William Waldegrave: thinking on the new NHS

Richard Smith

rs: We are now a month away from the NHS reforms. Are you confident that they are going to work, or might you find yourself presiding over the collapse of a major British institution?

ww: The reforms are going to work. There will be no collapse, but there will be plenty of teething troubles. There's a longish way to go to get the information base fully established, and there's more to do to get real costings. But no matter how long we had taken to prepare we would still have a lot to learn when we started: we will need to learn by doing.

rs: Does that mean that a month into the new health service things won't be much different from now?

ww: That's probably right. But I hope that even in that time we will begin to see some positive things, but it will take longer than that for the benefits to come through.

rs: Will things be very different in two years?

ww: Two years in, we will have seen considerable changes. And there will be new problems. For example, shifting referral patterns may mean difficult decisions for whoever sits in my chair—me, I hope. Thus, what should we do about hospitals that are not getting support? Should they have more investment or should money be invested in different places?

rs: Do you think that the changes will have a lot more impact in some places than others?

ww: They are bound to have more effect where there is real choice in provider units. Eventually the reforms will mean that we will have to address the problems of London, which have been postponed far too long.

rs: Is that the reason for the changes?

ww: No. The reason is that we need to have an up to date resource allocation system rather than the old incremental system, which was creaking at the seams. But one of the benefits will be that politicians will have to grip problems that they have avoided gripping for too long.

Benefits and problems

rs: What will be the major benefits of the changes?

ww: The major benefit will be that we will have far more hard data about what we are doing—about what we can get for our money and about how much things cost. There will also be real gains in devolved management. People should have a clearer view of what their roles are in this great organisation. For the first time we will have people whose explicit duty it is to produce a public health strategy for their population and other people whose explicit duty is to run hospitals and other provider units.

It has been the confusion between these two roles that has helped to make the NHS so difficult to manage at the moment. Usually if people are not managing things well it is because they aren't being given clear enough roles and objectives. I hope that there will be better hospital management, more explicit public health strategies, and more leverage for GPs and patients—because they will have more identifiable choices.

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MP for Bristol West since 1979, William Waldegrave became Secretary of State for Health in November 1990, having been minister of state at the Foreign and Commonwealth Office. Educated at Eton, Corpus Christi College, Oxford, and Harvard, he has been a fellow of All Souls, Oxford, and a member of Mr Edward Heath's think tank under Lord Rothschild.

rs: But did it need changes as radical as those that have been proposed to achieve those ends?

ww: The more I read about the stresses and strains in other peoples' health systems the more I think that the answer is yes. The original achievement of establishing the NHS was putting together variegated services and providing them free. That was a considerable triumph. But nobody ever took hold of the whole system and asked what is the best way of allocating resources within it. So I think that the present changes are in a sense a second founding of the health service.

A lot of the same questions are being addressed in other countries—Holland, Spain, and Germany, for example—although we are being more radical. They are watching what happens here with great interest to see whether the internal market mechanism is the best way forward. Quite a lot of them will, I think, follow us.

rs: There have been several upheavals in recent years. Is this one significantly different from the others?

ww: I think it is. We've battered away over the past 40 years trying to improve outcomes in essentially a top down way. And when things weren't going well we set up another tier of administration or took one away or changed its boundaries. Ultimately, you can't run an organisation employing nearly a million people and spending £30 billion a year like that. You have to give the people down the line the power to improve it themselves. That's what all this is about.

rs: Is it analogous to the collapse of the economies in Eastern Europe?

ww: I think that's true. It ran as well as it did—and that was very well in some respects—because of the immense skill of individual people and an affection for the service. It has had a huge share of the ablest people in the country. But we politicians haven't supplied a rational system for those working within it.

rs: What will be the major problems of the new health service?

ww: The major problems are going to be with lack of refinement in the information base and with the changes eventually forcing people like me to take some tough political decisions. But that's really a benefit.

There are going to be some snags: somewhere a computer system is going to go down or somebody's going to misunderstand something. But the top management within the management executive is extremely aware of that. I spend a lot of my time cross examining them about what they will do when these problems arise. I've been saying to managers that there is only one real sin—and that is not to ask for help.

rs: It is being argued that you and the management executive are backpedalling on the reforms and slowing down. Is this true?

ww: It's not true in that I am determined that we should get the system in place in the original timescale because we will only learn how to improve it once it's in place. It is true that I slowed down by a year the movement at a regional level to weighted capitation. Paradoxically that gives regions greater opportunity to move to weighted capitation at a district level because they all have more money.

I think that in some ways my reaffirmation of our commitment to the NHS as a public service has been misinterpreted as a backing away from the reforms. But it's not: this is all about how to run a public service with a proper resource allocation system.

Too fast and too dogmatic?

rs: You've been in your job a comparatively short time. Do you think that the reforms have been too fast?

ww: It's difficult for me to say because I suspect that there would have been a lot of pressure and a bit of a race however long we'd had to prepare it—it's like that with a deadline for any great organisation. So in general, no. We've swapped an early start with a first year where we all get used to the system—in the words of the cliché, the steady state.

rs: You talked of the importance of these reforms to give the service more room to be bottom up, but the ideas themselves have been terribly top down. A very small group of people dreamt them up and pushed them through in the face of opposition from many people in the service. Was that a good idea?

ww: I think that if I was going to have done anything differently from what was done then I would have gone for more consultation, so long as the consultation was genuine—that is, people were seeking to make a new system. If that kind of consultation had been on offer then more of it would have been a good thing. But it's impossible for me to judge at this point whether the personalities then about were actually in the business of real consultation or of just trying to stop everything.

Who calls the shots?

rs: The history of the health service shows that it is the politicians who make the dramatic changes rather than the people within the service. Is that inevitable?

ww: I think that it probably is. After all, the NHS is a

political system, a public health service. It's the political perception that we haven't provided a proper framework for the professionals to work within that has two or three times since the foundation produced political change. I think that is inevitable.

rs: Is it possible that the management executive might in the future make larger changes itself?

ww: If we have now—as I believe we have—created a rational system that will run for many years and develop its own dynamic then I hope that what you say is right. In terms of running the health service we should move away from politics. David Owen said recently that I should emulate Iain Macleod, who came in just after Aneurin Bevan and said that he wanted to be the first health minister to pass no legislation but just run the health service. That would be a legitimate ambition for me because we will next month have a system in place that will no doubt need lots of fine tuning and improvement but which will then enable us to turn our attention to talking about outcomes.

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But we will never in a politically accountable system get away from the continuing dialectic about resources. One of my jobs is to be a link between the service and the Treasury and try to win decent resources for it. But within whatever resources we've got we should now be talking about where our priorities in health outcomes lie and less about how to manage the service, leaving that increasingly to the professional management structure.

rs: Some managers say that it's terribly difficult working in the health service because the ground keeps moving under your feet. You've no sooner got to grips with one thing than a lot of further changes come in. They also complain that it's hard to plan because you know your budget only for next year and not thereafter.

ww: That is, indeed, an inherent problem of a public sector in a country where we haven't really got inflation under control. I came in as a junior minister ten years ago at the end of a period when we had had quinquennial financing for universities, and it would be wonderful to get back to that. It's one of the reasons why stopping inflation is not just a theoretical macro-economic objective.

Patient choice

rs: One aim of the changes was to increase patient choice. But if everything is to be laid down in contracts won't choice actually be reduced?

ww: I'm always a little sceptical about how much choice there is now. It's true that while we are dealing with block contracts we will mirror the previous system, but as we get disaggregated information we will get more extracontractual referrals, and as we get more GP fundholders we will get more pluralism in the system.

I hope that one of the benefits of the new system will be that the spurring of laggard departments and specialties by the fear that they might lose patients will mean, paradoxically, that there will be less need to go elsewhere to get good treatment. But if the GP fundholding initiative goes well it should produce a radical increase in pluralism.

RS: But won't non-fundholding GPs who refer in a maverick way mess up the system?

ww: If they refer in a maverick way they will, but the hope is more that as non-fundholders watch the fundholders—many of whom are among the best practices—get good deals for their patients they will want them too.

GP fundholding seems to me a good example of how if you are trying to get dynamic and improvement into a system you've got to trust the best people to do it themselves and give them the weapons to do it. People say that it's dreadful that the patients of a fundholding practice might be at an advantage, but that seems to me fine because it will spur others to catch up. That's far more likely to produce a general and shared improvement than me sending out guidelines from on high. But it will produce an uneven and pluralistic movement towards improvement; I accept that.

Disappearing units

RS: Don't the changes also mean that if you are a trust or a directly managed unit and you don't do well you might just disappear?

ww: This market has ultimately got to be a managed market in that, just as now, the person sitting in my chair will have to look at capital plans. But we will have the immense advantage that the internal market should tell us what the doctors and patients down the line are actually wanting. It won't remove from us the need to make very difficult decisions about hospital closures.

RS: It'll be diabolical for any MP who has a unit in his constituency close.

ww: But no different from now. Now units close because somebody produces a splendid plan, but after the changes we will have much more information about what the public wants in terms of quality and travel patterns and the like. And thus we can say to MPs, whatever you say this is what your constituents and their GPs are voting for with their feet.

RS: But at the moment it's usually smaller places that close. Isn't one of the implications of the reforms that a large hospital could go under?

ww: Just look for a moment at smaller hospitals. In terms of rural areas it'll be interesting to watch whether GP fundholders and others don't take quite radical steps forward in doing things outside the big hospitals. Or we may find the opposite, and the indications from America are that patients will travel a long way to the famous high tech hospital. It'll be interesting to see how it goes.

Bureaucracy versus management

RS: Part of your political credo is that you are suspicious of bureaucracies, and yet some hospital managers say to me: "Here is the government telling me to be entrepreneurial and yet I get another 150 page document telling me to do this and that."

ww: I have the utmost sympathy with them. The only way to deal with that is for me and the people right at the top to conduct guerilla warfare against the number of people that there are in the higher tiers. And regions have got slimmer in some respects, and the centre is pretty thin. But we have to restrain ourselves from making helpful suggestions to people all the time.

RS: Does that mean you're going to sack half the Department of Health?

ww: No, there's plenty for them to do—but in somewhat different directions from in the past. The developing role will be the health strategy role, the

public health role—both locally and at the centre. But we will have to be quite self restrained at the centre on what we set targets on. We should only do so where it's right to set targets nationally.

RS: It seems, though, that the management within the health service is growing very rapidly, and from the point of view of doctors this looks like bureaucracy.

ww: Well, no one is going to say that the management is yet good enough at hospital level. It's getting better, and I'm increasingly impressed by the senior hospital managers who I meet. But I get plenty of stories still about the wrong sort of management further down the line. I used to work in a factory where, when the whistle blew, all the direct labour force went to the pub and the managers went on working until 2 30 am, trying to get a new order from Korea. In the hospitals it often seems to be the other way round.

We've got to get the message across that management means face to face leadership. There's plenty more to do in developing the careers of managers in hospitals, which should be a perfectly satisfactory career, and we should have doctors and nurses seeing it as a good career for themselves—as you do with scientists. My first job was working for Lord Rothschild, who had been a scientist and then became a manager of science. We want some—not many—of those very able people to go up the management stream.

RS: But I'm not only talking about its quality but also its quantity.

ww: The two go together because if management is obviously providing the necessary leadership and doing things well then people turn from being bureaucrats into leaders. One man's bureaucrat is another man's leader. If you've got a good manager who's letting you get on with your job, providing resources, bringing people together to take the necessary professional decisions, then you tend not to see him as a bureaucrat. If he's just a bloke who turns up and says that you can't do what you're trying to do then you regard him as a bureaucrat. It is a matter of skills.

Information

RS: It does seem that lack of information is one of the main limiting factors at the moment. How fast is that going to be turned round?

ww: The first objective was to make sure that the financial flows were going to work, that there would be a system of settling the invoices between providers and purchasers. That, I'm pretty certain, is going to work throughout the system.

The second and much more exciting objective is to build up what will start off as a pretty crude database on comparative costings. We're getting some amazing results from the initial tariffs: with one procedure pricing ranges from £300 to £17 000. Somebody's doing something on marginal costing, while somebody else is setting up a whole department and charging the capital costs. That information will rapidly get refined as people understand what they are about and the systems gets better.

Then there will be a marvellous new tool in the clinicians' hands. They will have a much better idea of the resource implications of what they are doing. I'm always impressed when I talk to clinical directorate groups or senior consultants about how they try to face up to difficult resource decisions but how difficult it is for them because the database they work with is so weak.

Meanwhile, the poor old district is just struggling along to get a bit more money out of region to keep going all of its institutions and has no time to try to

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think of a proper district health strategy, which is what it should be doing.

RS: But information has costs. It will be expensive to gather this information.

ww: It must be worth it. We don't want to gather unnecessary information, but in an institution that spends £30 billion a year the weakness of the database is dreadful. The primitiveness of the information system in the NHS is one of the things that astonished me most when I came here.

Though it's irksome when it's being set up—as it is in any business—when it runs properly it'll be a real tool for the people who want to deliver goods to the patient.

RS: But you can see that in the short term if it means that you get a computer and you don't do somebody's hip replacement. . . .

ww: In the short term it's extremely irksome, but it is, in the real sense of the word, investment—that is, it's putting off a valuable bit of consumption in exchange for benefits in the future. But I can see that when you've got a ward closed and you've got to do hip operations and somebody says, we've got to get a £5m computer, that's extremely irksome. But you cannot run this great system without proper information.

RS: But doesn't it mean that you should find new money for information.

ww: We have found new money. There was £300m plus last year, which was consolidated into the base.

Negotiating terms and conditions of service

RS: Another problem is that if you're going to stop negotiating terms and conditions of service of doctors, nurses, and other groups centrally and let individual units do it all around the country then that's going to mean more bureaucracy.

ww: With doctors in training we have of course decided to have central negotiations, although I must say the more I see of the national training system the more I think that it needs a radical improvement—we are wasting a lot of people's time. But with the rest there is a real choice about whether we should have local negotiations.

Let's start at the easy end. With ancillary staff it's easy to demonstrate that there are local labour markets that do differ quite radically. That should be devolved. It'll take some time to do, but it will be to the benefit in living standards of people who are genuinely underpaid.

The argument really comes about consultants. Somebody put the point to me the other day: "Look, I work in north Wales. The Christie will steal all my best people because it will pay more." That's the traditional argument, but I have at the back of my mind what happens when you get new science based companies. In Bristol [Mr Waldegrave's constituency] we have the leviathans of Rolls Royce and British Aerospace, but we also support literally hundreds of high tech small firms who specifically come and pinch their people—and they do that by paying a bit more.

Why should we prevent the chap in north Wales saying "I really want to make my hospital a centre of excellence in this particular thing. I'm not a famous hospital. But if I can pay a couple of people a bit more I can really make something good in this area." I think that we should give people that choice.

I doubt if differential salaries will be used much because it is a profession, and people watch each other closely. But I think that it may help the disadvantaged more than the grandees. The grandees get good people anyway.

I remember when the new universities were being

set up. The most famous example was Warwick, which decided to set up the best mathematics department outside Cambridge. And it did—by tempting people with jolly good conditions of service. I think that we should have that flexibility.

RS: Do you think it might mean then that psychogeriatricians get paid more than heart surgeons?

ww: It could conceivably. I don't know what it will mean—it would be rash to predict by specialties. But let me give you another example. One of the strengths of the Oxford and Cambridge collegiate system is that the colleges have some of their own resources so that if they want they can pay a bit more and get the best people in. I can imagine a hospital saying: "Look, we are losing too many patients, everybody's going down the road. We haven't got anybody with a real reputation. Let's take a deep breath, save some money from somewhere, and put it into getting a lead character who will raise our reputation." That seems legitimate.

RS: The original point of my question was that you will have to have a lot of people in local units negotiating over terms and conditions of service.

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ww: They've got to learn to negotiate, and that's why nothing dramatic will happen overnight. These decisions will often be taken, I think, by clinicians themselves, saying that they want to bring in a grand chap to provide some leadership. Because you're quite right: if every management everywhere said that they were going to start from scratch and negotiate everybody's contract they wouldn't be able to do it.

Fundholding practices

RS: There's a lot of anxiety about GP fundholding practices—that they won't have the necessary management skills or information to make the changes work.

ww: I've talked to a number of fundholders now, and I'm not too worried about their management skills. They are among the better practices. But I am more worried about whether they will be given the information. What we are finding is they are not making much difference to referral patterns because the information is not disaggregated enough, but what they are doing is elbowing their way into demanding more quality. And that is having an effect of waking up districts and other GPs.

RS: I think that many of these doctors feel exposed. Here they are about to start with a new health service, and they are not sure what it all means.

ww: The ones I talk to are pretty confident that they will be able to show some benefits for their patients in terms of quality and convenience pretty quickly. But they will be one of the elements of the system that will exert pressure to get better information. They will be the grit in the oyster.

RS: So are you confident that we will have many more in a year's time?

ww: I don't really know, but there seem to be a lot coming forward for the second wave. And I get a lot of

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letters from people saying that they would like the project to be extended in various ways. It'll catch on.

Waiting lists

RS: Waiting lists—at the moment it seems that they are going up, and one of your key advisers has just resigned. Are you confident that the new health system is going to reduce waiting lists?

ww: It should. It's not going to magic them away, but if it enables us to allocate resources better and get better value for money at the same quality then it should enable us to have more resources for providing health care—which should reduce waiting lists. Also, some of the things that are happening in primary care—with minor surgery, for example—should help to get some people who shouldn't be on waiting lists off them.

But waiting lists are a symptom of a system not working as well as it should. And if the health system works better then they should come down. But you can't just treat a symptom; you have got to get at the underlying structure.

RS: So will they be down in a year's time?

ww: A dangerous prediction, but I very much hope so. But it would be rash to expect dramatic changes in the first year.

One of the things that I believe about this whole system is that it will enable the people sitting in my seat to make a stronger case with colleagues in the Treasury when bidding for resources. We will be able to demonstrate rather more clearly what we are getting for our resources.

RS: One of the dangers is that if tremendous emphasis is put on waiting lists then people shift resources from other less politically visible areas.

ww: That's correct. And John Yates [the adviser on waiting lists who recently quit] made a perfectly fair point when he said you must be careful not to put resources into the most minor things. But waiting lists in the present system are a symptom of things not working well with local management—albeit only one symptom.

Audit and resources

RS: Everyone agrees that medical audit is a good thing, but doctors are interested to know whether you will respond with extra resources if audit throws up deficiencies resulting from inadequate resources.

ww: Audit is an absolutely necessary development, and the more explicit and open the system is, the easier it is to win arguments about resources. The trouble with people sitting in my seat over the years is the vague feeling among colleagues also bidding for resources that no matter how much money you pour into the health service you never get anything for it. It's not true, but it should be easier to demonstrate with the new system what we will get for another billion pounds.

RS: But at the end of the day won't Britain have to spend a higher proportion of its GNP on health?

ww: Anybody sitting in my chair will say yes, like every other spending minister, but the weakness is that I have no way of knowing at the moment. It sounds sensible to say that, though there's the irritating example of Japan spending less and having better health. It's true that the French and Germans are spending more, but we should put aside the example of America, which is a shambles and wasting money hand over fist. My instinct says that we should usefully spend more, although we get an extremely good result out of our system—but only by putting intense pressure on poeple.

But because we have such an old fashioned resource allocation system it is difficult to know whether there is a well founded case for spending more—we don't have enough information coming out of the system. We don't know whether we are wasteful or not. If we can get a better database, demonstrate that we have rational allocation systems, and show that we are meeting rational public health priorities then we can say that we deserve more money and perhaps get it.

This is the first part of a two part interview. In next week's interview Mr Waldegrave talks about the special problems of London, community care, preventive medicine, public health strategy, and the future.

ANY QUESTIONS

Is there any evidence that long term administration of parenteral vitamin B complex reduces the risk of neurological morbidity in patients with chronic alcohol dependence?

This question is complex. Starting with the work of Peters in Oxford in the early 1930s considerable evidence exists to show that reversible and, if persistent, permanent brain damage may result from giving animals a diet that is inadequate in thiamine (vitamin B1).¹ This has been shown in a variety of animal models, including primates, and is seen in patients both with and without alcohol dependence who show similar brain damage associated with an inadequate thiamine supply that responds, albeit sometimes only partially, to the administration of parenteral thiamine. The parenteral route of administration overcomes the problems with absorption of vitamins, which depend on active transport across the intestine, seen in patients with alcohol dependence.² Similarly, different types of brain damage have been associated with deficiency of vitamin B12 or nicotinic acid.

The important question as to whether patients who have reduced circulating levels of vitamin B complex are at increased risk of developing brain damage remains unanswered. Investigations have found a correlation between vitamin B1 or folic acid status and cognitive impairment. Our studies showed a highly significant association between low levels of vitamin B1 and parameters of brain damage with computed tomography.³ Further work is awaited.

Theoretically, if the brain could be supplied with a high dose of thiamine it might be possible to activate an enzyme important in energy production.

This enzyme, called transketolase, has been shown to be damaged by a lack of its cofactor, thiamine, or possibly by acetaldehyde, a product of alcohol metabolism.⁴ Further information, however, is required, especially about other thiamine dependent brain enzymes. The potential size of the problem has been emphasised in recent work by Harper and Krill, who reported that brain damage associated with the Wernicke-Korsakoff syndrome (due to low vitamin B1 levels) has been found in approximately 2% of random necropsies not specifically performed on patients with alcohol dependence. This brain damage was frequently unrecognised in life.

Peripheral neuropathy has also been associated with thiamine, vitamin B6, and vitamin B12 deficiency, but causal link is difficult to investigate because of the slow regeneration of damaged nerve cells.

There are many reasons patients with alcohol dependence may become vitamin deficient.⁴ It may seem logical that patients with low circulating levels of the B complex vitamins should be at increased risk of neurological morbidity but so far this is unproved. —A D THOMSON, *editor, Alcohol and Alcoholism*

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