursing, anaesthesia, out-patients, medical records, laboratory and the like; for physical plant design, structure and functioning. The Commission also specifies the need for a comprehensive quality assurance programme and various outcome measurements.

79. It is noticeable that through the registration procedures in the Registered Homes Act, independent hospitals and nursing homes are required to reach certain standards. We think it anomalous that NHS hospitals are not covered by a systematic inspectorial procedure which applies certain explicit standards and closely examines the outcome of a DHA's activity. The advantage to the public is that they can be guaranteed that all NHS hospitals will meet the required standard. For health authorities and staff, a national inspectorate could help ensure that the NHS did not slip into providing what we have earlier described as a second class service. For the Government, too, there are a considerable number of benefits. The main one being an assurance that it can afford to delegate much more responsibility to health authorities because our proposed National Agency can ensure that agreed standards are being adhered to.

ORGANISATIONAL RECOMMENDATIONS

80. The NHS has been through a number of re-organisations in the last four years and we do not believe that a further major structural change would be in its best interest. There are, however, a number of organisational matters which need attention, not least in terms of the NHS's relationship with the Government. We believe that at national level a radical shake up is needed if the NHS is to provide the required dynamic management in the years leading up to the year 2000.

81. It is worth reflecting that the present Government review of the NHS is the fifth major review or organisational change of the NHS to have taken place in the last fifteen years. (1974 Re-organisation; Royal Commission on the NHS and Patient First - 1979; NHS Management Inquiry Report - 1983). That it has been necessary for successive Governments to do this indicates a general unhappiness with the organisation of the NHS. Aside from the funding issue, a recurring theme has been the unsatisfactory relationship between Government and the NHS stemming from the Secretary of State's accountability to Parliament and the role of health authorities as his agents.

82. We acknowledge that ministers have to respond to criticism in Parliament about various aspects of the running of the NHS. A constant theme of reports from Parliamentary Committees has been for the need for tight central control over health authorities and this has been reinforced by the actions of individual MPs who have made representations to Ministers about specific decisions made by local health authorities. Additionally there has been frustration on the part of Ministers, and indeed Parliament, that important policy priorities established for the NHS have not been implemented as quickly or as fully as desired.

83. For health authorities, the frustrations have been no less. Interference by Ministers and officials has been a constant theme. Flavour of the month policies have abounded and health authorities have been frustrated due to the numerous policy guidelines, directions, controls and instructions which have emanated from the

Government, sometimes conflicting with each other and hardly ever distinguishing as to the priority to be accorded to each one or as to their priority over other areas.

84. Looking back at the NHS over the last 40 years, the Association concludes that the relationship between Ministers and their agents, the health authorities, has been one of confusion with wasteful energy devoted to bureaucratic procedures governing that relationship. This, in turn, has undermined the confidence and ability of local managers to be dynamic, thrusting and entrepreneurial.

85. It is of little surprise that in the NHS Management Inquiry Team Report, led by Sir Roy Griffiths, so much attention was paid to the role of the DHSS and its relationship with the NHS. The report stressed that it was not for the centre to engage in the day to day management of the NHS and stated that as a coherent management process is developed of planning, implementation and control, the DHSS should vigorously prune many of its existing activities. The Report stated that the requirement for central isolated initiatives should disappear once a coherent management process is established. Most importantly, the Inquiry Team recognised that a real demonstration of management will was required if the NHS was to break free from the present top-down approach to detailed management and yet be held to proper account for performance and achievement.

86. To what extent has this been achieved? A considerable strength of the original Inquiry Team report was that it was not very prescriptive. It contained a small number of key recommendations along with a critique of NHS management and could be seen in many respects as an 'agenda for action' rather than as setting out in close detail every facet of the NHS that needed to be changed. This meant that health authorities had considerable latitude in deciding how to interpret Griffiths and in

deciding what action to take. This is evidenced most clearly by the enormous variations in management structures introduced by health authorities to suit local circumstances. However, in his paper entitled 'The Future of NHS general management: Where Next?', Gordon Best, Director of the King's Fund College, has argued that following the initial stages of introducing general management, there is now to be seen a trend towards greater centralisation. In particular, he suggests that a number of developments indicate that the DHSS - consciously or otherwise - is engaged in a process of 'repossessing' general management. We share his view and conclude that the original hope of the NHS Management Inquiry Team for a more constructive relationship between the DHSS and health authorities themselves has not been fully realised.

87. Our view has been confirmed very recently by the House of Commons Social Services Committee which drew attention to this matter in their paper on NHS Resources, (1st Report 1987/88 Session - 264-1), when it noted that the long list of priorities and targets set for the NHS goes far beyond the list of "central initiatives" and the Committee wondered if the word "priority" was not seriously devalued by so many priorities. It said 'we are seriously concerned by the apparent absence of any sort of relationship between "priorities" set by the government and the system of budgetary planning in the NHS.' The Social Services Committee referred to the NHS Management Inquiry Report and said that in contrast to the recommendation on cutting down central initiatives:

'To date, what seems to have happened is that management has been required to cope with an ever increasing number of central, isolated initiatives within increasingly tight cash limits'.

THE NATIONAL NHS MANAGEMENT AGENCY

88. We share the Committee's view. We do not believe that the necessary pruning of DHSS activities, as recommended by the Inquiry Report, has taken place and propose that a radical change be made in relation to the central management of the NHS by establishing the NHS Managment Board as a management agency outside the DHSS. The NHS Management Agency would effectively provide a focus for the leadership of the NHS and negotiate a contract with Ministers to provide a given level of service in return for an agreed allocation of resources. Such a contract would be very much focussed on key national policies and priorities as laid down by Ministers and would be subject to questioning and debate in Parliament.

89. The Association would put forward three main arguments for the establishment of a management agency. First, despite some notable achievements, it believes that the NHS Management Board is less effective than it could be by being placed within the DHSS. Secondly, there is very little indication that under present arrangements, the DHSS is able to resist the temptation to interfere in the activities of health authorities. Thirdly, we believe that the recent report of the Efficiency Unit to the Prime Minister on improving management in government indicates a way forward. (Improving Management in Government: The Next Steps-Report of the Efficiency Unit - 1988 under the supervision of Sir Robin Ibbs).

90. The report recommended that agencies should be established to carry out the executive functions of Government within a policy and resources framework set by a department. The report says that an agency of this kind might be a part of Government, or it may be more effective outside Government.

91. The report stated that:

> "These units, large or small, need to be given a well defined framework in which to operate, which sets out the policy, the budget, specific targets and the results to be achieved. It must also specify how politically sensitive issues are to be dealt with and the extent of the delegated authority of

management" ... "The framework will need to be set and updated as part of a formal annual review with the responsible Minister, based on a long term plan and an annual report. The main strategic control must lie with the Minister and Permanent Secretary. But once the policy objectives and budgets within the framework are set, the management of the agency should then have as much independence as possible in deciding how those objectives are met" ..... "The presumption must be that, provided management is operating within the strategic direction set by Ministers, it must be left as free as possible to manage within that framework. To strengthen operational effectiveness, there must be freedom to recruit, pay, grade and structure in the most effective way ....."

92. The report concludes by saying:

"The substantial gain we are aiming for is the release of managerial energy. We want to see managers at all levels in the public service:

- eager to maximise results,

- no longer frustrated or absolved from responsibility by central constraints,

- working with a sense of urgency to improve their service."

93. The Association believes that an NHS Management Agency would provide such a focus for the NHS and provide enormous benefits in improved management, effectiveness, efficiency and in producing the permanent and easily identifiable leadership which the Service at present lacks.

REGIONAL HEALTH AUTHORITIES

94. There has been some debate about the future role of RHAs. The Association believes that a regional structure is required within the NHS. It is very unlikely that our proposed Management Agency could directly allocate funds to 190 DHAs and negotiate a seperate contract with each one. There are a number of essential functions which need to be done at a regional level. These include the overall allocation of resources to districts; review of their performance; strategic planning over a region; manpower planning; the co-ordination of supra-district services. NAHA is less sure of some of the service functions of RHAs. These include ambulance services, works, computers, management services and related areas. It would be perfectly possible for these to be controlled by DHAs, acting on a consortium basis.

95. In many cases, it is the blurring of these two areas of RHA activity which is the cause of much of the contention between RHAs and DHAs, and we consider it vital that any duplication of responsibilities should be eradicated. If it is accepted that RHAs will be confined in future to a more strategic role, then it would be advantageous if the present boundaries of RHAs could be reviewed to ensure that they are consistent with present day circumstances.

96. The Association would prefer this regional tier to be run as part of the NHS, as now, staffed by NHS officers and under the control of a health authority rather than as regional outposts of the Management Agency. In essence, we would argue for the Management Agency to contract with RHAs. Each RHA would agree to provide a negotiated level of service centred around a limited number of key priorities. They would be funded on that basis and be given incentives for efficient performance along with maximum freedom to carry out their responsibilities.

97. DISTRICT HEALTH AUTHORITIES

The Association sees the district health authority as the pivotal tier of NHS management around which services will be planned and provided in conjunction and in close co-operation with neighbouring districts. In addition, the DHA will have crucial public health responsibilities in relation to the health of the population for which they are responsible.

Maximum Decentralisation

98. In our earlier comments, we have remarked on the introduction of a limited internal market mechanism, along with the need for health authorities to be provided with incentives for efficient performance and to be given financial freedom to borrow capital. We accept that there are further opportunities for efficiency and rationalisation in relation to the establishment of uniform information systems and in such areas as procurement policy. But in the crucial management and policy making area, we would argue for considerable freedom to be given to district health authorities to manage their own affairs. As we see it, the district health authority would contract with the regional health authority to provide a certain level of service. This contract would very clearly set out the main short-term and long-term priorities for each health authority. These key objectives must necessarily be both limited and prioritised; they must be achieveable and would include an assessment of the service's performance in relation to the users as explained earlier in this paper. It must also be a key component of such a contract that health authorities have sufficient resources to carry out the contract.

99. In return, health authorities would be under an obligation to deliver on the key objectives set out in the contract. We believe that the contract should be very widely publicised so that the staff and population of the district know very clearly what is expected of the

health authority. Those authorities who exceed their targets should be rewarded with additional finance, whilst those authorities who do not deliver without good reason will be called to account. We believe that such an approach would create the kind of dynamic, innovative and thrusting authorities which will be required.

100. For district health authorities there are a number of pre-conditions which need to be established before they could be expected to take on such a role effectively. First and foremost is the relationship between clinicians and health authorities.

Relationships with Consultants

101. Health authorities will be required more than ever before to explain variations in clinical and other, performance relative to other districts. This is entirely reasonable but represents a considerable challenge.

102. We believe that in any future funding system, it will be essential to develop clinical budgeting across every district in the NHS and to ensure that clinicians are brought into the mainstream of resource management. This should be linked with a system of clinical audit and might also include creation of specific incentives to encourage clinicians to take an interest in the costs of their activity.

103. It is our belief that the results of the current work on resource management in the pilot districts will not be readily transferred and beneficial to other authorities unless there is a structured managerial framework within which such concepts can be applied. The concept of clinical divisions could be formalised as a managerial entity. This would allow the appointment of clinical directors who would have real authority, in a managerial sense, over consultant colleagues to a degree which would allow them to have effective control over any budget

allocated to the specialty concerned. The creation and appointment of clinical directors would also provide an impetus to the process of clinical audit, quality control and outcome measurement etc. This, however, is only to be considered as a model since we are strongly of the view that management arrangements are for local determination.

104. Arising from the 'Achieving a Balance' initiative, registrar contracts are in the process of being transferred from DHAs to RHAs. Whilst this will allow for more effective career planning, this will entail regionally controlled manpower planning for relatively junior doctors. It is essential that this is balanced by a move towards DHA employment of consultants. The Association has consistently argued that all DHAs should employ consultants, since the present arrangement makes it very difficult for non-teaching authorities to enforce conditions of service and work agreements. We also consider that to a doctor pursuing a career in hospital medicine, having a career goal of a consultant status contract with a DHA would benefically affect that doctor's relationship with DHAs throughout his/her career.

105. The Association considers that district general managers should take part in the interview and appointment of consultants. The district general manager has overall responsibility for meeting the objectives of the health authority. The obligation to deliver on the part of general managers means that they must have greater influence on how money is spent, and how resources are used. Consultants have a crucial effect and influence on the control of NHS resources, including staff. It is important, therefore, that an assessment should be made, at the time of their appointment, of the consultant's managerial ability as well as their clinical capability. In assisting with the selection of a consultant, the general manager would be solely concerned with a potential appointee's <u>managerial</u> performance and would not, in any way, be involved with an assessment of their <u>clinical</u> performance.

106. On making consultant appointments, health authorities and the appointee should have a very clear idea of what is required of the consultant, including expected workload and the effect the appointment will have on the overall objectives of the health authority. The contract should allow for flexibility in working practices, and take account of the changing needs of a particular district. Appropriate reference should be made to the consultants' accountability for resources. This would be particularly relevant where a consultant held the budget for a department.

107. The Association also considers that just as general managers are regularly reviewed, the same process should apply to consultants. It is stressed that reviews of clinical performance should be by their peers. However, there should also be an opportunity for management and consultants to consider both their present working relationship and whether any improvements could be made. The possibility of relating an element of consultants' pay to performance, should be considered, in relation to a review of the present merit awards system. Also worthy of debate is the nature of the contract to be negotiated and whether they should be subject to renewal from time to time, rather than being seen to be tenured for the consultant's working life.

108. Local Pay Determination

The present centralised system of pay determination is largely outdated and indeed, given the difficulties the NHS faces in recruiting sufficient professional staff, can be a positive barrier to effective management. Although a number of moves have been made recently to introduce flexibility, the present national system is too restrictive and inflexible. This is largely due to the number of tightly defined grades; this causes problems for managers seeking to use their workforce more flexibly to recruit in areas of local shortage and to introduce new posts with mixed duties. Reports by NAHA and the King's Fund have pointed the way to a much more flexible and dynamic approach.

109. We recognise that a major anxiety about allowing local flexibility is that wage costs might soon spiral due to 'leapfrogging', with districts overspending their budgets and forcing other districts to follow suit. We believe this problem is exaggerated and that the regional review system and the use of cash limits offer sufficient controls to prevent this.

Primary Care Services

110. It is our understanding that the Government's review is primarily directed towards the Hospital and Community health services and our submission is directed towards that end. However, an undoubted strength of the NHS is the standard of primary care services. Paragraph 3.61 and part of paragraph 10.10 of the recent Government White Paper 'Promoting Better Health' makes the following comments on hospital referrals which are very apposite.

Paragraph 3.61

> "Health Authorities incur a very substantial cost through family doctor's decisions to refer patients to hospital and through their use of hospital diagnostic and treatment facilities. It is important that expensive hospital facilities are used in the most cost-effective way, and the wide variation in referral rates suggests that this may not always be the case. Family doctors (who have no information about the costs) have little reason to examine their criteria for referral. While in some circumstances a higher than average referral rate may be justified, a minority may refer substantially more patients to hospital than the requirements of the individuals concerned merit. Patients whose doctors make fewer than average referrals may not benefit fully from the hospital facilities available for their conditions. The Government therefore welcomes the work being done in some areas by family doctors and specialists to examine the criteria used in making referral decisions, a type of decision about which more needs to be known."

Paragraph 10.10

> "**Hospital Referrals:** FPCs and DHAs should act to ensure that the use of hospital facilities achieves the maximum benefit for patients and that services are used to ensure quality of care in a cost-effective way. FPCs will therefore be required to obtain independent professional advice on how to improve services in this important but difficult area."

111. We believe, and we must acknowledge that we are speaking here on behalf of health authority members of NAHA, that the division of responsibility between FPCs and health authorities is illogical and we would argue that all primary health care services should be brought within the jurisdiction of DHAs. We also believe that GPs need to be brought more into the managerial and planning process. We therefore propose that new contracts should be drawn up between health authorities and GPs which set the objectives of a practice for a specified term and detail the obligations of both sides to that contract. An effective primary health care system can absorb and cushion demands which would otherwise be made on the more expensive hospital service. Collaboration between the two sectors is therefore vital and the unification of such services under the district health authority would enhance such collaboration. This view is one not shared by our FPC members.

Health Authority Members and Chairmen

112. The role we have suggested for district health authorities is crucial; not the least of their responsibilities will be their effective relationship with the community that they are there to serve. In this respect we believe that health authority members have a major part to play in ensuring that the decisions of health authorities are sensitive to local circumstances, whilst in keeping and consistent with the overall priorities of the NHS. It is also important to recognise that the involvement of local people in health authority

management ensures public confidence in the decisions made. Often, however, the potential of members is not fully exploited; partly because insufficient attention has been paid to their selection, training and support, and partly due to lack of clarity as to their role. At a time when major changes are likely to occur in the NHS, it is particularly important that the contribution of members to health care should be evaluated and re-stated.

113. If our proposal to give more authority to district health authorities is accepted, it will be more important than ever to ensure that we have effective health authority members. To do this, we would commend the proposals made in our earlier report entitled 'Acting with Authority', ('Acting with Authority' - A consultative paper on the appointment, training and work of DHA members', NAHA 1986) This report makes a number of key recommendations designed to ensure that members' potential is fully exploited in the future. These include:

i) Drawing up a job specification for members.
ii) Improving recruitment and appointment procedures.
iii) Providing better training and support.

114. It will also be essential that DHA chairmen, who have such a major role to play, receive sufficient training and support. It is noticeable that a recent survey by the Association of DHA Chairmen indicated that the great majority devoted a considerable amount of time each week to their work. We envisage that even more demands will be placed upon Chairmen of DHAs in the future.

115. Service Funding and Service Provision

It is accepted that there is an important distinction to be made between the role of a DHA as funder of services and its role as a provider of services. It would be perfectly possible for DHAs to be the funding,

regulatory, planning and public health agency within their locality, whilst the actual management of hospitals could be undertaken by voluntary, charitable or commercial organisations.

116. The comments of Sir Roy Griffiths in his report 'Community Care : Agenda for Action' are particularly relevant. In discussing the role of social services authorities, he makes the point that ".... The role of the public sector is essentially to ensure that care is provided. How it is provided is an important, but secondary consideration and local authorities must show that they are getting and providing real value." He emphasised that "..... it was the responsibility of the social services authorities" ....." to ensure that these services are provided within the appropriate budgets by the public or private sector according to where they can be provided most economically and efficiently. The onus in all cases should be on the social services authorities to show that the private sector is being fully stimulated and encouraged and that competitive tenders or other means of testing the market, are being taken."

117. Up to this point, we have assumed that the district health authority would continue to be the a major provider of services. It is recognised, however, that there could be developments along the lines described by Sir Roy. The key-point for the Association is the necessity of there being a statutory health body at local level responsible for monitoring the health of the population and for taking steps to improve that level of health. Such a position must entail the ability of district health authorities to direct services to that end.

Section VII

SUMMARY OF KEY POINTS AND RECOMMENDATIONS

(i) The NHS is a popular and successful organisation which has provided a high standard of service to the public for forty years. (section I, para 1-5)

(ii) If the NHS had been fully compensated for the cost of pay awards and price inflation and received a 2% development addition each year for demographic pressures, medical technology and key government priorities, the NHS would not be in its present crisis. (section II, para 8-16)

(iii) The nation must continue to have an equitable health service, free at the point of delivery. (section II, para 18)

(iv) There is a need for greater incentives towards efficiency and the development of limited internal markets. (section III, para 47)

(v) The development of internal markets is supported but a regional trial is welcomed as a way of exploring a number of identified problems. (section III, para 51)

(vi) Expansion of the private sector may lead to the NHS becoming a 'second class' service. (section IV, para 63-67)

(vii) The NHS needs to be reorientated towards the users of its services. This should be symbolised by the establishment of a contract between each DHA and its local population. (section VI, para 74)

(viii) A National Health Accreditation Agency should be established to monitor and assess the standard of service being provided by the NHS. (section VI, para 77-79)

(ix) The NHS Management Board should be established outside the DHSS. (section VI, para 88)

(x) The present bureacratic and wasteful controls placed on health authorities should be removed. (section VI, para 98)

(xi) RHAs to be retained on basis of slimmed down functions but with a more dynamic relationship with DHAs and the proposed NHS Management Agency. (section VI, para 94-96)

(xii) DHAs will be the pivotal tier of NHS management responsible for the planning and management of services and the development of a public health function. (section VI, para 97)

(xiii) Consultants to be brought more into the management process and to be employed by DHAs. (section VI, para 101-107)

(xiv) Local pay flexibility to be introduced. (section VI, para 108-109)

(xv) DHAs to administer family practitioner services. (sections VI, para 110-111)

(xvi) Role of health authority members to be strengthened. (section VI, para 112-114)

(xvii) The teaching and research capacity of the NHS should be adequately funded. (section V, para 68-72)

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