PO-CH/NL/0102

PART E

Part E.

SECRET

(Circulate under cover and notify REGISTRY of movement)

MANAGEMENT IN CONFIDENCE.

Begins: 18/5/88
Ends: 2/6/88.

Chancellor's (Lawson) Papers:

THE NATIONAL HEALTH SERVICE REVIEW

Disposal Directions: 25 Years

D Thelwall
9/8/95

PO -CH /NL/0102
PART E

MC5.29

CONFIDENTIAL

FROM: MARK CALL
DATE: 18 MAY 1988

PAYMASTER GENERAL

cc PS/Chancellor
Mr Saunders

JOB SPECIFICATION FOR NHS MANAGEMENT BOARD CHAIRMAN

Whatever the task description, it seems to me that the job specification should give emphasis to the personal qualities and attitudinal aspects of candidates. Thus, taking administrative competence for granted, the ideal candidate would have a mind open to the consideration of organisational change. He, or she, should welcome experimentation; and have a keen sense of the need for improved customer service. He will no doubt need a robust personality to stand up to strong producer interests. We should probably add that it should be someone who welcomes a challenge! Perhaps because these personal qualities are so important the DHSS found it sufficient to brief the PAU to seek "someone with a successful background in industry, management or commerce", on the basis that they will know the right man when they see him.

2. It could be of advantage to delay the appointment to such time as the results of the NHS review are known. Candidates should at least know for what it is they are applying. I'm not sure of the timing of Len Peach's retirement, but this could mean an interregnum. Is that worth consideration?

Mc

MARK CALL

CHANCELLOR OF THE EXCHEQUER

Ch

You might ask Hayden Phillips what truth if any in stories that Policy Unit pass papers to CPS & IEA

AA

week.16.5/m.3

SECRET

BF 2015

FROM: H PHILLIPS
DATE: 18 May 1988

CHANCELLOR

cc Chief Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Miss Peirson
Mr Turnbull
Mr Gieve
Mr Parsonage
Mr Saunders
Mr Call

NHS REVIEW: YOUR MEETING ON 19 MAY

This note sets out a checklist of elements which might feature in an Autumn package following the NHS Review (Miss Wallace's note to me of 12 May). It is in the form of an annotated agenda for your meeting. It distinguishes between each item in a package (including some comments); the timing in which each might come forward in the Review; and the nature of Treasury action.

2. The note separates items where action seems essential for improvements to the existing NHS; and items which might be considered as possible runners.

3. **Essential Improvements**

(a) Accelerating the resource management initiative - this includes the computerised cost and performance information data, based on patient records, which in our view, is essential; for example, to ensure that doctors become properly involved in the management process. Mr Moore has recognised this and said, in public, that resource management would be extended to all districts from the end of 1989. Timing: it may come up at the meeting on 24 May but more likely will come later and be settled in PES. Treasury Action: to make Mr Moore's timetable certain and agree action set in hand to achieve it. It may cost us a substantial PES bid for capital - some £200-£300m - spread over 1989-90 and 1990-91. We shall press for resulting efficiency savings to be scored.

(b) VFM Audit. We have agreed a descriptive paper with DHSS but, unlike DHSS, believe that the only organisation with the track record to succeed here is the Audit Commission. Legislation is required. Timing: the Chief Secretary has invited Mr Moore to discuss the issue; a meeting needs tobe set up. Treasury Action: to press for a decision, and give DHSS help on relations between the Audit Commission and the NAO/PAC. (DOE will need to be consulted).

(c) Changes to the Professions. There are two key elements - consultant's contracts (who holds them; their length; merit awards) and widening the access to nursing. Changes to both will require announced consultation with the professional groups concerned (in respect of nurses this process has already begun with Project 2000). The DDRB made some mildly critical remarks about consultants' merit awards. Timing: these are meant to be the subject of DHSS papers for a meeting in the week of 20 June. Treasury Action: to press for some radical changes, and work up what may be an acceptable price to pay in the Survey. We also need to consider whether in relation to GPs the changes in primary care being considered go far enough.

(d) Supply side measures to encourage the private sector. This covers your concern with the apparent brake on the release of consultant time to the private sector, private sector help in building hospitals; and fuller use of other private sector expertise. Timing: papers are planned for week beginning 6 June. Treasury Action: prepare contingent notes on supply of doctors, "private financing" of NHS projects, and a view on private sector contribution to reducing NHS waiting times.

(e) Competitive tendering. This is at present confined to non-clinical services and needs to be opened up eg pathology. Timing: not listed in the review work programme but should be

brought into it. Treasury Action: letter at official level to DHSS putting the issue firmly on the agenda.

(f) Internal Market Experiments in the NHS. Some regions, like East Anglia, are anxious to start pricing and trading services. Others should be encouraged. Timing: not listed on the Review progamme but now has a momentum of its own. Treasury Action: to ensure action and be ready to acknowledge in the Survey some specific funding of start-up costs.

4. Possible Changes

(a) Healthcare buying agencies: Mr Moore's basic proposal to transform the existing NHS monolith. But will it? And will it be sufficiently realistic and economical? Timing: the next review paper from Mr Moore. Treasury action: to probe for realism, and work-up views (and, if necessary, papers) on cost control mechanisms.

(b) Independent hospitals - breaking up the existing system of 'secondary care' including control by charities, management-buy-outs, other forms of privatisation. Can this be done effectively as an end in itself within the NHS and separately from (a) above? Timing: next DHSS paper and subsequent meetings. Treasury Action: more detailed work on accountability, and capital and running cost controls.

(c) Medical Audit - peer review of doctors by doctors. This depends, in our view, on a robust data base (the resource management initiative). Is it suitable for a Government initiative which could unite the profession in opposition? Should a select group of leading doctors be stimulated to propose it? Timing: not formally listed in the Review agenda but will come up under audit. Treasury Action: nil.

(d) Tax relief. Schemes covering employees and the elderly are left on the table, but Mr Moore will keep pressing for contracting out and hypothecation. Timing: for week beginning 6 June. Treasury Action: our papers. The Revenue will let you have an outline for the weekend.

(e) Cash limiting of family practitioner services. Timing: not yet separately identified in the work programme but comes up under 4 (a) above. Treasury Action: to press for the issue to be properly addressed.

5. These are the main points in an Autumn package which we think you and the Chief Secretary should consider. I have not listed charging although it remains, in our view, a key issue in terms of the economics and financing of health care. There are a range of of linked issues which will come up in the Survey and elsewhere, eg the relationship between NHS reform and the Griffiths proposals on Community Care; pharmacists' contracts review; PPRS review; medical research (report by Lords Committee).

6. There is also the speech you are to make in June. Mr Saunders has given you a note about it and you are to discuss this with us separately.

HP.

HAYDEN PHILLIPS

MANAGEMENT IN CONFIDENCE

pps pm (can BF?)

FROM: D RAYNER

DATE: 19 MAY 1988

1. MISS PEIRSON

2. CHIEF SECRETARY

cc Chancellor
Mr Anson
Mr Phillips
Mr Luce
Mrs Case
Mr Revolta
Mr Saunders
Mr A M White
Mr Willis
Mr Davis
Mr Call

SPECIAL HOSPITALS: SPECIAL HEALTH AUTHORITY

The enclosed letter of 11 May from the PS/Social Services Secretary to the PS/Scottish Secretary proposes the creation of a special health authority to take over the management of the 4 special hospitals (ie those for the criminally insane). This submission recommends acquiescence. HE agree.

Background

2. Mr Moore's proposals (for which the Home Secretary has already expressed support) are set out in the Annex to Mr Podger's letter. The special hospitals are at present managed directly by DHSS, not as part of the NHS; and as three separate management structures, which are called Special Health Authorities but do not have the usual powers of SHAs. Mr Moore proposes creating a new single Special Health Authority to manage the hospitals which would have the same sort of powers as other SHAs. Individual General Managers would be appointed to the hospitals. The paper leaves open the question of whether the new SHA might eventually be absorbed into the NHS (as is the plan for the Disablement Services Authority).

Discussion

3. DHSS principally want the change in order to strengthen, and to distance themselves more from, the management of special hospitals. In one respect, the timing is perhaps not ideal. The policy on the major Broadmoor redevelopment is still very unsettled: Stage I of the rebuilding has just about ended, at hugely greater cost than planned, and DHSS are busy reconsidering whether to proceed at all with the later stages (no decision will

30/9/15

be taken before the end of 1988) or indeed whether possibly to sell the Broadmoor site (because the value of the site probably outweighs the money spent on Stage I, and because of staff recruitment problems). It does not seem ideal to set up a new more devolved structure for the special hospitals when such major policy questions are outstanding. However DHSS, to whom we have mentioned the point, are unpersuaded; and setting up an SHA would not absolutely preclude such possible policy changes.

4. DHSS have also recently referred to the possibility of using any organisational change as an opportunity to exclude the Prison Officers Association as the representative union in the special hospitals. This is welcome (although it hardly squares with the idea of "developing stronger links with the Prison service"); but the question arises as to whether the creation of the new SHA would make it more or less difficult to achieve. HE advise that it would probably make little difference either way: if the POA decided to make an issue of union representation in the special hospitals, they would be in an extremely strong position to prevent any change.

Costs

5. Mr Moore's paper says it is not envisaged that the proposed changes would make additional demands on resources "the aim being to introduce tighter and more effective control of existing resources". In fact, DHSS are <u>already</u> pressing for increased provision for the special hospitals in 1988-89, and the new SHA might well press more publicly for higher expenditure on the grounds that conditions in the special hospitals are inadequate. However, tighter management is desirable, and the answer to those greater pressures is probably to support eventual absorption into the NHS.

Running costs

6. At present the administration costs of the special hospitals (some £60 million a year, out of total CFS running costs of around £80 million) are included within DHSS' overall running costs limit. The question of future running costs treatment is not addressed in the paper, but DHSS have written at official level

to seek exemption of the special hospitals from running costs control. Creation of an SHA would not automatically exempt them - the Disablement Services Authority is still subject to that control (and DHSS have also asked for exemption for the DSA) - but we are considering the matter with RC. If we wish to recommend exemption, we shall submit the case to you separately. (Absorption into the NHS would mean automatic exemption.)

Conclusion

7. I attach a draft reply acquiescing in the proposed management changes, and supporting eventual absorption into the NHS (suggesting it should be within ~~5 years~~ a specified period). The reply also asks for officials (and you) to be consulted on the drafting of the proposed national policy paper.

D Rayner.

D RAYNER

MANAGEMENT IN CONFIDENCE

DRAFT LETTER FROM: PS/CHIEF SECRETARY

TO: PS/SOCIAL SERVICES SECRETARY

SPECIAL HOSPITALS: SPECIAL HEALTH AUTHORITY

The Chief Secretary has seen a copy of your letter of 11 May to David Crawley enclosing details of your Secretary of State's proposed changes to the structure and management of the special hospitals.

2. The Chief Secretary is content with the proposals, assuming they do not preclude the possibility of major policy changes on, for example, the future of Broadmoor, and welcomes your Secretary of State's assurance that the aim is to introduce tighter and more effective control of existing resources. He supports the idea of eventual absorption into the NHS (preferably within ~~the next 5 years~~ a specified period).

3. The Chief Secretary would be grateful if his officials (and himself) could be consulted on the drafting of the proposed national policy paper.

4. I am copying this letter to the recipients of yours.

Mr Rayner
I suggest your advice through Miss Pearson, keeping Mr Willis in touch
KB 13/5

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000
From the Secretary of State for Social Services

MANAGEMENT IN CONFIDENCE

David Crawley Esq
Private Secretary to
The Rt Hon Malcolm Rifkind MP
Secretary of State for Scotland
Dover House
Whitehall
LONDON
SW1A 2AU

11 May 1988

Dear David,

I am writing about changes my Secretary of State proposes in the management of the four special hospitals at Broadmoor, Moss Side, Park Lane and Rampton.

The Secretary of State has been reviewing the current management arrangements for the hospitals to decide whether any changes are needed to meet management and policy objectives for the special hospitals service and to provide stronger management and policy links with psychiatric provision elsewhere in the National Health Service and with the Prison Service and Prison Medical Service. He has concluded that changes are needed, and his proposals are set out in the annex to this letter. Because of the Home Secretary's particular responsibilities and interests in relation to the powers of the courts and the treatment of mentally disordered offenders, he has been informed of the proposals and has given his support.

My Secretary of State would welcome any comments your Secretary of State has on the proposals.

18215

E.R.

Copies of this letter go to private secretaries to the Chancellor, the Lord Chancellor, the Home Secretary, Secretary of State for Wales and the Secretary of State for Northern Ireland.

GEOFFREY PODGER
Private Secretary

Attachment to letter from DHSS.

MANAGEMENT IN CONFIDENCE

THE SPECIAL HOSPITALS SERVICE

Hospitals

1. The Secretary of State for Social Services is responsible for providing the Special Hospitals Service through four hospitals - Broadmoor, Moss Side, Park Lane and Rampton. The hospitals have been managed directly by the Ministry of Health and DHSS since the Home Office Board of Control was replaced by the Special Hospitals Service in preparation for the Mental Health Act 1959. Under Section 4 of the National Health Service Act 1977, the Secretary of State is required "to provide and maintain establishments (referred to as "special hospitals") for persons detained under the Mental Health Act"...."who in his opinion require treatment under conditions of special security on account of their dangerous, violent and criminal propensities".

Patients

2. The hospitals form a single national service and provide treatment for nearly 1,700 patients. Patients are admitted direct from the courts or transferred from prisons or other hospitals. Admissions are determined centrally by the DHSS, through a multi-disciplinary Admissions Panel.

Management

3. The Secretary of State for Social Services is responsible ultimately for the management of the hospitals and the care of the patients. He is advised on all matters pertaining to the Special Hospitals Service by a multi-disciplinary group of DHSS officials comprising the Special Hospitals Service Board (SHSB).

4. Local management boards have been established for the hospitals, and all management functions have been delegated to them except patient admissions, employment and the allocation of resources. The local management boards are special health authorities (SHAs). There is one each for Broadmoor and Rampton, and a combined one for Moss Side and Park Lane which share a single site. The local management boards are supported by Hospital Management Teams (HMTs) comprising a Medical Director, Chief Nursing Officer and Administrator. The HMTs are led by the Medical Director. They are accountable to DHSS for

the exercise of the HMT management responsibilities which DHSS still discharges directly. They are accountable to the local management boards for the exercise of the functions for which the local management boards have delegated responsibility.

Need for change

5. There is an urgent need to develop a coherent policy for the Special Hospitals Service, in itself and in relation to other services on which it has a direct bearing - the hospital and community psychiatric services; the prison service and the prison medical service. There is a need to end the geographical, service and professional isolation of the Special Hospitals Service and ensure that the hospitals are regarded as part of the spectrum of psychiatric treatment. Unless the present management weaknesses are corrected, this policy requirement will not be met.

Proposals for change

6. The following changes are proposed to correct the existing management weaknesses and more effectively meet the policy requirement:

(a) create Special Hospitals Service SHA: create a shadow SHA, drawing on the SHSB, local management boards and DHSS staff, pending the necessary legislative change, to be responsible for overseeing the necessary management of change at all levels;

(b) appoint General Managers: in each of the special hospitals, counting Moss Side and Park Lane as one hospital for this purpose, following open advertisement along NHS lines;

(c) review functions of SHSB and local management boards to determine future management arrangements in context of establishment of Special Hospitals Service SHA;

(d) develop national policy: for the future of the Special Hospitals Service, which is flexible enough to be implemented either through a central SHA or as part of the NHS, or both. This would require an appropriate budget, which would be managed by the central SHA through the General Managers in the hospitals.

7. The key elements are to establish a central SHA and to appoint General Managers in the hospitals. By establishing a central SHA, the Special Hospitals Service would be given the strengthened management and policy advice which it needs. The objective would be to link the Special Hospitals Service more closely to the NHS, either through complete integration over time or through a preferably time-limited central body which could consider and recommend long-term policy and management arrangements. By appointing General Managers, the Special Hospitals Service would be brought into line with the rest of the NHS and provided with a function which is necessary for effective decentralisation of day-to-day management of the hospitals and delivery of central management and policy requirements.

Timing

8. There is a strong operational and policy requirement for early strengthening of the management arrangements. The aim is therefore to appoint General Managers by the autumn of this year and create the Special Hospitals Service SHA by 1 April next year. Work on a national policy paper to guide the future direction of the Special Hospitals Service will be carried forward in parallel.

Resource consequences

9. It is not envisaged that the proposed changes would make additional demands on resources, the aim being to introduce tighter and more effective control of existing resources. The proposals are designed to be met from the present revenue budget of the Special Hospitals Service (£59m for 1988/89). Better use of resources, particularly capital resources (£12m for 1988/89) and manpower (3318 staff at 1.4.89) should produce either savings over the longer term or an improved quality and quantity of service.

The Royal College of Midwives Trust

15 Mansfield Street, London W1M 0BE
Telephone: 01-580 6523/4/5 & 01-637 8823

Patron: Her Majesty Queen Elizabeth The Queen Mother

President: Miss Margaret Brain, SRN SCM MTD FBIM
General Secretary: Miss Ruth M Ashton, SRN SCM MTD

RA/mm

19 May 1988

The Rt. Hon. Margaret Thatcher, MP
Prime Minister
10 Downing Street
LONDON

Dear Mrs. Thatcher,

The Royal College of Midwives was pleased to be asked, whilst meeting with Mr. Moore, the Secretary of State, to submit comments to the Cabinet Review Team that is examining the funding and resource allocation for the National Health Service. I enclose these comments.

Yours respectfully,

Ruth M. Ashton

RUTH M ASHTON
General Secretary

THE ROYAL COLLEGE OF MIDWIVES RCM/145/88

15 Mansfield Street, London W1M 0BE

EVIDENCE TO THE PRIME MINISTER'S REVIEW OF THE NATIONAL HEALTH SERVICE

1. The Royal College of Midwives (RCM) has considered both the level of funding of the National Health Service (NHS) and the alternative methods of resourcing which are now under discussion. This paper sets out the College's view on these issues and the way in which they could impact upon the maternity services.

2. The Nation's Health and the Government Role

The College believes that no Government can abdicate responsibility for the health of the electorate. There is firm evidence that factors such as housing, environmental controls, nutritional standards and policies on smoking and alcohol affect health status. The outcome of

pregnancy can for instance be improved as much by enhancing the social environment of mothers as by high-technology medical intervention. The RCM does not consider that it is appropriate to consider the NHS in isolation from wider public health issues and it would urge the Government to review the health implications of their policies in other sectors. Failure to do this is detrimental to the overall level of health in the population and increases the call on the NHS

HEALTH CARE FUNDING

3. The Existing level of Funding

3.1 From the evidence available it is not possible to endorse assertions that the present level of N.H.S. funding is adequate. It is the view of the College that the general inflation factor used is unrealistic in relation to NHS cost inflation. Furthermore the impact of demographic change particularly the increase in the elderly population has been underestimated and the real cost of the Government's own priorities, (e.g. the transfer to community care), has not been accounted for. The

reliance on "efficiency" or "cost improvement" savings to maintain current levels of service or to undertake planned development have placed great strains on services and in many instances have proved counterproductive.

The past two years have seen increasing difficulties as a result of the failure to fully fund agreed pay awards.

On the capital side there has been an inappropriate level of investment in the infrastructure of the health service. The age of many hospital buildings, the poor quality of modern developments, the inability to fund and then utilise national computer and information systems, the changing nature of service provision, the need to accommodate shifts in revenue resources from Region to Region or from programme to programme and the pressures to reduce unit costs all indicate that more capital expenditure could be used effectively by the N.H.S. and should be provided for this purpose. To facilitate this, the College believes there is scope to introduce the use of private sector

borrowing for capital requirements in order to release revenue funds.

Data from abroad indicates that there is significantly less spent by the Government on health care in this country than our economic position would suggest. It would seem that no matter how health care is funded in the future, it is highly unlikely that the public element of spending can decrease and the College would support the view of many that it is desirable that public spending is increased. Any structural change in the present pattern of provision would undoubtedly entail vastly increased capital expenditure. At present, it would seem that the Government could accommodate increased spending without having to restrict other programmes. The conclusion must be drawn therefore that any further restrictions in health spending are not concerned with priorities or economic necessity but rather the Government's philosophy of the way in which health care should be provided.

4. Funding the Health Service - the national alternative

The College believes that there is still scope for change in the provision of health care within the present tax-funded system. Such a system is the most equitable. Any move away from general taxation would disadvantage low-paid workers and especially women who tend to defer expenditure on their own needs in favour of their children and families. Funding from general taxation is also administratively efficient. At present the administration costs of the N.H.S. compare very favourably with most commercial and charitable enterprises, while alternative systems would entail much higher costs in this respect. However, the College considers that a major drawback to funding from this source is that the level set has become a political decision unrelated to national health needs. It is proposed therefore, that the resource voted to the N.H.S. each year should be determined by a formula based on agreed demographic and other criteria, linked to per capita G.D.P.

5. Other options for funding

The College has examined the range of options being suggested as possible replacements for funding from general taxation:-

5.1 Earmarked Taxes - The College recognises that such funds would not have to compete with other claims on the national purse. However, it would seem administratively inefficient to collect a separate income tax for health, while a move to indirect taxation, such as increased V.A.T levels, would penalise those who at present do not pay income tax. In addition it may well be difficult to set the tax to raise the resources required for the N.H.S. reliably.

5.2 Social Insurance Schemes - (or National Health Insurance Schemes) The College would oppose any flat-rate insurance as estimates suggest that this would take a large proportion of the income of the low-paid and could become a real poverty-trap factor. It would be preferable to seek contributions on an ability to pay basis, although the same argument against an earmarked income tax would apply to a progressive insurance fund. If

such a fund operated the College would wish to see care still free at the point of need. A payment and claim-back system would be expensive to set up, would operate against the most vulnerable members of society and administrative costs would absorb resources which could otherwise be spent on direct health care. Finally, the RCM would oppose any contracting-out mechanism. It is not considered that the private sector can provide at present, or is likely to be able to ever provide an alternative comprehensive system of health care. Therefore, the vast majority are likely to require the N.H.S. at some stage of their lives. Contracting out would tend to be by the healthier and better off members of the population at certain periods in their lives and it is difficult to see how such a fund would operate on an insurance basis with only those less able to pay and most likely to require health care contributing to it. The College is concerned that contracting out, even with the provision of a safety net for those who need care but cannot pay is likely to lead to a two-tier system which would be unacceptable.

5.3 Private Health Insurance - The College recognises that international data suggests there is some scope to increase the contribution from private sources to health care in this country. However, given the present health infrastructure even a very much expanded private sector would not offer comprehensive care and the R.C.M would object to the introduction of a compulsory scheme of private health insurance. An expansion of supplementary or top-up private health insurance would be accepted with reservations. Firstly, any increase in private spending on health care should be matched by an increase in public spending, i.e. the value of total spending on health care should be maximised. Secondly, the effect of increased spending in the private sector should be monitored in relation to outcomes to ensure that resources were not being diverted to unnecessary treatments or higher administrative expenses. An inspectorate could ensure the maintenance of reasonable and comparable standards in both private and N.H.S. sectors. Thirdly, in those areas where the private sector absorbs staff it should provide and/or pay for training places. The College would suggest that if there is any large expansion of the private

sector, the N.H.S. will have to compete for staff and this will entail a realistic review of the pay and working conditions offered to N.H.S. employees. Finally, the College opposes the introduction of tax concessions to encourage the uptake of private health insurance.

5.4 The Private Sector and the Maternity Services - If there is to be an increase in private sector provision there are specific issues affecting the maternity services which the Government must address.

5.4.1 There are good public health reasons for keeping maternity care within the NHS and the RCM continues to support this system; maternity care safeguards the health of the next generation; a system that is not universally accessible, such as that in the United states, often leaves the at-risk mother vulnerable to poor care and has an adverse effect on perinatal mortality rates.

5.4.2 At present all health insurance policies exclude normal pregnancy and childbirth and maternity care

has to be provided by the NHS or paid for by the individual as opposed to the insurer.

5.4.3 Most health insurance covers "complications of pregnancy" and this could be a factor leading to more women having high technology births. There is some evidence that obstetricians are willing to help patients claim from their insurance by generously interpreting the criteria for certain procedures such as caesarean section. This could inflate the overall amount spent on maternity care without producing any comparable benefit in outcome statistics.

5.4.4 It will be essential to establish standards and monitor outcomes to ensure that national maternal, perinatal and infant mortality rates do not suffer. In a system where clients self-select into a variety of facilities - moderately well-off couples might choose to have their babies in pay facilities - it would be difficult to compare the effectiveness of different types of care meaningfully.

5.4.5 The present system that allows a consultant to conduct some private practice whilst holding an NHS contract can result in his being required to make clinical decisions simultaneously in separate locations. In order to minimise the effect of this, provided there is only a limited expansion in private care the private facilities should be in close proximity to the NHS unit. Should there be greater expansion of the private sector, consultant contracts will need careful examination and it may become necessary to separate those who practice privately from NHS consultants.

5.4.6 The RCM believes that there could be a place for some limited expansion in private health care even in the maternity services. The private sector might also be the main source for some advanced techniques, an example being in vitro fertilisation.

6. Other Ways of Increasing N.H.S. Income

6.1 All the suggested ways e.g. contracting of services, sale and leaseback, commercial trading,

part-pay charges, have been examined. The College believes that none of the methods currently under discussion would raise money reliably, uniformly or necessarily where it is most needed, neither do they provide a long term solution to the problem of attempting to provide health care with inadequate levels of national funding. Such activity is also likely to divert limited management resources away from the management of care. In addition certain factors, for example the sale of capital assets, sponsorship, deals with the private sector, can lead to considerable distortion in the planning of service provision. Furthermore, an increase in private facilities within the NHS would require considerable capital and revenue expenditure to improve available facilities and staffing levels if they are to compete with the commercial private sector. It would seem short-sighted to depend on such sources in preference to an adequate level of national funding.

6.2 The College would make comments about two specific suggestions to generate additional NHS income, which it believes would be inappropriate to maternity care.

6.2.1 Part-Pay Charges - The RCM would object to pregnant women being asked to contribute financially to their care. There is a very important public health dimension to maternity care and women should not be deterred from seeking care by being obliged to make any payments.

6.2.2 Sponsorship and Commercial Trading - Mothers with new babies are recognised to be vulnerable to advertising and commercial pressures. The ethical dimension of sponsorship (e.g. by baby food manufacturers) or commercial deals (e.g. with photographers) requires close examination.

7. RESOURCE ALLOCATION

Maternity Services - an acute facility? - The RCM notes that most of the alternative methods of sharing out national resources concentrate on the acute sector because it absorbs the most resources and because a significant proportion of users might be able to contribute to the costs of their care. The maternity services are presently classed as an acute medical service, however there are certain features which distinguish maternity from other specialities:-

- Pregnant women are not ill

- Health education promotion and preventative objectives are major components of maternity care

- There can be no waiting lists

- The majority of care is given in the community, not in acute facilities

- Research would suggest that the majority of women can be delivered without high technology care.

- Outcome data is relatively easy to collect and has been kept since the inception of the N.H.S. although this data has been 'broad-brush' and there is scope for improvement in the collection of data relating to care outcome.

Thus, in many of the proposed arrangements the maternity services need to be dealt with separately in order to ensure an appropriate standard of care.

7.1 Controlling Costs

One of the central features of the alternative proposals for distributing resources is that they focus on cost-containment. The RCM has supported the concept of cost effective care for some years, arguing that maternity services in this country could be provided within the N.H.S. at less cost and more effectively. Particularly within the following areas:-

- eliminating the duplication of midwifery and medical skills (the midwife is the appropriate practitioner for normal pregnancy and childbirth).

- developing and assessing evaluated protocols to ensure that costly high-technology procedures do not slip into standard use.

- ensuring that women receive appropriate care not a standard catch-all package that is largely unnecessary.

- refining outcome data in relation to patterns of care.

7.2 The College has also examined some resource allocation alternatives to see how far they would permit these measures to be implemented. The RCM considers it paradoxical that the Government has shown so little enthusiasm to tackle open-ended medical spending or to ensure that clinical services, as well as say ancillary services, are provided in the most cost effective way. It would view most favourably those proposals which apply a rigorous framework for all health professionals to operate in.

7.3 Funding of Service Plans and Internal Markets - If an approach were adopted which moved away from district self-sufficiency or towards a competing market for health care provision, it would be theoretically possible for mothers to have to travel to a neighbouring district or beyond to have their baby. This would generate problems of accessibility, take-up and continuity of care. The College is of the view that only in exceptional

circumstances should mothers travel any distance to receive care or to be delivered. Maternity should therefore be designated a "core" facility provided by every health district. The College recognises however that certain very specialised functions, such as neonatal intensive care or neonatal surgery will continue to be best provided in sub-regional or regional centres.

7.4 Funding of Costed Workloads - The problem with using Diagnostic Related Groups (DRGs) in the maternity services is that it could reward the tendency to "over treat" women. There would be considerable scope for slipping women into higher risk-groups to attract more money. It is also not clear how the maternity services, which are essentially local, could or indeed should benefit from improved cross-boundary flow payment arrangements.

7.5 Vouchers - The level at which the voucher is set would be unlikely to cover the costs of maternity care. While a separate maternity voucher could be issued there would be many difficulties. Would it, for instance, cover simply normal pregnancy,

childbirth and postnatal care or extend to all risks, including special and intensive care of the newborn?

8. Health Maintenance Organisations (HMO)

8.1 The College finds certain elements of this concept attractive. The contracting of professional staff within well-defined operational procedures, the use of medical audit and utilisation review, the importance of community services and the emphasis given to health education and patient participation in care programmes are all consistent with the College's policies. The RCM would endorse arrangements which enabled groups of professional staff to form partnerships to operate health care shops at primary level and contract their services to an H.M.O type authority. It would also support arrangements which enabled an H.M.O to contract directly with individual professionals such as midwives. Both these options would give midwives a place in the community to practice, along the lines of the Community Midwifery clinics advocated for some time by the RCM. Also, the emphasis on performance review and cost-effectiveness would

strengthen the midwives' ability to assist as many women as possible to experience a normal delivery in hospital, without unnecessary technical intervention. Midwives offer a cost-effective form of maternity care. Finally, the H.M.O's concern to monitor costs at secondary care level would also be an antidote to any drift to a high technology medicalised model of birth. Care would have to be taken to ensure that hospitals contracted by the H.M.O to provide facilities for confinements were local.

8.2 Transferring HMOs to the U.K. Situation - The RCM does not support proposals which suggest basing a UK HMO system on general practitioners. This would offer patients little choice and the focus on a medical practitioner paid by item for service would weaken the cost-control elements which are an important feature of the American prototype. The College finds proposals which envisage the patient registering directly with an H.M.O authority more acceptable. However, the College is seriously concerned with the implications of forward planning for secondary care in a health service which was reliant on a system of freestanding hospitals all

aiming to sell services to HMOs. Arrangements would have to be made to ensure that groups of high-cost patients or more difficult cases were properly catered for.

9. Maternity care in the Future

The RCM believes that with adequate levels of funding and the political will the possibility exists for change within the present system. The College is of the view that wholesale change of the structure of health services in this country will further delay necessary changes to develop a cost-effective and client-orientated system of care. However, no matter how health care is funded or organised in the future the College would only support change if certain principles are safeguarded for the maternity services

- maternity care provision must remain a free at the point of need service in order to safeguard the future health of the nation.

- The care of a woman through the process of childbirth extends through pregnancy, labour and to the post natal period - a time span of some nine to ten months. The process itself represents a normal life event which is based fundamentally within the context of the family. To be meaningful, therefore, any system in which care is delivered should maximise the objectives that care should be as near to a woman's home and family as possible, and should encourage continuity of professional support.

- Whatever health care system prevails it must be designed so that maternity care can more sharply be focused upon the groups who consistently show patterns of poor pregnancy outcome. Not only should this be the aim because of the greater need of these groups, but for a given input of resource such targeting will have the potential for increased marginal improvements in health.

- an integrated midwifery service must be maintained and strengthened; it should be lead by a senior midwife with overall responsibility for coordination and maintenance of standards, in which programmes of continuity of care can be developed.

- maternity care provision must fully recognise that the women requiring the service cannot be stereotyped; they present a range of health, socio-economic, educational and cultural needs which have to be identified and met if the service is to be effective.

- the midwife's role as an independent practitioner must be recognised and facilitated.

ERJ/mm
19/05/88

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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cc Miss Peirson
MW Partridge
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SECRET

Mr R Wilson
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19 May 1988

Dear Richard

REVIEW OF THE NHS

As promised at your meeting on Tuesday, I enclose a copy of the latest draft of our Secretary of State's paper for next Tuesday's Ministerial Group meeting, in the form in which we have put it forward for the Secretary of State's approval. I shall get the final version to you as soon as possible tomorrow.

Copies of this letter and its enclosure go to Hayden Phillips, Dick Saunders, John O'Sullivan and George Monger.

Yours ever,
David

D J CLARK

COPY NO 15/3

SECRET

HC

NHS REVIEW: WORK IN HAND

My attached paper examines key aspects of our approach to self governing hospitals.

2. Underlying these key aspects are a range of secondary, but important, issues on which working papers are being prepared. These cover:

* the constitution and accountability of providers
* the management of capital assets and investment
* manpower planning and supply, and the financing of medical and nurse training
* ensuring that contracts between buyers and providers give the right incentives
* the timescale of change and the programme of action for achieving it
* resource implications
* improving information

3. Colleagues will clearly want to consider the main points arising from these papers. But the best way of making progress might be for them to be looked at first by the Cabinet Ofice Group of Officials. The main points that arise from that work can then be brought to us. If that is agreed, I will arrange accordingly.

SECRET

SELF GOVERNING HOSPITALS: KEY ASPECTS

Note by the Secretary of State for Social Services

This paper examines two key aspects of self governing hospitals - role of the buyer; and how the new approach would work in practice from the point of view of the patient, the GP and the consultant. We are, I think, clearer about the virtues of "self-governing hospitals" themselves, but Annex 1 sets out some further thoughts on "health care providers" in case colleagues would like to discuss them at this stage.

I The role of the buyer

(a) Separation of buying and provision

2. The essential step we have to take if we are to establish self governing hospitals is to separate the buying and provision of health care.

* The major disadvantage of the present monolithic system, in which there is little choice and competition, is that the interests of the patients can take second place to those of the provider. In turn this has reduced the incentive for managers to improve services and the scope for people to spend more of their own money on health care.

* By contrast, the advantage of separating the purchase from the provision of care is that it will open up the system to competition. The patient would come first, not second.

3. The key to this will be the role of the buyer, or local health agency. The agency's starting point should be the needs and interests of the community, not those of the provider. This is a crucial change - we must not dilute its impact.

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4. At present, health authorities are responsible for both buying and providing health care. It is normal in the private sector for decisions to be taken regularly on whether to provide a service in-house or to buy in from outside. The public sector has not done this, although we have made substantial progress with our initiatives on competitive tendering. If we are to make a reality of the agency's independent choice, it should not also be the dominant supplier of health care. Otherwise, the agency's own services will tend to be favoured.

5. We shall want to consider the evolutionary route towards this goal, on which I set out some proposals in Annex 2. In deciding on the pace of change we must pay particular attention to:

* building on the progress we have already made in the NHS - for example in the successful introduction of general management

* maintaining the morale of those now working in the service who need to be reassured that there is a valued place for them in the reformed structure.

(b) **Who will the agency be?**

6. Basically, the agency will be a public sector body and the successor to the present health authorities and family practitioner committees. I deal with this in more detail in Annex 2.

(c) **What will the agency do?**

7. The agency will be responsible for ensuring that there is comprehensive health care for the population for which it is responsible. In particular it will:

* identify present and future health needs, taking account of consumer demand

* invite tenders from providers of particular services or groups of services, and negotiate and award contracts

* monitor the performance of providers against key quality, outcome and cost targets, ensuring that patients, family practitioners and consultants are fully informed.

8. The size of population covered will depend on a number of factors, including the extent to which the agency is responsible for community care as well as health care. But I expect these factors to point towards a typical population of around 500,000 - larger than district health authorities, about the same size as now covered by family practitioner committees and interestingly the same size as proposed in New Zealand for their equivalent body. We should not, however, aim to move to this size overnight, as Annex 2 explains.

(d) **How will agencies be funded?**

9. We will be able to draw heavily on our RAWP experience. Buyers would receive cash-limited allocations calculated according to

* population size, weighted for age profile and other relevant characteristics; plus

* the cost of servicing the capital assets employed by service providers (both existing stock and new investment), which would be charged within contract prices.

There should be no need to compensate for cross-boundary flows, as RAWP does at present, since each buyer's boundaries would be irrelevant to the location of the services it bought.

10. Within this cash limited allocation, there would have to be special arrangements for GPs. The issue we shall have to address here, though we do not need to settle it now, is how far we should use this opportunity to apply budgetary limits to the expenditure of GPs.

(e) **How will money follow patients?**

11. The form of the contract would determine the way in which money followed the patient. There would be broadly three different forms:

first, an average cost contract for a given number of treatments, where the money would follow each patient. This would apply in particular to cold elective surgery and possibly to maternity services.

second, a capitation contract where the money would go in advance of the patient - though in the longer run the money would follow patients as a group if the contract were moved. Such a contract would involve a set annual fee for the number expected to use the service whether or not they actually do. This would avoid the "credit card" approach to accident and emergency services, a criticism often levelled at the United States. Where a non-resident was treated there could be cross charging or a knock for knock arrangement. Besides accident and emergency services, this type of contract might apply to out patient referrals and acute episodes of mental or geriatric illness. A comparable contract would also apply, as now, to family practitioners.

third, a retainer plus marginal cost contract would incorporate elements of the first two. Under it, set annual fee would be paid so that the capacity was available. There would then be a price per patient based on marginal costs: for that part of the contract, the money would follow the patient. This would be an alternative approach for out-patient referrals and for maternity services.

II How the approach would work in practice

(a) **How the patient would see it**

12. The patient would

* retain a direct, personal relationship with the doctor responsible for his (or her) treatment.

* continue to look to his GP both for primary health care and for advice on, and referral to, hospital services.

* continue to enjoy access, and entitlement, to a comprehensive range of health services, free at the point of delivery.

* enjoy a better informed, and therefore more real, choice - exercised through his GP - between different consultants and different hospitals. He could for example make his own decisions on the balance of advantage between shorter waiting and less travelling. Administrative boundaries would not determine to the location of treatment.

* benefit from the impact of competition on the standards of service offered by providers.

* be able to look to a single body - the local health agency - as being responsible for ensuring that his health care needs can be met.

13. Annex 3 illustrates how the system might work in practice for an individual patient.

(b) **How the GP would see it**

14. The GP's primary responsibility would still be to the patients on his (or her) list. He would retain full clinical responsibility for those patients. And he would continue to refer them, as necessary, direct to consultants.

15. The main changes would be to the circumstances in which those referrals took place. At present GPs are free to refer a patient to whichever consultant they wish. Under the new arrangements I am proposing there would be - and should be - a trade-off between

* the local health agency's decision on where to place its contract or contracts for any given service, a decision which must be taken with cost-effectiveness as well as choice in mind; and

* the GP's clinical judgement as to what is best for his (or her) patient, which may be to refer him to a specialist at a hospital with which the buyer does not have a relevant contract.

16. The effect of this trade-off, without any modification, would be to constrain a GP's freedom of referral, and the profession would no doubt object to this. It is essential, therefore, that we modify it to preserve the GP's ultimate clinical freedom and enhance his ability to exercise it in practice. I believe that the arrangements I propose would do this, for the following reasons:

* in practice, a GP's freedom of referral is already constrained - by inadequate information; by the reluctance of some district health authorities to accept patients from elsewhere; and by the resources available in hospitals. In future the information available to him would be much better; DHA boundaries would be irrelevant; and local health agencies would be shopping in a more efficient provider market.

* in practice, too, GPs may take referral decisions on the basis of which consultants they happen to know, or of longstanding habit. The approach I propose would both prompt and help GPs to question such referral patterns and exercise a better informed choice.

* GPs collectively would be able to influence, though not determine, where local health agencies placed their contracts for hospital and other services. For example, each agency's decisions would need to take account of "their" GPs' preferred patterns of referral, and would need to offer GPs the maximum range of choice consistent with cost-effectiveness.

* GPs would retain the right to make referrals additional to those for which "their" agency had already contracted, whether to the same or to different providers. This right would be

  - financed by a cash-limited "back pocket" held by each local health agency for this purpose and calculated by them in the light of known referral patterns.
  - supported by a process of peer review, so that competing demands on these reserve funds could be resolved by the profession itself.

17. Annex 3 also illustrates how this might work in practice for the individual GP, and Annex 4 summarises the different geographical circumstances in which GPs would be exercising the choices open to them. I believe that the changes I propose would bring great practical gains, but in explaining and implementing them we would need to be alive to the fact that many established relationships between individual GPs and specialists would be disturbed.

(c) How the consultant would see it

18. Like the GP, the consultant would find his (or her) basic clinical responsibility, and his relationship with his patients, fundamentally unaffected. But there would be a number of changes which, whilst welcome to government, might not be welcome to many in the profession. In particular:

* consultants would no longer be employed by Regions or teaching Districts. Instead they would either be self-employed or, like other staff, employed by individual providers.

* whilst the principle of clinical freedom would be untouched, the consultant would find what was expected of him (or her) more tightly constrained by the terms of the contracts which local health agencies had entered into with the provider for whom he was working.

* there could be no security of tenure beyond the term of current contracts for the services for which he was responsible.

19. Against this there would be much in what I propose that would be attractive to consultants, especially to the majority who are committed to working hard for a better service. In particular:

* a more competitive form of provision should enable consultants to do more work - as so many tell us they would like to - without their services incurring the financial penalties which are inherent in the present system.

* consultants would have much greater influence in the management of <u>their</u> business - the delivery of the services in which they specialise - and much more scope to develop and market new ideas.

* there would be the prospect of higher earnings for the best consultants as providers compete for their skills.

20. As our work progresses we shall need to build up a balance sheet of how the changes we propose would affect consultants, GPs and nurses, and of how the professions as a whole would be likely to respond. We might take stock when we discuss the professions in June.

Conclusion

21. My further work since our last meeting has satisfied me that we are still on the right track. I invite colleagues to agree that we should continue our exploration of the way the self governing hospitals approach would work in practice.

May 1988

Annex 1

Health Care Providers

1. Under the "self-governing hospitals" model, public sector providers would be freer than they are now to consider what services they wish to offer and how to improve them. They would compete among themselves and with private sector providers on both the quality and the cost of the various services they offered. They would be free to sub-contract particular services and to subject their support services to competitive tendering.

2. It would be a mistake for government to decide in advance exactly how many providers of what kind would be needed, or to impose a rigid format on what such a market would generate by way of a longer term pattern of provision. Just as we have successfully embraced different models in our approach to privatisation, so we should recognise in our approach to the provision of health care the variety of circumstances we have to encompass. In particular:

* there is a spectrum of hospital care ranging from metropolitan areas with several teaching hospitals; through conurbations with a wide choice of acute services; suburban areas with a single district general hospital; to at the other end rural areas with substantial travel to district hospitals and a greater potential role for cottage hospitals. Annex 4 sets this out in more detail.

* there are over 1,800 NHS hospitals in England, of which 750 have fewer than 50 beds. Many are in practice closely interdependent. It would not be economic for every one of these hospitals to become "self-governing" - employing their own staff, negotiating their own contracts, and so on. Instead, it would make better management sense for some of them to work together when bidding for contracts, as they do now to provide a wider range of care.

* not all public sector providers would be based on mainstream acute hospitals. Of the 611 management units only 195 are solely "acute". The rest provide community health services, mental illness or mental handicap services, or a combination of different services. These are delivered partly through hospitals but also at patients' homes and through clinics, health centres and GPs' surgeries. GPs themselves would also be "providers" - seeing far more patients than are seen in hospitals.

3. We should therefore put in place a sufficiently flexible market framework to enable a variety of providers to emerge, and develop this framework in an evolutionary way. This suggests a three-stage programme:

* Stage 1: prepare the way by continuing to devolve responsibility to existing management units, involve doctors in hospital unit management, and develop information systems.

* Stage 2: allow units to float free of Districts and become "self-governing", probably at the same time as district health authorities and family practitioner committees are re-formed into the new buying agencies (Annex 2, paragraph 4).

* Stage 3: leave the market to generate new subdivisions and combinations of providers, perhaps with some providers opting out of the public sector entirely (for example through management buyout).

4. Providers who remain in the public sector will need to be accountable for their stewardship of public assets. We shall need to explore, and perhaps to experiment with, different models for satisfying the requirements of accountability and for dealing with related matters such as investment in capital and training. We need also to explore ways in which provider management could itself be franchised competitively: this could be especially valuable where there was little or no scope for alternative providers to enter the market, or where a hospital's failure in the market did not justify the closure of a valuable, or even essential, facility. We shall need to consider further papers on these issues in due course.

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Annex 2

Local Health Agencies

Local health agencies would be accountable to the Secretary of State for Social Services who would in turn be accountable to Parliament.

2. Broadly, such agencies could be based on one of three models:

elected bodies, like the proposed New Zealand regional health authorities.

appointed bodies, akin to the present health authorities and family practitioner committees. (Regional health authority and family practitioner committee members are all formally appointed by the Secretary of State, though nominations are drawn from various groups. District health authority members are appointed by regional health authorities or local authorities, though the chairman is appointed by the Secretary of State.)

government agencies, without any outside members.

3. In considering these models, we need to bear in mind:

first, that the agencies will be funded by central government money, not local. It would be important to have an organisation which focussed on value for money rather than becoming a pressure group for more resources. The New Zealand model does not seem appropriate for that reason.

second, we need to make the best use we can of existing management resources and to avoid the cost of unnecessary turbulence.

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third, our experience of managing the NHS has shown the need for good oversight of work of district health authorities and the value for this purpose of an effective regional tier.

fourth, we want to leave room for alternative buying agencies to develop if there is a demand for them.

4. Taking these factors together, the quickest way to make progress will be to adapt the existing structure rather than introduce an entirely new one. On this basis, the stages of development might be:

Stage 1. prepare the way by continuing to devolve responsibility from region to district, by implementing key aspects of the Primary Care White Paper, and by further developing the necessary information sytems.

Stage 2. re-form district health authorities and family practitioner committees into local health agencies, probably at the same time as providers begin to be floated free.

Stage 3. consolidate the skills and systems needed to make the new approach work.

Stage 4. in due course - allow competing buyers to emerge and review the role of the regional tier.

5. As part of this process we shall want to consider the continuing role of nominated members.

Annex 3

Patient and GP Choice

1. The "self-governing hospitals" model implies no change in a patient's treatment in an emergency, but it would have an impact on the way in which a patient and his or her GP would exercise choice over non-immediate referrals to a specialist. This note illustrates that impact by reference to a fictitious patient, Mrs Smith, and her GP, Dr Jones. It assumes that Mrs Smith has already chosen Dr Jones as her GP, is satisfied with the service he offers, and trusts his advice. It also assumes that the "self-governing" hospitals model has been in operation for around 3-4 years.

2. Mrs Smith is a widow aged 65. She lives alone in the suburbs of a large provincial town. She sees a lot of two friends who live in her street, and has a son, daughter-in-law and grandchildren who live two or three miles away. She is physically mobile, but is partially sighted and has a history of eye trouble, including a hospital admission five years previously for a cataract removal. She has recently developed mild diabetes. She has no private health insurance.

3. Mrs Smith's eyes are troubling her again. She hesitates to consult her GP because she is afraid of the consequences: she did not like her previous stay in hospital, and does not want to repeat the experience; and she is afraid of losing her sight. Nonetheless, encouraged and reassured by her friends and family, she makes an appointment to see Dr Jones.

4. Dr Jones is unable to make a firm diagnosis. Given Mrs Smith's history, though, he knows that the problem is not straightforward and suspects strongly that an operation will be needed. He reckons that this would involve a stay in hospital of about a week followed by two or three follow-up out-patient attendances. He also suspects, but cannot be sure, that Mrs Smith's condition will deteriorate quite quickly if not attended to.

5. Dr Jones explains all this to Mrs Smith and advises strongly that she should see a specialist, initially for an out-patient consultation and diagnostic tests. He reviews the three main options:

i. Mr A is the consultant at the district general hospital in the town. This is the hospital to which Mrs Smith was previously admitted, and to which she is therefore not well disposed. But the consultant is now different: Mr A was recruited by the hospital's management 18 months previously to revive a flagging opthalomology department and standards have improved dramatically. The available evidence, together with Dr Jones's own experience, suggests that Mr A deals admirably with relatively routine cases, but his department is not well equipped for more complex problems and so Mrs Smith might have to be referred on to a more highly specialised unit. An outpatient appointment could be arranged quickly, but pressure on operating theatres has recently extended ophthalmology waiting times to an average of 4 months: Mrs Smith might rate a high priority on Mr A's waiting list, but Dr Jones cannot be sure. The hospital holds the main contract for providing ophthalmology services for the local health agency's residents: the terms of the contract are adequate to cover Mrs Smith's out-patient, diagnostic and in-patient needs, although the relatively low price negotiated by the agency could encourage Mr A to refer Mrs Smith elsewhere for treatment.

ii. Mr B is a consultant at a provincial teaching hospital 50 miles away. The ophthalmology department there is strong, and both well equipped and well staffed to deal with complex cases. Dr Jones has a generally high opinion of Mr B, although Mr B's ratio of operations to patients seen is high and Dr Jones knows that Mrs Smith would prefer not to face an operation unless it was really necessary. Also, some of Dr Jones's patients have in the past found the hospital to be rather impersonal. An out-patient appointment could be arranged as quickly as one with Mr A and in-patient waiting times are substantially shorter - about a month on average. The local health agency's only other ophthalmology contract is with this hospital: the agency decided two years previously to increase from 10% to 20% the proportion of its

committed ophthalmology budget devoted to this contract, partly to put pressure on the district general hospital to improve its performance and partly in response to the changing preferences of its GPs. The agency has nonetheless asked its GPs to minimise the referral of relatively routine cases to this hospital as its prices are higher, reflecting its more specialised nature.

iii. Mrs C is a consultant at Moorfields Eye Hospital in London, 150 miles away. Dr Jones has occasionally referred difficult cases to Mrs C in the past, and has total confidence in her and the hospital's ability to deal with them. An out-patient appointment would take a little longer to arrange than one with Mr A or Mr B. In-patient waiting times average three months - shorter than those for the DGH, but Mrs Smith would be much less likely to rate a high priority on Mrs C's list than on Mr A's. The local health agency has no contract with Moorfields, but it does have a reserve budget to cover referrals without existing contractual cover, subject to peer review. Moorfields's prices are the highest of the three hospitals, but Dr Jones is satisfied that he could make a strong case for financial cover from the reserve budget. It could take up to three weeks to receive a reply to such a bid.

6. Having gathered all the relevant information Dr Jones discusses these options thoroughly with Mrs Smith. His advice is a referral to Mr B. Although he believes that a referral to Mrs C would be justified on clinical grounds, he is concerned about the length of time that would elapse before a diagnosis is made and, if necessary, an operation performed; and he is worried about how Mrs Smith would react to being so far from home. On the other hand, he believes that the history and potential complexity of Mrs Smith's condition makes a referral to Mr B clinically justifiable by comparison with a referral to Mr A.

7. Mrs Smith has only one doubt about agreeing to this: she feels she would cope much better with a spell in hospital if she could be visited frequently by her family and friends. In other respects her natural inclination to follow Dr Jones's advice is reinforced by her strong desire - having steeled

herself to consult him - to wait the shortest time possible for any necessary hospital treatment. For herself she sees the time to be spent travelling to out-patient appointments as a price worth paying for a shorter waiting time.

8. Mrs Smith discusses the position with her son and her friend. They work out between them how at least one of them can visit her every day, usually with a grandchild, if she is admitted to the teaching hospital. She telephones the surgery to ask Dr Jones to go ahead with the referral to Mr B.

Annex 4

Geographical Variations

1. This note describes the different types of area in which GPs would refer their patients to hospital.

2. Admission to hospital would continue to be by three main routes:

* directly via accident and emergency departments
* emergency referrals by GPs
* by a GP referral for an out-patient appointment followed if necessary by a decision by the consultant to admit for treatment as an "elective" patient or to refer the patient on for more specialised care.

All local health agencies, regardless of size or geographical coverage, would need to ensure that their contracts provided for access to hospital through these routes.

3. In deciding with which hospital to place a contract, local health agencies would need to judge the cost, quality and accessibility of services. The weightings given to these criteria would be influenced by the kind of area in which the agency operated. Broadly, the range would be:

i. areas including a teaching centre

By definition, these will be metropolitan areas, often with several teaching hospitals. About 15% of the population currently live in a district served by a teaching hospital. In these areas:

* GPs and patients currently have a wide choice of core and specialist acute services: contracts might appear to restrict this.

* except to the extent that separate provision is made for medical training, local health agencies would need to balance costs (which are high in teaching hospitals), the public's desire for the "best", and the need to ensure that teaching hospitals have sufficient numbers of routine cases to carry out their education function.

* there might be alternative private sector provision.

The net effect would be likely to be little change in public perception. There should be ample scope for placing contracts with several provider units. By raising awareness this should increase real choice.

ii. conurbations

In addition to those living in an area which includes a teaching centres, about 25% of the population live in heavily built up areas. In these areas:

* there would be a wide choice of core acute services. There should therefore be no difficulty in placing contracts with efficient providers while retaining some choice. The balance might be more difficult to strike where there was a high degree of consumer awareness, for example with maternity services.

* some choice would also be likely in specialist services. Greater competition might be encouraged where there was a teaching centre nearby and alternative private sector provision.

iii. mixed urban/rural areas with one district general hospital

About 45% of the population live in Districts of this kind which do not have a teaching hospital. In these areas:

* patient choice might be increased for some treatments depending on the accessibility of neighbouring units and the scale of private sector provision.

* the scope for competition in the provision of core acute services would be relatively limited.

* there would be unlikely to be significant change in the pattern of specialist referrals or of referrals from one consultant to another.

iv. rural/sparsely populated areas

About 15% of the population live in "rural" Districts. In these areas:

* there would be unlikely to be significant changes in the choice of core or specialist acute services. Accessibility would continue to be a major criterion.

* the new model might encourage more imaginative use of cottage hospitals. Contracts could be negotiated directly with GPs.

CHIEF EXECUTIVE NHS MANAGEMENT BOARD

18.5.4

APPOINTMENTS IN CONFIDENCE

PPS PT. BF/W Boys n Mons

FROM: R B SAUNDERS

DATE: 19 May 1988

APS/PAYMASTER GENERAL

cc PPS
PS/Sir Peter Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Call

CHIEF EXECUTIVE NHS MANAGEMENT BOARD

You asked if there were any specific points which might help in considering possible successors to Len Peach.

2. The next Chief Executive is likely to have to preside over a time of major upheaval in the NHS. Quite what it will involve will depend on the outcome of the present NHS Review. There may be major changes to push through with health authorities and with the medical profession. It is possible - though not certain at this stage - that NHS reorganisation may involve the job expanding to encompass GPs as well as hospitals (at present it covers only the latter).

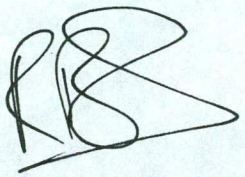
3. It therefore needs somebody with the drive and the capacity for innovation to see through major change. But this involves much more than simply setting targets and meeting them. It is not a straight line management job. The NHS Management Board does not "manage" the NHS; rather it seeks to persuade and cajole the regional and district health authorities. Each authority has its own parochial concerns, which it feels are not understood by the DHSS. Each resents interference, as it sees it, from the centre. Tact, firmness, considerable powers of persuasion and - not least - patience are needed.

4. The job is also of course highly political. The incumbent has to work within political parameters which are not the same as those of running a business. He is answerable to Ministers, and subject to Parliamentary pressure and scrutiny - for example, as Accounting Officer for the Hospitals and Community Health Vote, he is liable to appear several times a year before the PAC. The ideal

candidate would therefore either have some Whitehall or Westminster experience in his background, or be demonstrably capable of operating in an environment very different from the business world.

5. The DHSS have suggested that somebody with an industrial relations or personnel background - like Len Peach - might be well suited to the job. There is certainly a large man management element in the job, but there is more to it than that. There are deeply entrenched professional and trade union interests in the NHS. It would be very important that somebody with an industrial relations background did not allow himself to get too close to them at the expense of the wider management task.

6. In short, we need a good, tough, innovative manager, with the political sensitivity to handle the Whitehall end of the job and the diplomatic skills to persuade a wide constituency of different interests to line up behind possibly radical change.



R B SAUNDERS

SECRET

Inland Revenue

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London WC2R 1LB

FROM: A W KUCZYS
20 MAY 1988

1. MR CORLETT

2. MR ISAAC seen in draft

3. CHANCELLOR

NHS REVIEW : TAX RELIEF

1. At the Prime Minister's meeting on 9 May you agreed to arrange for a paper to be prepared, for consideration in the week beginning 6 June, on two options:

- tax relief for private health insurance premiums paid by the elderly; and

- exempting premiums paid by employers under a company scheme from taxation as a benefit in kind in the hands of the employers.

2. In Moira Wallace's note of 16 May you asked for an early note on the work being done for this paper on the second option, and in particular the case for restricting benefit-in-kind exemption to company schemes which cover all employees. The best way of meeting this request would seem to be to let you see an early draft of the paper, and

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cc PS/Chief Secretary
PS/Financial Secretary
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Culpin
Mr Turnbull
Mr Saunders
Mr Griffiths
Mr Call
Mr Battishill
Mr Isaac
Mr Corlett
Mr Beighton
Mr Lewis
Miss Rhodes
Mr Davenport
Mr Eason
Mr I Stewart
Mr Walker
PS/IR
Mr Kuczys

this is attached. (Mr Saunders saw a version earlier this week, but this has changed quite a lot as we have worked further on it.) Much of the work is by Mr Walker.

3. I should stress that this is only an early draft, and there are still some gaps to be filled and rough edges to smooth out, quite apart from any comments that you (and copy recipients) may have. On the other hand, time is quite tight. The week before 6 June is the Whitsun Recess when a number of those involved will be away from the office; so our aim is to try and finalise the paper if at all possible by next Friday (27 May).

4. It would be very helpful, therefore, to have your initial views on this draft. In particular:

a. Is the paper broadly on the right lines? Are you content with the tentative conclusion, that a case for tax relief for the elderly could be made out, though there are strong doubts about its cost-effectiveness; and that it is very difficult to find arguments for exempting benefits-in-kind of some employees but doing nothing to help less favoured employees or the self employed - and it could lead to pressure to go much wider?

b. Are you content to leave a number of detailed questions open in the paper? (For example, whether "the elderly" should be defined as the over-65s, those of pension age, or the over-60s; and whether relief should be at marginal rate or basic rate only.)

c. We have drafted this as a paper by officials. It would obviously need some redrafting, if you wished to send out a paper in your own name. Alternatively, if you are content with the general line, it could go under cover of a note by you drawing out the main points you want to emphasise. If the latter, we will

of course let you have a draft next week, but are there any particular points you would want to make?

d. Are you happy with the treatment of benefit-in-kind exemption limited to all-employee schemes? Our own evidence, which is somewhat anecdotal, does not square with the Orros paper - that is, we do not think the great majority of company schemes are restricted to management (or, if they have been in the past, this is now changing). In any case, we do see practical difficulties with this proposal. We can of course do more work on it if you would like. But do you agree that it should not have too much prominence in this paper for Colleagues?

5. There may of course be other aspects which you (or others) want to change.

AWK

A W KUCZYS

DRAFT 20 MAY 1988

TAX RELIEF FOR PRIVATE MEDICAL INSURANCE

Note by Inland Revenue

Introduction

1. This paper covers two options which were identified for further consideration at the Prime Minister's meeting on 9 May. The options are:

i. to give income tax relief on premiums paid for private medical insurance for the elderly; and

ii. to exempt employees from tax on premiums paid by employers under company schemes.

Tax relief for the elderly

2. The elderly are heavy users of health services. Those over [65], representing [15] per cent of the population, pre-empt [40] per cent of total NHS expenditure in the country.

3. At the same time, they are less likely to be covered by private medical insurance than the population as a whole. 350,000, or [4] per cent of those over 65 are covered by private medical insurance; whereas over the population as a whole the cover is [10] per cent. Hardly any over-75s are insured. The reasons for this relatively low coverage appear to be:

- reluctance of insurers to provide coverage for new subscribers over 65

- even where insurance is available, it is relatively expensive (a typical policy costs [£300] for a couple aged 30, but [£600] for a couple aged 65); and (understandably) the restrictions in the cover tend to bite harder on the elderly than on others.

- some of the big NHS costs (eg for long-term care) are not insurable on any terms.

4. The combination of these factors means that the elderly represent a very heavy call on NHS resources. The question is whether tax relief on their private medical insurance premiums would provide a practical, cost-effective and politically sustainable method of attracting them into the private sector for at least some of their needs and easing pressure on the NHS.

5. On the practicalities, a tax relief scheme for the elderly could be operated by the Revenue on the lines of the MIRAS scheme for mortgage interest relief. That is, basic rate relief would be given at source by reduction of the premium, with the Revenue dealing directly with the insurance providers. The possible arrangements are described in more detail in the Annex. A MIRAS-type scheme would mean that the benefit of the relief (in effect, a public expenditure subsidy) would be available to non-taxpayers (if any of them were in the market for this type of insurance).

6. Decisions would be needed on:

- whether, where the taxpayer was a higher-rate payer, relief should also be given at the higher (40 per cent) rate

- the age (60 or 65) at which entitlement to relief would begin

- the type of policy which would qualify for relief, and by whom such policies would be approved (on the assumption that relief would need to be restricted to genuine medical expenses); and whether the qualifying premiums should have an upper limit

- whether the relief should be available only for the elderly themselves, or whether (at the cost of added administrative complication) it should be available also for others who pay for an elderly person's membership.

7. The cost-effectiveness of the relief would be determined to a large extent by the take-up. This is because of the deadweight cost of giving relief to those who already have private medical insurance. For example, relief at the 25 per cent basic rate on an average premium of £600 for 170,000 existing subscribers would cost about £20 million (deadweight).

8. It is difficult to estimate the number of new elderly subscribers who would be attracted in by the relief, but some American research suggests that it could amount to perhaps another 10 per cent. If that is right then the overall cost of relief would not be much more than £22 million. But even that assumes that insurers would in future be prepared (by constrast with the

present common rule) to take on new clients amongst the elderly.

9. The question therefore is whether that cost would represent a good "buy" in terms of savings in the NHS by encouraging perhaps 20,000 new elderly people to move to the private sector for certain specified medical services. A 10 per cent increase in premiums would amount to about £8 million. If the simplifying (and generous) assumption is made that in the long run the level of premiums represents broadly the medical costs the insurer expects to bear, then the cost of tax relief (£22 million) would substantially exceed the saving (£8 million) to the NHS.

10. On the wider political implications, the introduction of relief would represent a (limited) reversal of the Government's general policy of abolishing or reducing tax reliefs for special categories of taxpayers. The consistency of policy would probably come under attack.

11. If the relief were restricted to the elderly, the criticism might be deflected on the basis that this was a de minimis relief, narrowly targeted at a particularly deserving group for whom the market in private medical care was not at present working well.

12. But the question is whether it would be possible to hold the line at the elderly. There would undoubtedly be pressure for the relief to be extended more widely, particularly to younger people not in a position to benefit from employers' health insurance schemes. If the line could not in practice be held, there would be major implications both for the cost and for wider tax policy issues.

Benefit in kind exemption

13. The second proposal is for just such an extension to other groups, by exempting premiums paid by employers as a benefit in the hands of employees. The same questions arise: would this be practical? would it be cost-effective? and on what basis could the dividing line be defended?

14. As far as practicality is concerned, exempting the benefit would be relatively straightforward (see Annex for details). Exemption would effectively give employees relief at their marginal rate. In contrast to relief for the elderly, it would be more difficult operationally to give relief only at the basic rate.

15. It is not clear that extending relief in this way would be cost effective. At present, over 750,000 employees above the £8,500 threshold for taxing benefits in kind enjoy the benefit of employer-paid medical insurance. The deadweight cost of exemption for these employees would be around £80 million. The extent to which a change in tax treatment would stimulate additional employer provision is very hard to gauge, since the price mechanism involved is indirect - the cost to the employee would have been reduced but the decision whether to provide insurance rests with the employer whose costs would be unchanged. US evidence relating to employer-provided insurance suggests that an increase in provision of 10 per cent might not be implausible. If it were 10 per cent, it would take the total cost to about £90 million. But this figure should be treated as little more than illustrative. On this basis, the relative cost-effectiveness of this proposal will be exactly the same as tax relief

for the elderly: ie the tax cost would substantially exceed the new premiums and the benefit to the NHS.

16. Moreover, employer-provided insurance cover is a growth area: the number of employees covered is already rising at about [5] per cent a year. There is an argument that this sector is growing quickly enough not to need a tax-based boost. (Indeed there is already some fiscal incentive because medical cover, like other benefits, is exempt from employer and employee NICs).

17. One possible variant would be to grant exemption only where a company scheme applied to all employees. This might do most to widen coverage, by encouraging the extension of existing schemes, limited to managers or "staff", to the whole workforce. However, there is no reason to believe that, in general, existing schemes are limited to senior employees. Increasingly, this sort of benefit is being provided to all employees - which is one reason for the growth in coverage. And it is not clear how the rule could in practice be enforced.

18. Some employers themselves provide medical attention for their employees or pay for their treatment. Any exemption should reasonably extend to these arrangements also.

19. As we see it, the most difficult issue is to find the rational basis on which to defend the dividing line for the exemption. Why should people of working age get tax relief for private health insurance if - but only if - they are employees and their employer is prepared to pay the contributions to the insurers directly? What

are the grounds for excluding everyone else - other employees? the self-employed?

20. The arguments for special relief for the elderly are that they find it difficult to get insurance and they have to pay in effect a surcharge. For employees in the big company schemes the situation is precisely opposite: health insurance cover is offered on a plate, and at a discount.

21. In all comparable fields - pensions, disability insurance, education and (at present) health insurance - the tax legislation tries so far as possible to treat on an equal footing employees generally and the self-employed. This reflects the Government's general policy, emphasised by successive Chancellors, that there should be no special tax advantage to employers and employees to arrange for their remuneration to be taken in kind, rather than cash.

22. To put this point another way, the benefits in kind charge is not a special penalty on employer-provided medical cover. It provides income tax neutrality between the employee who receives part of his pay in benefits, and the employee or self-employed man who is paid wholly in cash and buys his own benefits. If the Government wants to provide a special tax relief, it now provides that relief across the board. To defend a limited exemption - confined to employer-financed benefits - it would on the face of it be necessary to identify some special (presumably social) reason why collective employer-financed group schemes were more desirable than private individual insurance - or why these particular employees were in more need

of health insurance than other employees or the self-employed.

23. If pressure led to extending relief to all for private medical insurance the cost would rise substantially to around £250 million (or more if demand increased significantly). And, as noted in the Treasury paper of 22 April, that in turn could lead to pressure for concessions in other areas (eg for those who opt out of State education by educating their children privately) which, apart from any other considerations, would be very costly.

Conclusion

24. Neither tax relief for the elderly nor benefit in kind exemption poses insuperable operational difficulties. A relief for the elderly alone might cost around [£22] million, if (despite the considerable deadweight cost) such a relief were felt to offer good value for money or other political advantages. For people of working age we have not so far been able to identify an argument for confining an exemption to employer-paid premiums. So there would be considerable pressure for a more widely available relief, at significantly greater cost - and, beyond that, to treat other forms of "opting out" similarly.

ANNEX

Operational and practical considerations

1. This annex covers:

- operational and staffing implications for the Inland Revenue
- compliance costs and benefits for employers and insurance providers
- possible limits to relief and vetting of policies
- timing questions

A. Tax Relief for the Elderly

2. Operationally, the best way to give tax relief for the elderly would be to arrange for insurance providers to give basic rate tax relief at source. The Inland Revenue would set up a special unit, along the lines of the existing unit for mortgage interest relief at source (MIRAS) to deal with the insurance providers and their claims for repayment. Some technical expertise would be needed to check that the policies offered were acceptable. Relief could be given also at the higher rate, but this would have to be handled by individual tax offices - at an additional staff cost.

3. The overall Inland Revenue staff cost of granting relief for the elderly on this basis is [10] at basic rate only, plus another [15] at marginal rate.

4. As for compliance work for insurance providers, giving relief at source for the elderly would add to their costs: the arrangements would clearly have to be kept as simple as possible to keep such additional work to a minimum. But the insurance providers should be getting a significant amount of new business as a result of the relief, and would thus have no ground for complaint.

5. Some limit to the relief in each individual case may be desirable. Relief could, for example, be restricted to a maximum of, say, 25 per cent above the average subscription in order to prevent those who could afford it getting tax relief on policies which included cover going well beyond essential medical care. But limiting relief in this way would be operationally difficult. And it could hit those who, because of their age or previous health record, found cover more expensive than the average. The best way to control the type of cover provided would be for the Revenue (on the basis of advice from an expert body) to approve policies before they qualified for tax relief.

6. The timing of the introduction of any relief would depend on when a firm decision was taken to go ahead, when it was announced publicly and when the necessary legislation was enacted. The timetable from a decision (and announcement) on tax relief for the elderly, to implementation, would depend on three factors:

i. setting up the new Inland Revenue unit, and other necessary Inland Revenue procedures (eg for approving policies);

ii. BUPA and other providers setting up their own arrangements for operating relief at source; and

iii. the need for primary legislation.

Of these, i. should take around 6 months, and is unlikely to be critical. The most problematic is likely to be iii. With, say, an Autumn 1988 announcement, the first legislative opportunity is likely to be the 1989 Finance Bill (unless Parliamentary time were found for a short Bill specifically for this purpose). Regulations covering details of the scheme would have to follow Royal Assent to the primary legislation (July/August 1989 in the case of the Finance Bill).

7. This suggests that an Autumn 1989 or January 1990 start of operations should be feasible, for relief at basic rate only. If, however, relief were to be given at marginal rate, the scheme would really need to come into operation from the start of a tax year: that would point to an April 1990 start.

B. Benefit in Kind Exemption

8. Operationally, exempting employer-provided medical insurance as a benefit would be relatively straightforward. Once the initial job of amending PAYE codes had been done, there would subsequently be less work for Tax Offices, and a small staff saving in the Inland Revenue.

9. If the exemption were available only to those schemes where the whole work-force was offered insurance, there would be a [small] Inland Revenue staff cost to ensure that only those employers who

met the criteria were given the tax relief; but this staff cost would be [partly] off-set by savings in the Tax Offices dealing with the employees concerned. The overall Inland Revenue staff effect would be [negligible].

10. An exemption for employer-provided private medical insurance should entail a reduction in the compliance burden on employers. At present, employers have to send the Tax Office annual returns detailing the benefits-in-kind provided for most employees. Exemption would mean that no returns would be needed for the 200,000 employees whose only benefit was private medical insurance.

11. If relief were given only at the basic rate, it would continue to be necessary to obtain information from employers, and any staff savings in the Revenue would be reduced.

12. The earliest practicable starting date would be April 1989. An Autumn 1988 announcement would be desirable. Legislation could be in the 1989 Finance Bill.

13. A benefit-in-kind exemption which applied only to all-employee schemes would, however, be more complex. It is difficult to see how arrangements could be set up before the legislation was in place: this points to a starting date of April 1990.

C. Wider Options

14. Neither of these options appears unduly difficult operationally. But if the logic of introducing both reliefs ultimately led to giving relief for all individually-paid subscriptions, the operational effects would be much more

far-reaching. Basic rate relief at source would be essential; and if, in addition, higher rate relief were given by tax offices, the level of extra work would rise at about the time other major changes (eg Independent Taxation of husband and wife) were being absorbed.

2369/11

APPOINTMENTS IN CONFIDENCE

pup

FROM: ROSIE CHADWICK
DATE: 20 MAY 1988

MR R B SAUNDERS

cc PPS
PS/Chief Secretary
PS/Financial Secretary
PS/Economic Secretary
PS/Sir Peter Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Cropper
Mr Tyrie
Mr Call

CHIEF EXECUTIVE NHS MANAGEMENT BOARD

The Paymaster General was grateful for your minute of 19 May.

He comments that

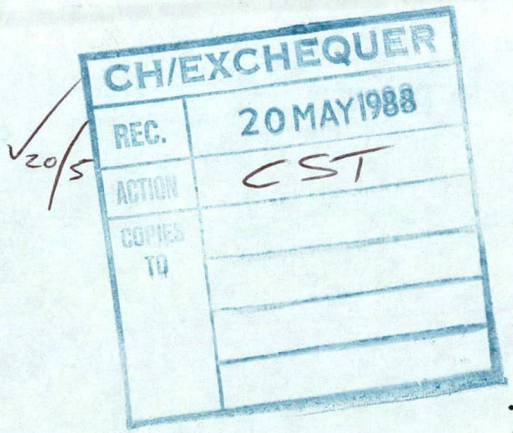
2. a what has emerged on the specifications from within HM Treasury reduces him to despair on the DHSS's simplistic catch all. It is a difficult job, and effectiveness in it is more likely if the search is targetted to specifically relevant experience. The Paymaster would have thought it classically a case for a search firm, rather than putting one's wetted finger in the air.

REC

ROSIE CHADWICK
Assistant Private Secretary

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000
From the Secretary of State for Social Services

PAPER HC21



SECRET

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

20 May 1988

Dear Paul,

NHS REVIEW

I attach a copy of my Secretary of State's Paper (HC21) for the NHS Review Meeting on Tuesday 24 May.

Copies of this letter and its attachment go to the Private Secretaries to the Chancellor, the Chief Secretary, Professor Griffiths and Mr O'Sullivan (Policy Unit) and to the Private Secretaries of the Minister for Health and Sir Roy Griffiths in this Department and to Mr Wilson (Cabinet Office).

Yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

SECRET

HC 21

NHS REVIEW: SELF GOVERNING HOSPITALS

Note by the Secretary of State for Social Services

My attached paper examines key aspects of our approach to self governing hospitals.

2. Underlying these key aspects are a range of secondary, but important, issues on which working papers are being prepared. These cover:

* the constitution of providers

* the management of capital assets and investment

* manpower planning and supply, and the financing of medical and nurse training

* ensuring that contracts between buyers and providers give the right incentives

* the timescale of change and the programme of action for achieving it

* resource implications

* improving information, including information on costs

* a balance sheet of how the changes we propose would affect consultants, GPs and nurses.

3. Colleagues will clearly want to consider the main points arising from these papers. But the best way of making progress might be for them to be looked at first by the Cabinet Office Group of Officials. The main points that arise from that work can then be brought to us. If that is agreed, I will arrange accordingly.

(i.e this is all still a bit half-baked!)

May 1988

DC1.7/16

SECRET

SELF GOVERNING HOSPITALS: KEY ASPECTS

Note by the Secretary of State for Social Services

1. This paper examines two key aspects of self governing hospitals - role of the buyer; and how the new approach would work in practice from the point of view of the patient, the GP and the consultant. We are, I think, clearer about the virtues of "self-governing hospitals" themselves, but Annex 1 sets out some further thoughts on "health care providers".

I The role of the buyer

(a) Separation of buying and provision

2. The essential step we have to take if we are to establish self governing hospitals is to separate the buying and provision of health care.

* The major disadvantage of the present monolithic system, in which there is little choice and competition, is that the interests of the patients can take second place to those of the provider. In turn this has reduced the incentive for managers to improve services and the scope for people to spend more of their own money on health care.

* By contrast, the advantage of separating the purchase from the provision of care is that it will open up the system to competition. The patient would come first, not second.

3. The key to this will be the role of the buyer, or local health agency. The agency's starting point should be the needs and interests of the community, not those of the provider. This is a crucial change - we must not dilute its impact.

4. We shall want to consider the [illegible]olutionary route towards this goal, on which I set out some proposals in Annex 2. In deciding on the pace of change we must pay particular attention to:

* building on the progress we have already made in the NHS - for example in the successful introduction of general management and our initiatives on competitive tendering

* maintaining the morale of those now working in the service who need to be reassured that there is a valued place for them in the reformed structure.

(b) Who will the agency be?

5. Basically, the agency will be a public sector body and the successor to the present health authorities and family practitioner committees. I deal with this in more detail in Annex 2.

(c) **What will the agency do?**

6. The agency will be responsible for ensuring that there is comprehensive health care for the population for which it is responsible. In particular it will:

* identify present and future health needs, taking account of consumer demand

* invite tenders from providers of particular services or groups of services, and negotiate and award contracts

* monitor the performance of providers against key quality, outcome and cost targets, ensuring that patients, family practitioners and consultants are fully informed.

7. The size of population covered will depend on a number of factors, including the extent to which the agency is responsible for community care as well as health care. But I expect these factors to point towards a typical population of around 500,000, resulting in about half as many agencies as there are now district health authorities. This would be about the same size as now covered by family practitioner committees and interestingly the same size as proposed in New Zealand for their equivalent body. We should not, however, aim to move to this size overnight, as Annex 2 explains.

(d) **How will agencies be funded?**

8. Buyers would receive cash-limited allocations calculated according to

* population size, weighted for age profile and other relevant characteristics; plus

* the cost of servicing the capital assets employed by service providers (both existing stock and new investment), which would be charged within contract prices.

There should be no need to compensate for cross-boundary flows, as RAWP does at present, since each buyer's boundaries would be irrelevant to the location of the services it bought.

(e) **How will money follow patients?**

9. The way in which money follows the patient would depend on the nature of the work for which the agency was contracting. In-patient hospital care covers

immediate treatment such as accidents and other medical and surgical emergencies

urgent treatment such as cancer surgery, for which admission must be prompt when required

treatment for chronic illness such as geriatrics and mental illness

non-urgent ("elective") treatment, such as hip replacements and hysterectomies, for which timing can be a matter of choice.

10. Most hospital treatment falls into the first three categories. An agency's concern for these will be to secure treatment when required, but within a fixed budget. This points to

* a capitation contract, where the money would go in advance of the patient. Such a contract would involve a set annual fee for the number expected to use the service whether or not they actually do. Where a non-resident was treated there could be cross charging or a knock for knock arrangement. A capitation-based contract might also apply to out-patient referrals.

11. For most "elective" treatment it should be possible for the money to follow each patient, through

* an average cost contract, for a given number of treatments.

12. A third alternative, which incorporates elements of the first two forms of contract, would be

* a retainer plus marginal cost contract, under which a set annual fee would be paid so that the capacity was available. There would then be a price per patient based on marginal costs: for that part of the contract, the money would follow the patient. This might be a useful approach for, say, maternity services.

II How the approach would work in practice

(a) How the patient would see it

13. The patient would

* retain a direct, personal relationship with the doctor responsible for his (or her) treatment.

* continue to look to his GP both for primary health care and for advice on, and referral to, hospital services. [via the buyer?]

* continue to enjoy access, and entitlement, to a comprehensive range of health services, free at the point of delivery.

* enjoy a better informed, and therefore more real, choice - exercised through his GP - between different consultants and different hospitals. He could for example make his own decisions on the balance of advantage between shorter waiting and less travelling. Administrative boundaries would not determine to the location of treatment.

* benefit from the impact of competition on the standards of service offered by providers.

* be able to look to a single body - the local health agency - as being responsible for ensuring that his health care needs can be met.

(b) **How the GP would see it**

14. The GP's primary responsibility would still be to the patients on his (or her) list. He would retain full clinical responsibility for those patients. And he would continue to refer them, as necessary, direct to consultants.

15. The main changes would be to the circumstances in which those referrals took place. At present GPs are theoretically free to refer a patient to whichever consultant they wish, although this is limited in practice. Under the new arrangements I am proposing there would be - and should be - a trade-off between

* the local health agency's decision on where to place its contract or contracts for any given service, a decision which must be taken with cost-effectiveness as well as choice in mind; and

* the GP's clinical judgement as to what is best for his (or her) patient, which may be to refer him to a specialist at a hospital with which the buyer does not have a relevant contract.

16. The effect of this trade-off, without any modification, would be to constrain a GP's freedom of referral, and the profession would no doubt object to this. It is essential, therefore, that we modify it to preserve the GP's ultimate "clinical freedom" and enhance his ability to exercise it in practice. I believe that the arrangements I propose would do this, for the following reasons:

* in practice, a GP's freedom of referral is already constrained - by inadequate information; by the reluctance of some district health authorities to accept patients from elsewhere; and by the resources available in hospitals. In future the information available to him would be much better; DHA boundaries would be irrelevant; and local health agencies would be shopping in a more efficient provider market.

* in practice, too, GPs may take referral decisions on the basis of which consultants they happen to know, or of longstanding habit. The approach I propose would both prompt and help GPs to question such referral patterns and exercise a better informed choice.

* GPs collectively would be able to influence, though not determine, where local health agencies placed their contracts for hospital and other services. For example, each agency's decisions would need to take account of "their" GPs' preferred patterns of referral, and would need to offer GPs the maximum range of choice consistent with cost-effectiveness.

* GPs would retain the right to make referrals additional to those for which "their" agency had already contracted, whether to the same or to different providers. This right would be

- financed by a cash-limited "back pocket" held by each local health agency for this purpose.
- supported by a process of peer review, so that competing demands on these reserve funds could be resolved by the profession itself.

17. Annex 3 summarises the different geographical circumstances in which GPs would be exercising the choices open to them.

(c) How the consultant would see it

18. Like the GP, the consultant would find his (or her) basic clinical responsibility, and his relationship with his patients, fundamentally unaffected. But there would be a number of changes which, whilst welcome to government, might not be welcome to many in the profession. In particular:

* consultants would no longer be employed by Regions or teaching Districts. Instead they would either be self-employed or, like other staff, employed by individual providers.

* whilst the principle of clinical freedom would be untouched, the consultant would find what was expected of him (or her) more tightly constrained by the terms of the contracts which local health agencies had entered into with the provider for whom he was working.

* there could be no security of tenure beyond the term of current contracts for the services for which he was responsible.

19. Against this there would be much in what I propose that would be attractive to consultants, especially to the majority who are committed to working hard for a better service. In particular:

* a more competitive form of provision should enable consultants to do more work - as so many tell us they would like to - without their services incurring the financial penalties which are inherent in the present system.

* consultants would have much greater influence in the management of their business - the delivery of the services in which they specialise - and much more scope to develop and market new ideas.

* there would be the prospect of higher earnings for the best consultants as providers compete for their skills.

Conclusion

20. My further work since our last meeting has satisfied me that we are still on the right track. I invite colleagues to agree that we should continue the development of the self governing hospitals approach.

May 1988

DC1.7/16

Annex 1

Health Care Providers

1. Under the "self-governing hospitals" model, public sector providers would be freer than they are now to consider what services they wish to offer and how to improve them. They would compete among themselves and with private sector providers on both the quality and the cost of the various services they offered. They would be free to sub-contract particular services and to subject their support services to competitive tendering.

2. It would be a mistake for government to decide in advance exactly how many providers of what kind would be needed, or to impose a rigid format on what such a market would generate by way of a longer term pattern of provision. Just as we have successfully embraced different models in our approach to privatisation, so we should recognise in our approach to the provision of health care the variety of circumstances we have to encompass. In particular:

* there is a spectrum of hospital care ranging from metropolitan areas with several teaching hospitals; through conurbations with a wide choice of acute services; suburban areas with a single district general hospital; to at the other end rural areas with substantial travel to district hospitals and a greater potential role for cottage hospitals. Annex 4 sets this out in more detail. Not attached!

* there are over 1,800 NHS hospitals in England, of which 750 have fewer than 50 beds. Many are in practice closely interdependent. It would not be economic for every one of these hospitals to become "self-governing" - employing their own staff, negotiating their own contracts, and so on. Instead, it would make better management sense for some of them to work together when bidding for contracts, as they do now to provide a wider range of care.

* not all public sector providers would be based on mainstream acute hospitals. Of the 611 management units only 195 are solely "acute". The rest provide community health services, mental illness or mental handicap services, or a combination of different services. These are delivered partly through hospitals but also at patients' homes and through clinics, health centres and GPs' surgeries. GPs themselves would also be "providers" - seeing far more patients than are seen in hospitals.

3. We should therefore put in place a sufficiently flexible market framework to enable a variety of providers to emerge, and develop this framework in an evolutionary way. This suggests a three-stage programme:

* Stage 1: prepare the way by continuing to devolve responsibility to existing management units, involve doctors in hospital unit management, and develop information systems.

* Stage 2: allow units to float free of Districts and become "self-governing", probably at the same time as district health authorities and family practitioner committees are re-formed into the new buying agencies (Annex 2, paragraph 4).

* Stage 3: leave the market to generate new subdivisions and combinations of providers, perhaps with some providers opting out of the public sector entirely (for example through management buyout).

4. Providers who remain in the public sector will need to be accountable for their stewardship of public assets. We shall need to explore, and perhaps to experiment with, different models for satisfying the requirements of accountability and for dealing with related matters such as investment in capital and training. We need also to explore ways in which provider management could itself be franchised competitively: this could be especially valuable where there was little or no scope for alternative providers to enter the market, or where a hospital's failure in the market did not justify the closure of a valuable, or even essential, facility. We shall need to consider further papers on these issues in due course.

Annex 2

Local Health Agencies

Local health agencies would be accountable to the Secretary of State for Social Services who would in turn be accountable to Parliament.

2. Broadly, such agencies could be based on one of three models:

elected bodies, like the proposed New Zealand regional health authorities.

appointed bodies, akin to the present health authorities and family practitioner committees. (Regional health authority and family practitioner committee members are all formally appointed by the Secretary of State, though nominations are drawn from various groups. District health authority members are appointed by regional health authorities or local authorities, though the chairman is appointed by the Secretary of State.)

government agencies, without any outside members.

3. In considering these models, we need to bear in mind:

first, that the agencies will be funded by central government money, not local. It would be important to have an organisation which focussed on value for money rather than becoming a pressure group for more resources. The New Zealand model does not seem appropriate for that reason.

second, we need to make the best use we can of existing management resources and to avoid the cost of unnecessary turbulence.

third, our experience of managing the NHS has shown the need for good oversight of work of district health authorities and the value for this purpose of an effective regional tier.

How?

fourth, we want to leave room for alternative buying agencies to develop if there is a demand for them.

4. Taking these factors together, the quickest way to make progress will be to adapt the existing structure rather than introduce an entirely new one. On this basis, the stages of development might be:

Stage 1. prepare the way by continuing to devolve responsibility from region to district, by implementing key aspects of the Primary Care White Paper, and by further developing the necessary information sytems.

Stage 2. re-form district health authorities and family practitioner committees into local health agencies, probably at the same time as providers begin to be floated free.

DC1.7/16

Stage 3. consolidate the skills and systems needed to make the new approach work.

how? very vague

Stage 4. in due course - allow competing buyers to emerge and review the role of the regional tier.

5. As part of this process we shall want to consider the continuing role of nominated members.

Annex 3

Geographical Variations

1. This note describes the different types of area in which GPs would refer their patients to hospital.

2. Admission to hospital would continue to be by three main routes:

* directly via accident and emergency departments
* emergency referrals by GPs
* by a GP referral for an out-patient appointment followed if necessary by a decision by the consultant to admit for treatment as an "elective" patient or to refer the patient on for more specialised care.

All local health agencies, regardless of size or geographical coverage, would need to ensure that their contracts provided for access to hospital through these routes.

3. In deciding with which hospital to place a contract, local health agencies would need to judge the cost, quality and accessibility of services. The weightings given to these criteria would be influenced by the kind of area in which the agency operated. Broadly, the range would be:

i. areas including a teaching centre

By definition, these will be metropolitan areas, often with several teaching hospitals. About 15% of the population currently live in a district served by a teaching hospital. In these areas:

* GPs and patients currently have a wide choice of core and specialist acute services: contracts might appear to restrict this.

* except to the extent that separate provision is made for medical training, local health agencies would need to balance costs (which are high in teaching hospitals), the public's desire for the "best", and the need to ensure that teaching hospitals have sufficient numbers of routine cases to carry out their education function.

* there might be alternative private sector provision.

The net effect would be likely to be little change in public perception. There should be ample scope for placing contracts with several provider units. By raising awareness this should increase real choice.

ii. conurbations

In addition to those living in an area which includes a teaching centres, about 25% of the population live in heavily built up areas. In these areas:

* there would be a wide choice of core acute services. There should therefore be no difficulty in placing contracts with efficient providers while retaining some choice. The balance might be more difficult to strike where there was a high degree of consumer awareness, for example with maternity services.

* some choice would also be likely in specialist services. Greater competition might be encouraged where there was a teaching centre nearby and alternative private sector provision.

iii. mixed urban/rural areas with one district general hospital

About 45% of the population live in Districts of this kind which do not have a teaching hospital. In these areas:

* patient choice might be increased for some treatments depending on the accessibility of neighbouring units and the scale of private sector provision.

* the scope for competition in the provision of core acute services would be relatively limited.

* there would be unlikely to be significant change in the pattern of specialist referrals or of referrals from one consultant to another.

iv. rural/sparsely populated areas

About 15% of the population live in "rural" Districts. In these areas:

* there would be unlikely to be significant changes in the choice of core or specialist acute services. Accessibility would continue to be a major criterion.

* the new model might encourage more imaginative use of cottage hospitals. Contracts could be negotiated directly with GPs.

20.5.1

SECRET

BRIEF

FROM: R B SAUNDERS

DATE: 20 May 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir Peter Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Satchwell
Mr Tyrie
Mr Call

Ch/ DHSS paper has some serious lacunae. It looks as if Mr M wants to keep Tuesday's meeting off the detail, but unless some of the difficult issues are addressed in full session the further work by officials will just waste time. mpw 20/5

NHS REVIEW: MEETING ON 24 MAY

The Prime Minister's next meeting will take a further paper from Mr Moore on "self-governing hospitals".

2. The paper is disappointing. Instead of telling us more about how the suggested system might work in the real world, it is still in very general terms, extolling the theoretical virtues while eschewing practical details. Most of it is about the proposed "buyers" (now redesignated "local health agencies"), but without adding very much to the previous paper. We learn that they are to cover population areas of some 500,000, rather larger than the typical DHA (paragraph 7) and that their funding will be based on something like RAWP, but not much else. See for example paragraph 6, which purports to describe what the agencies will do. It gives no indication of how they will in practice set about these tasks, what these will involve and what resources they will need to do them.

3. We believe that DHSS have been doing rather more work on the proposals than the paper would suggest. We understand that Mr Moore has deliberately chosen this approach because he fears that an attempt to spell out proposals in detail would illustrate the large number of difficult decisions needing to be taken, and may thus put his colleagues off the whole idea. We think this is mistaken. It is only by examining the hard detail, and discussing

Hence, I am sure the "you don't need to bother with this, let's have the Official group look at it in detail" approach!

the difficult questions, that the Group will really get into the issues. It is only by this process that we will discover whether the model can be made to stand up. I offer below the questions which need to be put.

The providers

4. The analysis needs to start with hospitals. There are very real dilemmas in setting up "self-governing" hospitals in the public sector. Paragraph 4 of Annex 1 promises further papers in due course. But we really need some indication of

- the corporate form of the hospitals and in what sense they are accountable to the Secretary of State
- to what extent the Secretary of State may be liable for their losses
- their powers to hold and deal in capital assets (eg land)
- how capital expenditure will be financed: whether directly by Government or by NLF lending
- how decisions about new capital projects are to be taken and approved.

These are not just technical questions. They bear directly on major structural issues like whether there needs to be a regional tier between the hospitals and the Secretary of State, and what form of financial supervision the Secretary of State needs to exercise over their activities.

5. Privatisation is not addressed. Is it envisaged that some or all the hospitals will go into the private sector sooner or later? Are they to be constituted in a way which readily permits later privatisation?

except by means of an implicit hostility. X in para 2 of annex 1 looks like the beginnings of a defence against our presumption that as many hospitals as poss should be independent.

6. A related issue - although one which I do not recommend you to raise at the meeting - would be how we respond to new privately-financed hospitals built primarily for NHS use. Our private finance rules clearly indicate that we should be seeking offsets within the public sector capital programme (or whatever EFL or other control total exists under the new regime), but we may have great difficulty in holding this line. This is a problem which we will need to face up to squarely in any system of this sort. We shall need to establish clear ground rules from the start.

The buyers (local health agencies)

7. The functions of these agencies would seem to include at least the following:

a. Placing contracts with providers (ie hospitals). But what would this mean? Would there be separate contracts for each specialty? How would they be negotiated, and how would the provider performance be monitored? If contracts were placed with more than one hospital in any given clinical area, would proportions of total business be specified? What expertise will the buyers need - accountants, lawyers, doctors?

b. Place contracts with GPs, as Family Practitioner Committees do now. The relationship of this to the other functions is tricky - see below.

c. Some form of planning function (as the paper puts it "identify present and future health needs, taking account of consumer demand"). To whom will they account for their plan and progress against them? How would these plans relate to capital decisions, whoever takes them? What is to stop these plans turning into means of generating pressure for further public expenditure?

d. They will presumably need some relationship with the community they serve. The idea (Mr Moore's paper, paragraph 2) is that "the patient would come first, not second". How will the local population call them to account? How do we stop them becoming a lobby mobilising local support for higher expenditure?

SECRET

8. It might be easier to address some of these questions if we had a clearer idea of what the agencies would be like, how they would be managed and how many staff they would need. Annex 2 sheds little light on this, other than coming to the unsurprising conclusion that they should not be elected bodies.

9. We see real problems in the relationship of GPs to these agencies. In theory, the agencies would be buying primary as well as hospital care. They would be entering into contracts with GPs in much the same way as with hospitals. We might achieve the significant prize of cash limiting the Family Practitioner Service, with agencies deciding priorities between primary and secondary care within cash limits. But the proposals in the paper show how quickly this would blur. If the system is to continue in effect to allow GPs absolute freedom of referral, then the placing of contracts becomes intimately bound up with the preferences of the local GPs. There is a danger that GPs would come to dominate the agencies, and hence the system. This would be most undesirable.

Indeed. GPs will be both bought by the agency, and buyers themselves (via this "back-pocket" - para 16 of main note)

How to get there

10. Mr Moore makes the point, quite rightly, that we need to adopt an evolutionary approach. This is dealt with in very general terms in annex 1, paragraph 3 and annex 2, paragraph 4. It would be better however to have some hard evidence of the problems in setting about this. Three regions are currently said to be thinking about an internal market experiment, with East Anglia the furthest advanced and most in tune with Mr Moore's ideas. I suggest you ask at the meeting how this work is coming along.

11. You might also take the opportunity to get on record your views about the immediate steps, discussed at your meeting yesterday. I attach a check list.

R B SAUNDERS

SECRET

SHORT TERM IMPROVEMENTS IN THE NHS

1. Acceleration of resource management initiative - Mr Moore has said publicly that this should be extended to all districts from the end of 1989.

2. Better VFM audit arrangements.

3. Taken together, 1 and 2 will tend to lead naturally to the emergence of more medical audit.

4. Extension of competitive tendering to clinical areas.

5. Reform of professional practices, including consultants' contracts and entry qualifications to nursing.

6. Further steps to encourage the private sector.

7. Further consideration of the scope for charging.

ps2/93M

SECRET

~~BF 24/5 fm~~

MW → Kuczys 23/5

FROM: MISS M P WALLACE
DATE: 23 May 1988

MR KUCZYS

cc PS/Chief Secretary
PS/Financial Secretary
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Culpin
Mr Turnbull
Mr Saunders
Mr Griffiths
Mr Call

PS/IR
Mr Isaac - IR
Mr Corlett - IR
Mr Walker - IR

NHS REVIEW: TAX RELIEF

The Chancellor was most grateful for your minute of 20 May, attaching an early draft of the tax relief paper. He would like to discuss this, and this office will be in touch to set up a meeting.

MOIRA WALLACE

ps2/97M

Mosa.

Treasury Chambers, Parliament Street, SW1P 3AG
01-270 3000

23 May 1988

John Studd Esq MD FRCOG
King's College Hospital
LONDON SE5

Dear John Studd

Many thanks for sending me a further note setting out in detail your ideas about how we might expand the private health sector. I found our chat very interesting, and I shall certainly make sure that your suggestion is considered in our Review.

Most helpful.

Yours ever

NIGEL LAWSON

MANAGEMENT IN CONFIDENCE

cc
Chancellor
Mr Anson
Mr H Phillips
Mr Luce
Mis Peirson
Mrs Case
Mr Revolta
Mr Saunders
Mr D Rayner
Mr A M White
Mr Willis
Mr Davis
Mr Call

Treasury Chambers, Parliament Street, SW1P 3AG

Geoffrey Podger Esq
Private Secretary
Department of Health and Social Security
Richmond House
79 Whitehall
London
SW1A 2NS

RP

23 May 1988

Dear Mr. Podger,

SPECIAL HOSPITALS: SPECIAL HEALTH AUTHORITY

The Chief Secretary has seen a copy of your letter of 11 May to David Crawley enclosing details of your Secretary of State's proposed changes to the structure and management of the special hospitals.

The Chief Secretary is content with the proposals, assuming they do not preclude the possibility of major policy changes on, for example, the future of Broadmoor, and welcomes your Secretary of State's assurance that the aim is to introduce tighter and more effective control of existing resources. He supports the idea of eventual absorption into the NHS (preferably within a specified period).

The Chief Secretary would be grateful if his officials (and himself) could be consulted on the drafting of the proposed national policy paper.

I am copying this letter to Paul Stockton (Lord Chancellor's Office), Philip Mawer (Home Office), David Crawley (Scottish Office), Jon Shortridge (Welsh Office), and David Watkins (Northern Ireland Office).

Yours faithfully,

Jill Rutter

JILL RUTTER
Private Secretary

23.5.1

SECRET

FROM: R B SAUNDERS

DATE: 23 May 1988

1. CHIEF SECRETARY

2. CHANCELLOR OF THE EXCHEQUER

cc Chancellor
(advance copy)
Paymaster General
Sir Peter Middleton
Mr Anson
Sir Terence Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Tyrie
Mr Call

Ch/CST will not be able to look at this until after 4.00. You might like to look now and then if CST has any crucial amendments we can feed them in after 4, subject to checking with you. mpw 2315

NHS REVIEW

I attach as requested at this morning's meeting a draft minute setting out our points on Mr Moore's latest paper.

2. I also attach for information a copy of the Annex on how the system would work in practice, which DHSS officials prepared earlier but Mr Moore decided not to circulate.

R B SAUNDERS

I have made a few changes, but am sure CST will want some more.

23.5.2

SECRET

DRAFT MINUTE FROM THE CHANCELLOR TO THE PRIME MINISTER

PM type up-keep as draft for now

NHS REVIEW

I have seen ~~the Secretary of State's~~ John Moore's paper (Self-governing Hospitals - HC21). ~~Having considered it carefully, I~~ I believe it raises a number of questions about both the practicalities and the overall desirability of the scheme ~~have yet to be convinced that the proposed structure can be made to work.~~ It may help therefore if I set down before tomorrow's meeting some of the questions ~~I shall be asking.~~ that seem to me to need answering.

At the heart of the scheme is the

2. ~~The basic~~ idea ~~is~~ that the buyer (the local health agency) will be responsible for procuring services from providers on behalf of patients. In their referral decisions, GPs will be constrained largely by the contracts made by their buyer, but will on occasion be able to refer patients elsewhere. How will these constraints be applied in practice? In what ways will the freedom of GPs be constrained? Will there be a vetting procedure for ~~individual decisions?~~ extra-contractual referrals, and, if so, what criteria will be applied?

3. The buyer must have sufficient control over the system to keep within his cash limit. He must therefore control not only the extra-contractual referrals made by GPs, but also the proportion of referrals made under different contracts with different hospitals and for different conditions. He needs to control both the flow of patients to individual hospitals and the rate at which they are treated. In effect, he, rather than the consultant, will have to regulate the queue.

4. This is an enormous task. Yet if the buyer is to be more than simply a paying agent, he must in effect take over some of these functions from both consultants and GPs. But these are intended to be administrative agencies, not making clinical decisions. Can this be sold to the medical profession? How will large scale duplication be avoided?

5. How will the cash limits be set? Will it be acceptable for more efficient agencies in some parts of the country to be able to buy a wider range of health care than less efficient ones elsewhere? What happens if the money runs out before the end of the year - will it be realistic to tell a profligate buyer that he has made his bed and must lie in it? What is to stop the buyers from forming powerful and vocal lobbies for higher public spending?

6. I therefore see a very real difficulty at the heart of these proposals: how to reconcile the buying function of the new agencies with the traditional rights of doctors in relation to their patients, and whether control over costs is thereby lost. I am not sure that the Secretary of State's paper addresses this as clearly as I would like.

7. I should like at an early stage to see a clear list of the practical benefits which would flow from a reorganisation on these lines, and the extent if any to which the same benefits could be achieved by modifications within the existing system.

8. I am copying this minute to the Secretary of State, the Minister for Health, the Chief Secretary, Sir Roy Griffiths at DHSS, Professor Griffiths and Mr O'Sullivan (Policy Unit) and Sir Robin Butler and Mr Wilson (Cabinet Office).

The Guardian

Radical reforms urged to shift responsibility for welfare away from central government

Local councils win vote of confidence in care report

4

David Brindle
Social Services Correspondent

THE role of local authorities in caring for the elderly, disabled and mentally ill should be strengthened, according to a report published yesterday. The study into the future of long-term care, commissioned by the Government, gives councils a robust vote of confidence.

Its author, Sir Roy Griffiths, said: "Elected local authorities are best placed, in my judgment, to assess local needs, set local priorities and monitor local performance.

"What is needed is strengthening and buttressing of their capacity to do this by clarifying and where necessary, adjusting responsibilities and to hold them accountable."

He urges radical changes to give local authorities the lead role as "arrangers and purchasers — not monopoly providers" of community care services.

"Merely to tinker with the present system would not address the central issues and would forego the benefits that could be obtained by more concentrated action," he said. "The proposals as a whole are aimed at enabling that opportunity to be taken."

Sir Roy is the report's sole author although he was assisted by an eight-strong team of advisers.

The team's terms of reference were "to review the way in which public funds are used to support community care policy and to advise on the options for action that would improve the use of these funds as a contribution to more effective community care."

The report dealt with care in people's own homes, group homes, residential care homes, hostels and nursing homes but excluded care for children and hospital in-patients.

Sir Roy considered funding outside his remit but he insisted that this must be provided at appropriate levels.

The report said the present system, whereby responsibility for care is shared between local government, the National Health Service, voluntary and private sectors and informal carers was unclear and patchy. One agency should take responsibility for identifying and assessing needs and organising suitable care.

The Government should appoint a minister with responsibility for the policy who would set overall objectives and standards, review local performance and distribute grants.

The aim, however, should be flexibility to allow local innovation. "To prescribe from the centre will be to shrivel the varied pattern of local activity," Sir Roy said.

The Government would fund local councils through grants of between 40 and 50 per cent of the costs of care programmes. These would be varied according to local population and its ability to pay for services.

Local authorities would amend their social services role to ensure that care packages suited individual needs.

The report said: "If community care means anything, it is that responsibility is placed as near to the individual and his carers as possible. The onus should be on the social services authorities to show that the private sector is being fully stimulated and encouraged."

Social security benefit would no longer be automatically paid to people in residential care. Applicants would be means-tested by social services and a residential allowance, lower than existing ones, may be payable. The local authority would then decide how much to top up the allowance.

The report also recommends the transfer of the community care element of the social fund to local councils.

Staff could come from a new multi-disciplinary auxiliary workforce covering social services, the voluntary and private sectors. They would be given limited training and would give help to the elderly and disabled.

"There is little likelihood that the professions will be available in the numbers required to cover all aspects of community care, but more importantly it is a waste of resources to be leaving this type of practical work to them," Sir Roy said.

Long-term planning should continue, the report said. With many middle-aged people increasingly well-placed and willing to make their own provision for old age, there is a need for a range of options.

Community Care: An Agenda for Action; HMSO; £3.90

813

Buyers

* Are the Buyers to be concerned with quality of service + patient convenience & location choice as well as cost-effectiveness?

ps2/95M

SECRET

cc Chief Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Parsonage
Mr Call

Treasury Chambers, Parliament Street, SW1P 3AG
01-270 3000

23/5/88

PRIME MINISTER

NHS REVIEW

I have seen John Moore's paper (Self-governing Hospitals - HC21). I believe it raises a number of questions about both the practicalities and the overall desirability of the scheme. It may help therefore if I set down before tomorrow's meeting some of the questions that seem to me to need answering.

At the heart of the scheme is the idea that the buyer (the local health agency) will be responsible for procuring services from providers on behalf of patients. In their referral decisions, GPs will be constrained largely by the contracts made by their buyer, but will on occasion be able to refer patients elsewhere. How will these constraints be applied in practice? In what ways will the freedom of GPs be constrained? Will there be a vetting procedure for extra-contractual referrals, and, if so, what criteria will be applied?

The buyer must have sufficient control over the system to keep within its cash limit. It must therefore control not only the extra-contractual referrals made by GPs, but also the proportion of referrals made under different contracts with different hospitals and for different conditions. It needs to control both the flow of patients to individual hospitals and the rate at which they are treated. In effect, it, rather than the consultant, will have to regulate the queue.

This is an enormous task. Yet if the buyer is to be more than simply a paying agent and is to keep within its cash limit, it must in effect take over some of these functions from both consultants and GPs. But the buyer is intended to be an administrative agency, not responsible for making clinical decisions. Can this be sold to the medical profession? How will large scale duplication be avoided?

How will the cash limits be set? What happens if the money runs out before the end of the year - is it realistic to think that we can tell a profligate buyer that he has made his bed and must lie in it? What is to stop the buyers from forming powerful and vocal lobbies for higher public spending? Are the buyers to be concerned with quality of service, convenience of location and patient choice as well as cost-effectiveness?

I therefore see a very real difficulty at the heart of these proposals: how do we reconcile the buying function of the new agencies with the traditional rights of doctors in relation to their patients? And is there not a risk of control over costs being lost in an attempt to square the circle?

I should like at an early stage to see a clear list of the practical benefits which would flow from a re-organisation on these lines, and the extent, if any, to which the same benefits could be achieved by allowing the money to follow the patient within the framework of a system very much more like the present one, although with greater autonomy for major hospitals and hospitals of high standing.

I am copying this minute to John Moore, Tony Newton and Sir Roy Griffiths at DHSS, Professor Griffiths and Mr O'Sullivan (Policy Unit) and Sir Robin Butler and Richard Wilson (Cabinet Office).

[N.L.]

23 May 1988

For background information

May 24, 1988.

THE GERMAN HEALTH SERVICE

The health service operates within the framework of the German social security system, which covers the entire population of 62 million people. It makes provision for the aged, for dependants' allowances and for misfortunes such as sickness, accident, mental or physical handicap, accidents at work and unemployment.

The protection comes mostly from the statutory insurance schemes, either public or private and collectively known as the health insurance scheme.

The health insurance scheme

The health insurance scheme is divided into two categories:

a. Employees with a monthly income of up to DM 4,500 must be insured under one of the statutory health insurance schemes -- a variety of local, company and wage earners' schemes;

b. Anyone whose earnings are above the ceiling can opt for exemption from this insurance liability and join one of the 49 private schemes, where premiums are generally higher but the policies are geared to individual requirements and kept within limits by the insured paying directly part of the medical expenses involved.

At present almost 5,200,000 people are privately insured out of a total work force of 26 million. The vast majority of the German population is therefore covered under the National Health Insurance Programme (Gesetzliche Krankenversicherung) which since it was launched in 1883 has been the mainstay of German health policy.

There are many separate sickness funds, such as for example local sickness funds and those looking after farmers, seamen or miners. The fund boards and the medical profession together are legally responsible for seeing to it that the members get the services they are entitled to. In effect, the responsibility nowadays falls almost entirely on doctors joined together in regional health insurance physicians' associations (Kassenärztliche Vereinigungen).

REPORT FROM THE FEDERAL REPUBLIC OF GERMANY
EMBASSY: 23 BELGRAVE SQUARE LONDON SW1X 8PZ TELEPHONE 01-235 5033

The funds themselves retain two main functions: collecting members' contributions and paying for the services given. Because the insured person does not have to pay for his treatment, doctors get payment through their regional association -- which acts as an intermediary with the sickness fund administrators. The funds are self-governing, with equal representation of the insured and the employers on the two decision-making bodies of each fund, the assembly and the board.

The statutory health insurance schemes are financed by matching contributions from insured employees and employers. How much an employee pays depends on his or her income. Up to a certain level every contributor pays the same percentage of gross income for medical insurance, so that people with higher incomes pay more. A maximum amount for which the percentages are calculated is set out and adjusted with salary increases.

The huge rise in expenditure has forced the schemes to increase contribution rates considerably in the last few years: in 1970 the rate was 8.2 per cent, in 1987 12.6 per cent. The employee and employer each pay half, with lower rates for special categories such as pensioners or students.

Choice of doctors

Members of statutory health insurance schemes and spouses or children insured with them are free to choose any doctor or dentist registered with a sickness fund and any hospital. General practitioners can refer patients to a specialist or a hospital where they deem it necessary.

The treatment voucher (Krankenschein) the patient gets from his sickness fund -- and which is valid for a period of three months -- entitles him to free treatment. The cost of the treatment carried out by the physician is paid by the funds according to agreed rates which the physician claims on the voucher.

Hospital treatment

If hospital treatment is necessary the sickness funds pay standard rates which cover the costs for adequate care and all the treatment considered necessary. This rate is the same for all hospitalised patients, regardless of which fund they are insured with, but it only includes the actual costs arising from use of the facilities and treatment. Calling on extra services means the patient has to pay from his own funds or have an additional insurance on top of his

statutory one. Additional insurance has become increasingly popular as the patient can then opt for special services such as a private doctor or a room to himself.

For people carrying private insurance the financing scheme is different: they have to pay bills in advance and they are then reimbursed after the treatment (Kostenerstattungsprinzip).

The sickness funds cover not only medical and dental treatment. They are also financially responsible for:

- Measures for illness prevention and early diagnosis of disease, such as annual cancer tests for women over 20 and for men over 45; various vaccinations; tests for children up to their fourth birthday;
- Provision of medicines and courses of therapy;
- Unlimited hospital treatment;
- Subsidies for dental protheses.

Apart from these benefits a patient can receive certain payments from the fund, such as:

- Sick pay up to five days when having to care for a sick child under eight;
- Sick pay in cases of disablement after the legal obligation of the employer to continue paying wages has ceased (Krankengeld);
- Costs of hiring domestic help when hospitalised;
- In-home sick care;
- Maternity assistance and pay before and after childbirth;
- Death allowances to help pay for burial costs.

Price of health

The benefits which the statutory health insurance schemes give their members are expensive. Due to better medical care and longer life expectancy, health care expenditure has been steadily increasing in the last few decades.

In 1960 benefits paid out by statutory health insurance schemes totalled DM 9,000 million. By 1970 the total had grown to DM 23,800 million and in 1985 it was DM 113,600 million.

Review needed

Because of the huge increase in costs, the health service is running short of money. To control the cost explosion in the health sector a number of

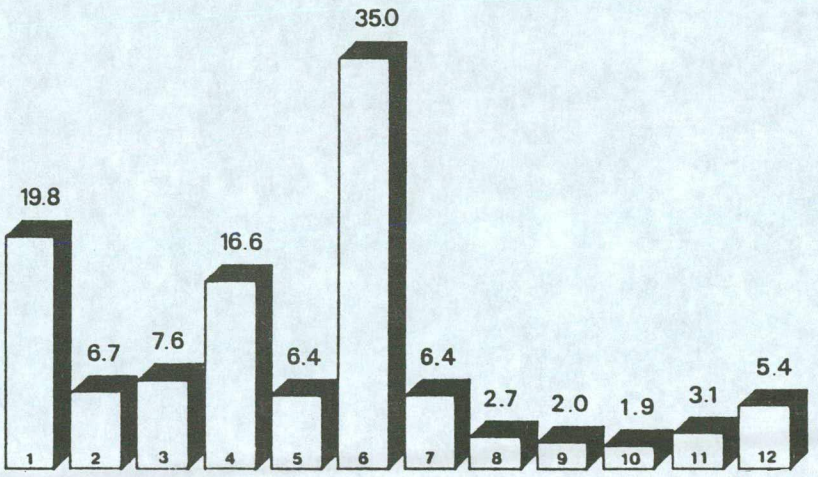
measures were introduced to reduce expenditure without lowering standards of medical care. A first step was the 1977 Cost Reduction Act (Kostendämpfungsgesetz), but this had only a temporary effect.

New reforms envisaged in the Health Expenditure Bill expected to reach the statute book in Bonn this year affect the actual structure of the insurance scheme.

Health care will remain guaranteed but the health insurance schemes will only have to pay for what is medically necessary and essential. Anyone wanting more extensive (or expensive) benefits must pay for them himself. To a certain extent patients will also be charged for medicines, medical aids and special items such as hearing aids.

Sickness prevention plays an important role in the Bill to be adopted later this year. In addition, the Government and the medical profession, teachers and academics are encouraging the public to pursue health life styles. The governing principle is that it is not for the state but for the individual to ensure a healthy way of life and to make sure that when the need for treatment arises everyone involved has an interest in effecting a cure as economically as possible.

Total expenditure of statutory health insurances 1985 in DM billion
(1985 total DM 113.6 bn)



1. Treatment by physicians
2. Treatment by dentists
3. Dental prothesis
4. Medicines and dressings supplied by pharmacies
5. Social remedial courses & therapies
6. Hospital treatment
7. Sick pay
8. Maternity pay
9. Death grants
10. Sick care at home/ transport costs
11. Sickness prevention
12. Administration costs

30 yrs ago charges incl 4.7% of cost of NHS, now 2.7%.

Some interesting figures here, which tend to support the view that there is scope for more NHS charging

1.MR SAUNDERS
2.CHANCELLOR

From: J M SUSSEX
Date: 24 May 1988

cc Chief Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Mr G H Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Satchwell
Mr Call

Ch/ Table at back is v. helpful now RB 24/5

NHS RECEIPTS FROM PATIENT CHARGES

You asked for a comparison of NHS receipts from patient charges expressed as a percentage of personal disposable income, today and in the 1950s. Detailed UK figures are shown in the attached table.

2. From the inception of the NHS in 1948, patients have been charged for some hospital, specialist and ancillary services. Dental and ophthalmic charges were introduced in 1951/52 and prescription charges in 1952/53. From 1952/53 for the rest of the 1950s payments by patients in respect of NHS charges represented **0.2 per cent** of UK personal disposable income. NHS charges were a similar proportion of disposable income in 1969/70 but had fallen to only **0.13 per cent** by 1978/79. Prescription and dental charges increased markedly in the early 1980s so that by 1986/87 (the latest year for which UK figures are available) patients' payments of NHS charges were back to the level of the 1950s: **0.2 per cent** of personal disposable income.

3. This stability is remarkable in view of the increasing share of an increasing national income that has been spent on the NHS since the 1950s. Roughly 3.4 per cent of UK GDP was spent on the NHS in 1952/53 compared with 5.1 per cent in 1986/87, by when GDP had risen by nearly 130 per cent in real terms. Thus while as a nation we have spent an increasing share of our income on the NHS as that national income has grown, the same pattern has not been reflected by our spending as individuals on the NHS, which has shown no increase as a proportion of personal disposable incomes.

4. During the 1950s patient charges met roughly **4.5 per cent** of total NHS expenditure. This proportion has since declined substantially , reaching a low point of **1.9 per cent** in 1978/79, before rising again to a level of about **2.7 per cent** in 1986/87.

J M Sussex

NHS CHARGES - UNITED KINGDOM

£ million (money of the day)

Year	1 Gross Expend. by Cent. Gov. on the NHS	2 Receipts from NHS patient charges	3 2 as % of 1	4 UK Personal Disposable Income	5 2 as % of 4
1949/50	446	3.0	0.7	9135	0.03
1950/51	460	3.4	0.7	9675	0.04
1951/52	475	7.9	1.6	10455	0.08
1952/53	518	20.0	3.7	11228	0.18
1953/54	499	24.2	4.6	12025	0.20
1954/55	525	25.0	4.5	12646	0.20
1955/56	568	26.7	4.5	13965	0.19
1956/57	621	28.6	4.4	14862	0.19
1957/58	661	32.7	4.7	15665	0.21
1958/59	711	33.0	4.4	16306	0.20
1959/60	735	35.0	4.5	17414	0.20
1969/70	1729	58.0	3.2	32572	0.18
1978/79	7992	157.0	1.9	117951	0.13
1979/80	9397	202.0	2.1	143036	0.14
1985/86	17833	489.0	2.7	243100	0.20
1986/87p	19249	536.0	2.7	262348	0.20

Notes: (i) UK personal disposable income is for calendar years 1949 to 1954 and then for financial years 1955/56 to 1986/87

(ii) p = provisional

(iii) CSO figures in all cases

RP

Frank Field Esq MP
Chairman
Social Services Committee

Thank you for your letter of 16 May about our review of the National Health Service.

When we announced the setting up of the review in January, we made it clear that the review was internal to Government. That remains the position and any working papers relating to it are not in the public domain. As you know, the rules governing the release of such papers to Select Committees are very clear. I am therefore unable to agree to your request to release to your Committee the papers you are seeking.

I am sorry I cannot be more helpful.

PRIME MINISTER

cc PS/CST
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Saunders
Mr Griffiths

This is DHSS' proposed reply for the PM to send to Frank Field. Not yet cleared with their Ministers. Any comments by close tonight please, if possible, and the Chancellor can then look at it overnight.

mpw 24/5

Frank Field Esq MP
Chairman
Social Services Committee

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cc PS/CST
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Saunders
Mr Corrigibus

PRIME MINISTER

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MPW 2415

MC5.40

SECRET

FROM: MARK CALL
DATE: 24 MAY 1988

CHANCELLOR

cc Chief Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Miss Peirson
Mr Parsonage

NHS CHARGING

I am a little worried about paragraph 13, 'star' 3 of the DHSS paper. This states categorically that all patients will enjoy free service. I have the impression that this is a firmer wording than Mr Moore has used in speeches ("no-one shall be denied treatment because of their inability to pay" ...) but I haven't checked all of them. If that is so are we in danger of casting in stone a principle without a conscious decision? In particular does this rule out "topping up" charges for enhanced service or better 'hotel' facilities?

2. We often seem to be searching for imperfect substitutes for the missing price mechanism. Surely some charging is better than none? Provided there were exemptions for those who couldn't afford to pay (for simplicity one might define that by benefit entitlement), that might not cause such a public reaction. After all that is the direction we are being urged to go on the Community Charge, by relating it to the ability to pay.

3. Do you want to lay out in more detail the room for manoeuvre on charging in your speech to the Leicestershire BMA? In the latest draft the final sentence of paragraph 12 ("... largely free at the point of use") contrasts with the DHSS paper.

MARK CALL

Copy as requested — No10 may already have sent out the final reply

DHSS

With the Compliments of

Department of Health and Social Security

Richmond House
79 Whitehall
London SW1A 2NS
Tel. No. 01-210

HC/04860

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Secretary of State for Social Services

PO 1694/1146

Ms Janice Richards
10 Downing Street
LONDON
SW1

25 MAY 1988

Dear Janice

Thank you for the letter of 16 May from Mark Addison I enclose a draft reply.

Yours sincerely

pp EDWARD SCARLETT
Private Office

ENC

Frank Field Esq MP
Chairman
Social Services Committee

Thank you for your letter of 16 May about our review of the National Health Service.

When we announced the setting up of the review in January, we made it clear that the review was internal to Government. That remains the position and any working papers relating to it are not in the public domain. As you know, the rules governing the release of such papers to Select Committees are very clear. I am therefore unable to agree to your request to release to your Committee the papers you are seeking.

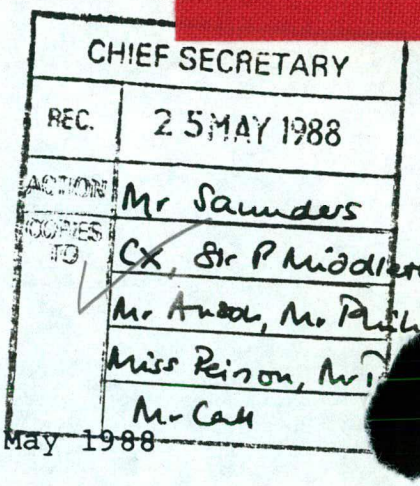
I am sorry I cannot be more helpful.

PRIME MINISTER

SECRET

10 DOWNING STREET

LONDON SW1A 2AA



From the Private Secretary

25 May 1988

Dear Geoffrey,

NHS REVIEW

The Prime Minister yesterday held a further meeting to discuss the review of the National Health Service, the sixth in the present series. I should be grateful if you and copy recipients would ensure that this record of the discussion is shown only to those with an operational need to see it.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Social Services, the Chief Secretary, Treasury, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. O'Sullivan (Policy Unit). The meeting had before it a paper by the Secretary of State for Social Services dated 20 May, 'NHS Review: Self-Governing Hospitals' (HC 21) and a minute by the Chancellor of the Exchequer dated 23 May.

The following were the main points made in discussion:

a. The essence of the structure proposed in HC21 was the separation of the buying of health care from its provision. This structure would open up the system to competition between the providers and ensure greater responsiveness to patient needs. It was needed to produce the major change in attitudes which was required in the NHS.

b. One objection to the proposed structure was that it would entrench NHS bureaucracy. The buying agencies would be too much like the present District Health Authorities under another name. It would be simpler for GPs to deal direct with the hospitals, or at least to use an intermediary body as no more than their agents. On the other hand, it was argued that the structure proposed in the paper was necessary to retain effective cash-limiting, which was essential.

c. Another possible objection was that the role for the GPs in the new structure was unclear. GPs might complain that their freedom of referral would be effectively reduced.

week.16.5/m.13

SECRET

FROM: H PHILLIPS
DATE: 25 May 1988

CHANCELLOR

cc Chief Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr ~~Saunders~~
Mr Griffiths
Mr Satchwell
Mr Tyrie
Mr Call
Mr Kuczys - IR

Chy I don't know if Hayden will raise at this afternoon's meeting. You might like to see.

NHS REVIEW: FUTURE WORK

In the light of your meeting yesterday with the Prime Minister, and now that Mr Moore's proposals for reorganisation on the basis of healthcare "buyers" have been pretty well ruled out, a fair bit of work will fall to the Treasury over the next few weeks in order to bring practical proposals forward. Although we do not yet have the note of your meeting with the Prime Minister it would be helpful if we could take a few minutes of your meeting this afternoon to check with you and the Chief Secretary that we are working on the right lines.

2. I understand the note will record that the package we discussed with you last week together with the Chief Secretary's suggestion that money should be targeted at the more effective and efficient hospitals should form the principal basis for further discussion of changes to the NHS. On this basis I have discussed with the Cabinet Office the work which should now come forward for the next two meetings of the Prime Minister's group on 7 June, and in the week beginning 20 June respectively. These are

(a) 7 June - a paper from the DHSS on encouraging private sector involvement in the provision of health care (this will need a good deal of input from here)

PHILLIPS TO CX 25 MAY

our paper on taxation; and, if possible,

a paper which developed the proposal for directing money at the most efficient hospitals (if this cannot be done in time for 7 June it will have to slip a fortnight later; and

(b) week beginning 20 June - a paper which set out the package of proposals now on the table (this would be in the name of the Secretary of State for Social Services but would be presented, if agreed, in consultation with you); separate reports in addition to their coverage in the main paper on vfm audit and on consultants' contracts; and a joint Treasury/DHSS paper on the control of capital allocations in the future particularly in relation to self-governing hospitals within the NHS.

3. You will want to feed in your ideas in response to the paper Mr Studd has sent to us on the supply of consultants to the private sector, and alongside the work we now do on the package of proposals now agreed we should work up our profile of the overall costs and benefits of the emerging shape of the review. And we shall be doing this alongside our initial work on DHSS's PES bids.

4. If you and the Chief Secretary are content we shall now set this work in hand.

HP.

HAYDEN PHILLIPS

BF 27/5

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

25 May 1988

CH/EXCHEQUER
REC. 26 MAY 1988
ACTION MR SAUNDERS
COPIES TO CST PMG SIR P. MIDDLETON MR ANSON SIR T. BURNS MR PHILLIPS MISS PEIRSON MR TURNBULL MR PARSONAGE MR GRIFFITHS MR TYRIE MR CALL

Dear Geoffrey,

NHS Review: Submission by the Royal College of Midwives

I attach for the information of members of the NHS Review Committee a submission from the Royal College of Midwives.

I am copying this letter to the Private Secretaries to the Chancellor of the Exchequer, Chief Secretary, Minister of Health and to Sir Roy Griffiths and Sir Robin Butler.

Ch/ mostly v. predictable, but passage at flag X is quite interesting

MPW

Yours,

Paul

(PAUL GRAY)

Geoffrey Podger, Esq.,
Department of Health and Social Security.

I see no flag X
But para 5.4.3 certainly gives pause for thought: there may be other instances of this sort of thing.

week.16.5/m.19

SECRET

FROM: H PHILLIPS
DATE: 26 May 1988

PS/CHANCELLOR

cc PS/Chief Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Parsonage
Mr Call
Mr Kuczys - IR

Chf content with this, and for us to write to No10 as drafted? Content.

mpow 26/5

NHS REVIEW

The work programme set out in Mr Gray's letter of 25 May recording the decisions of the Prime Minister's meeting sets a problem for us in adequately preparing one paper for the meeting planned on 7 June. This was touched on in my minute of 25 May to the Chancellor about the work we now had to set in hand and, as you know, we briefly discussed it with him. The paper in question concerns the proposal for topping up allocations to the more successful hospitals.

2. We need to discuss this with the Chief Secretary (which we will do tomorrow) then do the work, and submit it to Ministers for their approval. If we were to meet the deadline of 7 June we would have to circulate the paper by Friday 3 June. I do not think we can make a practical job of this in that time scale given the bank holiday weekend and absences next week, and, in any event, the Chancellor recognised that the agenda for 7 June is a full one.

3. I have warned the Cabinet Office of this difficulty and they accept this change but I think it would be helpful if you could send a draft along the lines attached to No.10.

4. The amount of paper for the meeting in the week beginning 20 June now looks formidable: a main paper on the 'package'; a paper on topping up allocations; and separate notes on vfm audit,

consultants' contracts, and capital. This seems too much, and I am also concerned that Ministers might be faced with an overall paper without having satisfied themselves of key practical details in controversial areas. What I would propose therefore is that

(a) the first meeting after 20 June considers topping-up allocations; self-governing hospitals (within broadly the present structure) and capital (which is very much linked to this change); consultants' contracts and any other pay issues; and vfm audit; and

(b) the first meeting in July takes an overall 'package' paper, ie the first full step in summarising the results of the Review.

5. This timetable would enable us to start work now on the package, and on our overall assessment of its costs and benefits, but not have it tabled until Ministers have probed the important detailed papers, and the Chancellor has formed his own view of costs and benefits. The DHSS will, I think, go along with this, and if the Chancellor and the Chief Secretary are content, I will tell the Cabinet Office of our revised plans.

6. Finally I should mention that DHSS have warned us that Mr Moore may wish to put in a further note on contracting out and rebates for 7 June. I told them that while I was not surprised he wished to try to revive the issue we regarded it as sidelined by the Chancellor's earlier paper and previous discussion. I imagine they will want to see what we say on tax relief before deciding what to do.

HP.

HAYDEN PHILLIPS

week.16.5/m.20

SECRET

pse type filed

~~DRAFT~~ LETTER TO PAUL GRAY NO.10 ~~FROM MR A C S ALLAN~~

NHS REVIEW

Your letter to Geoffrey Podger of 25 May recording the results of the Prime Minister's meeting on 24 May invited the Chancellor to arrange for a paper to be brought forward for 7 June about topping up allocations to the more successful hospitals.

2. In view of the amount of work in hand for the meeting on 7 June, which has a pretty full agenda, and the desirability of producing practical proposals in consultation with the DHSS, we would be grateful if that particular paper could be postponed to the meeting in the week of 23 June.

3. I am copying this letter to Geoffrey Podger and ~~the~~ Richard Wilson in the Cabinet Office.

MPW

MC5.49

CONFIDENTIAL

FROM: MARK CALL
DATE: 26 MAY 1988

CHANCELLOR

cc Chief Secretary
Financial Secretary
Paymaster General
Economic Secretary
Mr Anson
Miss Peirson
Mr Cropper
Mr Tyrie

CHIEF EXECUTIVE, NHS MANAGEMENT BOARD

You asked me to develop, in conjunction with the Special Adviser at DHSS, further thoughts on the job description for the Chief Executive of the NHS Management Board. Margaret Peirson and I met with Charles Hendry to pursue this. Charles has just arrived in post and has not surprisingly given this little thought as yet. It was not clear how advanced DHSS thinking is, but such enquiries would more appropriately be followed up by officials.

2. When Victor Paige left the DHSS Management Board (MB) Tony Newton took over the Chairmanship. The Chief Executive post was created and Len Peach appointed. The Chief Executive took over many of the managerial responsibilities of the old post of Chairman, although Treasury officials have not been able to locate any job description specifically relating to Len Peach's appointment. Margaret Peirson has, however, unearthed some material which describes the old post of Chairman and which casts useful light on the responsibilities of the Chief Executive. For simplicity I have laid out in Annex A the main responsibilities of the Chairman at that time, indicating those which have been taken over by Tony Newton or on which there is input from both. Following our discussion with Charles Hendry, I have laid out in Annex B what would seem to be the main points required in a job description for the Chief Executive expected to pilot the changes resulting from the Review. (I am sure this is not an exhaustive list.)

3. My view is that an assessment of the specific experience required of candidates would be difficult until we have a much better idea of the outcome of the Review. Until then, we won't know where to look for candidates, although we can be fairly sure of the general qualities which will be needed.

4. As important as the qualities and experience of the individual would seem to be a clear understanding and acceptance of (and hopefully enthusiasm for) the unique nature of the job. There are key differences between the task facing the new Chief Executive of the NHS MB and an equivalent post in a large commercial organisation.

He would have to work within the constraints of the political process, developing an effective relationship with the Secretary of State and the Whitehall machine.

He would have to know how to deal with the media. Whatever the outcome of the Review the Daily Mirror will probably continue to run scare stories.

The NHS MB has little 'line authority'. Rather than managing in a direct sense it "seeks to persuade and cajole" (Dick Saunders' words) the Regional and District Health Authorities. We, of course, may seek to shift the emphasis.

5. The worst outcome would be another successful businessman who leaves after a year claiming that it's impossible to run such an organisation with the meddling of Ministers, the intransigence of the producer interests, and the glare of the media.

6. The outline job description in Annex B is quite demanding. In the absence of 'renaissance man' candidates it may be worth considering splitting the job, and appointing a Chief Executive and a 'managing director'. This would separate the leadership/external responsibilities from the nitty gritty operational ones.

7. On timing, Charles Hendry thinks its not impossible that Len Peach might decide to stay on for another year. There seems to me to be advantage in someone coming in who would see through the changes, and that could take several years. If he does decide to go in the Autumn, his retirement would best be announced soon, otherwise it might be seen to be a protest resignation at the outcome of the Review.

Mc

MARK CALL

MC5.50

APPENDIX A

PAST DEFINITION OF NHS MB CHAIRMAN'S ROLE

The 'overall mission' of the NHS MB is summarised in the Moseley Report as:

- to bring about continuing improvements in health services to patients and to secure the implementation of the Secretary of State's service policies;

- to provide authoritative and challenging leadership to health authorities and their managers;

- to achieve a visible and positive impact on the perception of the NHS by the public, by its staff, and by Parliament.

The Chairman's responsibilities were seen as

1) developing a wide range of administrative, financial and other functions relating to the management of the HCHS, line management responsibility for 1900 (April 1986) staff.

2) Secure effective implementation monitoring and improved delivery of policies for health care in accordance with the Secretary of State's policies and strategic objectives.

3) Acts as senior adviser to the Secretary of State in accounting to Parliament for the discharge of the Secretary of State's statutory responsibilities in relation to the HCHS.

4) Responsible for securing that the activities of individual members of the NHS MB are co-ordinated and geared towards common objectives.

5) Member of Health Services Supervisory Board, HPSS Policy Committee; Departmental Research Committee, Departmental Management Board.

6) Has crucial role in Department's relations with Regional General Managers and with Regional Chairmen.

7) Acts as spokesman on NHS matters to official bodies, such as the Pay Review Bodies.

Tony Newton as Chairman taking some responsibility for numbers 3, 4 and 7.

d. In view of these difficulties, the Group should consider whether it could better achieve its main objectives by changes which, at least at first, were within the present structure. One of the most important of these objectives was that money should follow the patient, so that successful hospitals were rewarded rather than being penalised, as at present. One method of doing this would be by not allocating to hospitals in advance all the money that was available, but withholding a proportion which could later be distributed to those hospitals which had been successful in attracting more patients by greater efficiency. An important question to consider on this approach was whether it might lead to higher expenditure, because in practice the reserve might have to be additional: in principle it should be possible to make offsetting reductions in allocations to the less efficient hospitals.

e. Whatever the precise approach adopted for the buying of health care, other changes within the present structure which would be important in meeting the Government's objectives, and should be considered further, were: the creation of independent hospitals (with each hospital being independent as far as possible, although some grouping might be necessary); acceleration of the resource management initiative; better value for money audit; medical audit; extension of competitive tendering; reform of professional practices; and encouragement of the private sector.

f. Changes of this sort in the short term were compatible with moving in the medium and longer term in the direction described in the Secretary of State's paper. For example, more buying-in of services by District Health Authorities was desirable on any account and taken far enough would lead to the separation of buying and provision of health care.

The Prime Minister, summing up the discussion, said that the Group saw considerable attraction in proceeding by changes within the present structure. They believed that it would be unwise to try to do too much too quickly. They were particularly interested in the proposal which had been put forward for withholding part of the financial allocation to the hospital service for later distribution to the more successful hospitals. But the Group would need to consider as a whole all the changes within the present structure which had been identified at the meeting.

For the next meeting of the Group on 7 June, it had already been agreed that they would consider a paper by the Secretary of State on greater involvement by the private sector, and a paper by the Chancellor on tax incentives to the private sector. They would also wish to consider in more detail at that meeting the proposal for topping up allocations to the more successful hospitals. The Chancellor should arrange for such a paper to be brought forward. At the subsequent meeting in the week of 23 June they would want to

consider a further paper bringing together the other changes within the present structure which had been identified at the meeting; and also a paper on the method of allocating captial to hospitals. The Secretary of State should arrange for these papers to be prepared, in close consultation with the Chancellor of the Exchequer.

I am copying this letter to the Private Secretaries of the Ministers at the meeting, and to the others present.

Yours,
Paul

(PAUL GRAY)

Geoffrey Podger, Esq.,
Department of Health and Social Security.

APPENDIX B

MAIN ELEMENTS OF A JOB DESCRIPTION FOR NHS MB CHIEF EXECUTIVE

The Chief Executive should:

- Understand and be willing to work within the constraints of Government policy.

- Have an ability to work with (and be familiar with?) the Whitehall process.

- Be able to steer the NHS through a difficult period of change as the Review is implemented. This will involve the development of cost and management information systems. He will thus need proven management skills relevant to a large organisation.

- Be effective in handling internal communication. He will need to provide leadership within the organisation, and gain credibility and influence with RHA Chairmen and DHAs, in the absence of line authority. (Communication to individual NHS employees cannot be left entirely to representative bodies.)

- Be effective at handling external communications. Through relations with the press and otherwise he would be responsible for the management of the public perception of the NHS. (The Secretary of State and Minister of State would, no doubt, also input to this.)

27/5

26/5/88

CONFIDENTIAL

Prime Minister

REVIEW OF THE NATIONAL HEALTH SERVICE: A SCOTTISH PERSPECTIVE

I am grateful for the invitation in your Private Secretary's letter of 21 March to offer my suggestions to the NHS Review Group.

This minute discusses operational issues of service delivery: it does not cover financial issues, including the balance between public and private funding.

Our principal objectives must be to widen patients' choice and to improve the performance of the Health Service in delivering patient care and value for money. To do this, we need to introduce competition and to foster sound management practices. An organisation of the size of the NHS cannot be reshaped or made to change direction overnight; and there are limits on what can be done even within the lifetime of a Parliament. Our strategy for change should therefore be clearly focused on creating the necessary mechanisms within the Health Service to drive it effectively to meet our objectives.

Everyone is a customer of the Health Service at various times of life; and we must recognise that the demand for health services is almost literally infinite. Increasing demand is fuelled not only by advances in medical technology and rising expectations of the appropriate quality of life at different ages, but also by the ignorance of consumers and providers alike of the costs of their choices. There are a number of themes which flow from this analysis. For convenience I group these under the headings of patients, health professionals and management.

Patients

We need to ensure that patients are treated more like customers and less like supplicants. The gap between best practice and what is tolerated in some areas remains too wide. Our White Paper "Promoting Better Health" had as one of its main themes making the primary care services more responsive to the consumer. We need to develop this theme in relation to the hospital services too, under the heading of the Patients' Charter. The NHS already ensures free access to treatment: but too many people have too little say in how, where and when that treatment is provided.

We know from our waiting list initiatives that we can make Health Boards use their resources more effectively and so reduce some of the worst delays. But we also need to stop these delays building up. This will require more and co-ordinated investment in computers to provide the information necessary as a basis for informed choice. We should recognise, however, that one of the consequences of success here will be an increased demand for resources; and this point must be addressed along with the other funding issues arising from the review.

Health Professionals

The deficiencies of the present contractual arrangements between consultants and their employing authorities are well recognised and have been the subject of comment in this year's Review Body Report. The very existence of a model contract, agreed between Health Departments and the medical profession, may act as a disincentive to employers to add to the contract to oblige consultants to take part in the evaluation of clinical methods, to participate in reviews of resources, to contribute to planning and budgeting processes, or to accept some corporate responsibility for the functions of their authority. Clearly it would be difficult to withdraw the model contract unilaterally; but we must seek agreement on the incorporation of management objectives in consultants' terms of appointment. We must also encourage management to evolve ways of engaging the co-operation of consultants in setting and achieving these objectives. Disciplinary procedures are presently under review: we must find ways to speed these up.

Management

Scotland has a single integrated tier of management in the form of 15 Health Boards (and the Common Services Agency). These Boards also cover the work of Family Practitioner Committees in England. While we could operate at least as effectively with fewer Boards, the political trauma of negotiating even a marginal adjustment in their number would be considerable and, I judge, would divert our energies and the public's attention from changes which promise more immediate benefits. I would not reconsider the pattern of Health Boards unless it makes sense to do so in the context of a fresh look at the structure of local government.

The composition of Boards needs to be revised in the aftermath of the introduction of general management. Fewer members will make them less cumbersome, though it would be difficult to avoid including certain types of member to deal at local level with service committee appeals and discipline.

The drive for efficiency in support services has already delivered significant savings. The programme of competitive tendering will continue that process and should be extended. The programme of rationalising the NHS estate must continue (though disposal receipts will inevitably decline as the historical pattern of our holdings changes to match present-day requirements).

But we can also take the idea of competition closer to the care of patients by developing the concept of an internal market for certain categories of patient care. At present the allocation of resources for Hospital and Community Health Services in Scotland is made through the SHARE formula. One of the most significant adjustments to the basic distribution reflects the treatment of patients resident in other areas - cross-boundary flow. The data base for this adjustment is presently three years old and it will never be practicable to reduce this lag to less than two years. Thus the simplicity of the present arrangement is bought at the price of delays in compensating Boards for the extra costs they incur when they open new facilities offering services for which their residents previously had to travel.

I think that there may be merit in removing the payments for cross-boundary traffic in acute and obstetric in-patients from the SHARE calculations and substituting a regime of direct payments from the exporting to the providing board for these services. Much will depend upon whether we can obtain adequate information on costs; and we will need to develop ways of helping General Practitioners to take cost-effective decisions about where to refer patients. Some progress, on an experimental basis, might be possible in 1989-90. In the longer term, the development of cost data on Diagnostic Related Groups may enable us to consider more radical changes to the SHARE allocation system for wider categories than cross-boundary flow - for example, all acute in-patients.

A regime of direct payments should promote more informed decision-making and cost-effectiveness; and through time it ought to promote the quicker development of innovative services. By contributing to a better match of supply and demand, it should also help to reduce waiting times.

Preventive Medicine

Prevention is better than cure. Yet we remain preoccupied with cure and give limited attention to prevention. Health promotion and health education are notoriously difficult areas for both policy choice and subsequent evaluation. We need to increase the importance which we give to this work. I shall seek to ensure that this area of activity is given a more positive steer at national level in Scotland

I look forward to joining in further discussions on the Review. It is important that there is adequate time to consider the implications of the emerging conclusions for the distinctive Scottish Health Service.

I am copying this minute to Nigel Lawson, John Moore, Peter Walker and Tom King.

MR

M R

26 May 1988

HMP14723

ps2/12M

CONFIDENTIAL

FROM: MISS M P WALLACE
DATE: 27 May 1988

MR CALL

cc PS/Chief Secretary
PS/Financial Secretary
PS/Paymaster General
PS/Economic Secretary
Mr Anson
Miss Peirson
Mr Cropper
Mr Tyrie

CHIEF EXECUTIVE, NHS MANAGEMENT BOARD

The Chancellor was grateful for your minute of 26 May, which he found most interesting.

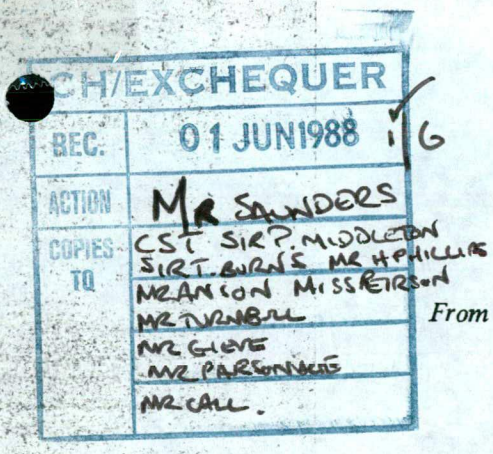
2. He has commented that he is inclined to agree with the Paymaster that it may be most sensible to call in a search firm. He believes the Paymaster may have a suitable one in mind.

MOIRA WALLACE

CONFIDENTIAL

BF 3/6

prup.



10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

27 May 1988

NHS REVIEW

I enclose, for the information of members of the NHS Review Group, a paper by Dr Clive Froggatt, one of the participants at the first Chequers Seminar, on medical audit and incentives for change in general practice.

I am copying this letter to Alex Allan and Jill Rutter (HM Treasury), Jenny Harper (Department of Health and Social Security), Sir Roy Griffiths (Department of Health and Social Security) and Richard Wilson (Cabinet Office).

PAUL GRAY

Geoffrey Podger, Esq.
Department of Health and Social Security

CONFIDENTIAL

CFG

From Dr. Clive Froggatt, C.C.

59 Hatherley Road,
Cheltenham, Glos.
GL51 6EG.
0242 580911

Mr. Paul Gray,
Private Secretary,
10 Downing Street,
London SW1A 2AA

23rd May 1988

Dear Mr. Gray,

I enclose a letter and papers for the Prime Minister in response to your letter of 29th March.

I apologise for the delay in writing but Lord Trafford established a group of which I was a member to submit collected views from those to whom you had written. The enclosed papers, however, expand a little more on those aspects about which you expressed a particular interest.

I shall be happy to expand on any aspects of these papers if requested to do so.

With best wishes,

Yours sincerely,

Clive Froggatt.

Enc

From Dr. Clive Froggatt, C.C.

59 Hatherley Road,
Cheltenham, Glos.
GL51 6EG.
0242 580911

The Rt. Honourable Mrs. Margaret Thatcher, FRS, PC, MP,
10 Downing Street,
London SW1A 2AA

23rd May 1988

Dear Prime Minister,

Lord Trafford will submit shortly a Paper which embraces most of my responses to your request for further information from me on medical audit and incentives for change in general practice. I enclose a few other perspectives in the accompanying papers.

Rational debate about the National Health Service seldom occurs in public. The principle reason for this is that those working in the NHS believe that the only way to obtain extra resources is to stimulate public anxiety by highlighting whatever deficiences exist. The Opposition exploit these anxieties and indeed are encouraged to do so by the medical and allied professions. This is not only disruptive to the NHS - and the Government - but also tends to distort the pattern of provision since emotive issues gain maximum publicity and quite often, therefore, more resources (e.g. AIDS).

It would be in the interests of both the National Health Service and the Government to establish an alternative outlet through which those working in the health service could channel their anxieties and thoughts about the level of resources or quality of care provided. In the accompanying papers, I refer to an independent medical audit authority. This may be the appropriate body to which such concerns should be made known.

I shall be happy to discuss these ideas or any other aspects of the NHS review with your office in the future.

Yours sincerely,

Clive Froggatt

Enc

From Dr. Clive Froggatt, C.C.

NHS Review : Independent Medical Audit Authority

The absence of clinical and financial audit in the National Health Service lies at the root of the problems confronting the service today. Without financial audit it is impossible to make valid comparisons between two health authorities or reliable judgements on the value for money obtained from certain procedures. Without medical audit the performance of the medical and nursing profession cannot be assessed properly and decisions on clinical priorities have to be taken on less objective grounds (making managers more susceptible to the vagaries of medico-political pressure groups). Demands for additional resources, either in terms of finance or personnel, are more difficult to assess. This makes inappropriate decisions more likely leading to secondary problems for patients, those working in the health service and the Government. Political challenges from the Opposition (or medical profession itself) are clearly more difficult to counter unless precise information on matters of fact is available.

Evaluation of the effectiveness of the health service is highly complex and needs to embrace aspects such as quality of care, the importance of patients perception of good care, clinical freedom and the balance of quality and quantity of life. It is made more complex by the vested interests of Government, DHSS officials, politicians, RHA and DHA managers, consultants, nurses and the patients themselves.

With greater autonomy and more responsibility for service provision being devolved from the centre to the periphery, it

becomes increasingly important for all concerned that an independent body is charged with the responsibility to audit health care services.

Such a body must establish independence both from the Government, Health Authorities and any other vested interests. It must establish a reputation for analysing the problems of health care delivery and it must make a practical impact on the delivery of health care services.

The remit of the body should extend from financial management into area of clinical audit with protocols being established centrally, but implemented locally, by District Clinical Audit Officers working alongside those responsible for financial audit. Together they would work on value for money reviews of the services provided.

Like local authorities, health authorities face many new challenges in the next few years. Demands on health services are changing and the way in which resources are used will come under ever increasing scrutiny.

Over the past five years, the Audit Commission has established itself by demonstrating the strategic importance of audit and value for money (VFM) review of many public and semi-public services delivered locally. Its reputation for independence and penetrating analysis makes it well placed to assume the responsibility for independent medical audit. The organisational structure of the commission lends itself to a fairly simple adaptation enabling it to embrace the proposed responsibility for health care services.

At the outset the Audit Commission was viewed with considerable scepticism and even hostility by local authorities. The health service, particularly the medical profession, are likely to have a

similar attitude. There may be some token resistance from the medical profession particularly on clinical audit, since it favours peer review and self-audit - claiming that this is taking place already to a significant degree. Evidence exists to show that this is not the case. However, local authorities no longer oppose the Commission's existence and engage now in a regular constructive dialogue about its work and future direction.

The Audit Commission has undertaken special studies involving the police, education and social services. Hostility and scepticism were overcome by having seconded to the study group professional and technical experts who enjoyed the confidence of those working in the special fields under audit.

Special studies generate two products. The first is a report which aims to describe best practice and demonstrates the way in which others could move towards a best practice approach. It indicates opportunities for savings and improvements in effectiveness. The second product is a detailed guide for use at local level. It gives comparable statistics, performance indicators and an analytical approach so that key drivers of performance could be identified quickly at a local level. The methodology of such studies already undertaken in local authorities is directly applicable to the health service. Other features of the Commission include a quality control function with close links to the accountancy bodies which would be invaluable to District Financial and Clinical Auditors.

The Commission has also developed coherent and disciplined mechanisms for bringing the central work into the audit process and vice-versa. These involve:

*The development of unit cost profiles

*The preparation of VFM focussed audit guides

*Tracking systems to monitor efficiency gains achieved

Finally, having recognized that management structures and competence are critical to efficient service provision, the Commission has developed a methodology of analysing central management and administration. The two local auditors, financial and clinical, will combine an understanding of the principles of good management with close knowledge of local circumstances and will be well placed, therefore, to help those authorities which lack now a strong corporate management.

Conclusion

The Audit Commission structure and methodology is readily adaptable to the health service; and, its political independence is acknowledged. It is placed uniquely to audit, advise and stimulate the National Health Service. Its experience shows that it can co-ordinate the skills and procedures required to promote economy, efficiency and effectiveness in the running of the NHS and, at the same time, provide hard data upon which the Government may base its plans for future provision within the health service.

Incentive for change

The single most important incentive is financial. Professional satisfaction is highly valued but not as much as money.

The profession should be approached with a carrot and stick. The carrot will be a modest increase in remuneration and the stick will be contractual changes designed to ensure that greater attention is given to the outcome for patients. The intention will be to reward a better quality of patient care.

Quality

It is difficult to measure quality and impossible to define precisely what makes one doctor better than another. However, by broadening the basis of assessment, using a basket of performance indicators, it would be possible to identify practices which are either better than others, or better than they themselves used to be.

A dynamic shift towards higher standards of care can be taken as a sign of improving practice and should be rewarded appropriately. Once the base-line levels of provision have been established, practices can be given annual targets to achieve.

The parameters of assessment will include: levels of vaccination/immunization, screening for cervical cancer and other aspects of care which may be covered currently by the "items of service" category. In addition, the assessment of quality will include information on, for example, the percentage of a practice's elderly population that have been screened, the number of patients who attend the practice

based smoking cessation course, and the provision of, and use of, a wider range of services, such as minor operations, hypertension and diabetic clinics etc. Finally, comparative consultation rates, average time taken to obtain an appointment, referral and admission rates, prescribing patterns and practices, and, possibly, the frequency of complaints could all be taken into account.

A district based clinical auditor will be able to assist in the evaluation of the practice profile that will have been built up from the performance indicators mentioned.

The parameters of assessment will be subject to variation from time to time and will be biased towards areas and aspects of health care on which the health service is required to focus.

Most of the information needed on performance indicators can be gathered easily and cheaply directly from practices. Much of the information would be appropriate for inclusion in the practices Annual Report. With the introduction of information technology into surgeries and FPCs, more specific and sensitive information can be gathered.

Other Incentives

Contractual changes should be made which ensure that financial incentives yield identifiable improvements in patient care. GPs need no reminder that their independent contractor status should be valued highly. As such they should demonstrate their entrepreneurial skills by assuming greater responsibility for patients in primary care, remunerated where appropriate by the local DHA. This should be possible once DHAs are autonomous. Diversity of health care provision should be encouraged.

Professional satisfaction is enhanced by the proper, and full, use of anciliary staff - including practice managers. FPCs should ensure that an appropriate balance is achieved in the primary care team.

Finally, continuing medical education (CME) is imperative. Attendance has fallen at postgraduate centres since it ceased to attract any remuneration. Resources need to be made available both to GPs themselves and their clinical tutors. The content of CME should be focussed on those areas which result in higher quality patient care and better value for money for the NHS.

Conclusion

The White Paper contains the framework for negotiations with GPs which are under way now. Its references to contractual changes are implicit and accepted by the profession.

With additional finance on the table, the profession must accept a contract with the NHS which makes specific demands for co-operation on clinical and financial audit. They should be encouraged to be innovative and entrepreneurial. FPCs/DHAs should be encouraged to promote changes in the delivery of care which may involve contractual arrangements with local GPs.

GPs should be committed to CME to raise the standards of patient care and give services which represent better value for money.

Treasury Chambers, Parliament Street, SW1P 3AG
01-270 3000

Paul Gray Esq
10 Downing Street
LONDON SW1

27 May 1988

Dear Paul,

NHS REVIEW

Your letter to Geoffrey Podger of 25 May recording the results of the Prime Minister's meeting on 24 May invited the Chancellor to arrange for a paper to be brought forward for 7 June about topping up allocations to the more successful hospitals.

In view of the amount of work in hand for the meeting on 7 June, which has a pretty full agenda, and the desirability of producing practical proposals in consultation with the DHSS, we would be grateful if that particular paper could be postponed to the meeting in the week of 23 June.

I am copying this letter to Geoffrey Podger, and Richard Wilson in the Cabinet Office.

Yours,

Moira.

MISS M P WALLACE

IMES

Beardwood reports on the way France runs its health system, and the contrasts it offers with Britain's National Health Service

Looking well but needs some strong medicine

ONE DOCTOR speaks angrily of the recent day when hospital managers told him that money for medicines had run out. A college of surgeons warns that if the government does not change its policies there will be an exodus of medical staff. Throughout the health service there are grumbles about shortages of money, and the heavy burdens and light pay-packets of doctors and nurses.

Yet this report comes not from Britain, where funding for the National Health Service (NHS) has become a contentious political issue. It comes instead from France, where, in the forthcoming National Assembly elections, the health service is a muted issue at best. France has been cited by some British opposition MPs as a model for the UK – at least in the sense that it spends much more on health care than Britain does. The British Government's response is that the NHS's problems will not be cured by throwing money at them.

Ironically, both sides of the British debate can find much in France to support their conflicting views of the future shape of the NHS. On the one hand, the French undoubtedly spend liberally on health; on the other, the system is insurance- rather than tax-based, and can boast lively competition between the public and private sectors, as well as much co-operation between them.

But neither higher spending nor a large and prosperous private sector is in itself a cure for what ails both the French and British health services: an ageing population, insistent public demand for the latest, and presumed best, medical technology, and a huge and unwieldy health-care establishment jealous of its privileges and reluctant to change.

In 1985, the latest year for which comparative figures are available, total health-care spending in France was 8.5 per cent of gross domestic product (GDP). In Britain, the percentage was 5.9. The cash differences were even larger. In US dollars, adjusted for differing local purchasing power, France spent $1,071 per capita on health in 1985, and Britain only $627. But those gross figures conceal an important contrast between the two countries. In France, only 71 per cent of health spending is public; in Britain, the figure is 90 per cent.

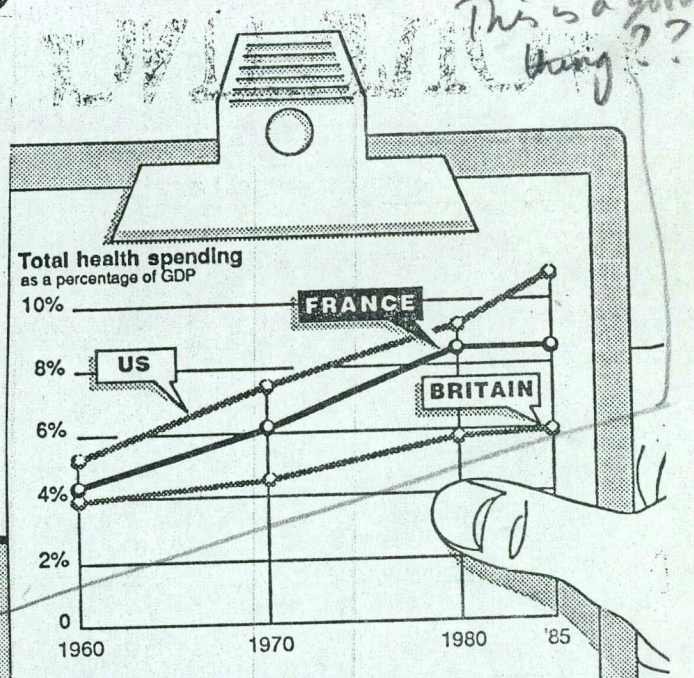
But is France's health-care system proportionately "better" than Britain's? The question is almost impossible to answer, since it raises at least three other questions: What is "better"? How responsible is the health-care system for improvements in health? And are the French getting value for money? The Organisation for Economic Co-operation and Development (OECD) put the challenge this way in a recent report: "The principal problem in designing policies to achieve efficiency stem from the difficulties in defining and measuring the output of health systems, as well as the general lack of clinically agreed-upon standards of appropriateness for medical care."

Superficially, to be sure, France's hospital system is in better shape than Britain's. There are more beds per thousand people and the occupancy rate is about 70 per cent, compared with more than 80 per cent in the UK. No hole-in-heart French babies make prime-time TV news and front-page headlines because their surgery has been postponed, as has happened in Britain. Old people do not hobble around for years waiting for their worn-out hips to be replaced with plastic ones. Waiting lists for operations, even complicated ones, are measured in days rather than weeks, months and even years.

Undoubtedly, though, the French pay a high price. In Britain, general tax revenues finance the NHS. In France, health spending is covered mainly by social security contributions: 5.9 per cent of gross income from every wage-earner, plus 12.6 per cent from the employer, with no upper limits. Self-employed people pay 11.5 per cent of their gross income. But that is not the final bill. Most people covered by social security also subscribe to one of the not-for-profit *mutuelles* or to private health-insurance plans. This is because social-security reimbursements do not cover all medical bills, particularly those for treatment that the state regards as unnecessary or too expensive.

Voluntary health-insurance cover also means that people can afford private rooms and the specialists of their choice. Indeed, there is keen competition for patients between the public and private sectors. Most of the 1,849 public hospitals, with more than 500,000 beds, are municipally owned: together with the 2,087 private hospitals, with about 212,000 beds, they must attract patients if they are to pay their way. And, of course, both sectors are competing essentially for the same pool of francs – social-security reimbursements. Like most things in France this reimbursement system is highly bureaucratic, requiring doctors, pharmacists, hospitals and other health-care providers to complete complicated forms. The patient must pay, then claim reimbursement – which is often slow to arrive.

Notoriously, though, public hospitals are often more expensive than



Infant death rates (male) per 1000 live births	France	US	Britain
1930	90.2	65.6	71.9
1950	52.1	33.4	32.7
1980s*	11.2	12.8	12.2

Life expectancy (male) at birth	France	US	Britain
1930	54.3	57.7	58.8
1950	63.9	65.6	66.5
1980s*	70.9	70.9	71.3

* Various years 1980–85
British figures are for England & Wales

Source: OECD

private ones. A 1987 study done for the Groupe Fondation de la Liberté, a right-of-centre research group, showed that an identical appendectomy in the Paris region cost FFr 12,881 (£1,199) in a public hospital and FFr 6,269 (£586) in a private clinic – making the public hospital 105 per cent dearer than the private one. The most expensive private hospital in the survey charged FFr 15,633, but that probably included a private room.

The private sector is more than holding its own in competition with the public hospitals. Although they have only some 40 per cent of the beds, the privately-owned hospitals and clinics provide 55 per cent of the surgery and more than half of all maternity care, kidney dialysis, and cancer treatment. More than 84 per cent of private clinics are small, with fewer than 100 employees.

Taxed with their inefficiency, public-hospital administrators argue that they support research and teaching and invest in expensive equipment. The argument is less than convincing. Only 27 per cent of the 1,849 public hospitals are designated as "centres hospitalo-universitaires". As for costly equipment, the public sector gets less use out of it. A recent study done for the hospital directors' professional body showed that on average a body scanner in the public sector was used for 55 hours a week – and in private clinics for 71 hours.

Statistics for the public sector are rarer than they should be, and usually late. Patients are presented with "global" bills – typically, FFr 2,600 a day for surgery. Everything is lumped in together: consultation with specialists, body-scanning, X-rays, surgery, medicines. Why, ask the critics, should social security pay exactly the same daily rate for patients who have very different treatments, requiring varying services?

Another likely cause of the public hospitals' high costs is that bureaucratic inertia has spawned sloppiness and sloth. For example, average staff absenteeism in hospitals is 15 per cent, which compares with 9 per cent for the working population as a whole (absenteeism is defined to include maternity and sick leave.) The practical effect is that the average hospital must pay 1.92 people to ensure that one is on duty. The hospitals' paymaster, the social security department of the Ministry of Health, sets a poor example: it suffers from 25 per cent absenteeism in the department that collects contributions and a remarkable 35 per cent in its public offices. In all, social security employs 180,000 people, 45 per cent of them in the health department, and the rest responsible for family allowances, old-age pensions, and related functions. The Inspection Générale des Affaires Sociales estimates that 23,000 employees could be made redundant.

In theory, compulsory pay-roll deductions should cover the state's share of health spending. In practice, the government has to chip in with FFr 6bn in 1986. Social security also borrows short-term from public-sector savings banks. And, every now and then, because social-security payments are late, public-sector hospitals run out of cash – which explains why that surgeon was told there was no more money for medicines. As he recalls: "Of course, that was ridiculous and the management found some more money next day. But it shows what a mess we are in."

Some staff members also complain about being paid late, sometimes two weeks or more behind time. And most have no fat on which to live. Salaried surgeons – after 15 years of studies – are paid FFr 15,400 a month at the bottom of the career ladder and FFr 26,000 at the top. To be sure, they can earn overtime payments – FFr 800 for overnight duty – and in teaching hospitals the pay is slightly better. But in 1986 only 400 candidates sat competitive examinations for 555 vacant surgical posts, and only 214 passed. Internes and foreigners filled the gap. The Collège National des Chirugiens warns: "In the next 15 years France will lose half its surgeons to countries where they are paid better and respected more." The Collège sees 1992 as the year in which the exodus will gather speed. In that year remaining barriers to the free movement of labour within the European Community are supposed to fall.

Nurses, some 92 per cent of them female, earn a starting salary for a 39 hour week of FFr 7,200 a month, rising to FFr 12,800. On top, they receive bonuses equivalent to a thirteenth month, usually paid well in arrears. They also have five weeks of paid holidays, now virtually standard for salaried employees in both the public and private sectors. Many nurses complain of long, unpaid extra hours and of staff shortages in public hospitals. Agnès Jacquinot, who has worked in private clinics and is now with a large regional hospital, says she prefers the public sector because it offers "a good spirit and job security. But it is terribly under-staffed."

As in Britain, nurses argue that they are being paid less than secretaries for doing skilled, highly responsible jobs, and working unsocial hours – though that term has not yet entered the French lexicon of complaint, even in translation. Only a quarter of nurses belong to a union, slightly more than the national average for union membership, calculated variously at between 15 and 18 per cent of people in work. The most active union in the hospital service, the politically centrist Force Ouvrière, is worried that if pay and conditions do not improve soon there could be an outburst of unrest. "The situation is becoming intolerable," says a spokesman.

But no quick fix is in sight, no miracle cure. Public demand for health care is pressing inexorably against public willingness and ability to pay for it. Ironically, the more that medical science prolongs life the more trouble it stores up for the health-care system, in the form of more old people requiring yet more care for longer periods. In 1980, 14 per cent of French people were over 65; by the year 2010, according to an OECD study, that percentage will be 16; and by 2030 no less than 22 (the figures for Britain are 15, 15, and 19). People aged more than 70 are only 8 per cent of the French population, but they account for about 16 per cent of total hospital costs and some 15 per cent of other health-care costs.

Health reformers say there are two essential courses of action to cope with these alarming trends.

- First, inefficiencies must be wrung out of the system, even if the bureaucrats take to the barricades: the difference between costs in the public and private sectors is simply indefensible. Henri Guillaume, former director of planning in the prime minister's office, puts it this way: "Our institutional system has proved its effectiveness, but places obstacles to innovation."
- Second, the French people – like the British – must do more to care for their own health, instead of relying upon remedial treatment. For example, 148,000 people were injured in traffic accidents in 1953; last year the figure was almost 248,000, of whom some 53,000 were seriously hurt, and 9,855 died (the British death toll was 5,100). Virtually all road accidents, says the Gendarmerie Nationale, are caused by bad driving – and its root causes are impatience and drunkenness.

Like Britain's NHS, France's health system has been in large part a remedial service, charged with repairing the ills that people have brought on themselves. In France, as in Britain, the burden is becoming intolerable.

What ails both French and British health services is an ageing population, insistent demand for the latest technology and an unwieldy health-care establishment

increases in revenue pressures in the form of double running costs which in this Region are now estimated to run between £5 and £6 million per annum.

Capital for General Needs

The RHA is currently investing £10 million in the development of a Regional Distribution Centre which will provide a central supplies service. It is estimated that this will result in a revenue saving of £2.5 million per annum. A similar shceme concerning a cook/chill method with catering services is being planned. The capital cost would be of the order of £15 million and would produce a revenue saving of £3 million per annum.

NH6/64M

CONFIDENTIAL

BF 6/6

FROM: MISS M P WALLACE

DATE: 1 June 1988

MR SAUNDERS

cc PS/Chief Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Call

NHS REVIEW: A SCOTTISH PERSPECTIVE

The Chancellor has seen Mr Rifkind's minute, offering his suggestions for the NHS Review. The Chancellor has asked whether any analysis has been done of the cost-effectiveness of health promotion and health education, to which Mr Rifkind suggests priority ought to be given.

MPW.

MOIRA WALLACE

ps2/13M

RESTRICTED

FROM: MISS M P WALLACE
DATE: 1 June 1988

MR SAUNDERS

cc PS/Chief Secretary
PS/Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Tyrie
Mr Call

NHS REVIEW: SUBMISSION BY THE ROYAL COLLEGE OF MIDWIVES

The Chancellor has seen the Royal College of Midwives' submission to the NHS Review. He noted in particular the comment in paragraph 5.4.3 that obstetricians may be generously interpreting the criteria for "high technology" procedures such as caesarean sections, where patients' health insurance covers them for "complications of pregnancy". He thinks that this certainly gives pause for thought, and there may be other instances of this sort of thing.

MOIRA WALLACE

pa/hp/6 **SECRET**

FROM: H PHILLIPS
DATE: 1 June 1988

CHANCELLOR

cc: Chief Secretary
Paymaster General
Financial Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Miss Peirson
Mr Turnbull
Mr Culpin
Mr Parsonage
Mr Call

Mr Isaac
Mr Corlett
Mr Kucys

NHS REVIEW: TAX RELIEF

Attached is a draft paper (with a short covering note) for you to consider submitting to the Prime Minister's group for its meeting on 7 June. There is also a brief for your use at the meeting.

2. The paper itself is substantially shorter than the previous draft, and the passage on benefit-in-kind very short indeed. I hope this reflects however the key points you wanted to make. There may be a slight risk in this approach that colleagues may ask for more detail and therefore for further work to be done, especially if there is any pressure to look at proposals which would cover employees other than in company schemes, and the self-employed. Against that possibility the Inland Revenue will provide you with some additional material about the costs of such an extension.

3. In the short draft covering note to the paper I have included a reference back to the general disadvantages of such schemes which you dealt with in your earlier paper on contracting out, and a reference, in square brackets, to an extension of charging in the NHS. We could run the argument that if we were ready to tackle the problem of the 'cliff edge' for the elderly through tax relief, this could be well balanced by increasing the scale or scope of charging for others. But this might be too provocative for the paper and might better emerge, if it does, from the discussion.

4. Mr Corlett and I will talk to the general line of the paper in the official group tomorrow but without tabling a draft. Your paper will need to go round on Friday 3 June.

HP.

HAYDEN PHILLIPS

[DRAFT 1/6/88]

DRAFT MINUTE FROM THE CHANCELLOR TO THE PRIME MINISTER

cc Secretary of State for
Social Services
Minister of State (Health)
Sir Robin Butler
Sir Roy Griffiths

NHS REVIEW: TAX RELIEF

I attach a paper, for discussion at our meeting on 7 June, on two possibilities:

- tax relief for private medical insurance premiums paid by the elderly; and

- exemption from tax as a benefit in kind of premiums paid by employers under company schemes.

My conclusion is that, if we are to do anything in the way of encouraging private medical insurance through the tax system, it should be confined to the first option. Tax relief for the elderly could be defended as a worthwhile measure to help people stay in insurance schemes at the point where at present they tend to be priced out. Any extension to employees in company schemes is unlikely to prove cost effective; and it would lead to pressure, which in my view would be very hard to resist, to do something for other employees and the self-employed - or for tax incentives in other areas.

More generally, many of the same considerations apply to these schemes as to contracting out which was dealt with in my minute of 22 April; being seen to give benefits to those who already have them, risking therefore a dangerous divisiveness and possibly failing to deliver a net increase in private sector provision. At the least a tax relief confined to the elderly minimises some of these pitfalls. [Similarly the question of wider use of charging

I remain of the view that a better way of and surer

remains relevant to reducing the "cliff edge" of choice between the public and private sectors as well as being a surer way of drawing more private funding into health care.] and would be to return to the question of how we might extend the scope of charges paid by non-exempt groups.

I am copying this minute, and attachment, to John Moore, Tony Newton, Sir Robin Butler and Sir Roy Griffiths.

TAX RELIEF FOR PRIVATE MEDICAL INSURANCE

Note by the Chancellor of the Exchequer.

1. At the meeting on 9 May I agreed to provide a paper on two possibilities identified by the Group: tax relief on premiums paid for private medical insurance for the elderly; and tax exemption for employees on premiums paid by employers under company schemes.

Tax Relief for the Elderly

2. The elderly are heavy users of health services. At the same time, they are less likely to be covered by private medical insurance than the population as a whole.

3. The reasons for the low coverage are:

- In the past, insurers have been reluctant to provide cover for new subscribers over 65. (However, BUPA have recently introduced a new scheme, albeit with fairly limited cover, for new subscribers up to 75).

- The price of insurance, even for existing subscribers, rises sharply from age 65 onwards. And the restrictions in the cover tend to bite harder on the elderly than on others.

- Some of the major requirements of the elderly (eg for long-term care) are not at present insurable on any terms.

4. The combination of these factors means that the elderly represent a very heavy call on NHS resources. Many of those with private medical insurance drop out on reaching retirement. The question is whether tax relief on their private medical insurance premiums would provide a practical, cost-effective and

politically sustainable method of retaining them within the private sector for at least some of their needs.

5. On the practicalities, a tax relief scheme for the elderly could be operated by the Revenue on the lines of the MIRAS scheme for mortgage interest relief. That is, relief would be given to subscribers "at source", by reduction of the premium, with the Revenue reimbursing the insurance providers direct. The relief could best be targeted on those who find it difficult to afford medical insurance now, by making it available only at the basic rate of tax. And by making it available on all policies where the person insured was over 60, regardless of who paid the premiums, people of working age might be encouraged to pay for their parents' insurance.

6. A number of detailed questions about exactly what policies would qualify for relief would need to be discussed by officials in the Inland Revenue and DHSS.

7. The cost-effectiveness of the relief would be determined by the deadweight cost of giving relief to existing subscribers; and by the extent to which it encouraged existing subscribers to maintain their cover on reaching 60 (or attracted new subscribers, both under 60s and over 60s).

8. The deadweight cost of relief at basic rate only for the over-60's would be £25 million. The behavioural effect - the increase in the number of subscribers as a result of giving relief - is, however, very uncertain. If the increase was only marginal, then the extra money going into private health care would be less than the cost of tax relief. In that case, the relief would not represent a good buy. An increase of at least a third in the number of over-60s covered would be needed before we began to achieve "value for money" from the change.

9. While any view of the behavioural effect is necessarily speculative, I believe there are good reasons to be optimistic, particularly if we do not take too short-term a view:

- As I have already noted, we need to take account of those currently under 60. Where they have cover now, they may be more inclined, with tax relief, to keep up their subscriptions after they retire. And those who do not have cover may be more inclined to start, if they feel that tax relief will mean they can afford to continue into old age.

- We are starting from a very low base. Since only 4 per cent of the over-60s have private medical insurance now, an increase of a third means only another 1.5 per cent of that age group.

10. On the wider political implications, the introduction of this relief would, of course, run counter to the general policy I have pursued - of reducing special reliefs for particular sorts of expenditure, and of cutting tax rates across the board, so as to leave people to make their own decisions about what they do with their money. If exceptions to this general rule are made, it is important that they can be tightly ring-fenced. A relief targeted on the elderly would be well understood and should not give rise to irresistible pressure for extension to other groups.

11. My conclusion, therefore, is that a scheme of tax relief for the over-60's is practical, politically attractive and containable; and, while there is no guarantee that it will be cost-effective, there is reason to be optimistic about the effect in the medium term.

Benefit-in-kind exemption

12. I have also looked at exempting from taxation, as a benefit-in-kind in the hands of the employee, premiums paid by employers under a company scheme.

13. Company schemes covering employees are already growing quite nicely - recently the number of employees covered has been rising at about 3% per year.

14. There is already a substantial fiscal incentive for employers to introduce such schemes. As compared with a corresponding amount of cash pay, the employer saves NIC - at 10.45% - on the cost of the premium. And where the employee is below the upper earnings limit, there is also a saving of his own contribution - up to 9%.

15. Since employer schemes are already much larger than insurance taken out by the elderly, the deadweight cost of tax exemption would also be much larger - some £80m. And its effectiveness in expanding cover could be less than with the elderly since the incentive would be indirect - the employee's tax position would be improved, but not the position of the employer who has to pay the premium.

16. A benefits-in-kind exemption would build on the existing success of company schemes. But it would be extremely difficult to justify limiting a tax relief in that way, because it would put employees lucky enough to have a company scheme at a (further) advantage compared with everyone else who paid for their own insurance - other employees and the self-employed. And it could have wider repercussive effects, with pressure to exempt other "worthy" benefits in kind (such as workplace nurseries), or to opt out of other forms of State provision (such as education).

17. My conclusion is that this proposal is unlikely to be good value for money and it would be very difficult to defend the discrimination, which it necessarily implies, in favour of employees in the big company schemes and against other employees and the self-employed. It is, therefore, much less attractive than relief for the elderly.

mjd 3/145m

SECRET

(pl type this final, and flagged draft behind

FROM: MISS M P WALLACE

DATE: 2 June 1988

(which shd keep as draft)

MR PHILLIPS

cc PS/Chief Secretary
PS/Paymaster General
PS/Financial Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Miss Peirson
Mr Turnbull
Mr Culpin
Mr Parsonage
Mr Call

Mr Isaac
Mr Corlett
Mr Kuczys
PS/IR

NHS REVIEW: TAX RELIEF

The Chancellor was most grateful for your minute of 1 June, attaching a draft paper and short covering note. The Chancellor has made some drafting amendments to the covering note, notably dropping the square bracketed sentence on charging and I attach his redraft for information.

2. On the main paper itself, the Chancellor has ~~made~~ some drafting comments ~~which I have~~ set out below. In addition to these, he would like the paper further amended so that the order is reversed: first a "no" to company scheme relief, and then a qualified "yes" to relief for the elderly. This may require some consequential drafting changes.

3. His detailed ~~drafting amendments~~ comments are as follows:

(i) Paragraph 4, final sentence - ~~amend to read:~~ add at end words:
"...~~retaining them within the private sector for at least some of their needs~~ or even of attracting new elderly subscribers."

(ii) Paragraph 5, final sentence - amend to read: "~~and~~ And if the relief were to be made available on all qualifying policies..."

(iii) Paragraph 7, first sentence - amend to read: "The cost-effectiveness of the relief would depend on the dead weight cost..."

(iv) Paragraph 9, first sentence - amend to read: "...I believe there are some grounds for optimism, provided we do not take too short-term ~~of~~ a view"

(v) At the end of paragraph 9, the Chancellor would like a reference to the progress that is already being made (specifically the BUPA scheme for the elderly). ~~and to the need for the~~ DHSS would need to make clear to private insurers that ~~once such a relief was in place,~~ it was now up to them to go out and get the business.

He also thinks we should spell out ~~here~~ at this point that if we introduced a relief of this kind

(vi) Paragraph 10, first sentence - amend to read: "On the wider political implications, the introduction of this relief would, of course, be an exception to the general tax policy we have pursued..."

(vii) Paragraph 10 - amend final words to read: "There is some reason to be optimistic about the effect in the longer term".

(viii) Paragraph 12 - amend to read: "I have also looked at the case for exempting from taxation, ..."

(ix) Paragraph 13 - amend to read: "Company schemes covering employees are already growing quite satisfactorily - in recent years the number of employees covered has been rising at about 3 per cent a year."

(x) Paragraph 14 - amend to read: "One factor in this growth is undoubtedly the fact that there is already a substantial fiscal incentive...". And amend final sentence to read: "And where the employer's is below the Upper Earnings Limit, there is also a saving of his own contribution of up to 9 per cent.

(xi) Paragraph 15 - amend first sentence to read: "Since the coverage of employers' schemes is already much larger than for insurance taken out by the elderly, the dead weight cost of tax exemption would also be much larger - some £80 million and

rising." And add new final sentence to read: "It is most unlikely that the overall effect of a scheme of this kind would be other than a reduction in private spending on health care".

(xii) Paragraph 16 - amend slightly to read: "Moreover, while a ~~our~~ benefits-in-kind exemption would build on the existing success of companies schemes, it would be extremely difficult to justify limiting a tax relief in that way, because it would put employees fortunate enough to have a company scheme at a (further) advantage compared with everyone else who paid for their own insurance - not merely other employees but also the self-employed." At end of paragraph delete words ~~from~~: "or to opt out of other forms of State provision (such as education).

MOIRA WALLACE

mjd 3/145m

SECRET

~~BF 3/6~~ pmp

FROM: MISS M P WALLACE
DATE: 2 June 1988

MR PHILLIPS

cc PS/Chief Secretary
PS/Paymaster General
PS/Financial Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Miss Peirson
Mr Turnbull
Mr Culpin — Mr Saunders
Mr Parsonage
Mr Call

Mr Isaac
Mr Corlett
Mr Kuczys
PS/IR

NHS REVIEW: TAX RELIEF

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sentence to read: "And where the employee is below the Upper Earnings Limit, there is also a saving of his own contribution of up to 9 per cent.

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MOIRA WALLACE

Taking into account the value of the relief.

mjd 3/146m

SECRET

DRAFT MINUTE FROM THE CHANCELLOR TO THE PRIME MINISTER

cc: Secretary of State for Social Services
Minister of State (Health)
Sir Robin Butler
Sir Roy Griffiths

NHS REVIEW: TAX RELIEF

As requested, I attach a paper, for discussion at our meeting on 7 June, on two possibilities:

- tax relief for private medical insurance premiums paid by the elderly; and

- exemption from tax as a benefit in kind of premiums paid by employers under company schemes.

My conclusion is that, if we are to do anything in the way of encouraging private medical insurance through the tax system, it should be confined to the ~~first~~ second option. While in general our tax policy is one of the lowest possible rates on the broadest possible base, tax relief for the elderly could be presented as a well-targeted special case designed in particular to help people stay in insurance schemes at the point where at present they tend to be priced out. Any relief for employees in company schemes would be unlikely to prove cost effective; and it would lead to pressure, which in my view would be very hard to resist, to do something for other employees and the self-employed - not to mention tax incentives in other areas, for which there is considerable pressure.

More generally, these schemes tend to share the disadvantages of contracting out which I addressed in my minute of 22 April; helping those who can already afford private health insurance and, at the end of the day, failing to deliver a net increase in private sector provision. At least a tax relief confined to the elderly minimises these pitfalls.

I am copying this minute, and attachment, to John Moore, Tony Newton, Sir Robin Butler and Sir Roy Griffiths.

PWP

SECRET

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

2 June 1988

Dear Moira,

NHS REVIEW

Thank you for your letter of 27 May. The Prime Minister is content for the Chancellor's paper on topping up allocations to the more successful hospitals to be postponed on the basis you propose.

I am copying this letter to Geoffrey Podger (Department of Health and Social Security) and Richard Wilson (Cabinet Office).

Yours,
Paul

PAUL GRAY

Miss Moira Wallace,
H M Treasury

SECRET

mjd 3/150m

SECRET

pl walk copy to PS/CST, with apologies for excluding them 1st time

FROM: MISS M P WALLACE
DATE: 2 June 1988

MR SAUNDERS

cc Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Saunders
Mr Call

(they should have had top, not Mr S - woops!)

GERMAN HEALTH SERVICE

... I attach an information sheet on the German health service which the German Embassy has circulated to MPs as background briefing. The Chancellor thought you and others might be interested in the proposed reforms described on the last page, which are to limit the health care provided under insurance schemes to "what is medically necessary and essential". In principle, the Chancellor thinks there would be a strong case for importing something on these lines into UK practice, and we have asked our Embassy in Bonn to find out more about how it is proposed that the border-line will be drawn. Subject to the outcome of their further researches, the Chancellor thinks we may want to consider putting in a paper on this to the Review.

MPW.

MOIRA WALLACE

For background information

May 24, 1988.

THE GERMAN HEALTH SERVICE

The health service operates within the framework of the German social security system, which covers the entire population of 62 million people. It makes provision for the aged, for dependants' allowances and for misfortunes such as sickness, accident, mental or physical handicap, accidents at work and unemployment.

The protection comes mostly from the statutory insurance schemes, either public or private and collectively known as the health insurance scheme.

The health insurance scheme

The health insurance scheme is divided into two categories:

a. Employees with a monthly income of up to DM 4,500 must be insured under one of the statutory health insurance schemes -- a variety of local, company and wage earners' schemes;

b. Anyone whose earnings are above the ceiling can opt for exemption from this insurance liability and join one of the 49 private schemes, where premiums are generally higher but the policies are geared to individual requirements and kept within limits by the insured paying directly part of the medical expenses involved.

At present almost 5,200,000 people are privately insured out of a total work force of 26 million. The vast majority of the German population is therefore covered under the National Health Insurance Programme (Gesetzliche Krankenversicherung) which since it was launched in 1883 has been the mainstay of German health policy.

There are many separate sickness funds, such as for example local sickness funds and those looking after farmers, seamen or miners. The fund boards and the medical profession together are legally responsible for seeing to it that the members get the services they are entitled to. In effect, the responsibility nowadays falls almost entirely on doctors joined together in regional health insurance physicians' associations (Kassenärztliche Vereinigungen).

REPORT FROM THE FEDERAL REPUBLIC OF GERMANY
EMBASSY: 23 BELGRAVE SQUARE LONDON SW1X 8PZ TELEPHONE 01-235 5033

The funds themselves retain two main functions: collecting members' contributions and paying for the services given. Because the insured person does not have to pay for his treatment, doctors get payment through their regional association -- which acts as an intermediary with the sickness fund administrators. The funds are self-governing, with equal representation of the insured and the employers on the two decision-making bodies of each fund, the assembly and the board.

The statutory health insurance schemes are financed by matching contributions from insured employees and employers. How much an employee pays depends on his or her income. Up to a certain level every contributor pays the same percentage of gross income for medical insurance, so that people with higher incomes pay more. A maximum amount for which the percentages are calculated is set out and adjusted with salary increases.

The huge rise in expenditure has forced the schemes to increase contribution rates considerably in the last few years: in 1970 the rate was 8.2 per cent, in 1987 12.6 per cent. The employee and employer each pay half, with lower rates for special categories such as pensioners or students.

Choice of doctors

Members of statutory health insurance schemes and spouses or children insured with them are free to choose any doctor or dentist registered with a sickness fund and any hospital. General practitioners can refer patients to a specialist or a hospital where they deem it necessary.

The treatment voucher (Krankenschein) the patient gets from his sickness fund -- and which is valid for a period of three months -- entitles him to free treatment. The cost of the treatment carried out by the physician is paid by the funds according to agreed rates which the physician claims on the voucher.

Hospital treatment

If hospital treatment is necessary the sickness funds pay standard rates which cover the costs for adequate care and all the treatment considered necessary. This rate is the same for all hospitalised patients, regardless of which fund they are insured with, but it only includes the actual costs arising from use of the facilities and treatment. Calling on extra services means the patient has to pay from his own funds or have an additional insurance on top of his

statutory one. Additional insurance has become increasingly popular as the patient can then opt for special services such as a private doctor or a room to himself.

For people carrying private insurance the financing scheme is different: they have to pay bills in advance and they are then reimbursed after the treatment (Kostenerstattungsprinzip).

The sickness funds cover not only medical and dental treatment. They are also financially responsible for:

- Measures for illness prevention and early diagnosis of disease, such as annual cancer tests for women over 20 and for men over 45; various vaccinations; tests for children up to their fourth birthday;
- Provision of medicines and courses of therapy;
- Unlimited hospital treatment;
- Subsidies for dental protheses.

Apart from these benefits a patient can receive certain payments from the fund, such as:

- Sick pay up to five days when having to care for a sick child under eight;
- Sick pay in cases of disablement after the legal obligation of the employer to continue paying wages has ceased (Krankengeld);
- Costs of hiring domestic help when hospitalised;
- In-home sick care;
- Maternity assistance and pay before and after childbirth;
- Death allowances to help pay for burial costs.

Price of health

The benefits which the statutory health insurance schemes give their members are expensive. Due to better medical care and longer life expectancy, health care expenditure has been steadily increasing in the last few decades.

In 1960 benefits paid out by statutory health insurance schemes totalled DM 9,000 million. By 1970 the total had grown to DM 23,800 million and in 1985 it was DM 113,600 million.

Review needed

Because of the huge increase in costs, the health service is running short of money. To control the cost explosion in the health sector a number of

measures were introduced to reduce expenditure without lowering standards of medical care. A first step was the 1977 Cost Reduction Act (Kostendämpfungsgesetz), but this had only a temporary effect.

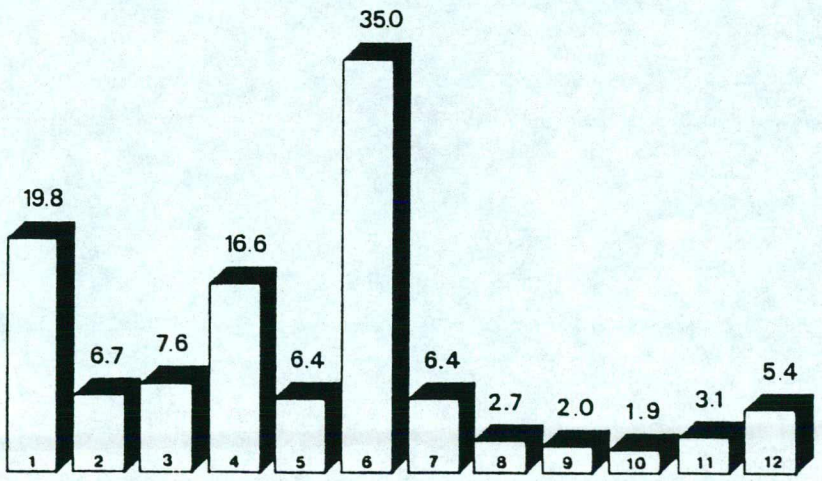
New reforms envisaged in the Health Expenditure Bill expected to reach the statute book in Bonn this year affect the actual structure of the insurance scheme.

Health care will remain guaranteed but the health insurance schemes will only have to pay for what is medically necessary and essential. Anyone wanting more extensive (or expensive) benefits must pay for them himself. To a certain extent patients will also be charged for medicines, medical aids and special items such as hearing aids.

Sickness prevention plays an important role in the Bill to be adopted later this year. In addition, the Government and the medical profession, teachers and academics are encouraging the public to pursue health life styles. The governing principle is that it is not for the state but for the individual to ensure a healthy way of life and to make sure that when the need for treatment arises everyone involved has an interest in effecting a cure as economically as possible.

Total expenditure of statutory health insurances 1985 in DM billion

(1985 total DM 113.6 bn)



1. Treatment by physicians
2. Treatment by dentists
3. Dental prothesis
4. Medicines and dressings supplied by pharmacies
5. Social remedial courses & therapies
6. Hospital treatment
7. Sick pay
8. Maternity pay
9. Death grants
10. Sick care at home/ transport costs
11. Sickness prevention
12. Administration costs

RBS 2/6

CONFIDENTIAL

FROM: D P GRIFFITHS
DATE: 2 JUNE 1988

1 MR SAUNDERS

2 CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Burr
Mr Richardson
Mr Meadowes
Dr Baker
Mr Call

GREAT ORMOND STREET

Issue

1. An out of court settlement with one of the contractors responsible for the faulty construction of the Great Ormond Street cardiac wing has resulted in a payment by the contractor of £8m. Treasury officials have advised that this should be surrendered to the Consolidated Fund in line with normal policy in respect of windfall receipts. Mr Newton has now written to argue that DHSS should be allowed to keep its share of the receipts (£5.6m) which would be spent on AIDS and drug misuse programmes. (The remaining £2.4m would be for the use of the UGC.)

Recommendation

2. We do not consider that DHSS have made out a satisfactory case for the receipts to finance additional expenditure. We therefore recommend that they should be surrendered. HE and GE agree with this advice. A draft reply to Mr Newton is attached.

Timing

3. Routine.

Background

4. The cardiac wing of Gt Ormond St children's hospital was built with substantial defects and has required very substantial

69/6

remedial work. Claims have been pursued against the contractors and in turn there have been various counter-claims. So far the total cost to the hospital of the remedial work and litigation has come to about £22m (the bulk being incurred in the years 1983 to 1987). This has mostly been borne on the HCHS capital Vote, although the University Grants Committee has contributed about a third. We have not made any additional money available to cover these extra costs.

5. Two claims have now been settled out of court with the hospital's receiving some £8.4m (including a contribution to its legal costs). We are satisfied that in the circumstances this was the best policy, given the likely length of the legal proceedings and their uncertain outcome . One claim and counter-claim remain to be settled but there is little chance of any further receipts (claim and counter-claim are roughly equal and have similar chances of success so attempts are being made to reach agreement on the basis of both being dropped).

6. Given that they have had to find so much more money for the cardiac wing than forecast and provided, DHSS feel it is only right that the receipts should accrue to them and were originally proposing to broker them to the RHAs. We did not consider this warranted making an exception to our general rule that extra in-year receipts should be surrendered to the Consolidated Fund. DHSS had made no case for extra capital expenditure nor was a claim on the Reserve in prospect if the receipts were not retained.

7. Unsurprisingly DHSS have now responded that, if they are allowed to retain the money, they will not have to come to us with in-year bids. The money would be spent on two areas: continuing the public education campaign aimed at drug misusers; and implementing the recommendations of the Advisory Committee on Misuse of Drugs (ACMD) regarding AIDS and drug misuse. Both areas would be current rather than capital spending. This is presented as a compromise solution,although most of the compromise would come from the Treasury. (It is not clear what use the UGC would make of their share of the receipts and HE see no reason why they should receive extra funds this year.)

Discussion

8. Whether the DHSS keep these receipts or whether they are surrendered has no bearing on Great Ormond Street itself. There are no plans to give it any more funds for capital expenditure this year.

9. There would clearly be little point in our insisting that the receipts be surrendered if there were genuinely pressing claims on the Reserve of an equivalent size. But equally we should guard against the use of windfall receipts to support expenditure for which provision would not otherwise have been made. We would therefore want to see as good a case for the retention of the receipts as we would for a claim on the Reserve. Mr Newton's letter does not make this case.

10. On the basis of the information we have at present we would certainly be doubtful about the case for providing more money for the drugs education campaign. It has already been decided that AIDS campaigns should be linked with this programme and there is obviously a case for considering a single campaign to avoid wasteful duplication.

11. The ACMD proposals do have resource implications but again at this stage it is not clear what additional provision might be necessary. The Government have accepted the ACMD's advice that services for drug misusers should be developed but the only decisions taken so far on the detailed recommendations have been negative ones: the expansion of syringe-exchange schemes is not being pursued at least for the time being; nor will condoms be made available in prisons. It should be noted that there is already provision for the expansion of services for drug misusers. Health authorities were allocated £5m per year from 1986/7 to develop drug treatment and rehabilitation services and a further £1m p. a. in 1987/8 and 1988/9 to curb the spread of HIV infection among drug misusers.

12. It is possible that we may eventually decide to provide extra resources for these areas but there is at present no case for allowing DHSS to appropriate the Gt Ormond St receipts.

D P GRIFFITHS

DRAFT LETTER TO :-

The Rt Hon Tony Newton OBE MP
Minister for Health

GREAT ORMOND STREET, AIDS AND DRUG ABUSE

Thank you for your letter of 23 May.

I see no reason why we should be unable to establish a sensible way forward on these issues but our starting points are rather different. Though I should be willing to consider proposals for increasing expenditure to combat drug misuse, they must be assessed on their individual merits. The latter are far more important than the fact that additional expenditure could be financed by hypothecating windfall receipts.

At present I am not convinced that there are compelling reasons for the extra provision you are now seeking for the drugs misuse and AIDS programmes. I recognise that we have acknowledged the importance of the issues raised by the Advisory Council for Drug Misuse report and accepted the need to develop services for drug misusers. But we have yet to commit ourselves on the detailed recommendations other than those such as the expansion of syringe exchange schemes and the availability of condoms in prisons which we have specifically rejected - at least for the time being. I therefore consider that it would be premature to discuss the

question of any additional provision at this stage. As regards the drug misuse education campaign, I am again unconvinced of the need for extra funding. As you have noted, there are existing resources which could be re-allocated if the continuation of the campaign is judged to be a top priority.

In the circumstances therefore I consider that the receipts from the Great Ormond Street settlement should be surrendered to the Consolidated Fund.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Minister for Health

The Rt Hon John Major MP
Chief Secretary to the Treasury
H M Treasury
Treasury Chambers
Parliament Street
LONDON
SW1 3AG

2 27 APR 93

Dear Chief Secretary,

GREAT ORMOND STREET

As you may be aware a settlement has now been achieved in the long-standing matter of claims against one of the main contractors by the Hospital for Sick Children at Great Ormond Street in respect of serious structural faults in the cardiac wing. The settlement is worth £8 million. The settlement owes much to the determination of the Authority and its General Manager, and it has received considerable publicity because it closely coincided with the opening of the new wing by the Prime Minister on 27 April. We are advised by leading counsel that it is the best available in the circumstances though it is significantly less than the £20 million rebuilding and £2 million litigation costs that have been incurred, and which we have met by topslicing health authorities' allocations.

Against this background I was dismayed to learn that your officials have not been able to agree that the compensation payment should be retained by the NHS (and the UGC in respect of whom £2.4 million applies). The argument I gather is that under Government Accounting rules the sum must be surrendered to the Consolidated Fund. I find this hard either to understand or accept, in view of the fact the money in question had to be taken from what would otherwise have been available to Regions.

E.R.

Leaving the narrow accounting argument aside, however, may I suggest that the most sensible course would be to allow the NHS to keep its share of the compensation (and the UGC likewise), in order to avoid us having to come to you for relatively small sums to deal with the sort of small but politically sensitive issues which keep cropping up during the year? I have in mind at the moment particularly two points on the inter-related issues of AIDS and drug misuse. One is the continuation of the public education campaign aimed at drug misusers, which we can only secure by taking money from some or all of proposed campaigns on teenage smoking, alcohol abuse and nurse recruitment. The other is a modest amount of £3-4 million needed to implement recommendations of the Advisory Committee on Misuse of Drugs; this we cannot find at all, and our inability to do so, which is a cause of concern both to the Expert Advisory Group on AIDS and to Home Office Ministers, looks like causing considerable embarrassment.

I do hope you can see your way to accepting this compromise.

Yours sincerely.

Tony Newton

TONY NEWTON

(Approved by the minister and signed in his absence).

YdeS/D.7

Ch/ok? OK, hpw

MISS WALLACE

FROM: R B SAUNDERS

DATE: 2 June 1988

cc Mr Phillips
Miss Peirson

POLICY ISSUES IN AMERICAN HEALTH CARE

David Willetts has invited me to attend a "private seminar" which the CPS are organising on this subject on 21 June. There will be 3 American guest speakers - an academic economist, a private sector health manager and Dr William Roper who heads the federal agency which runs Medicare and Medicaid, and is a former adviser to President Reagan.

2. I am disposed to accept the invitation, but perhaps you could let me know if you think it likely that the Chancellor would see any difficulty.

R B SAUNDERS

SECRET

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

2 June 1988

Dear Moira,

NHS REVIEW

Thank you for your letter of 27 May. The Prime Minister is content for the Chancellor's paper on topping up allocations to the more successful hospitals to be postponed on the basis you propose.

I am copying this letter to Geoffrey Podger (Department of Health and Social Security) and Richard Wilson (Cabinet Office).

Yours,
Paul

PAUL GRAY

Miss Moira Wallace,
H M Treasury

SECRET

008/3295

FROM: CHIEF SECRETARY
DATE: 2 June 1988

CHANCELLOR

cc:
Mr Anson
Sir Anthony Wilson
Mr H Phillips
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Griffiths
Mr Call

INDEPENDENT AUDIT AUTHORITY

I attach a copy of a letter and enclosure from Mr Clive Froggatt who attended one of the Prime Minister's seminars. His note arises from a conversation over lunch.

It is of interest:-

(a) because it is clearly similar to our thinking and

(b) because Mr Froggatt is part of a small group under Tony Trafford reporting direct to the Prime Minister.

By coincidence I bumped into Tony Trafford in the Commons canteen and he told me (gratuitously) that he had just sent a report on the NHS to the Prime Minister (presumably the one Mr Froggatt refers to).

[has been circulated (same as this enclosure)]

JOHN MAJOR

From Dr. Clive Froggatt, C.C.

59 Hatherley Road,
Cheltenham, Glos.
GL51 6EG.
0242 580911

The Rt. Honourable John Major, PC, MP,
Chief Secretary for the Treasury,
H.M. Treasury,
Whitehall,
London S.W.1.

23rd May 1988

Dear Mr Major,

When we met in March at Chequers for a discussion on the NHS Review I mentioned the relationship between input and output in the Health Service. You asked me to expand my thoughts.

I am sorry that it has taken so long to respond but since that meeting Lord Trafford has formed a group which included Ian McColl, Cyril Chantler, John Butterfield and me and most of my thoughts have been included in a report which he has prepared for the Prime Minister and will be sending to her before Whitsun.

I enclose now some expanded notes on the establishment of an independent audit authority. In my view, this is the way forward to improving the relationship between the resources (both financial and in personnel) made available to the Health Service and the outcome for patient care. We need to establish much more information not only on unit costs but also quality of care. Once the base line has been established targets can be set against which performance can be measured and incentives provided accordingly. I should be happy to expand on any aspect of these papers.

With best wishes,

Yours sincerely,

Clive Froggatt.

Enc

From Dr. Clive Froggatt, C.C.

NHS Review : Independent Medical Audit Authority

The absence of clinical and financial audit in the National Health Service lies at the root of the problems confronting the service today. Without financial audit it is impossible to make valid comparisons between two health authorities or reliable judgements on the value for money obtained from certain procedures. Without medical audit the performance of the medical and nursing profession cannot be assessed properly and decisions on clinical priorities have to be taken on less objective grounds (making managers more susceptible to the vagaries of medico-political pressure groups). Demands for additional resources, either in terms of finance or personnel, are more difficult to assess. This makes inappropriate decisions more likely leading to secondary problems for patients, those working in the health service and the Government. Political challenges from the Opposition (or medical profession itself) are clearly more difficult to counter unless precise information on matters of fact is available.

Evaluation of the effectiveness of the health service is highly complex and needs to embrace aspects such as quality of care, the importance of patients perception of good care, clinical freedom and the balance of quality and quantity of life. It is made more complex by the vested interests of Government, DHSS officials, politicians, RHA and DHA managers, consultants, nurses and the patients themselves.

With greater autonomy and more responsibility for service provision being devolved from the centre to the periphery, it

becomes increasingly important for all concerned that an independent body is charged with the responsibility to audit health care services.

Such a body must establish independence both from the Government, Health Authorities and any other vested interests. It must establish a reputation for analysing the problems of health care delivery and it must make a practical impact on the delivery of health care services.

The remit of the body should extend from financial management into area of clinical audit with protocols being established centrally, but implemented locally, by District Clinical Audit Officers working alongside those responsible for financial audit. Together they would work on value for money reviews of the services provided.

Like local authorities, health authorities face many new challenges in the next few years. Demands on health services are changing and the way in which resources are used will come under ever increasing scrutiny.

Over the past five years, the Audit Commission has established itself by demonstrating the strategic importance of audit and value for money (VFM) review of many public and semi-public services delivered locally. Its reputation for independence and penetrating analysis makes it well placed to assume the responsibility for independent medical audit. The organisational structure of the commission lends itself to a fairly simple adaptation enabling it to embrace the proposed responsibility for health care services.

At the outset the Audit Commission was viewed with considerable scepticism and even hostility by local authorities. The health service, particularly the medical profession, are likely to have a

similar attitude. There may be some token resistance from the medical profession particularly on clinical audit, since it favours peer review and self-audit - claiming that this is taking place already to a significant degree. Evidence exists to show that this is not the case. However, local authorities no longer oppose the Commission's existence and engage now in a regular constructive dialogue about its work and future direction.

The Audit Commission has undertaken special studies involving the police, education and social services. Hostility and scepticism were overcome by having seconded to the study group professional and technical experts who enjoyed the confidence of those working in the special fields under audit.

Special studies generate two products. The first is a report which aims to describe best practice and demonstrates the way in which others could move towards a best practice approach. It indicates opportunities for savings and improvements in effectiveness. The second product is a detailed guide for use at local level. It gives comparable statistics, performance indicators and an analytical approach so that key drivers of performance could be identified quickly at a local level. The methodology of such studies already undertaken in local authorities is directly applicable to the health service. Other features of the Commission include a quality control function with close links to the accountancy bodies which would be invaluable to District Financial and Clinical Auditors.

The Commission has also developed coherent and disciplined mechanisms for bringing the central work into the audit process and vice-versa. These involve:

*The development of unit cost profiles

*The preparation of VFM focussed audit guides

*Tracking systems to monitor efficiency gains achieved

Finally, having recognized that management structures and competence are critical to efficient service provision, the Commission has developed a methodology of analysing central management and administration. The two local auditors, financial and clinical, will combine an understanding of the principles of good management with close knowledge of local circumstances and will be well placed, therefore, to help those authorities which lack now a strong corporate management.

Conclusion

The Audit Commission structure and methodology is readily adaptable to the health service; and, its political independence is acknowledged. It is placed uniquely to audit, advise and stimulate the National Health Service. Its experience shows that it can co-ordinate the skills and procedures required to promote economy, efficiency and effectiveness in the running of the NHS and, at the same time, provide hard data upon which the Government may base its plans for future provision within the health service.

Incentive for change

The single most important incentive is financial. Professional satisfaction is highly valued but not as much as money.

The profession should be approached with a carrot and stick. The carrot will be a modest increase in remuneration and the stick will be contractual changes designed to ensure that greater attention is given to the outcome for patients. The intention will be to reward a better quality of patient care.

Quality

It is difficult to measure quality and impossible to define precisely what makes one doctor better than another. However, by broadening the basis of assessment, using a basket of performance indicators, it would be possible to identify practices which are either better than others, or better than they themselves used to be.

A dynamic shift towards higher standards of care can be taken as a sign of improving practice and should be rewarded appropriately. Once the base-line levels of provision have been established, practices can be given annual targets to achieve.

The parameters of assessment will include: levels of vaccination/immunization, screening for cervical cancer and other aspects of care which may be covered currently by the "items of service" category. In addition, the assessment of quality will include information on, for example, the percentage of a practice's elderly population that have been screened, the number of patients who attend the practice

based smoking cessation course, and the provision of, and use of, a wider range of services, such as minor operations, hypertension and diabetic clinics etc. Finally, comparative consultation rates, average time taken to obtain an appointment, referral and admission rates, prescribing patterns and practices, and, possibly, the frequency of complaints could all be taken into account.

A district based clinical auditor will be able to assist in the evaluation of the practice profile that will have been built up from the performance indicators mentioned.

The parameters of assessment will be subject to variation from time to time and will be biased towards areas and aspects of health care on which the health service is required to focus.

Most of the information needed on performance indicators can be gathered easily and cheaply directly from practices. Much of the information would be appropriate for inclusion in the practices Annual Report. With the introduction of information technology into surgeries and FPCs, more specific and sensitive information can be gathered.

Other Incentives

Contractual changes should be made which ensure that financial incentives yield identifiable improvements in patient care. GPs need no reminder that their independent contractor status should be valued highly. As such they should demonstrate their entrepreneurial skills by assuming greater responsibility for patients in primary care, remunerated where appropriate by the local DHA. This should be possible once DHAs are autonomous. Diversity of health care provision should be encouraged.

Professional satisfaction is enhanced by the proper, and full, use of anciliary staff - including practice managers. FPCs should ensure that an appropriate balance is achieved in the primary care team.

Finally, continuing medical education (CME) is imperative. Attendance has fallen at postgraduate centres since it ceased to attract any remuneration. Resources need to be made available both to GPs themselves and their clinical tutors. The content of CME should be focussed on those areas which result in higher quality patient care and better value for money for the NHS.

Conclusion

The White Paper contains the framework for negotiations with GPs which are under way now. Its references to contractual changes are implicit and accepted by the profession.

With additional finance on the table, the profession must accept a contract with the NHS which makes specific demands for co-operation on clinical and financial audit. They should be encouraged to be innovative and entrepreneurial. FPCs/DHAs should be encouraged to promote changes in the delivery of care which may involve contractual arrangements with local GPs.

GPs should be committed to CME to raise the standards of patient care and give services which represent better value for money.