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Policy Study No. 78

NHS

the road to recovery

Hugh Elwell

CENTRE FOR POLICY STUDIES

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8 Wilfred Street, London SW1E 6PL
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The author

Hugh Elwell was born in 1932 and educated at Newport Grammar School. He joined the armed services from school and left the army in 1958 to become a management trainee at BUPA; he left BUPA in 1976 while General Manager and member of the Board. Hugh Elwell has travelled widely looking at systems of health care and has lectured extensively in the USA. He is at present an adviser to major groups in the field of health care.

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Introduction

The National Health Service is sick, but not so sick that it cannot be put on the road to recovery. Injecting more taxpayers' money into the enterprise will not help. Spending must be made more effective, and accountablity must be improved.

Given that the health service is free at the point of supply, rationing is inevitable. But it must be operated in a fairer form than that of the waiting lists on which some 700,000 patients are now queueing for in-patient treatment.

Few national institutions have attracted such analysis, particularly by economists, proving or disproving the efficiency of the system. One thread is common to almost all the comment: that since the foundation of the NHS demand for health care has consistently exceeded supply. And three considerations are commonly raised in predicting the future:

1 An ageing population – people living longer and requiring more care as a result, disproportionate to the demands of the young;
2 Further developments in medical science and technology, causing higher real expenditure and leading to:
3 A continuing rise in expectation of health from a population most of whom have always known a 'free' service and to whom the concept of 'price' for health care is unfamiliar.

In this paper we suggest that by trimming bureaucracy and thereby reducing the distance (illustrated by the circular chart on page 13) between the patient and the service which provides his treatment – and by giving him incentives to take an interest in the quality of service – accountability and value for money in the NHS will be enhanced. At present a criss-cross mesh of agencies combine to provide the service. We shall argue that structural changes, going far beyond the recommendations of the 1983 NHS management inquiry under Sir Roy Griffiths, are needed to create that sense of local accountability which is essential if the service is to become more comprehensible to the consumer. Abandoning management by consensus in favour of management by clearly-defined decision-takers (as Sir Roy suggested) is only the first step.

In any such restructuring, proper methods must be developed for measuring the effectiveness of the services and –

above all – more room must be given for the voice of the patient to be heard by those who have the power to set things right. But there is a caveat. Improvements in the NHS will not – cannot – decrease the yawning gap between resources and demand. Indeed they can serve only to widen it. For we all die; and the longer we postpone the day of death, through the skill of doctors, through the care of nurses, through the miracles of technology, through the care we take of ourselves, the greater will be our eventual call on medical resources, and the lesser our ability to meet them. Our demand for care increases with age. Those who attain the biblical three-score years and ten demand on average five times the expenditure on their health than those who die younger. That one test of excellence should be an increase in the gap between resources and demand is a hard saying but an ineluctable one.

Thus it is that rationing becomes ineluctable too – whether by the purse, by the random dictation of doctors, or by other criteria. What the electorate may not sensibly demand is that the gap be diminished. Demand is infinite, resources are finite.

Summary of recommendations

1 THE FUNDAMENTAL OBJECTIVE must be to make spending more effective, accountability tighter, and the inevitable rationing of health care fairer. The citizen must be brought into close touch with the service and given a more effective voice. Better ways must be found to assess better how care of the patient reflects, or fails to reflect, the money spent.

2 DISTRICT HEALTH AUTHORITIES should, to these ends, combine under their roofs almost *all* functions of health care – including primary care and community services and in effect become *the NHS* in their area. Family practitioner committees should become part of District Health Authorities, and their general managers be represented on District Health Authority boards. District Health Authorities would agree locally as many questions as possible of pay and conditions.

Patients should, with the consent of their 'parent' District Health Authority, be allowed to cross boundaries for services which it did not provide.

District Health Authorities should encourage private tendering for services (laundry, food and cleaning are but the start).

District Health Authorities should publish full annual reports and accounts – of interest to local media.

Looking further ahead, District Health Authorities should be empowered to:-

- contract out management of their private beds to the private sector.
- raise private capital to build hospitals which they could then administer.
- join with private capital to finance expensive items of equipment.

3 REGIONAL HEALTH AUTHORITIES should have their role limited to supervising, co-ordinating, monitoring, and arranging for 'ultra-specialist' services: their staff should be of a size appropriate to their functions.

4 GENERAL PRACTITIONERS should undergo regular retraining, as suggested by their Royal College. Patients should be given greater freedom to change their GPs despite the problem of 'the list', of the occasional hypochondriac and

the advantage of familiarity with patients' medical histories. Patients other than those receiving family credits should pay a modest fee for visits, and more if they visit a 'new' GP. GPs would not, of course, be obliged to accept payments.

5 NHS HOSPITALS should appoint associations of friends who would involve themselves with District Health Authorities, and operate financial appeals; their chairmen would ex officio be members of the Community Health Councils.

Hospital patients should pay a modest 'hotel' fee – a minimum of £15 a night and maximum of £75 for their stay. This could be insured against at little cost.

6 GROWTH OF INSURANCE SCHEMES should be encouraged; employees in company schemes who earn up to £12,000pa should be allowed their contributions tax-free; and all the registered self-employed should be allowed to set their premiums against tax. A health bond is proposed which would work on the basis of the new Personal Equity Plan: i.e. the investment return on such bonds would be free of tax.

7 A SEPARATE SECRETARY OF STATE for health care should be appointed with Cabinet rank. The double portfolio of health and social security, together responsible for almost half the State's expenditure, is too much. The Secretary would chair a *single* board which would be responsible for all aspects of general practice as well as for hospital and community care services.

The status quo

Except during the period 1974 to 1982, when area health authorities provided an additional tier of bureaucracy between regions and districts, the structure of NHS bureaucracy has remained substantially the same since the foundation of the service. The Secretary of State for Health and Social Security – before 1968 the Minister of Health – and his department superintend a structure in England and Wales which branches down through 15 regional health authorities to 191 district health authorities. Also directly accountable to the DHSS are 98 family practitioner committees, which are responsible for local 'primary care' services – GPs, dentists, chemists and opticians. The voice of the NHS consumer is meant to be heard through the community health councils who do not, however, have any statutory representation on the district board, on the recommendation of whose chairman they are appointed by the Secretary of State.

Ideally the activities of the RHAs and DHAs would be monitored by the DHSS. In practice they are not. Data concerning expenditure and performance is of a poor standard. In recognition of this fact a study was conducted by Mrs Elizabeth Kroner on 'information retrieval in the NHS', whose proposals to accumulate NHS data and thereby to assess levels of activity and the monitoring of activity were accepted.

This Government's principal initiative to improve NHS management was its establishment of the NHS Management Inquiry in 1983 under the chairmanship of Mr (now Sir) Roy Griffiths. In presenting its recommendations, the Inquiry stated that its main intention was to have 'a small, strong general management body . . . at the centre . . . to ensure that responsibility is pushed as far down the line as possible, i.e. to the point where action can be taken effectively.' The consensus management which had bedevilled the NHS since its foundation was to go. No longer would decisions be taken by committee so that when anything went wrong, or indeed right, it was impossible to pin responsibility.

The Inquiry recommended the establishment, within the existing, statutory framework, of a Health Services Supervisory Board, which would determine a strategy and approve a budget

for the NHS, and receive reports on the service's performance; and, under the direction of the Supervisory Board, an NHS Management Board which would implement the Supervisory Board's policies in order to give the lead in management and control performance. The management board was to assume all the various existing NHS management responsibilities in the DHSS.

Further down the line, reviews of accountability were to be extended by regional and district chairmen down to unit level, with general managers identified at all levels and responsible for clear decision-taking. Throughout the NHS a personnel function was also to be clearly established which would seek to improve systems of remuneration and recruitment, not only to secure staff of a high calibre but also to operate a scheme of sanction and reward for them. Also, to take into account the enormous landownership of the NHS, a property function was to be developed which would manage the property on a more commercial footing. The Inquiry laid particular emphasis on involving the public in the expansion of accountability, by recommending ways for more 'feedback' from consumers about the service provided for them.

In its response to the Griffiths report in June 1984, the Government said that the Inquiry had endorsed the DHSS view of the management task when it said: 'It cannot be said too often that the National Health Service is about delivering services to people. It is not about organising systems for their own sake . . . the driving force behind our advice is the concern to secure the best motivation for staff. As a caring, quality service, the NHS has to balance the interests of the patient, the community, the taxpayer and the employees.' The Government agreed with the findings of the report and about the urgency of implementing its recommendations.

The first indications are, though, that an attempt to develop accountability in the use of funding has been fudged by the civil service. Whereas Griffiths proposed an autonomous management board, the DHSS has set up another department within their department, staffed by DHSS civil servants. Autonomy has thus been drastically curtailed. This fudge has ensured that the drive to introduce commercial-style practices and attitudes in management has been stillborn, and the earlier

talk of 'sanction and reward' become hollow rhetoric. In a Parliamentary Question on 24 April 1986 the Labour MP Mr Laurie Pavitt asked the Minister of Health, Mr Barney Hayhoe: 'What is his [the Secretary of State for Social Services'] policy towards the inclusion by NHS unit general managers in documents setting out management objectives of clauses reserving the right to impose penalties on NHS staff who in the judgment of the unit general manager concerned, fail to meet management objectives?' Mr Hayhoe answered: 'There are no arrangements for the imposition of penalties on any NHS staff who fail to achieve management objectives.' Critics have often suggested that the Labour party believe the NHS exists as much for the benefit of its 1.2m employees as for the patients. Now the Government seems to be giving some endorsement to that belief, and playing down the idea that the service should be run like an £18bn a year business (which it is). It is a classic case of civil servants getting their own way to preserve the 'quiet life'.

The implementation of Griffiths' proposals should be only a start of what could be done – given the political will – to improve the quality and accountability of the service. The high calibre of the private sector, which has blossomed in the last decade, has been attributable to strong management, lack of restrictive practices among staff and the need to satisfy paying customers. We shall now look at what can be done to introduce such improvements further into the National Health Service.

The search for improvement

In brief, the main improvements which could be made to the present NHS system are as follows.

1 District health authorities should take on responsibility for all NHS services in their area – becoming responsible for primary care and community services in addition to their present duties. DHAs should implement performance reviews, strict budgetary controls and more competitive tendering for services hitherto provided 'in house'. Regional health authorities should be left merely with a supervisory and co-ordinating function, and in addition be responsible, say, for ultra-specialist services such as heart transplantation. The less bureaucracy at regional level the better.

2 More encouragement must be given to the private sector for its own sake and for the sake of the NHS, with whom it could share facilities, staff and equipment.

3 Fees at point of service should be levied on patients except those on family credit when they use GP or in-patient services. This would help instill some awareness of cost and an incentive to participate in the service. Modest insurance schemes such as those run by friendly societies and hospital benefit associations would provide a cheap way of covering the hospital 'hotel' charge for bed and board.

4 Hospitals should establish associations of friends to lobby for them and to co-ordinate fund-raising. Friends would have a direct voice on the district health authority board via the Community Health Council – the chairman of an association becoming one of the members of the CHC.

5 The recommendations of Griffiths should continue to be implemented but should be regarded as merely a stage in the continuing development of the service.

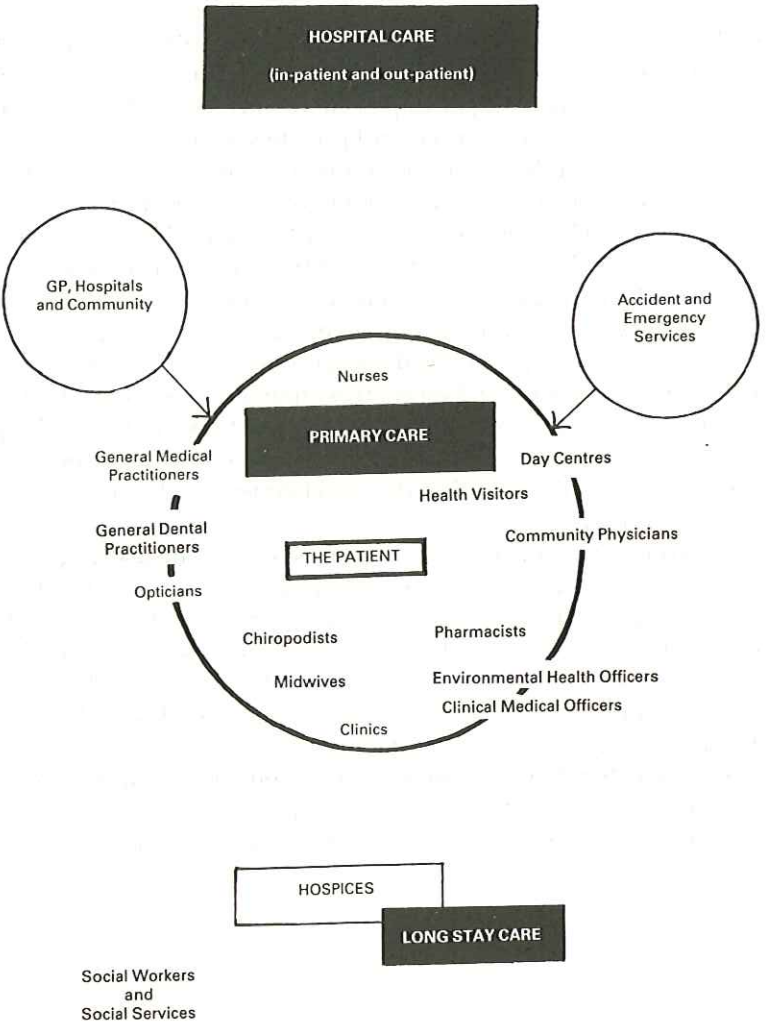
Most of these points are contentious in the extreme. But we shall see how, given the political will, a government could justify them as being not just for the benefit of the service, but for the benefit of the people.

Reconciling the irreconcilable?

The National Health Service was conceived at a time of great social stress and born at a time of great social change. As a collective act of faith subscribed to at one time or another by all major political parties its social impact was enormous. The NHS attempted to revolutionise the provision of health care, making care available irrespective of class, income or creed. Its success in doing so may be measured by the fact that the 1948 structure still exists today, virtually unchanged. Whether, though, the revolution is producing the results which its architects intended or desired is more questionable.

Since the NHS was formed, all Labour Governments have been vocal in their intention to provide more resources for health care, though their records have seldom matched their aspirations. Conservative Governments have found that their desire, when in opposition, to change the system does not accord with the reality when in government. This Government's cry that 'The NHS is safe with us' may be open to interpretation, but as a pre-election battle cry it does not indicate a crusading spirit for change; rather, the recognition of the need for political expediency. For successive opinion polls have shown that, whatever its flaws, the NHS is a remarkably popular institution. Small wonder that it is used as a high card in general elections. But a system of health care that is open-ended in its commitment and financed mainly from taxation will be sure to show even greater signs of stress as the factors outlined earlier assert more influence. The queues for hospital treatment and the rationing which this implies are the obvious signs of this stress. It is impossible to conceive of a national system of health care where the supply of the service ever equates with the demand – and difficult to see how greater funds poured into a system so ill-controlled as the NHS (in terms of its use of resources) are likely to lead to better service for the patient. Still, though, the Government understandably loses no opportunity of making political capital by proclaiming its NHS funding increases, whilst all the time the patient becomes more detached from any recognition of the actual cost of treatment, and from any ability to assess value for money.

Provision of Care – The Mix of Services



A study group was established in 1981 by the then Secretary of State for Health and Social Services, Mr Patrick Jenkin, to identify alternative sources of NHS funding and to assess ways of promoting more private sector provision. Its findings have never been made public. Since no action has been taken on them, even with a huge Government majority in the House of Commons, the conclusion must be that the political will is lacking to change the health service's funding or to pursue financial incentives for the development of a more successful private system.

Private health care will continue to grow, in default of any Government encouragement. It will grow most in those areas of care where the NHS is seen to be most deficient, that is primarily in the field of elective surgery and in the care of the elderly. But for the bulk of the population, reliance will be placed on the NHS for the fulfilment of most, if not all, needs of health care.

NHS care is provided through a system whose different tiers have overlapping boundaries (illustrated by the circular chart on page 13). Its attempt to provide a network of interlinking services sometimes achieves an efficient co-ordination of care, but a means of determining the effectiveness of the service as a whole is missing.

Too mechanistic an approach to measuring the effectiveness of all the components of health care would prove counter-productive. Health care does not lend itself easily to qualitative assessments. But some way of assessing whether patient care is reflecting the amount of money spent on the service must be found. The Black report on 'Inequalities in Health' identified unacceptable holes in the system – and suggested that the Beveridge ideal of 'ensuring that for every citizen there is available whatever medical treatment he requires, in whatever form he requires it' is an ideal – or myth – far from fulfilment.

The NHS management inquiry: its results and implications

In February 1983 Ralph Howell MP, who has a particular interest in dismantling bureaucracies, asked the Secretary of State for Social Services, in a Parliamentary question, whether he would 'state the terms of reference of the team of enquiry looking into NHS manpower'. Mr Kenneth Clarke, then the Minister of Health, replied that the inquiry had not been given terms of reference. 'Mr Griffiths and his team have been appointed as expert advisers on the effective use and management of NHS manpower and related resources. They have been set two main tasks; to examine the ways in which those resources are used and controlled inside the NHS, so as to ensure the best value for money and the best possible services for the patient, and to identify what further management issues need pursuing for these important purposes'.

Roy Griffiths, deputy chairman and managing director of Sainsbury's, and his team reported with commendable speed in October 1983 with a paper setting out their broad strategy for the introduction of management accountability into the NHS. After a period of consultation the Secretary of State, Mr Norman Fowler, announced on 4 June 1984 that he proposed to implement the broad thrust of the Griffiths proposals under four main headings: an enhanced programme of training for doctors and nurses under the supervision of a new NHS training authority; 'value for money' initiatives with scrutiny of all expenditure and with built-in audit procedures, all savings to be used expressly for the benefit of better patient care; management budgets to be introduced at all levels of the NHS; and the appointment of general managers – again at all levels of the health service – by the end of 1985.

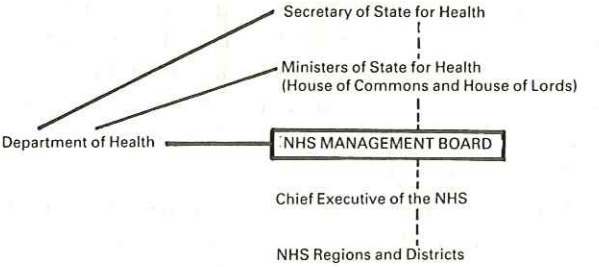
Although the term 'the health service' was much used in the paper, it must be remembered that the report was confined essentially to the hospital service, though its proposals clearly have relevance to the rest of the service, too. Griffiths' proposals have been dismissed by many as being unnecessary and superficial. That their implementation will have, and is having, a major impact on the way the NHS is run and will be run is, however, undoubted. Functional management, with the

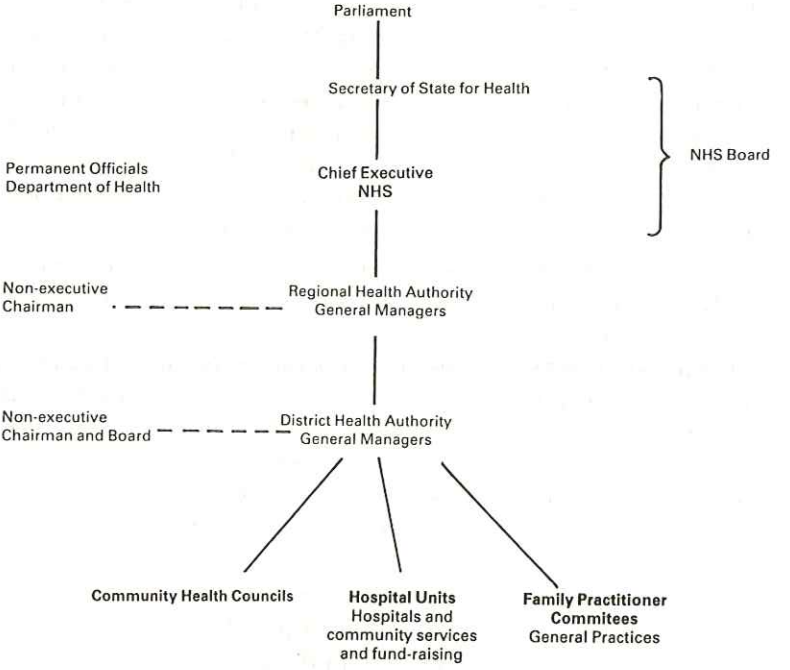
authority and the responsibility for decision making within limits agreed by the management board, is starting to take over from consensus management. Whatever the quality of the new decision making – it is too early to judge – it has brought one undoubted benefit. It is now obvious who is responsible for the the success or failure of a decision.

Griffiths' study suffered limits of time, and to a certain extent of scope – and one can assume it was something of a 'damage limitation' scheme by a politically sensitive Secretary of State. Recognising, however, the delicacy of anything to do with the health service, it required an act of great political courage by Norman Fowler to implement what was, by NHS standards, a major revolution in the management of its resources in order to demonstrate that 'value for money', far from militating against good patient care, should in fact improve it. One must question nevertheless whether the Griffiths inquiry went far enough. The way in which the NHS is funded must to a great extent determine the way the service is structured. The present position, however, where a Secretary of State for Health and Social Security is responsible to Parliament for over 50% of Government expenditure is highly questionable, whatever the calibre of the departmental officals concerned.

Expenditure on the NHS in England now exceeds £18bn; that of social security some £40bn. The Secretary of State is expected to bestride, like some colossus, two vast departments whose links are by no means intimate – and which were joined only for an internal political stratagem by a Labour administration in the mid 1970s. The size of the task is such that an appointment should be made at Cabinet level of a Secretary of State for Health Care. The appointment would recognise not only the complexity of an economic and political minefield, but also acknowledge that even the most competent minister (and the present incumbent is as competent as any) must find it difficult presenting the case for both social security and health in any budget debate with his Cabinet colleagues. Inevitably there will be the argument that there are not enough Cabinet posts for the appointment; similarly, that health and social security – both dealing with 'people' – are compatible. Both arguments can be dismissed; answering the one by pointing out that with two Ministers in the Cabinet for employment (and health is just another such political

A Simplified Structure of Command in England*





* Scotland, Northern Ireland and Wales organise themselves differently.

time-bomb) there should be one post available for health; and the other by stating that the two departments of health and social security were always separate until the cosmetic operation referred to earlier, and (despite their apparent contiguity at the Elephant and Castle) still remain separate in terms of operation. Responsibility – and accountability – to Parliament and public for the provision of a national health service should be vested in one person of Cabinet rank. How better could a Conservative Government make its concern for the NHS clear than by creating a Cabinet post specifically for it?

Griffiths recommended the setting up of an NHS supervisory board with overall responsibility for the strategy of the health service, and a management board with responsibility for the day-to-day running of the service. The recommendations were accepted and the boards are now in being. To an outsider not privy to the thinking behind the decision it is difficult to see the reason for the duality. The Secretary of State is responsible for the NHS, and should therefore be intimately involved in its day-to-day running. He should chair an NHS Board of Management, with a chief executive responsible to him for detailed administration of the service. Such a board should be composed of members with senior management experience outside the NHS in areas of special skill – personnel, finance, property, for example – and of four existing RHA chairmen, voted by their peers onto the board for a period of two years.

The remit of the present management board encompasses only the hospital and community care services, but does not run to responsibility for general practice; again, it is hard to see why. Health care provision is hard to separate at point of use, and to remove the responsibility for general practitioner care from the existing management board is nonsensical. The NHS Management Board should have total responsibility for all aspects of health care, and be more accountable to the Secretary of State for the establishing and achievement of stated objectives against a defined budget.

The roles of regional and district health authorities are called into question in examining the role of a management board. There is confusion, if not in the Griffiths' report itself, at least in its implementation. The main point to establish is that the NHS structures – whether at regional or, as we suggest, mainly at

district level – must be responsible for the total provision of health care in their respective areas, and for the mix of services, be they primary, secondary or tertiary care, most appropriate to the locality. Region and district plans should reflect the mix of services, as should the financial budgets. In examining the NHS structure in England (Scotland, Northern Ireland and Wales seem to organise themselves in a different and arguably more effective way), one must inquire into the proliferation of services at regional level. Indeed, is a regional health authority required? If it is objected that nearly two hundred district health authorities are too many for effective management control by the NHS chief executive (even with modern computer techniques), regional level could retain control of certain responsibilities; the development of a regional strategy based on district plans, the provision of ultra-specialist services, the monitoring of districts' performance and the distribution of regional funding to districts. It is important that RHA staffing is the minimum commensurate with these duties. The DHA would become the NHS for its area, with the responsibility for providing the mix of services necessary to meet the present and potential demands of the population in the geographical area it covered. With the development of the

family practitioner committees reporting directly to the DHSS, there has been a degree of obscurity over the way that the hospital and community service, and the GP service, have co-ordinated their efforts at local level. In many parts of the country, coordination has been good: in others, gaps are discernible. Perhaps more to the point, little attempt at monitoring performance against expenditure on either side of the service has been made – perhaps little can be made with the present

structure. The DHA would become responsible for ensuring this was done. FPCs would remain in being; would be responsible, as now, for the GP, dental, pharmaceutical and optical services, but they would become part of the DHAs. In this way, GPs would become more closely associated with the total provision of care within the district.

Joint co-ordination and control of DHA and FPC services would be essential. The general manager of the FPC – the chairman's post would become unnecessary – would be part of the DHA management team along with unit general managers and those with specialised management skills. Cash-limiting of the family practitioner services was ruled out in the April 1986 green paper on primary health care, and is clearly regarded by the Government as politically unacceptable. Stronger co-ordinated management could achieve the same goal, given incentives to managers to do so, without the political difficulty.

With the maximum of autonomy consistent with the need to work within agreed budgets and achieve agreed objectives, the DHA would move increasingly towards agreeing local pay and conditions for as many groups of staff as possible, and move away from nationally agreed pay deals which are, in many cases, totally incongruous with local conditions. The DHA would be responsible for implementing a nationally agreed pricing structure for all patient care activity, as a result of which patients seeking and obtaining care outside their own parent DHA would be paid for by that DHA – cross boundary patients would carry a price tag, and a DHA with underused capacity or with special facilities would gain financially when used by patients from other DHAs. To maintain the rationing element of the service patients would be able to move only with the permission of the DHAs concerned. The more expensive cases would need to be strictly rationed by the RHA. The risk that any particularly inadequate DHAs would lose so many patients – and so much money – that they would be construed as failing to provide an adequate health service in keeping with their statutory obligations would need to be carefully weighed and guarded against.

Development of competitive tendering has been slow and has achieved mixed results – but has been shown to produce substantial savings where wholeheartedly implemented. It should be accelerated, and be extended to as many aspects of

Authority activity as possible – laundry, feeding and cleaning are but the start. Final choice of tenderer would be subject to audit scrutiny, as with any other aspect of DHA expenditure – for all DHAs will be expected to produce an audited income and expenditure account, to a standard set nationally. This would include a commentary on all services that had been put out to tender, with details not only of the winning bid, but of the next most competitive. Presentation of the DHA reports and accounts to, among others, the local media, would result in both local coverage and enhanced local interest in the way the NHS at a local level was being run.

What of the patient?

No amount of structural change is of value unless it produces two key benefits: better patient care for the same expenditure and more effective use of money spent. It is useless to spend more money if the service provided is not improved. Clearly a well defined system of measurement should be set up against which patient care and expenditure may be assessed. Faltering steps have been taken in the hospital service – and there is talk of it in general practice – to establish performance indicators, based on the development of better information. The result should be more effective decision making, and a greater awareness of the return, in terms of patient care, from a given expenditure. Those providing the service, however, are the same people who will attempt to measure its success. The patient or prospective patient has all too little say in changing an inadequate local system.

For most people, access to the NHS is through the general practitioner, on whose list the patient has been placed. In most parts of the country choice of GP is very limited and, even where choice exists, those GPs perceived to be good are usually unable or unwilling to take more patients. The numbers of GPs in any area are restricted by the Medical Practices Committee, which decides what is the 'right' GP service for the population and geography of a locality. In country areas, though less so elsewhere, local folklore indicates which GPs are 'good', but no general rule exists for assessing the quality of care. Even if a GP is felt to be an inadequate doctor the patient can do little about it. Complaints about GPs may be made to the local FPC or community health council. But negligence has to be proved – a long, time-consuming and costly business. Patients with a history of complaining find it increasingly difficult to be accepted on a GP's list, and in consequence are directed to a particular doctor only to be moved on again at six monthly intervals.

The Royal College of General Practitioners has sought to rectify the lack of formal assessment in general practice by producing a discussion paper which suggests all GPs undergo retraining at regular intervals: a suggestion hard to fault. Another RCGP proposal, which seems to find some favour in the recent green paper, is more contentious: that the medical competence of GPs should be regularly assessed by their peers. There is no

reason to suppose that such a performance review would improve the standard of general practice. Also, a case can be made for patients having a voice in the performance review of their GPs. Good medicine is not just about the provision of technically competent care, but also about the ability of the doctor to get to know all about the patient, not just about the apparent illness for which treatment is being sought.

Rather than a performance review by peers it is much preferable for a patient to go to another doctor if he is not satisfied. This is difficult for many reasons, not least the existence of the 'list'. Other problems are those of the hypochondriac who hawks himself around from one doctor to another, and of the doctor ignorant of the medical history of the patient. None of these is insurmountable. The patient could carry a medical history card (akin to a driving licence). A fee could be introduced for visiting the list doctor, a higher fee for a home visit, and both fees doubled if the patient chooses to see another doctor. Unlike the illogical prescription exemptions, those receiving family credits would not pay to see their own doctor, and would pay half the standard fee if they chose to see another. GPs might resent having to collect money from patients, but their remuneration system would be restructured to take into account patient fees, and those reluctant to charge would in any case be at liberty to provide their service free. It is accepted, though, that the large real increases in the costs of dental treatment in recent years have meant that fewer people visit a dentist. (But these sums of money involved are, of course, far higher than the token charges we are suggesting.) At present the GP is paid for all patients on his list, irrespective of the standard of care and whether the patient is ever seen. A charge at point of consultation would help inadequate GPs to become aware that the fewer patients they saw, the less they would be paid. The patient would better understand that health care from a GP, as from a dentist, carries a price for the service given.

Involving the public in their health service

Only those who work in the NHS tend to understand it, and they understand only the part for which they work. Not only does the patient or potential consumer not understand, but he has little knowledge of how to influence changes in local health care.

Community Health Councils are the mechanisms for local involvement. They comprise 18-24 members, half appointed by local authorities, a third by voluntary organisations and the rest by RHAs, and they serve for four years. CHCs' budgets are approved by RHAs. The statutory duty of CHCs, as set out in the NHS Act 1977, is to represent the interests in the health service of the public in the district covered. They have a right to be consulted and informed by health authorities. They must publish an annual report, to which the matching DHA must publish a reply. A burgeoning part of their work in recent years has been advising the public how to complain about the NHS. Some CHCs are both active and influential; some apparently moribund. All are viewed with mixed feelings by the NHS management, to whom they can become irrelevant if not vocal, and disproportionately time-wasting if they are vocal. As a court of appeal to provide help in cases of poor service they should be more effective. That they fail is not so much because of their inclination as because of their membership, which is all too often divorced from the NHS units with which they liaise.

To help rectify this, all NHS hospitals should appoint an 'association of friends', a group of locally interested people, the chairman of which should be appointed ex officio to the CHC, as we suggested on page 11. The associations of friends would be composed of lay people with an active interest in their local NHS units; who were in touch with the specific problems; and involved with the DHA over wider issues. Each association would operate financial appeals for its hospital. Labour MPs especially have decried as 'nurses with begging bowls' this form of charitable contribution to the NHS, but views seem to be changing with the demonstrable effectiveness of the hospice movement. Thanks to the associations of friends, fund-raising could be harnessed to specific units within the broad DHA strategy. All appeals would have formal, audited accounts. Though much money would be raised through fetes or flag days,

substantial amounts could come from annual donations, allowable against tax by the donor (unless the tax element were already covenanted). In deprived areas of the country where scope for financial contributions from the public is limited, other forms of participation could be encouraged. The Treasury might decide that all associations of friends must be registered as separate charities unless it were accepted that each DHA should have a formally registered charity attached to it.

Charitable donations might seem a drop in the ocean against the £18bn NHS annual budget but many thousands of pounds have been raised for local units like this. Smaller hospitals with particular local appeal are more attractive to donors than large, impersonal units, and there is fortunately a move away from the disastrous policy of the 1960s and 1970s when larger and larger units were being built. At that time many small or GP units were swept away, leaving just 400 and resulting in the formation by a committed group of GPs of the Association of GP Hospitals. Those that are left are meeting demands cost-effectively. And fund-raising becomes the expression of local goodwill.

As the strain increases on NHS funding it is hard to see where greater resources are to come from unless there is a payment by the hospital patient when using the service. As contentious as the suggestion for payments by patients to GPs is the proposal that hospital patients should be charged £15 a night to a maximum of £75 (those on social security would not be charged). A mechanism for collection now exists following DHSS guidelines on tightening up the collection of private patients' fees. A board and lodging charge would provide the unit with additional funds and would make the patient an active participant in the way the service was provided. The voice of the consumer is so far unheard in the call to improve quality of care in the NHS and there is little opportunity for in-patients to express their views. If they had to pay for the service at time of provision they would have the incentive to participate.

The board and lodging charge could in any case be insured for at very little cost, if not by the existing health insurers then by the many hospital contributory associations and friendly societies which provide low-cost benefits to their mainly blue-collar members. This would also help instil the idea of value, which is essential if patients are to have more incentive to take an active interest in the NHS.

The mixed economy in health care

When the NHS started in 1948 it was thought that private care would no longer be required. A national health service free at point of use and providing a comprehensive range of services would have neither room nor demand for private care. The reality has been rather different. At the end of 1985 about 5m people were insured against the cost of private in-patient care. Contrary to the view fostered by political opponents of private medicine, subscribers to the insurance schemes come from all walks of life and social classes, with both companies and unions sponsoring schemes. There was little encouragement for the growth in the insured population from Conservative administrations, and active discouragement from the socialists; Mrs Barbara Castle's antagonism in the 1970s to private beds in NHS hospitals reduced their number but also gave considerable publicity to the reasons for people being prepared to pay for private care.

The Conservatives *did* give a moderate incentive when they agreed that employees earning up to £7,500pa should be allowed company insurance schemes tax free. Could not this threshold be raised to £12,000pa? It would be even more valuable to the economy if *all* the registered self-employed were to be allowed to set their health insurance premiums against tax. (Companies may allow health insurance premiums against corporation tax, but the self employed have no such relief.)

With the proposal in the March 1986 Budget for personal equity plans, the return on which can be added tax-free to the individual's investment fund, we suggest that a health bond be introduced which would work on the same principle. The investment return on such a bond could be allowed, free of tax, for the payment of the premiums of registered health insurers. Such a scheme provides an incentive to save and a tax-efficient way of paying for a proportion of health costs.

Company-sponsored or paid schemes account for 70% of the insured population in a high proportion of which the company pays for all or for selected members of staff. Most companies see this as an employee 'perk'. Little attempt has been made to provide a cost benefit analysis of having care delivered to an employee at the most convenient time. British companies *are* learning from the US to assess the true cost of absenteeism, ill

health, stress and hazardous working conditions. What they have not done is try to assess the cost of health insurance premiums. Health and safety legislation has helped improve working conditions; and occupational medicine, a private sector service, is not thought to have any of the political stigma normally associated with private care.

The growth of private hospitals to meet increasing demand – currently 80% of private in-patients are insured against the costs of all or part of their treatment – was slow initially, but the last ten years have seen it accelerate from 4,500 beds in 1975 to 10,500 in 1985. With such a relatively small market place – private medicine is used by less than 10% of the population – matching demand for beds with supply is not easy, due to the delay or 'lead time' in building new private capacity when the demand for it arises. Imbalance is most acute in the London area. Supply and demand may well equate in the long term, recognising that the lead time to build a hospital ten years ago in the private sector used to be three years, and now is a maximum of eighteen months. Another important part of the picture is the amount of 'high technology' equipment to be found in the private sector. Private hospitals' capacity to perform complex procedures makes them almost self-contained, and also provides NHS managers with an opportunity to use their facilities on a contractual basis – which has already happened in some cases. Lack of NHS money rather than demand has stopped this practice from spreading. The development of new and highly equipped hospitals is thus most relevant to the NHS; although this trend has been taken little into account by NHS planners this should change now that the service is introducing more responsible management.

The creation of DHAs with greater autonomy would present an opportunity for both private and NHS local services to be geared more closely to the demands of the local population. It is nonsense for the NHS to build new hospitals in areas with a high proportion of insured people without taking this into account, and without considering the potential of extant, fully equipped private hospitals.

The question of pay beds in the NHS is ripe for reconsideration. On the one hand, in the greater part of England where abundant private capacity already exists, consumer choice would be little impaired if they ceased to be available. On the

other hand, where there *is* need for beds and NHS capacity exists, several possibilities suggest themselves. DHAs, provided that the cost of their beds was properly established, might contract out their management to the private sector (which could indeed tender for the running of whole hospital units). Or DHAs might even raise private capital in order to build hospitals which could then be rented out by them. An extension of such a plan might be a joint venture between the DHAs and private capital whereby expensive items of equipment (eg nuclear magnetic resonance units) could be financed and operated in cooperation by a management company in the private sector.

Problems and possiblities of cooperation and competition between the public and private sectors will become clearer once the quality and determination of new NHS management manifests itself.