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BRITAIN'S BIGGEST ENTERPRISE

ideas

for radical reform of the NHS

Oliver Letwin and John Redwood

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INTRODUCTION

The National Health Service is the biggest enterprise in Britain. It absorbs some £21 billion a year -- almost £500 from every adult in the country. It treats almost one hundred thousand patients a day. And it is the largest employer in western Europe, with just under one million employees -- almost twice as many as in our entire civil service.

An enormous amount of human effort goes into sustaining this apparatus. The great majority of the staff are extraordinarily conscientious, working night and day to keep the system going. But the system itself is a bureaucratic monster that cannot be tamed. It neglects the interests of patients, treats people as 'cases', desperately overstretches some doctors and nurses, diffuses responsibility and constantly redistributes funds in incomprehensible ways.

For many years, the fashion has been to pretend that this bureaucratic monster is just a slightly wayward and much loved pet. Successive superficial 'cures' for its behavioural disorders -- introducing new tiers of administration, removing new tiers of administration, installing new Boards and new managerial posts, and the like -- have been regarded as politically permissible. But fundamental changes, aimed at altering the nature of the beast, have been classified firmly as taboo. Any politician foolhardy enough even to mention such revolutionary ideas has immediately been subjected to taunts by the fashionable intelligentsia, and bitter accusations of being uncaring and uncompassionate.

In the past few weeks, there have been the first, faint signs that the fashionable consensus is about to crack apart. A spate of criticism has been aimed at the results achieved by the NHS, and has been met (in the Press and in Parliament) not merely by the usual ritualistic calls for increased funding but also by fundamental attacks on the system itself. This is no surprise: the pretence that all is basically well had to end sometime; the only question was when.

The aim of this paper is to ensure that the debate about the nature of the NHS, prompted by the new shift in mood, becomes as deep and wide-ranging as is necessary. We do not by any means suppose that we can provide instantaneous solutions. Our intention is merely to identify the worst deficiencies of the present arrangements, and to bring forward a series of options for radical reform which need to be investigated openly, at the highest level and in the immediate future.

WHAT IS WRONG WITH THE SYSTEM?

Our present National Health Service was designed as a public sector safety net, to provide a basic standard of care for those who had inadequate resources to pay for private doctors. In the nationalisation proposals put forward by the Labour Government after the war, many features of the already flourishing private sector were preserved. Consultants in hospitals were allowed to carry on with private practice in addition to their NHS jobs, and GPs were allowed to remain as free enterprise partners, often mixing private fees with NHS work.

NHS patients were not meant to imagine that they (unlike those in the private sector) were entitled to receive luxury treatment. The spirit was that of wartime: stoic queueing, spartan surroundings, briskly efficient doctoring. Nevertheless, because it was -- for many people -- better than anything that had gone before, it had the appearance of a miracle, a huge stride towards (an admittedly somewhat puritan) Utopia.

Since the war, public expectations have changed: the attitudes built into the NHS have not.

The most glaring example of the gap between the 1940s system and our 1980s expectations is the continued existence of waiting lists. At the end of 1986 (the latest date for which reliable figures are available), there were almost 700,000 people on NHS waiting lists; of these, half were destined to wait more than two months for treatment, and one in fifty for more than a year.

Despite the propaganda of Labour politicians, this was nothing new. In fact, when Labour left office in 1979, waiting lists were even higher -- with over 750,000 people quietly biding their time.

In the Soviet Union and other 'planned' economies, waiting lists and shortages of supply are still the norm, as they were in the Britain of the 1940s. Luckily, the Britain of 1988 is no longer accustomed to such phenomena. Our shops are full of the food that people want to buy; our car salerooms are full of the cars people want to buy; our travel agents offer their customers a thousand trips to far away places at bargain prices. Everywhere one goes in modern Britain, supply quickly matches demand -- except in the National Health Service.

It is important to recognise that NHS waiting lists are caused by the system itself rather than by any lack of funds. Indeed, if funding were to increase even faster than it has during recent years, the long-term effect might well be to increase waiting lists. If, for example, funding doubled in a single year, the first effect would be the fast expansion of present facilities, which might well cut queues. But the next effect would be the discovery and installation of new techniques for curing diseases that were previously left uncured. Once the new cures became available, all those suffering from the relevant disease would of course want treatment. At some stage -- probably quite soon -- demand would again exceed supply, and the NHS would be forced back into rationing supply by creating long waiting lists.

Put simply, the point is that a system in which queues are the only method of rationing the amount of health care, cannot eliminate waiting lists -- without literally infinite funding.

Supporters of the present system sometimes argue that queueing is a good method of rationing supply because it enables doctors to give priority to those most in medical need rather than to those most able to pay. This argument at least has the merit of being honest, since its proponents are thereby admitting that waiting lists constitute an intrinsic feature of the NHS. But a problem with the argument is that it neglects the effects of rationing by queues on the attitudes of those who work in the Service.

Rationing by queue -- as one can see anywhere behind the iron curtain, or in the NHS -- turns customers or patients into a 'nuisance'. Each extra bit of demand needs to be met by lengthening some queue, without any more money coming into the hands of the providers. The administrators of the service inevitably tend to become dictatorial, graciously allotting space on the queues to each new patient as if admission were a privilege. And this general attitude quickly spreads to other aspects of the service.

One classic example is the practice of setting a common appointment time for dozens of individuals attending outpatient clinics. What kind of institutional mind is it that dreams of subjecting patients and their families to needless hours of sitting, while a consultant deals with others who have been invited for the same time?

Another, even more grotesque example of the attitudes engendered in the administrators by the system is the organisation of casualty departments. Often patients are made to queue, and pushed from pillar to post, with their injuries becoming ever more painful. They are registered and docketed like parcels in a railway station, and then (again like parcels) left to moulder quietly on some hard bench. The eventual quality of the medical help, when it comes from an individual doctor, may be superb -- but the patient is by then only too well aware that the system regards him as 'another case', not as a valued customer.

The wards themselves tell the same story. Who would go to a holiday resort, however cheap, that looked as uninviting as an NHS ward? Little or no privacy, little access to the simplest items of modern technology such as telephones and televisions, very restrictive visiting hours, poor food with little choice. No one could run a resort on that basis. It is doubtful whether long stay prisoners in maximum security gaols fare much worse.

Not that this means that the medical staff have an easy life at the expense of their patients. On the contrary, the system operates quite as badly for most of them. They too are shoved around and lined up like parcels by the administration. Junior doctors find themselves working hours which would not be permitted by any penal institution; living in a daze of overwork, they are forced to change jobs every few months to suit some unseen administrative schedule of vacancies. The fact that they provide such decent medical services as they do is a tribute to their dedication.

It need be no surprise that, in a system dominated by administrators, the responsibility for the mess is diffuse. As the Griffiths Report pointed out, if Florence Nightingale were alive today and walking the corridors with a lamp, she would undoubtedly be doing so in order to find out who was in charge.

At the apex of the pyramid sits the Secretary of State (who also runs, as a harmless sideline, our £40 billion social security system). He is ably supported by a number of junior ministers -- none of whom is likely to spend more than two or three years learning and doing the job before being transferred to some other department. There are almost 100,000 civil servants dividing their time between health and social services. There is the National Health Service Management Board, with a ministerial chairman, a deputy chairman, a chief executive, a chief medical officer, a chief nursing officer, six executive directors, and three others. There are the inter-regional coordinating committees. There are the Regions. There are the Districts. The poor little hospitals and GPs sit down at the bottom, trying to support the weight of this massive administrative structure above them.

Each of the administrative tiers has what civil servants call 'a degree of autonomy' -- a euphemism, meaning that they spend their time quarrelling with one another and making political points. The Management Board fights the civil service; the Regions fight the centre; the Districts fight the Regions; and everybody fights the Secretary of State. If something goes wrong, the buck is passed around with brilliant legerdemain.

This is the NHS: a system that costs £21 billion a year, employs a million people, has no clear lines of responsibility,

rations by queue like a wartime government, treats each patient as nothing more than a new problem and leaves junior medical staff at the mercy of unseen administrators . Radical change is needed.

HOW CAN THE SYSTEM BE IMPROVED?

The need for change is now widely accepted. But there is much debate about the right kind of change. There is no hope that it can be resolved in a few easy sentences: the defects of the system are so basic and the importance of health so great, that sustained thinking and fundamental reappraisal is required. The range of options which needs to be considered is itself a matter for considerable debate. It should include, as a minimum:

1. Establishment of the NHS as an independent trust.
2. Increased use of joint ventures between the NHS and the private sector.
3. Extending the principle of charging.
4. A system of 'health credits'.
5. A national health insurance scheme.

1. Establishment of the NHS as an independent trust

Some of the most obvious defects in the current system might be remedied by a thorough-going administrative overhaul which carried the Griffiths proposals to their logical conclusion. The NHS could, for example, be separated entirely from the DHSS and be made into an independent trust, publishing its own accounts and governed by its own, apolitical Board. With such a Board in place, the political elements of the present system -- particularly the regional authorities -- could be removed, with

professional hospital and district managers taking their place. Under such an arrangement, responsibility for the whole system could be placed squarely on the shoulders of the Chairman and Chief Executive, with subordinate managers having clear responsibility for their respective sections of the operation.

Administrative changes on this scale would be an entirely different affair from the many minor alterations which have taken place over the last few years. Removal of the NHS management from the political sphere and the establishment of clear lines of responsibility would have great effects on the system. But, when such administrative change is considered, two fundamental questions must be addressed:-

1. How will it alter the basic attitudes of administrators towards patients? and
2. How will it eliminate queues (without infinite funding) or improve the present conditions in NHS hospitals?

There may perhaps be good answers to these questions; but, if they do exist, they are by no means obvious. It seems, prima facie, unlikely that attitudes towards patients (for example) will be much improved merely by altering the administrative framework.

2. Increased use of NHS/private sector cooperation

The Government has recently focused attention on the ability of the NHS to benefit from private sector involvement in many aspects of its work. Does this offer a long-term solution to the problems of the system?

Certainly, the private sector could make a great contribution to increasing the 'friendliness' of hospitals, and

to providing patients with more comfortable conditions. For example, television rental companies could rent out televisions and videos to individual patients, with remote controls and with headsets to control noise. British Telecom could provide telephones for patients who wish to keep in touch with neighbours, friends, relatives and businesses from their bedside. Catering firms could provide alternative food to the basic meals supplied by the hospital for those who wish to exercise choice. More hairdressing, cosmetic and beauty services could be made available, and a variety of entertainments could be supplied through private enterprise. For the privilege of supplying to hospitals, firms could make rental or royalty payments to the NHS bringing in much needed funds. In addition, as John Peet suggests in his CPS pamphlet 'Healthy Competition', competitive tendering could be extended to cover not just support services but also surgery facilities, primary care services and hospital building -- as is already the case in some parts of Britain.

So far so good. But serious questions remain: would any of this get to the root of the problems? Could it do anything to establish clear lines of responsibility in the NHS? Would basic attitudes towards patients and rationing by queues be altered?

These questions do not seem to have positive answers.

Increased private sector involvement in the NHS will not do miracles. Indeed, even if combined with the establishment of the NHS as an independent trust (to give clear lines of responsibility), it is most unlikely to bring about rapid and widespread change in basic attitudes, or to eliminate waiting lists.

3. Extending the principle of charging

Another avenue which has been tentatively explored by the Government is charging. In principle, this could be extended to the point of universality -- a charge for every service. That could permanently solve the problems of waiting lists and of basic attitudes towards patients -- since the NHS could charge enough for each service to ensure that demand matched supply, every patient would become a valuable customer, bringing funds to the system. If combined with the establishment of the NHS as an independent trust, this would in effect turn the NHS into a nationalised non-profit service competing on level terms with the private sector, and at arms-length from the Government.

There is, however, one overwhelming defect in this approach. How would those in need of health care be able to afford it? Some might be able to take out enough insurance to cover most of their needs -- but for many the expense would be too great. The signal advantage of the NHS -- its ability to take care of those most in need, regardless of their income -- would be lost: a case of throwing the baby out with the bath water. The introduction of universal charging could not, therefore, by itself constitute an adequate response to the defects of the present system.

4. A system of health credits

One way of preserving the advantages of charging (while overcoming its overwhelming disadvantage) would be to instal a system of 'credits' (similar to the scheme advocated by James Hourston in his Aims of Industry pamphlet, A Health Alternative).

Each individual patient would receive, from his GP, a 'credit note', entitling him to treatment for a specific complaint. This credit note would cover the charge levied by the NHS for the treatment in question. If the patient chose instead to go to a private sector hospital, he would be entitled to carry the credit with him -- making up any difference in cost out of his own resources or through private insurance. Since each NHS hospital would be funded solely through the receipt of 'credits' from patients, all administrators would have a direct incentive to make their hospital attractive, welcoming to patients and medically successful. In short, increased competition would be created not only between the NHS and the private sector but also between one NHS hospital and another. Under such an arrangement, it might be possible to go even further than the establishment of the entire NHS as an independent trust or company: each major hospital or district could be separately established, with only a national funding authority left at the centre to administer the payment of credits.

Unfortunately, this system has another drawback: it does nothing to guarantee that the 'right' amount of money will be available for spending on health care. As now, it would leave the government in the awkward position of having to make a choice, year-by-year, about the proportion of GDP to be spent on the NHS, without any method of bringing home to individuals the amount that they are spending on their health.

5. A national health insurance scheme

A method of overcoming the drawback of a pure 'credits' scheme is to ally it to a national health insurance system. Under such a system, every adult would contribute a fixed insurance premium each year to a national health insurance fund. The fund would be administered by independent trustees, who would have a duty to balance its books each year, by ensuring that a sufficient premium was set to cover all the 'credits' likely to be issued by GPs in that year (and to create a surplus for contingencies).

There are several ways in which such a system could operate. The insurance premium could be actuarially adjusted, like car insurance, to reflect the varying risks associated with different categories of contributor -- though this would need to be balanced by subsidies to those who were not well off, and were either already ill or in a high - risk category. Another possibility would be to retain a fully means-tested system, where premiums would correlate with incomes, and where no-claims bonuses and other traditional features of insurance were absent -- though this would remove incentives for people to limit the use of their insurance cover. Between these two possibilities, lies a spectrum of feasible combinations.

One variant would be a flat premium, which would not vary either with the income of the individual insured or with his risk of ill-health. To avoid this being regressive, a corresponding reduction in the average income tax rate, and steepening in the tax rates for higher-rate taxpayers would be required; in addition, those on social security would need to be given an

immediate increase to cover the first year premium (with this amount thereafter being indexed as part of the general indexation of social security payments).

Yet another variant would be to model the scheme on the State Earnings-Related Pension. Everyone would pay an income-based health insurance charge; but people could decide to make their own alternative provision, and to receive a modest rebate.

Under any of these schemes, NHS hospitals would charge the full cost of each treatment, and would receive credits from the insurance fund (via GPs) to cover these costs. Queues would be out of the question since the NHS would have no interest in receiving its credits (and hence its cash) later rather than sooner. Supply would match demand at whatever level of health care was fundable out of the premium set (just as it now does in the private sector).

The existence of a national health insurance scheme would not, of course, be to the detriment of the private sector. Indeed, under any of the variants, contributors to the national scheme could be given rights to carry some or all of the insurance cover to the private sector, either in the form of rebates for private insurance or in the form of 'credits' usable in private sector hospitals. The administrators of the insurance scheme would be at arms length from the NHS itself, and would be happy to see patients getting the treatment they needed, whether in a public or in a private sector hospital. To a great degree, the divisions between the public and private sector would fade.

A system of this sort would be fraught with transitional difficulties. And it would be foolhardy to move so far from the present one in a single leap. But need there be just one leap? Might it not, rather, be possible to work slowly from the present system towards a national insurance scheme? One could begin, for example, with the establishment of the NHS as an independent trust, with increased joint ventures between the NHS and the private sector; move on next to the use of 'credits' to meet standard charges set by a central NHS funding administration for independently managed hospitals or districts; and only at the last stage create a national health insurance scheme separate from the tax system.

THE NEED FOR ACTION NOW

We have sketched no more than the beginnings of ideas, restricted to the management of hospitals (which form only one part of the service). The NHS is a huge system with huge defects. Remedies will have to be on the same scale. Attitudes ingrained in administrators and politicians will need to be altered. None of this can happen unless the Government commissions a fundamental review of the entire system, operating like the review of Social Security, holding public hearings but coming to conclusions within a few months. Such a review should build on the management changes now being implemented and on Clause 4 of the Health and Medicine Bill. It should investigate methods of establishing the NHS as an independent trust and of increasing co-operation between the NHS and the private sector. It should have an open agenda on health credits, insurance schemes and any other serious and radical suggestions. Above all, it should be started immediately.