Policy Study No. 95

In sickness and in health

managing change in the NHS

John Redwood MP

CENTRE FOR POLICY STUDIES

Policy Study No. 95

In sickness and in health

managing change in the NHS

John Redwood MP

CENTRE FOR POLICY STUDIES
8 Wilfred Street, London SW1E 6PL
1988

The author

John Redwood is MP for Wokingham in Berkshire. Before his election in 1987 he was adviser to various shadow ministers and ministers from 1975 onwards, culminating in his job as head of the Prime Minister's Policy Unit from 1983 to 1985; in which position he advised on a wide range of domestic policy issues. He has written several books on economic and industrial policy and has been making a special study of the Health Service for the last six months. This pamphlet distils the evidence which he has submitted to the Prime Minister's Inquiry into Health Policy. His previous pamphlets for the CPS include *Equity for Everyman: new ways to widen ownership* (1986); and, with Oliver Letwin, *Britain's Biggest Enterprise: ideas for radical reform of the NHS* (1988).

The Centre for Policy Studies never expresses a corporate view in any of its publications. Contributions are chosen for their independence of thought and cogency of argument.

ISBN 1-870265-32-7

© Centre for Policy Studies, May, 1988
Printed in England by G.Donald & Co. Ltd.
92-94 Church Road, Mitcham, Surrey, CR4 3TD

Contents

		Page
1	The problem defined	5
2	Duties of the NHS Management Board	8
3	Relations with employees	10
4	Management of property	14
5	Towards patient choice	16
6	Quality of service	19
7	Competing pressures on the NHS	21
8	The union problem	22
9	Towards an internal market	24
10	Finance	26
Conclusion		29
Appendices		31

1
The problem defined

IT SEEMS LONGER THAN THREE MONTHS AGO THAT OLIVER LETWIN AND I first wrote about health.* We attracted considerable public attention to the problems facing health policy and the difficulties of running a monopoly health service in the United Kingdom. We are delighted that a high level inquiry is now at work under the chairmanship of the Prime Minister.

Further enquiry has convinced me that the extra money being committed to the Health Service needs to be committed on new terms. There must be major changes to ensure that it will be spent in the interests of the patients to improve the quality of health care. And there will still need to be substantial, regular increases in public funding for the health system, as indeed there have been in recent years.

Extra cash from private sources will have to supplement this public funding. Money is no simple substitute for change, but it will be needed to buy the changes required. The essential principle of care, free at the point of use, whatever people's income, should be protected, and access to that care greatly improved.

The Government has pointed to many successes in its defence of the Health Service in recent years. A large number of extra patients are now being treated. Many health staff are much better paid in real terms than they were in 1979 and many extra people have been recruited. The 1988/9 pay award exceeded expectations, and gave another real and substantial increase to nurses. New types of treatment are now generally available which were either strictly rationed or had not been dreamed of some ten years ago. The average age of the population is growing, people are living longer and the general standard of health of the country is improving. Many babies survive their early days where before they would have died at birth. Many elderly people not only have a longer but a much better life because of a variety of new operations.

* *Britain's biggest enterprise: ideas for radical reform of the NHS*

Nonetheless, there remains considerable public agitation about the state of the Health Service and not all of it is Opposition propaganda. There are genuine difficulties of access, quality and demand. The most serious problem that has emerged is the difficulty which some patients have in obtaining access to the care they require. Not that limited access is a new problem. The Health Service has had to put up with rationing ever since its foundation after the war. Waiting lists have always been long. Certain kinds of surgery and treatment have effectively been unobtainable under the Health Service for some. A system of concealed rationing is worked by general practitioners who decide not to refer some patients to consultants for some types of operation. There is also a form of open rationing where patients are referred but there is no real chance of their getting the treatment or the operation they require within a tolerable period of time. Debates in the House of Commons have been heated where the Opposition has identified groups of patients in particular health districts who have been denied access for the treatment they require. The most dramatic examples are those of the Birmingham heart babies needing acute coronary treatment, where it was alleged that treatment was not available when the patients needed it.

The second, related problem concerns care. Most people are full of praise for the Health Service for the quality of treatment it gives. However, complaints are growing about the standards of service in related areas. For example, many patients are treated badly in their dealings with out-patient clinics. They are given a common appointment time only to discover when they turn up that they must wait for hours before seeing the consultant. In some hospitals criticisms are made of the standard of food and the quality of the hotel services. Some grumbles are inevitable given institutional catering and the pressures which patients are under. Whilst most patients are careful to say how good the nurses are, often working in difficult circumstances, disillusion can be found with the standards of hotel accommodation and care.

In contrast with the US, the quality of surgery and the rates of success have not become an issue in the United Kingdom where there is a general feeling that the quality is high. There is little evidence on which to base a judgement how far this is

justified. The Health Service never publishes statistics by district or hospital for the relative success or failure of different types of operation. National figures suggest that whilst hundreds of people die each year as a result of operations or following operations, as a proportion of those undergoing surgery it is very small.

The third general concern relates to how the Service can cope with the ever growing demand. Here there are twin problems: one caused by the ageing of the population and the other by the development of new types of surgery and treatment.

The average cost to the Health Service of looking after someone over the age of 75 is over £1475 per annum. This compares with about £195 for a person of adult working age (1987/8 figures). As the population grows older these pressures will increase. At the same time improved surgery and other techniques enable more and more conditions to be tackled later and later in life. More surgery is undertaken for the ageing population as well as the additional courses of drug treatment and more frequent domiciliary visits or hospital stays. People are asking whether any system of health care can keep pace with this explosion of demand, and in particular whether it is feasible for a publicly funded system to do so. I believe that it can, provided that a greater element of private choice and partnership is introduced.

2

Duties of the Chief Executive and the NHS Management Board

Reform should start with a major strengthening of the NHS Board and its powers. Established under the Griffiths proposals, it was never given the powers it needed to do its job effectively.

The new Board should operate free of the Regional layer of administration. It needs new powers and terms of reference. It must be granted public funding adequate to keep pace with demand and costs. It should also aim to free spare and underused resources from within the health service – it should be possible to save £1 billion by improved management.

At present it is impossible to tell what is an adequate level of public funding, given the style of management and the lack of reliable information. Growth of real resources of about 2% per annum would be a reasonable target – unless general economic growth fell below such a level, in which case funding should increase at the same rate as GNP. This should meet the extra demand arising from both the ageing of the population and from the technological improvements. It would be in addition to modest efficiency gains of about 1% per annum (which might well be a substantial underestimate).

At present the Chief Executive does not hire and fire staff. He communicates with 12,000 managers via a two-monthly magazine. He has little say over property and staff deployment. He has no say over medical matters. His job is wrongly entitled and grossly misshapen in its terms of reference. The Chief Executive on behalf of the Board should have the following powers:

1. The right to draw up a short list of candidates for General Manager in each district, when it is appointing a new one.
2. The right to be consulted about candidates for District Chairmen who would continue to be appointed by the Secretary of State.
3. The right to advise the Secretary of State on the allocation of monies between districts.

He would have the following duties:

1. To set up and run an efficient and simple system of management information, so that each District provided him with monthly snapshots of the quality, quantity and cost of care in their territories.
2. To investigate major variations from budget and from average experience.
3. To promote best practice throughout the country.
4. To recommend management change to the Secretary of State in any District consistently failing to perform.
5. To promote new remuneration systems for management geared to performance.
6. To secure national standards and a focus for the national image and morale of the NHS.
7. To promote policies for developing an internal market within the NHS as outlined later in this pamphlet.

The General Manager in each district would relate to the District Health Authority in the same way as subsidiary Managing Directors relate to subsidiary company boards. They would have, subject to DHA approval, powers to:

1. Hire and fire hospital managers.
2. Settle contractual terms with all staff including senior medical personnel.
3. Organise and run the properties and services.
4. Account for their stewardship to the NHS Management Board.

Each district would gain new powers and rights over property, capital proceeds from sales, staff and contracts in return for giving the NHS Management Board a say in the appointment of the General Manager. Lines of communication would be shortened and improved.

This new system would soon deliver substantial improvements in patient care and major savings in costs. The next few chapters deal with the several inter-related issues to which the Board should address itself.

3

Relations with the employees

At the core of many of the difficulties of the Health Service lie a series of management and union issues. It is doubtful whether a large organisation employing about one million people can ever be run as a successful unified whole. The structure of the Health Service is to management what the tower block is to housing and architecture. It is a grandiose paper construction totally out of sympathy with human nature and out of joint with the times. There is growing evidence to suggest that no management can systematically run very large units with very large numbers of people over the whole diversified nation.

Certainly the experience of the Health Service bears this out. Whilst the National Health Service implies through its name that it should provide comprehensive care to all the nation on a consistent basis, evidence abounds that differences are huge in quality of care and in access to care between different districts and hospital units of the country. The effort to address this in purely financial terms by the much disliked RAWP formula seems to have done little to even out the standards. It has created acute difficulties for some hospitals in the hard-pressed South East area which is experiencing population and demand growth; as well as in London, where hospitals try to maintain high quality research and teaching against the background of dwindling resources and declining population.

Variations in costs and efficiency are huge. Staff usage varies fivefold between different districts. The cost of keeping medical records is five times higher at Charing Cross than in West Cheshire. The cost of building maintenance at West Birmingham is five times that of North Hertfordshire. National management does not seem to have any firm grip on the Service.

The Appendix illustrates the range of these variations (prised from a reluctant DHSS via the indicators deposited – late – in the House of Commons Library). The fact that the 1986/7 figures were not available until the spring of 1988 suggests that they are not used for serious management purposes. No self-respecting national management would put up with the wild variations in quality and efficiency suffered by the NHS.

Union problems are becoming severe. The Conservative Government's union legislation has made great progress in turning the industrial minefield of Britain into a much less explosive place. In many companies there is much more co-operation between managers and workforce. Indeed, there is now a virtuous cycle in many sectors of the economy -- with rising productivity leading to rising real wages, without huge and damaging industrial disputes.

But there has been no such progress in key public sector services. These retain the characteristics of British unionism typical of the 1970s. In the Health Service there is a damaging battle for membership and support between three competing unions. Both NUPE and COHSE are actively trying to recruit staff away from the Royal College of Nursing which bases its activity on the laudable premise that nurses should not withdraw their labour because this could harm patients. NUPE and COHSE have wrestled with this problem together with their friends and colleagues in the Labour Party; and have sought to characterise their strikes as being 'days of action' or protest. They have also attempted to represent them up as being about the level of funding and the national interest, rather than simply about pay and conditions. This in many ways makes them more damaging and harder to handle.

Unionisation has been paralleled by the continual growth of a bureaucracy of middle and junior administration and clerks. There are now so many layers of management within the Health Service that it is extremely difficult for central management to communicate a message down the line with any hope of seeing it implemented in the spirit in which it was intended. Administrative costs are in excess of 10% of the total expenditure on the hospital services. (For years we were told that they were only 5%, but analysis of the accounts showed me that this referred only to headquarters staff). Efforts are made to decentralise the Service within the regional and district structure. But at the same time people wish to see it centralised as they look to the centre for funding and argue that the basic fault of the whole system is the choice of any particular level of funding. Organisations which always blame an external force or cause for whatever is going on within them, should be listened to with a certain scepticism.

The Health Service has a similar mentality to that of the British car industry in the 1970s which claimed that all its shortcomings were due to government policy towards it: the tax level was wrong; or the exchange rate was wrong; or the interest rates were wrong; or, simply, the Government did not spend enough on it. But the 1980s have seen a major rebuilding of the British motor industry. Managers within the industry now understand that external matters are not nearly so important as the design of cars, the productivity of the manufacturing units, the way in which cars are marketed. No attitudinal change of this kind has occurred in the Health Service. This is not to suggest that we should replicate in the Health Service a profit-seeking mentality. However the NHS does need a management style which understands that the patients come first, and that managers in the Health Service are endowed with resources substantial enough to solve many of the problems themselves. Good Hospital and District General Managers need to be encouraged, and best practise should be spread more widely. Individual financial incentive may help in people's pay packets.

There are too many managers, too much badly-presented information and an erratic style of management. There are too many statistics never used to manage the Service, whilst essential figures like the cost of an operation are not available. Some people point complacently to the allegedly higher administrative costs of overseas systems. Yet these often include the cost of insurance and insurance claims – which means that they are raising money as well as spending it, so should not be compared with the bare headquarters costs in Britain. To be at all comparable the British administrative costs should include the costs at hospital level and the cost of the Inland Revenue: over half all the income tax collected is needed to meet the bills of the NHS.

Staff morale is low in many NHS hospitals. The common explanation is inadequate pay. But how can that be true when the rates of pay in private hospitals, where the morale is usually much higher, are generally similar to, or the same as, those of NHS hospitals? And has the latest pay award solved that? There are no reports of private medical staff going on strike or indulging in days of protest. The visitor to private units is immediately struck by the good morale of the staff and their good relationships

with managers. Conversely, in the National Health Service administrators at the lower levels seem to be becoming themselves heavily influenced by union campaigns. Some see themselves not as managers but as instigators of action and protest against the health authority or against the Government on the grounds that money is short, and that more money would solve all the problems.

One most sensitive issue is nurse management. Many nurses and sisters have said that they do not like the current system of nurse managers placed over their heads, and wish to go back to the system whereby the sister is in charge of the ward and reports only to the matron. Hospitals need a good general manager and a matron in charge of the nurses. They do not necessarily need the whole range of other managers which has been introduced in the wake of the Griffiths reforms. Nor do they need a lot of junior managers intermediating between the man at the top and the sisters and nurses on the wards. More good nurses need to be retained as nurses, and paid for their skills and experience, rather than to be 'promoted' into an administrative job.

It could be argued that a large hospital of 1500 to 2000 beds presents a problem different in scale. Here, indeed, we may need smaller management groupings. There could still be a general manager of the whole hospital, but there might be four or five other senior managers responsible for individual blocks within the hospital, perhaps with their own separate matrons.

4

Management of property

Opportunities in property management are legion. Some major old-fashioned hospitals are in the centres of towns where the site is too constrained but which would be extremely valuable for an alternative use (retail, for example). Here there may be a good case for building a new unit partly out of the proceeds of subsequent property transactions once the new unit is constructed. Other properties are simply redundant.

The NHS is one of the biggest landlords in the country owning 50,000 acres of property. The estate is undergoing rapid change. Huge capital programmes expended in recent years have built a new group of 'mega' district general hospitals; but a consequence has been that very many smaller hospitals which the community prized have been closed, and the staff have been concentrated in very big units where management problems are more severe and unionisation more intense. Mercifully, many small hospitals are still left; and the public mood would favour their rehabilitation and use, whether as GP surgery units or as small residential hospitals catering for geriatric services, maternity services or a basic range of surgical treatments.

Considerable work, however, remains to be done in rationalising the large estate. There are still too many units and plots of land and inadequate use of some of the better sites. Management is becoming aware of the opportunities here, as is evident from the large increase in sale proceeds from land and buildings in recent years.

But the accounting system still does not regard land and buildings as a true cost; since there is no depreciation. The Health Service got by on wishful thinking. Some day, somewhere, money would be available for necessary refurbishment -- so let's put off maintenance a little longer. The Health Service faces the problem that many buildings of the 1960s and 1970s were not built to last. Their flat roofs and concrete structures and cladding have aged very rapidly. Superimposed on updating Victorian and Edwardian institutions is the task of rebuilding or renovating comparatively modern ones.

An example in the West Berkshire Health District shows the scale of some of the opportunities. Smith Hospital, a small unit for dealing with autistic adolescents near Henley, at present looks after 12 young people. The total cost is £700,000 per annum (1988/9), or about £60,000 per patient. Only five of these patients come from the West Berkshire Health District itself – a relevant consideration given the budgetary constraints and the present clearly-defined boundaries in health care. These children could be relocated at other more suitable sites and a major asset freed, which would not only save substantial running costs but could raise £500,000 or more for an alternative use. Also in the West Berkshire District, the expensive but not very satisfactory office accommodation at Great Western House could be sold, since the District has a practicable site elsewhere, no longer needed for medical purposes, which could be converted into an office block. The office move would save £225,000 in a full year.

Sometimes thoughtful health districts like West Berkshire who wish to make the most of their property run into very great difficulties with local authorities. The Government should consider issuing a further planning circular saying that where there are spare buildings on an NHS site there should be a presumption in favour of change of use and redevelopment in view of the Health Service's need for funds (especially where a new hospital is being constructed elsewhere). This money should be additional to existing health budgets. The Government could then exercise its discretion on appeal in cases where the local authority was not persuaded.

5

Towards patient choice

The siren Opposition response to problems of access is to assert that everyone can have access to everything if only the Government loosened the purse strings a little. It conjures out of the air the phantasm that just for that elusive extra £300m or £400m or the elusive extra £1 or £2 billion the public could have all the health it wanted and more besides. There is little evidence to support this contention. The last £14 billion extra put in since 1979 has not had that desired effect of giving everybody access immediately to that which they seek. Indeed, ask the DHSS how much it would cost to clear the waiting lists, and the reply will not come because they do not have the information. The question is far from that simple. In Scotland, where spending per head on health is materially higher than in England, waiting lists are also higher.

When the Birmingham children were at the centre of the recent political debate lack of money was not the villain of the piece. If an extra £1 million would have solved the problem the Government should, and no doubt would, have found the money. But probing brought to light the fact that the problem lay in a shortage of intensive care nurses; and no amount of money in the world could suddenly transport such nurses to Birmingham, without removing them from some other hospital where they were already performing important work.

The Birmingham experience showed that the problems lay deeper, in training and in other decisions taken over a number of years. They were exacerbated by the difficulty experienced by patients in moving around within the Health Service. Glasgow has a successful child coronary unit with a very short waiting list but it was not thought possible that some of the less severe cases from Birmingham who could travel might move to Glasgow in order to free beds in Birmingham. Nor was it thought possible to transfer nursing and other resources from less acute specialities in Birmingham to the acute heart care centre. There are tight union and medical guidelines over training standards and over levels of staffing needed to carry out certain types of operation. The Inquiry should ask whether all these rules are

necessary for safety or whether some manning levels and training levels are not set unrealistically high to the detriment of patients wanting care. Heart operations are complicated and staff need training, but do 16 people need to be present for such surgery?

In order to tackle waiting list problems a number of management decisions have to be taken and promptly put into place. The first point is that cutting waiting lists has to be made an urgent priority. The Health Service needs to compile accurate figures and information on who is waiting where. It also needs to know which hospitals have spare capacity to tackle which kinds of treatment or problem, and it then has to marry the two together. A simple computer programme would enable the longest wait to be reduced by offering people the opportunity to go to a shorter-waiting hospital and consultant even if this did mean travel. Experience in Scotland suggests that people are prepared to travel considerable distances in order to get out of pain more quickly; there is no question of anybody forcing them to do so.

Breaking down impenetrable district boundaries would be an important step towards evening out the standards of health care over the country and for dealing with the most acute waiting-list problems. As managers sought to reduce waiting lists (making sure they were accurate and giving patients choice) they would also see from their computer screens where the shoe was pinching. Then they could start to take decisions which might shift resources from types of surgery and treatment which were relatively over-provided, or not so important, into the urgent types where the waiting times were unacceptable.

Simply to pour in more money may in the short term do little other than to increase the costs of the system. It takes time for people to respond, to go through the very long training necessary to become nurses and doctors. It will need changes in attitude, and use of staff, before extra money can ensure that more are cured. As the output of the system is determined by an amalgam of the number of nurses and doctors on the one hand and by the use of their time on the other, such extra money may do nothing to improve throughput of patients in the first instance. In the medium term, however, higher pay can act as a signal to the market-place and attract more people into the

profession.

There also needs to be a willingness, particularly on the part of some consultants and hospitals, to see the appointment of more consultants. Given the hierarchical structure of medical care in this country long waiting lists are going to be shortened only by allowing more consultants to be put into place; or by allowing the new level of staff doctor one rank beneath the consultant the right to carry out basic operations without the supervision of a consultant. Such doctors would typically have at least fifteen years' training and experience.

A simple alleviation to the most pressing problem of waiting lists is a national referral system where a GP can see a list of consultants and waiting times around the country and can book his patient in. GPs will have to be prepared to refer patients to consultants they do not know if the patient regards time as being crucial; and the patient must expect to be given a choice ranging from the consultant the doctor knows well, through to a consultant he does not know, but who can perform the operation soon. (He must of course be up to general NHS standards otherwise he would not be in the system). The same information system would allow data to be retrieved centrally to look at the allocation of staff and monies between specialities and districts in order to tackle the problems where they are most serious. Success in treating more people for more conditions will in the longer term add demand to the system as people live longer. The extra resources mentioned in later chapters would be needed to take care of them.

6
Quality of service

One problem, that of out-patients clinics, could be tackled quite simply by the NHS Management Board insisting that every such clinic be based on an appointment system, and each patient be given a different appointment time. In all reasonable circumstances consultants should turn up for the clinic or some locum should be appointed. No resource cost would be involved. People are already given appointment times – but they are ones that mean nothing, as in many hospitals every patient is given the same one.

Casualty wards need attention. Patients often sit for hours in pain. Part of the problem lies in the way in which their cases are organised. They are moved from pillar to post between nurse, consultant, doctor, X-ray department, consultant and nurse. A casualty department manager or general hospital manager should be able to streamline the system, with doctors making more on the spot decisions about what kind of information the nurses, X-ray departments and laboratories should collect before the patient sees the consultant or senior doctor for the decision on treatment. Such tests should be completed as soon as possible after the patient has arrived in the hospital. It should be possible to have everyone treated within two hours of arrival, as a minimum objective.

The hotel services of the hospital are much easier to tackle. Clause 4 of the Health & Medicines Bill makes a substantial advance. It gives hospitals powers to introduce private enterprise in the provision of non-medical services on a wide-ranging basis. It is to be hoped that they will welcome this, not only as a source of additional revenue but also as a means of raising the standards of hotel service within the hospital.

The use of Clause 4 and attention to the comfort of patients might lead to:

- a change in practice whereby hospitals organise their day by waking all patients up at some extremely early hour in the morning. Part of recuperation or preparation for an operation can involve having a decent night's sleep.
- private caterers might be allowed to offer an *à la carte*

menu to those who did not like the look of the standard *table d'hote* offered by the NHS. Subject to any dietary restraints, many patients and their visitors might take advantage of the trolley and kitchen service from the private caterer and be happy to pay for something different.

- The private sector could certainly take care of the need for televisions, newspapers, hairdressing, telephones and other facilities which could improve the patient's stay in hospital. At the same time, it could make a modest contribution to funding the total cost of the hospital service.
- Private/public partnership might extend further, with private monies building new amenity-bed wings, perhaps in conjunction with good hoteliers.
- More retail and service facilities for visitors to hospitals, provided by commercial interests.

7
Competing pressures on the NHS

The largest increase in costs comes through the ageing of the population. The principal cost of taking care of elderly people in permanent residential care falls on the taxpayer but is not by and large carried out in NHS hospitals. A large number of private residential homes have grown up, but meeting the costs of these remains, for some of the patients, a problem. The question has been studied recently by Roy Griffiths. He recommends centralising the whole Service on the local authorities. This could place the Government in future difficulties over the level of cost and the control of this programme as long as it remains paid for out of central taxation. The Government would be better advised to consider a scheme whereby elderly people in certain categories qualified for a voucher. This could be encashed in a variety of hospitals and homes prepared to take care of them to the required standard. At the moment provision is patchy and in some districts not enough homes have been registered.

The second main pressure – of technology – produces plenty of problems. However, it also presents opportunities. Most of the 191 districts are planning to have one major hospital within their district boundaries which could become a centre for hi-tec medicine. If the districts are sensible enough to allow the growth of their community hospitals for the less serious types of operation, they could obtain better use of the hi-tec equipment needed for the main hospital. In order to intensify their use such hi-tec specialities should be operated on a partnership basis with the private sector. Either the NHS hospital could buy the equipment and then sell time on it to the private sector, or joint funding arrangements could help carry the initial capital cost. Examples of this now work in practice but the principle could be extended more widely. For the most exotic treatments and machinery regional centres of excellence should be developed. Some services like pathology laboratories might be better separated and run as free-standing businesses on a district or regional basis. Mobile equipment of a specialist kind could be provided to many hospitals by a single company or provider.

8

The union problem

The Government has made it clear throughout the past troubles that it responded favourably to the arguments and submissions of the Royal College of Nursing; but it does not do so to the unhelpful orchestration of NUPE and COHSE. The Government should study how any structural reorganisation of the Service could ease the tensions within the large NHS labour monolith. Managers need more direct contact with their employees and some of the rows could be averted at the bedside or in the kitchens and elsewhere before it blows up into a major national problem. The Government should not doubt that it is facing a serious challenge in the form of NUPE's and COHSE's recruitment programme. Some of their members work closely with Opposition in Parliament to foster demoralisation within the Health Service.

In the ancillary services it is possible to bring in help from outside, should unions decide to suspend their work and co-operation within the hospital. It would not be hard to find other ways of feeding hospital patients, cleaning hospitals or carrying out the other manual tasks, where they have not already been contracted out.

The medical profession is another matter. It is even more in the interests of both sides to proceed by agreement. The public might blame the medical profession for precipitating a crisis, or the Government for getting into the position where disruption occurred.

Some wish to develop a new form of contract for consultants, clarifying their commitment to the NHS and limiting their powers. At present the balance is weighted in their favour, as they have tenure while the managers are often on relatively short contracts. The proposal to give District General Managers additional powers would answer this problem, although consultants may object to this change.

It would be wrong to tamper with GP arrangements, especially at a time of change in consultants' conditions of employment. GPs provide a good local service and are long-established as independent contractors for the NHS.

Doubtless it would be better for both managers and employees if the management hierarchy was reduced and the concentration was on good local management and units where managers knew all the employees by name. A small private hospital and an NHS hospital have different treatment of staff, with different attitudes towards the return of married women to work. In the NHS hospital the rosters are fairly inflexible, and part-time workers meet with antagonism (particularly part-time women who need to be flexible about their working hours because of school and home arrangements). Conversely, in a good private hospital part-time work related to the schedules of the individual consultants, who may themselves be working only one or two days in that particular hospital, is encouraged. Good managers are willing to allow a given nurse to miss a Tuesday afternoon if in return she will do an extra Thursday evening or whenever. When combined with a pleasant working atmosphere such flexibility can make all the difference between high and low morale. Exchanges of patients between public and private hospitals should be encouraged. The private sector needs the back-up provided by the high technology medicine of the NHS. And in some areas the NHS needs private hospitals to shorten waiting lists.

9

Towards an internal market

It is sensible that each district should have one major hospital and a group of smaller facilities and hospitals clustered around it. But there then need to be clear flows of patients and information across district boundaries, and centrally determined decisions on resources. A simple management information system illustrating patient need, GP demand, waiting lists and other pressures should provide the basis for these decisions. Most powers for day to day running should rest with hospital managers at each location.

The essence of the internal market is patient choice. Money must move with the patient when the patient wishes to change. The beginnings of an internal market do not have to rely upon the establishment of Health Maintenance Organisations or other new structures. They could depend upon the following simple precepts.

1. Patients have a right to change doctors whenever they wish.
2. Doctors have a right to tell patients of the range of service their practice offers and the style of medicine they believe in.
3. The patient has a right to a choice of consultant when he is referred to a hospital.
4. District General Managers manage the costs and quality of care provided.
5. District boundaries cease to matter. Patients and GPs between them choose where they will go to get treatment and the money will follow the patient.
6. The money following the patient should be the amount of cost actually incurred in carrying out that operation or treatment in that hospital, subject to maxima based on a figure related to average costs, laid down by the District and the NHS Management Board.
7. The NHS Management Board should monitor unit costs of operations and treatments very carefully hospital-by-hospital, and call in the worst-performing 10% every year to investigate them; and if necessary to change management styles or managers themselves for persistent under-performance.
8. Hospitals should be allowed to opt out and establish themselves as non profit-making trusts.
9. Hospitals should be encouraged to enter partnerships with the private sector, and Treasury expenditure rules should be amended to encourage such developments.

The NHS Management Board should collect and use simple data, by hospital and speciality, about cost, quality of service and access for patients; which it should use to manage the service as a whole and to direct new resources to where they are most needed.

10
Finance

The main outlines of the problem are becoming clearer. The present Inquiry needs to address itself to the issues of access, quality of care and growing demand. It also needs to address itself to the management issues of staff morale, management style and the use of people and property within our Health Service. There are then the broader, well-ventilated issues about the future financing of the Service. Should we continue with the pay-as-you-go tax-based system? Should we instead move towards some kind of private or public insurance scheme, or a mixture of the two? Should we move to a system of financing, within the tax-based system, which would turn general practitioners or districts into health management units buying surgery and treatment from a variety of providers? These are now firmly on the agenda; the correct answers will have great bearing upon the prime question of how to ensure high quality patient care.

Much has been made in recent months of comparisons between the proportion of GDP spent on health in the United Kingdom and that spent elsewhere. The United Kingdom does come at the bottom end of the scale, but the figures also reveal that the main divergence lies not in the costs of the public system but in the amount of money contributed freely by individuals. In the United Kingdom we have the lowest percentage of any advanced country: 0.6% in addition to the 5.6% spent through the public sector. A realistic target would be to expand the private provision fourfold from 0.6% to say 2.5%. Two ways of doing this have been suggested.

The first is to draw an analogy between health and housing. Just as the growth of private housing was greatly stimulated by mortgage interest relief so, it is argued, the growth of private health insurance above and beyond the National Health provision could be stimulated by tax breaks to employees and/or employers who take out private health insurance. The Treasury's main counter is that a 'deadweight' cost would result from the grant of tax relief to the 8% of the population who have already made private insurance arrangements without any such inducement. But this might be a price worth paying to stimulate more private health care plans.

A second way would involve more accurate targeting and could be cheaper. It is to convert a sizeable proportion of the income tax – a little over half – into a National Health tax. This would be progressive and related to income; the more money you earned the more you would pay. Then, modelled on the contracting out from the SERPS scheme, individuals and/or companies could be offered rebates if they were prepared to contract out all or part of their risks to a private insurance scheme. The rebate could be varied according to age and the degree of cover which the person wished to keep with the NHS. The Government would have to monitor the quality of these schemes so that no one was ever in the position where they were uninsured for certain specified risks. The individual would get only a modest rebate, since he would still need to make a substantial contribution to the pay-as-you-go health system to help pay for all those on lower income and for the elderly who did not have the means to pay for their own health costs.

With a 3% or 4% rebate the point might rapidly be reached where 20 million people were contracted out, and the proportion of private finance to GDP had risen to the 2.5% suggested above. There would still be a deadweight cost in this scheme but, depending upon the level of rebate chosen, it might be less than in private tax relief. The scheme would have the added advantage of bringing home the total cost of health care, with absolute clarity, to all those in employment paying the tax. Thus they would see that it now costs £30 a week for the average family to keep the NHS going.

The model would be the State Earnings Related Pension Scheme whereby the State provides a second income-related pension to all retiring employees, public and private, in return for a portion of their National Insurance payments. If an individual or company wishes to makes their own arrangements they are offered a rebate on the National Insurance levy.

Health management units

Considerable interest has been expressed in the concept of an enlarged health maintenance organisation. Either GPs or Districts would receive capitation fees in respect of all their

patients or resident population; they would then spend this money with a variety of hospitals and health providers to buy the range of care which their population needed.

The advantage of such a scheme lies in the cost control it might exert. The health maintenance unit or groups of GPs would be cost conscious because their capitation fee for a given range of patient would not vary; they would have an interest in keeping people healthy and in keeping the cost of care down. The scheme could introduce substantial competition into the hospital and treatment services as GPs or Districts competed to find lowest-cost, high-quality systems. The GP basis rather than the district basis would be best, since it would give genuine choice for individual patients as to which group of GPs they went to (a district-wide basis would be too large to offer most people effective choice); and since it might prevent health management units becoming parsimonious, interested only in balancing the books or taking higher remuneration, at the expense of patient care.

There are drawbacks. The level of annual fee for each patient would remain a highly charged political issue, and HMOs might be tempted to argue that problems lay in the inadequate level of the capitation fee rather than elsewhere in the health system. The Treasury would use the fee scale as a means of spending control. This would certainly be the case if the districts were chosen as the unit for the HMO, in which people would still have to accept whatever care was offered by the District. On the other hand the HMOs might encounter GP resistance – and the whole system would depend upon GPs welcoming it and wanting to make it work. Since the system might be kept short of cash GPs might not like it.

With an expanding private sector, if the insurance option were adopted, HMOs will probably emerge of their own in the private sector where they would not encounter the same problems.

Public sector HMOs are not recommended, as they would merely shift the location of the funding battlefield.

Conclusion

This pamphlet recommends some major changes in the provision of health care.

1. The Chief Executive and NHS Management Board at the centre should be strengthened. Regions should be abolished, and Districts should report direct to the Board. The Board should set national standards, influence District management and deal with poor performance in Districts.
2. The NHS should be strengthened by more partnership ventures between the public and private sector, and by breaking down boundaries not only between NHS districts but also between the public and private sectors so that operations can be carried out wherever they can best be performed.
3. A major increase in resources should be found through an expansion of privately financed care through a contracting-out insurance scheme; while preserving the important principle of the NHS that all should have access, free at the point of use, to high-quality care whatever their means and whatever their circumstances.
4. In order to prevent the system being constrained too much by resources money should move with the patient and reflect the actual costs of the treatment delivered.
5. New elements of competition between hospitals and other health providers should be introduced to prevent the system becoming massively expensive with runaway inflation of costs.
6. High-quality patient care should be a prime aim; at the top of the management's agenda should be the reduction of waiting times through a combination of good management information systems and the targeting of resources on those areas where they are most needed.
7. National Health Service Management staff should be offered a better deal by breaking down units into more manageable groupings and by reducing the huge management overhead which is as much a burden on staff morale as it is on the financing of the Health Service.
8. Substantial new revenues and savings should be generated from a bold programme of property renewal

and disposal, from additional resources coming in from private-sector providers of hotel services and from the administrative savings achieved by sweeping away the regions and some of the central overhead. £1000 million could be saved quite easily.

Appendices

		Page
1	1985/6 NHS Performance Indicators	32
2	1986/7 NHS Performance Indicators	40
3	College of Health guide to waiting lists	45
4	Parliamentary questions and answers	46

1

1985/6 NHS Performance Indicators

The ten top and bottom districts, in answer to the following questions, are:-

How much property does a district need to carry out its tasks?

District	*Building area in square metres per thousand people*
North Bedfordshire	38
North Hertfordshire	45
South Bedfordshire	47
East Hertfordshire	153
Chorley & South Ribble	159
Richmond, Twickenham	227
Paddington	251
Tameside & Glossop	290
Scunthorpe	298
Rugby	300
Lancaster	1,278
Tower Hamlets	1,280
Central Birmingham	1,334
South Manchester	1,337
City and Hackney	1,340
Central Manchester	1,353
Riverside	1,565
Bloomsbury	2,130
Preston	2,282
Hampstead	2,420

How much does it cost to maintain its property?

District	*Maintenance Cost/ Building Area £ per sq. metre*
North Hertfordshire	5.5
Brent	5.7
Rochdale	6.6
Cambridge	7.4
Haringey	7.4
Stockport	7.5
Ealing	7.6
Calderdale	7.9
Paddington	8.0
Winchester	8.4
South Birmingham	19.6
S.E. Staffordshire	19.7
Croydon	19.7
North Tees	19.9
West Lancashire	20.4
Merton and Sutton	20.8
Central Manchester	21.5
Rugby	23.0
Richmond, Twickenham	24.9
West Birmingham	27.2

How many ancillary staff are needed for a given number of patients?

District	*No. of ancillary staff per 1,000 in-patient cases*
Milton Keynes	5.7
Huntingdon	10.0
Rugby	12.0
Medway	12.4
Hounslow & Spelthorne	13.1
Bury	13.3
Worthing	13.6
Wycombe	13.7
Scunthorpe	14.6
Aylesbury	14.6
West Berkshire	19.7
Dartford & Gravesham	33.9
S. West Hertfordshire	34.1
Brent	34.1
Hampstead	35.2
South West Durham	35.8
Frenchay	36.2
Northumberland	36.9
Chorley & S. Ribble	37.7
Macclesfield	38.7
Halton	41.3

How many administrative and clerical staff are needed in relation to in-patient cases?

District	*Administrative and Clerical staff per 1,000 in-patient cases*
Scarborough	8.6
Hartlepool	9.9
North Hertfordshire	10.0
Bradford	10.3
Doncaster	10.6
Pontefract	10.6
South Tees	10.6
Rotherham	10.8
Scunthorpe	11.0
South Sefton	11.1
Lewisham & N. Southwark	21.4
N. West Hertfordshire	21.6
Tower Hamlets	21.8
Riverside	22.3
Macclesfield	22.8
Hampstead	23.6
Frenchay	24.0
Brent	25.2
Chorley & S. Ribble	30.2
Halton	46.7

How many nursing and medical staff are needed in relation to in-patient cases?

District	*Nursing and medical staff per 1,000 in-patient cases*
Scarborough	39.4
Milton Keynes	40.9
South Manchester	43.2
South West Surrey	44.4
Medway	45.0
Scunthorpe	45.3
Central Manchester	45.3
Huntingdon	45.8
Hartlepool	46.7
Pontefract	46.8
West Berkshire	57.7
Warrington	99.0
Kidderminster	101.2
South West Durham	102.8
N. West Hertfordshire	103.3
Mid Surrey	108.2
Northumberland	115.7
Frenchay	118.0
Macclesfield	127.2
Chorley & S. Ribble	142.4
Halton	160.9

Cost per case for medical records at hospitals

Major Acute Hospitals	*Admin & Medical Records* £
West Cheshire	24
Worcester Royal Infirmary	31
Rochford General	32
Wordsley	34
N. Tyneside	34
Royal D&E Heavitree	34
Derby City	35
Fairfield General	35
St Mary's	35
Rush Green	35
Royal Free New	99
Westminster	101
London Whitechapel	102
St Andrew's	109
Guy's	109
Bristol Royal Infermary	109
Middlesex	115
St Bartholomew's	115
Hackney	116
Charing Cross	124

Senior Doctors available per 100,000 people

District	*Senior Doctors/per 100,000 people*
South Warwickshire	1.8
Gloucester	2.0
Cheltenham	2.0
Tameside & Glossop	2.0
Blackpool, Wyre	2.1
South Bedfordshire	2.2
Crewe	2.3
Scunthorpe	2.5
Southport & Formby	2.5
Warrington	2.6
West Berkshire	4.1
City and Hackney	9.5
Harrow	9.7
South Manchester	10.0
Tower Hamlets	10.1
Islington	10.8
Central Manchester	10.8
Hampstead	11.9
Halton	12.7
Bloomsbury	16.7
Barking, Havering	36.3

What is the cost of drugs prescribed per patient?

District Health Authorities	*Cost of drugs per patient (£)*
Scarborough	21.5
Tameside & Glossop	21.9
Oldham	24.1
Solihull	25.2
South Cumbria	25.6
Bury	26.0
Kettering	26.4
Torbay	26.5
Salisbury	26.6
Worthing	28.1
Paddington	74.8
Lewisham & N. Southwark	74.8
Riverside	80.6
Tower Hamlets	81.5
Halton	84.5
Newcastle upon Tyne	86.6
City & Hackney	91.6
Camberwell	93.8
West Lambeth	100.5
Hampstead	153.5

2

1986/87 Performance Indicators

Again, the ten top and bottom Authorities are, for 1986/7

How many nurses and midwives are needed per 1000 in-patients treated?

	Number of nurses
Milton Keynes	41
Scarborough	41
South Manchester	43
Hartlepool	44
Scunthorpe	44
Medway	44
Rugby	44
Central Manchester	45
North Hertfordshire	45
Huntingdon	46
Brent	93
Warrington	95
Lancaster	97
South West Durham	98
Kidderminster	98
Mid Surrey	104
Northumberland	115
Macclesfield	117
Frenchay	121
N. West Hertfordshire	134
Chorley & S. Ribble	141

How many senior doctors in general medicine are needed to treat 100,000 in-patients?

	Number of doctors
Gloucester	71
Frenchay	84
South Warwickshire	89
Eastbourne	103
Blackpool, Wyre	103
Mid Staffordshire	105
Tameside & Glossop	105
Rugby	105
Wigan	117
South East Kent	121
Riverside	181
Huntingdon	517
Hull	521
Aylesbury	529
Tower Hamlets	544
Wycombe	558
Harrow	591
Hampstead	608
Cambridge	667
Bloomsbury	763

What is the cost of treating the average in-patient?

	£
Scarborough	456
Chester	494
S. E. Staffordshire	514
Worcester	542
Scunthorpe	543
Huddersfield	545
S Bedfordshire	545
Bromsgrove and Redditch	546
Medway	550
Torbay	551
Central Birmingham	1073
Tower Hamlets	1078
West Lambeth	1098
Riverside	1102
North Manchester	1107
Dartford and Gravesham	1117
Lewisham and North Southwark	1126
Wandsworth	1128
Bloomsbury	1146
Paddington	1158
Hampstead	1304

How many administrative and clerical staff are needed to treat 1,000 in-patients?

	Nos
Scarborough	9.3
Hartlepool	9.4
N. Hertfordshire	9.5
Bradford	10.2
Doncaster	10.5
South Tees	10.6
South Sefton	10.7
Rotherham	10.7
Scunthorpe	10.8
Bassetlaw	11
West Lambeth	21.5
Macclesfield	21.6
Lewisham and North Southwark	22.3
Tower Hamlets	23.6
Hampstead	24.3
Frenchay	25.1
Halton	25.1
North West Hertfordshire	25.1
Brent	25.4
Chorley and S. Ribble	33.6

What is the cost of maintaining the buildings?

	£ per sq. metre
Scunthorpe	5.4
North Bedfordshire	5.6
South Bedfordshire	5.6
North Hertfordshire	7.1
Ealing	7.2
Oxfordshire	8.3
Harrow	8.5
Calderdale	8.7
Chichester	9.0
Hillingdon	9.1
Central Manchester	19.1
Bromsgrove and Redditch	19.5
South Tees	19.8
Salop	19.8
Croydon	20.0
North Tees	20.2
Sunderland	20.2
Newham	20.4
West Birmingham	21.4
Rugby	24.4

3

College of Health Guide to Hospital waiting lists 1987

"It is almost a matter of geographical accident whether patients find themselves on a long waiting list or a short one."

Patients "do not even know how long the queue ahead of them is, let alone that in the neighbouring district there may be no queue at all".

Examples of waiting lists at March 1987

	Haringey	Bloomsbury
Oral Surgery	33 cases under 1 year	508 cases, 337 over 1 year
General Surgery	277 cases under 1 year	805 cases, 131 over 1 year
Urology	65 cases under 1 year	861 cases, 102 over 1 year
Gynaecology	130 cases under 1 year	1,080 cases, 60 over 1 year

4

Parliamentary Questions and Answers

Tuesday 15 December 1987

Staff employed on health matters

Mr John Redwood (C.Wokingham): To ask the Secretary of State for Social Services, how many staff are employed in his Department to work on health matters: and how many staff are responsible to the National Health Service Management Board.

Mr Tony Newton: The Department employs around 6,900 whole-time equivalent staff on health matters. Of these some 5,000 are Professional, Technical and Audit staff, the majority of whom are employed in running the Special Hospitals and the Disablement Services Authority (including the staff of the Artificial Limb and Appliance Centres).

The remaining staff work in support of Ministers in their Parliamentary and Departmental duties; these include some 650 who are accountable to the Chief Executive of the National Health Service Management Board.

Monday 1 February 1988

Hospital building expenditure

Mr John Redwood: To ask the Secretary of State for Social Services, which hospitals built in the last 10 years have needed more than £1 million of remedial expenditure in any one year; and how much has been spent on them.

Mrs Edwina Currie: Information held centrally on hospital building schemes in England shows only one instance of expenditure in one year of over £1 million on the remedy of defects: building and engineering costs of reinstatement of the cardiac wing of Great Ormond Street Hospital are currently estimated at £17 million.

Tuesday 2 February 1988

Hospital Building Costs

Mr John Redwood: To ask the Secretary of State for Social Services, how many hospitals built in the last 10 years have cost more than 15 per cent above the original estimate of construction cost; and what is the total amount of these overruns.

Mrs Edwina Currie: Information held centrally on National Health Service building schemes in England, which relates to schemes started since 1980, indicates that 5 out of 36 schemes, each valued at over £5 million and with a total value of £315 million,started and completed since 1980, overran the contractual sum by more than 15 per cent. Subject to resolution of outstanding final accounts, the total amount of these overruns is estimated to be £12.4 million.

Wednesday 3 February 1988

National Health Service Departments Operations

Mr John Redwood: To ask the Secretary of State for Social Services, how many people died as a result of operations in National Health Service hospitals in 1986; and how many of these deaths resulted from: (a) surgical error and (b) unnecessary operations.

Mrs Edwina Currie: This information is not held centrally. The recent Report of the Confidential Enquiry into Peri-Operative Deaths (CEPOD) looked at deaths in 1986 within 30 days of operations. It was in three Regions (Northern, South Western and North East Thames) found that the proportion of deaths which were attributable to avoidable surgical or anaesthetic factors was small. The overall death rate following half a million operations was found to be 0.7 per cent (3,500 deaths). Most of those who died were elderly and death was due to the progression of their illness or to other co-existing disease. Only one in 25,000 operations resulted in death which was thought to be due solely to 'avoidable surgical or anaesthetic factors' (20 deaths) although there were 'avoidable elements' in 0.14 per cent (700 deaths) which could have contributed to death. A copy of the CEPOD report has been placed in the Library.

Tuesday 12 April 1988

Waiting list targets

Mr John Redwood: To ask the Secretary of State for Social Services, if all districts will reach the target of all urgent cases being admitted within one month and all non-urgent cases within one year by March.

Mr Tony Newton: Targets of this kind, set in 1975, would no longer be appropriate in relation to the waiting list statistics now being collected, since these do not maintain the distinction between urgent and non-urgent cases, which is widely recognised to be too subjective to give reliable figures. However, as part of the Waiting List Initiative, we are encouraging health authorities to draw up local statements of policy on achievable in-and out-patient waiting times.

Tuesday 12 April 1988

Cost of reducing waiting time

Mr John Redwood: To ask the Secretary of State for Social Services, what estimate he has of the cost of treating all non-urgent cases waiting for more than one year and all urgent cases waiting more than one month, so that no one was in either position by July.

Mr Tony Newton: It is not possible to make a reliable estimate of the cost of reducing waiting time in the way suggested. The cost would depend on a range of factors, including the types of treatment needed, the extent to which extra staff, beds, equipment, operating theatre sessions and other facilities would be required and the number of new patients who would join the list between now and July.

28 March 1988

NHS Performance Indicators

Mr John Redwood: To ask the Secretary of State for Social Services
(1) what information he has as to why Hampstead, Preston and Bloomsbury District Health Authorities have large estates in relation to the resident population in their health districts; and if there has been a recent review of their property usage;

(2) what information he has as to the reasons for the number of staff in the ancillary, building and maintenance, administrative and clerical, professional and technical categories which Halton district employs in relation to its patient work load;
(3) what information he has as to the reasons for the level of costs of administrative and medical record keeping in the leading London hospitals and the Bristol Royal Infirmary;
(4) what information he has as to the reasons for the size of the complement of consultant and senior doctors in general medicine in the Barking and Havering district;
(5) what information he has as to why expenditure by West Birmingham, Richmond and Twickenham, Rugby, Central Manchester, Merton and Sutton and West Lancashire district health authorities on building maintenance is relatively high in relation to other authorities; and what plans are there to review their performance in this respect.

Mr Newton: I assume my hon. Friend's questions were stimulated by an analysis of Health Service Indicators. Although the purpose of the indicators is to raise questions at all levels about health service performance in delivering services to patients, most of the reasons behind detailed variations shown by indicator analysis can only be identified at local level where the analysis can be informed by local knowledge. This is why in our approach to the use of the indicators . . . we have concentrated on ensuring that detailed local analysis are undertaken and on monitoring the results and the action taken. My hon. Friend may therefore wish to direct his specific questions about the reasons for these variations to the District or Regional Health Authorities concerned. He will additionally wish to be aware that there is an initiative under way throughout the NHS to ensure that underused properties are either disposed of or put to better use.

A selection of recent studies

On health

HEALTHY COMPETITION: how to improve the NHS
John Peet £4.60

BRITAIN'S BIGGEST ENTERPRISE
ideas for radical reform of the NHS
Oliver Letwin and John Redwood MP £2.95

MANAGED HEALTH CARE
a new system for a better health service
Michael Goldsmith and David Willetts £2.95

A MIXED ECONOMY IN HEALTH CARE
David Willetts and Michael Goldsmith £2.95

On education

DIAMONDS INTO GLASS
universities and the Government
Elie Kedourie £3.90

OPTING OUT: a guide to why and how
Sheila Lawlor £3.90

AIMS OF SCHOOLING the importance of grounding
Oliver Letwin £3.90

A subscription to the Centre

Also available from the Centre: associateship for £25. This includes a minimum of ten policy studies published every twelve months, whose average cover price is £3.90; occasional papers and previous publications (while still in print) at half price; and half-price fees for the seminars, colloquia, conferences etc. which the Centre regularly holds. For full details please write or telephone to the Secretary to the Associates, CPS, 8 Wilfred Street, London SW1E 6PL (01-630-5818).