PO- CH/NL/0102

PART G

Part. G.

SECRET

(Circulate under cover and notify REGISTRY of movement)

Begins: 15/6/88
Ends: 23/6/88.

PO -CH /NL/0102
PART G

Chancellor's (Lawson) Papers:

THE NATIONAL HEALTH SERVICE REVIEW

Disposal Directions: 25 Years

10/8/95.

PO -CH /NL/0102
PART G

CHANCELLOR OF THE EXCHEQUER

G/ I have spoken to No10 to tell them that you will have to leave the Seminar on the NHS immediately before the lunch, on Friday July 8, & although they expect discussion to continue through the lunch, they are content - OST will also be present.

I have spoken to Mrs Lawson & Sylvie & they would like to depart for here before 2.00pm aiming in Stavely Stanton at about 4.00pm giving you time to change etc before leaving for Belvoir Castle at 6.30pm. Mark will travel to Belvoir separately by train.

Content? OK.

Julia 29/6.

week.13.5/mr.1

SECRET Covering
CONFIDENTIAL

FROM: H PHILLIPS
DATE: 15 June 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Parsonage
Mr Griffiths
Mr Sussex
Mr Wellard
Mr Tyrie
Mr Call

CH/ arrived before I had minuted out yr comments. I will have a word with Dick/Hayden about tactics – how to avoid X below, and we could discuss at next opportunity. HP

NHS REVIEW: SUBMISSION FROM LORD TRAFFORD'S GROUP

We thought you should see some initial comments from us on the paper that has been sent to the Prime Minister by Lord Trafford and others. Mr Satchwell's note of 15 June (attached) does this.

2. The paper will be influential with the Prime Minister. In particular it follows some discussion at the last meeting on 7 June that the possibility of major structural reform should be kept open, particularly through all hospitals being self-governing and having contracts for service and performance with DHAs. As Mr Satchwell points out this is a variation on the buying/providing model. Unfortunately Lord Trafford's paper will keep this 'big bang' approach to organisational change alive without, I imagine, stimulating the DHSS to turn it into a practical and cost-effective proposition.

X

HP.

HAYDEN PHILLIPS

14.6.1

CONFIDENTIAL

FROM: R C M SATCHWELL

DATE: 15 June 1988

1. MR PHILLIPS HP 15/6.

2. CHANCELLOR

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Parsonage
Mr Griffiths
Mr Sussex
Mr Wellard
Mr Tyrie
Mr Call

NHS REVIEW: SUBMISSION FROM LORD TRAFFORD'S GROUP

The report submitted to the Prime Minister by a group of doctors who attended the first NHS seminar at Chequers arrived too late for inclusion in my note of 8 June summarising the main proposals for reform. We understand however that the Prime Minister has seen it and is impressed by it. You may therefore like our quick comments.

2. Under the Trafford Group's proposals, DHAs would take over the functions of FPCs and the whole system would be cash-limited. The expanded DHA would then use its allocated budget to contract with competing GPs, hospitals and private contractors to provide a complete health care service for its resident population. Contracts would be performance related, in order to encourage efficiency. Financial incentives and penalties would be introduced through money following the patient in an internal market, so that the better hospitals and primary care teams attracted more resources and the worse ones less. Within hospitals, clinical teams would be given budgets and clinicians would become more involved in management. Consultants would have 7 year contracts with the DHA. Capital controls would be relaxed and districts would have easier access to capital from the private sector. DHA and unit management would be improved and there would be a greater emphasis on cost transparency. The responsibilities of RHAs would

be reduced and DHAs would report direct to the NHS Management Board, which would act as a "holding company", concentrating on strategy and review. Value for money and medical audit would become both obligatory and more widespread. Overall, the paper is similar to the "Buyers and Providers" option already discussed by the Review Group.

3. The paper shows a refreshing willingness to think radically and recognises (para 5 of p 3) that more money is not the answer. It also proposes a number of initiatives we would support, particularly the emphasis on better management, cost transparency and audit. But it doesn't really hang together as a package, and tends to skate over some fairly tricky issues.

i. Internal market The discussion of the internal market on page 10 understates the complexities of the "money following the patient" idea and fails to bring out fully the conflict between efficiency and clinical freedom when Hospitals A and B are in different districts. It is anticipated that money would go to hospitals that provided the "best" service. But best might well mean in practice the highest quality (and hence most expensive) rather than the most cost effective. A referral by a GP in District A to a hospital in District B might therefore necessitate the transfer of more money than District A would find acceptable within the terms of its cash limit. District A could solve this problem by writing a list of "preferred providers" into the contracts it enters into with GPs (as happens in the US). But this limits GPs' clinical freedom and, by extension, consumer choice. The paper is also very vague about the system of allocating funds to individual DHAs. It says it should be a "block grant which would vary depending upon the amount of services they ought to provide". This masks a rather complicated RAWP-type problem.

ii. GP unemployment The proposal to force GPs to compete for contracts with newly-merged DHAs/FPCs implies that at least some GPs will not be allocated contracts and so would become unemployed. Medical unemployment already exists to a

certain extent, but it tends to be of the short-term, frictional variety and mainly in the hospital sector. The sight of qualified and experienced GPs not having their contracts renewed might well be difficult for the general public to accept, and impossible to sell to GPs.

iii. Consumer choice The paper's authors believe that the proposed primary care system of contracts would "increase choice to the consumer". This is probably overstated. Patients are already free to choose their GP (although this choice is rarely exercised in practice) and GPs are already "entirely free to send patients wherever they (feel) the best service (can) be obtained" (p 6). The new system would not improve on that, and in some cases might actually reduce it; for instance, as outlined above, if a GP popular with his patients lost his contract with the DHA, or if the DHA needed to send patients to designated, cheaper hospitals in order to stay within its cash limit.

iv. Bureaucracy Many of the paper's proposals imply a reduction in manpower and bureaucracy; examples include the streamlining of DHSS and the RHAs, the abolition of "all the intermediate stages of the concealed cost of planning" (p 21), and the greater use of contracted-out services. At the same time, however, the new system would need many more (and perhaps more expensive) professionals in other areas; lawyers to draw up, award and monitor the DHA's contracts with hospitals, GPs and private contractors, accountants to run cost systems and "apply to the market to obtain finance" (p 14), health inspectors and auditors to monitor quality and standards, a National Health Service Research Authority to handle research. There is a danger here of a simple bureaucratic reshuffle of personnel away from RHAs to either the DHAs or the centre.

v. Capital The proposed removal of the distinction between capital and revenue expenditure and the new freedom to raise private capital subject only to "general approval" from the NHS Management Board sit oddly with a system which

has both the HCHS and FPS cash-limited. If such approval were not subject to stringent conditions, then there would be an incentive, irrespective of the viability of the individual project, to borrow now, and worry about the revenue consequences later. This would be unacceptable, since it would remove controls on both the appraisal of individual projects and the total volume of public sector capital spending. On the other hand, an approval system with genuine hurdles would be no different from the present position, in which case the arguments about private finance apply and freedom is constrained. (As an aside, the first example given in Annex A to the paper, which purports to show that regions need an expanded capital programme to fund cost-saving investments, produces a real return of only about 2% per annum. This would not be sufficient to meet interest payments on the capital borrowed, let alone repay the principal.)

vi. Cost control Cash limiting both the HCHS and FPS, and having the district responsible for all forms of health care, should in theory help contain costs overall. However, it is worth noting that the paper is silent about pay. Good managers are expensive; so are lawyers and accountants.

vii. Accountability Under the new system, hospitals would become "more self-governing" (p 7). This phrase covers a lot of difficult issues such as statutory responsibility, legal status (public or private sector) and accountability. A particular example is what happens if an individual DHA or unit got into financial difficulties as money followed patients to more efficient areas. Would the Government be forced to bail it out?

viii. Private sector The paper is dismissive of the private sector, arguing that the better the NHS, the less likely it is that DHAs will look to the private sector as potential service providers. This seems unduly pessimistic. The greater the separation between "buyers" and "providers", the less the distinction between public and private sector hospitals.

4. In summary, therefore, the Trafford Group's paper is stimulating and contains useful ideas. But it also leaves unanswered a number of difficult problems, which need to be resolved.

R. Satchwell.

R C M SATCHWELL

8/7

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

15 June 1988

Dear Gerald,

This is just to confirm timings for the NHS Review Seminar which the Prime Minister wishes to hold here on Friday 8 July. Those attending should arrive here at 0930 and lunch will be promptly at 1300 hours, thus allowing people to be away from here by 1430 at the latest.

I am copying this letter to the diary secretaries at the Scottish Office, Welsh Office, Northern Ireland Office, Treasury, Chief Secretary, Minister for Health and Trevor Woolley and Richard Wilson (Cabinet Office).

Yours sincerely,

Tessa

MRS. TESSA GAISMAN

Gerald D'Souza, Esq.,
Department of Health and Social Security

week.13.6/mr.3

CONFIDENTIAL

1. ACSA 2 pmp

FROM: H PHILLIPS
DATE: 15 June 1988

MR SAUNDERS

cc PS/Chancellor)
PS/CST) w/o
Sir P Middleton) enc
Mr Anson
Sir T Burns
Mr Culpin
Miss Peirson
Mr Turnbull
Mr Gieve
Mr Parsonage
Mr Tyrie
Mr Call

Mr Corlett)
Mr Kucys) IR

REVIEW OF THE NATIONAL HEALTH SERVICE: PRESS ARTICLE

In agreement with Mr Allan I am circulating the attached letter from Sir Robin Butler's office about handling the work on the NHS Review. I should be grateful if you could draw it to the attention of all those in ST2 who are concerned with the review.

2. The especial caution it requires is, in my view, also usefully applied to our contacts with other bodies eg institutions and study groups, especially those with particular axes to grind on health.

3. If you or other colleagues closely engaged on the review are approached by journalists for conversation or comment on the subject I should be grateful if you could let me know, as well as Mr Gieve.

HP.

HAYDEN PHILLIPS

1.7.6

FROM: MISS M E PEIRSON

DATE: 16 JUNE 1988

CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Mr Turnbull
Mr Parsonage
Mr Saunders
Mr Call

CH/interesting. See also pps behind on giving this man a job.

HEALTH REVIEW: VIEWS OF A DISTRICT HEALTH AUTHORITY MANAGER

1. I mentioned at the Chancellor's meeting yesterday that I had been talking to a DHA manager with more positive views about NHS funding than some people. You might like to know a little more of the discussion, which was most interesting. The manager in question is Mr Chris West, of Portsmouth DHA, who was one of the invitees to the Chequers seminars. He is well thought of in DHSS and indeed is clearly the best possible DHA manager one could hope to meet; he has done a tremendous amount for Portsmouth since he took up the post in 1982.

2. Mr West and I talked about what he had been doing in Portsmouth, and also about how he viewed various possible changes, under the following headings.

Income and Expenditure

3. Mr West has had absolutely no problem with his income and expenditure accounts, and resents the fact that the extra money handed out last December effectively rewarded the incompetent. He has some sympathy with inner city RAWP losers, but none for RAWP gainers like Gloucester. He told DHSS (Mr Hart) that he really did not want the extra money in December and did not want more to be handed out in the future, because he had successfully instilled in all his 8000 staff (doctors, nurses, etc) that money must not be wasted and cost consciousness was vital, and he did not want all that work thrown away. He actually used the December money to pay major 1988-89 bills in advance (rates, electricity, etc, amounting to £1.6m) and to build up his drug stocks, etc.

Cross boundary flows

4. Mr West is quite sure that Portsmouth is a net importer of patients. But his RHA (Wessex) uses for its allocation of money between its districts the results of a 1973 study, before the present motorway system was built, which showed Portsmouth to be a net exporter. Therefore he loses on the allocation of money within the RHA.

5. He has successfully introduced Körner, on a clerical basis (he got it in last September, though most of the Wessex districts have not yet). As a result, he could give information about patient flows, based on average speciality costs, monthly within a month or so. And he would be very happy to have the 1989-90 allocation of money based on the cross-boundary flows shown by the first 6 months of 1988-89.

Re-organisation

6. Mr West is against re-organisation if it can be avoided, since that leads to so much disruption. But he would favour the DHAs taking over the FPCs: he says his planning of services is inhibited by his not knowing what costs etc are likely to arise in the FPS. (He also thinks the RHAs are very over-staffed.)

Consultants' Contracts

7. Mr West thinks that consultants should be employed by the DHAs, on fixed-term contracts, with no merit awards but performance-based awards. (He confirms that merit awards are a scandal: consultants retire at 65, but can go at any time from the age of 60; their colleagues move heaven and earth to ensure that they get a merit award, or a higher merit award, within their last five years, in order to enhance their pension.)

8. Mr West thinks that consultants should not work part-time for the NHS. He says that if the number of their sessions is reduced to, say, 6 a week, then, since they have to devote one session to being on call, one to medical audit (see below), and one to teaching and research, that leaves only 3 sessions for out-patients and theatre, instead of 9 if they are full-time.

In any case, he cannot check up on whether all his consultants are pulling their weight and really fulfilling their NHS sessions (many are, but some are not).

9. Mr West therefore strongly favours letting consultants work full-time for the NHS or not at all: he says they would work very hard for the NHS at first, building up their reputation, and then some would switch to the private sector. (He says they work for the NHS for their pension, sick pay, holidays, etc; and for the private sector for piece-rate; and that at present many switch back from part-time NHS to full-time NHS within 3 years of retirement, in order to build up their pensions.)

Medical Audit

10. Mr West's consultants already do medical audit, looking as much at their own performance as other people's, eg their cross-infection rates, mortality rates, etc. But if Mr West did not give them a session for audit, he says they would not do it.

Nurses

11. Mr West is happy with the principles of the re-grading, for he believes strongly in rewarding clinical skills. He is rather worried that Wessex RHA may not allow - when distributing the DHSS funding - for the fact that Portsmouth does a great deal more training of nurses, and therefore has a higher qualified nursing population, than many other districts, so that the re-grading will cost Portsmouth relatively more.

12. He accepts the Project 2000 ideas for training etc, whilst agreeing that it will cost money in the short term. However, he has himself carried out a very successful campaign to re-recruit nurses who had left to have families.

13. I asked him what he had heard about the cause of the problem at Birmingham over heart babies. He said that it was because the English National Board, which accredits training courses and is the lackey of the RCN, told Birmingham that it must take untrained nurses off intensive care, which caused a sudden shortage of pairs

?!

of hands on intensive care. He thinks the Birmingham problem, and the media stories associated with it, was the cause of all the subsequent trouble in the media and elsewhere on health.

Privatisation

14. Mr West already buys and sells services a good deal. He has had to close down half his theatre wards in order to rebuild them (they were about to fall down), which caused his waiting lists to shoot up. He has therefore received some of the waiting list money, and has been buying hip operations (for example) from several sources, both private and public. He has a BUPA hospital in his district, and he sells them pathology and pharmaceutical services.

15. He says he can cost his patients well enough, without having a resource management initiative investment (he applied for the acute sector experiment, but he was already on the community care initiative experiment, and Winchester were given the acute sector initiative instead). But he finds that some others do not seem to know what they are doing: Barts wanted to charge £2,700 per hip operation, whereas he can get it done substantially cheaper anywhere else. And when Maidstone complained that they were unable to fill their wards with patients because they were so efficient that they were running out of money, he offered to ship them some Portsmouth patients at a profit, but Maidstone turned him down.

16. Mr West has also very recently started discussing with the American private health insurers AMI the idea that AMI should build a new private hospital on some land owned by Portsmouth DHA, and that Portsmouth should contract to buy services from that hospital. (That will provide useful competition with the BUPA hospital.)

MEP

MISS M E PEIRSON

SECRET

Inland Revenue

Policy Division
Somerset House

FROM: A W KUCZYS
16 June 1988

1. MR CORLETT 16/6

2. CHANCELLOR OF THE EXCHEQUER

Ch/ You may want to hold this for plane-reading - but if you do have time to look at it might be helpful to get officials on right track soon. Various questions at para 11 of Tony's minute - (d) and (e) in particular difficult. MPW 17/6

NHS REVIEW: TAX RELIEF

1. At the Prime Minister's meeting on 7 June you agreed to provide papers on

a. tax relief for the elderly at marginal (instead of basic) rate; and

b. (in effect) a higher P11D threshold for private medical insurance.

In addition, you wanted to send a note to the Prime Minister on work-place creches. Miss Rhodes is letting you have a draft separately. A draft paper on a. and b. is attached to this note. It was drafted before we saw Miss Rutter's note of 14 June about your meeting last Friday with the Secretary of State for Social Services and the Minister for Health.

---

cc Chief Secretary
Financial Secretary
Paymaster General
Sir Peter Middleton
Mr Anson
Sir Terence Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Culpin
Mr Saunders
Mr Parsonage
Mr Call
Mr Battishill
Mr Isaac
Mr Beighton
Mr Corlett
Mr Lewis
Mr Davenport
Mr R H Allen
Mr Walker
Mr I Stewart
Mr Boyce
PS/IR
Mr Kuczys

* I have made a note of answers. Re 11(d), I wd like an answer. Re 11(e) OK. PS. Now go over @ X:

2. Our conclusions, reflected in the paper, are:-

a. Tax relief for the elderly at higher rate would increase complexity, in a number of ways. It is unlikely that the increased take-up would be worth the additional price. And critics of the proposal might be able to claim that it was even more unfair. However, we cannot say that the administrative arguments are overriding. It is very much for your political judgement whether this has to be conceded.

b. Any form of benefit in kind exemption is open to the objections set out in your previous paper. Sir Roy Griffiths' suggestion, limiting the benefits to those below some specified income level, has some attractions; but it would add to the problems. We advise continuing to resist any relaxation on the benefit in kind front, except that if the over-60s are to get tax relief on premiums they pay themselves, they should also be exempt if their employer pays. (You have not volunteered this additional leg to the elderly relief before.)

3. That means that what you could be offering colleagues is a complete tax package for the over-60s, made up as follows (before taking account of additional relief resulting from increased take-up):-

	Cost (£m)	Staff cost
Basic rate relief	25	10
Higher rate relief	6	15
Company schemes (benefit in kind exemption, and relief on contributions by over-60s employees)	10	nil
TOTAL (rounded)	40	25

But there would be no specific encouragement for company schemes as such.

4. Much more could be said in the part of the paper dealing with benefit in kind exemption. At present it only discusses a threshold of £20,000. But you could incorporate some of the material in the Annex to this note, which sets out the proportion of employees getting medical insurance in various income bands and the effects of choosing different income levels for the benefits-in-kind exemption. And the paper does not discuss the position of directors who are not affected by the P11D limit and would not therefore benefit from a higher limit for medical insurance (a significant proportion already get medical insurance anyway).

5. Again, the paper does not discuss a further possibility which would be to limit any benefits exemption to employers who provided insurance for all, or virtually all, their employees on "similar terms", the approach adopted in the employee share scheme and PRP reliefs. That would not remove the basic objections to a benefits relief. But it would cut the initial cost, be somewhat fairer and could provide a much stronger spur to additionality. If something has to be done on the benefits side, this would be worth considering further. But you may feel that this part of the paper is already long enough, given the conclusion that the proposal is unattractive.

6. The paper does not need to be finalised yet - the meeting of the Ministerial Group to discuss it is not until 30 June. But it would be helpful to have your initial reactions now. And the official group will be discussing tax relief next Tuesday (21 June). If you agree, Mr Phillips (and we) would propose to let officials from Cabinet Office and DHSS know broadly how thoughts here are developing, without showing them the draft paper. Before the meeting of the Ministerial Group we will let you have briefing on some of the issues raised in the paper,

including the principles involved in the choice between giving relief at marginal rate or at basic rate only.

7. You will want to consider how, tactically, to avoid a re-run of the last meeting. For example, you may want a word with the Prime Minister (and perhaps show her a draft) before the paper is circulated.

8. If you conclude that the £40 million package for the over-60s will not be enough, then you may want to consider offering a reduction in the age threshold (say, to 55). We have tentatively included a final paragraph on these lines in the paper. You will need to consider whether, as a matter of tactics, it is better to hold it in reserve or to include something in your paper. If it is not included, there is a danger that the benefits hare will run too fast to be stopped. But, if offered, it will certainly be taken up and might still not deflect pressure from benefits-in-kind.

9. Lowering the age limit carries risks. Once the age threshold is divorced from retirement, it will be difficult to justify holding it at any particular level. And the costs mount quickly as the age limit is lowered. At 55, the revenue cost rises to £70 million (ie £30 million more), and the staff cost rises to 35 (because the number of higher rate payers goes up from 75,000 to 130,000). If you were forced down to age 50, the figures would be £100 million (ie £60 million more) and 50 (with 190,000 higher rate payers). And these, as with all the costs in the paper, are just the deadweight figures.

Conclusion

10. The paper was drafted on the basis that a scheme that singles out company-provided medical insurance for special relief is not desirable. But if, following your meeting with the Secretary of State for Social Services, you wish to offer more than relief for the over-60s, (even with the

benefits extension, and at marginal rates), you will need to consider what your order of preference is. We would suggest:-

i. a lower age limit - say 55 - for relief to the elderly. The main problem here is holding the line at what might seem an arbitrary point.

ii. the proposal covered in the previous paper of exempting all employer-paid insurance contributions from being taxed as a benefit-in-kind. The main problems here are the cost and the difficulty of holding the line at medical care.

iii. the idea of raising the benefits-in-kind threshold for medical insurance. This is in our view worse than ii. above: although less costly, holding the line would be just as difficult as under ii., and it would call in question the whole treatment of benefits-in-kind.

11. We should be grateful to know whether:-

a. you are broadly content with the shape of the paper and its conclusions.

b. you see any attraction in being prepared to offer a lower age limit than 60; and if so whether to mention this option in the paper or hold it in reserve.

c. you would like further work done on the idea of limiting any benefits exemption to employers who provide insurance on similar terms to all employees below the appropriate threshold. If so, do you envisage this as something for the paper or your briefing?

d. you would like any work done (eg an aide memoire of points to make, a copy of the next draft to hand

over) with a view to trying to get the Prime Minister on side before the paper goes to other colleagues.

e. you are content for us to indicate to Cabinet Office and DHSS officials our tentative conclusions, without showing them the draft paper.

12. You may want to discuss some of these questions.

A W KUCZYS

SECRET

ANNEX

1. Proportion of employees (except directors) by income band getting medical insurance benefits at present

Income band (£)	Percentage of employees in each band getting company-provided insurance
0- 8,500	1%
6,501-12,500	3%
12,501-15,000	3%
15,001-17,000	3%
17,001-20,000	13%
20,001-25,000	23%
Over 25,000	23%

2. Effect of exemption of benefit of employer-provided medical insurance at various income levels (assuming current level of provision)

Benefit Exempt up to £	Employees liable (thousands)	Employees exempt (thousands)	Percentage of employees getting medical insurance exempt	Tax cost £m
8,500 (as now)	655	135	17%	0
12,500	490	300	38%	10
15,000	430	360	46%	15
17,000	395	395	50%	20
20,000	275	515	65%	25
25,000	125	665	84%	40

Note: Tables do not include directors (of whom 135,000 get company-provided medical insurance) as the benefits-in-kind income limit has never applied to them.

SEC AJW9

NHS REVIEW: TAX RELIEF

Paper by the Chancellor of the Exchequer

1. At the meeting on 7 June we agreed that:-

   a. the question of restricting tax relief for the elderly to the basic rate should be looked at again; and

   b. a more limited benefits-in-kind exemption, targeted on those with earnings below a specified level, should be considered.

This paper reports on both points.

Tax Relief for the Elderly

2. Providing tax relief for private medical insurance for the over-60s at basic rate only would benefit 300,000 existing policyholders at a cost to the Exchequer of about £25 million. Allowing relief at the higher rate, in addition, would be of benefit to about one-quarter of this group - 75,000 policyholders. The Exchequer cost would rise to a little over £30 million. There would also be some additional administrative complication. That is because, while basic rate relief would be provided at source through a MIRAS-type arrangement, higher rate relief would have to be dealt with by tax offices, through individuals' PAYE codes or tax assessments.

The question is whether these additional costs are likely to be worthwhile.

3. Clearly, the higher the rate of tax relief, the greater will be the effect on behaviour of those who benefit: a 40 per cent relief is likely to bring in more new subscribers than a 25 per cent relief. But a 50 per cent increase in take-up would be needed before the extra money going into private health care exceeded the cost of tax relief, compared with an increase of 33 per cent if relief were given at basic rate only. Only those over-60s with incomes comfortably over £20,000 would benefit: those with income below that level would gain nothing at all from higher rate relief. So, on the one hand, the additional impact of higher rate relief will be strictly limited; while, on the other, it will give further ammunition to opponents of the scheme.

4. There is one other complication with giving higher rate relief. In my previous paper I noted that it would be attractive to let tax relief flow to whoever paid the premiums for a person over 60, so there would be encouragement for people of working age to pay their elderly parents' BUPA subscriptions. That raised no problems if relief were to be given at a flat rate in all cases. But it will frequently be the case that the parent benefiting would be either a basic rate taxpayer or not liable to tax at all, while the son or daughter paying the subscription is liable to higher rate tax. In principle, higher rate relief ought to be available in such a case. In practice, that would provide a strong incentive to dress up payments by the parent as payments by the son or daughter - regardless of the true position. This would, in turn, add to the cost of relief. In order to guard against it, some additional irritating [new] safeguards would be unavoidable.

5. In conclusion, tax relief for the elderly at the higher rate would increase the complications of the scheme, and could provoke more criticism. It would have a greater incentive effect, although it is questionable how substantial this effect would be. [But there is no over-riding objection to marginal relief, if that is what we decide on.]

Benefit in kind treatment

6. For company schemes, the suggestion was to limit benefit in kind exemption to employees with earnings below a specified limit. Since company schemes tend to concentrate on the higher paid, this would have the advantage of reducing the deadweight cost and concentrating the incentive where it is most needed.

7. It is true that, by historical accident, the tax system already contains an incentive of this kind: employees are not charged on medical insurance benefits and other benefits if their annual cash income plus the value of benefits is less than £8,500. But this income level is clearly too low for the purposes of this suggestion.

8. I have considered other possibilities; for example, something in the region of £20,000. It is at roughly that point in the income scale that the provision of medical insurance starts to become much more frequent, and it equates roughly with the point at which higher rate income tax liability starts. It would mean that the proportion of employees getting medical insurance who would be exempt from tax would go up from 17 per cent to 65 per cent at a cost of some £m25.

9. But while this approach has its attractions, it also has some further disadvantages to add to those relating to a general benefits-in-kind exemption which I described in my minute of 3 June.

10. First, having a second income limit would be a significant added complication for employers, increasing their administrative costs. It would, I know, be particularly unwelcome because the Revenue, with the Deregulation Unit, has recently been spending a lot of time helping employers to find ways of minimising the compliance costs of taxing benefits-in-kind.

11. Second, it would put further pressure on the main £8,500 income limit. Our consistent policy has been gradually to bring into line the tax treatment of payment in kind and cash by allowing the real value of the income limit to fall. The limit has not been increased since 1979. It is now widely recognised that it is anomalous to have any income limit in taxing benefits, and that it is right to let the present limit wither away. We are well on the way to success with this policy, since there are now relatively few full-time employees with cash pay plus benefits of less than £8,500. But there also continues to be pressure, as we have seen again in this year's Finance Bill debates, to increase the limit substantially. Setting a new limit for medical insurance - one of the commonest of benefits - would clearly add to this pressure, and make it more difficult to resist.

12. Third, - and this is the main difficulty I see with this proposal - it would compound what would be the perceived unfairness of a general benefits in kind exemption. Suppose we set the

limit at £20,000. It would not be easy to justify the difference in treatment between two employees receiving medical insurance from the same company where one is just above and the other just below that arbitrary dividing line. But what would be virtually impossible to justify would be the difference in treatment between two people on the same income, where one gets company provided insurance with tax exemption and the other pays for his own insurance. That is, we would be calculating the tax of the employee who earns £20,000 and pays £500 of premiums privately on £20,000, while the man next door who earns £19,500 and gets his premium of £500 paid by his employer would pay tax on only £19,500.

13. Exactly the same question would arise in relation to the self-employed. They particularly would regard a benefits exemption as unfair since there is no possibility of a self-employed person getting his employer to pay his insurance. And arguably the self-employed, who cannot expect sick pay from an employer, have a greater need to be insured against ill-health.

14. This is the fundamental objection to a benefits-in-kind exemption - and why I continue to believe we should rule it out, either in its general or this more limited form.

Benefits-in-kind and Relief for the Elderly

15. But if we decide to introduce a new tax relief for premiums paid for the over 60's, then that relief should also run for the benefits-in-kind charge on corresponding premiums. The argument is exactly the same in relation to the over 60's as it is for employees and the self-

employed generally - we should ensure that there is no difference in tax treatment between those who pay their premiums privately, and those who get them paid by their employers. Repealing the benefits charge for the over 60's would ensure that the sort of unfairness noted in paragraph 13 would not arise.

16. Including benefits-in-kind in the relief for the elderly, and giving relief at marginal rate, would increase the cost, at current levels of provision, to £40 million and would benefit 65,000 employees as well as 300,000 individual policyholders. This is the most far-reaching tax package I would be prepared to recommend.

[17. If we conclude that something further is still necessary then, rather than trying to single out company schemes for favourable treatment, I would be prepared to consider a reduction, from 60, in the qualifying age for tax relief generally. For example, relief at basic and higher rate and benefit in kind exemption, for premiums in respect of the over-55s would cost £70 million and benefit 550,000 people (as against £40 million and 365,000 for the over-60s). The staff cost would rise from 25 to 35. The justification for the new relief would then be moving away from the elderly as such, towards people of an age where the incidence of serious illness, and the cost of insuring against it, both start to rise significantly. But any cut-off point would be fairly arbitrary, and once we had moved significantly below retirement age, it might prove very difficult to stop there.]

NL

[24] June 1988

REVIEW.NHS

007/2761

CONFIDENTIAL

Thanks. LP spoke. 2:1 SW [illegible] PSM w [illegible] on Chris France re X.

FROM: CHIEF SECRETARY
DATE: 17 June 1988

CHANCELLOR

NHS REVIEW: AUDIT

I discussed with John Moore yesterday (15th) the question of bringing in the Audit Commission, on the basis of the agreed note by officials. DHSS and Treasury officials were also present.

2 I am glad to say that John Moore was fairly sound on the subject, though his officials were not. They, indeed, seemed to wish to renege on the agreement recorded in the joint paper concerning the objectives of independent and published audit reports. John Moore himself voiced his concern that an independent audit body might publish reports embarrassing to him, and his officials favoured keeping the aduit within the DHSS (as a "Next Steps" agency) in order to keep control over its activities.

3 Those concerns hark back to the original opposition of DHSS officials to publish comparisons of one health authority's performance with another's, which we believe will bring useful public pressure to bear on the health authorities to improve their efficiency. It was that opposition which started us thinking of the Audit Commission in the first place.

4 However, despite these arguments, John and I reached agreement that we should aim to bring in the Audit Commission as an independent audit body to replace the present DHSS auditors. We should need to work out carefully the intended relationship between the Audit Commission and the Secretary of State, and also the handling of the PAC and NAO.

5 If there were any difficulty with the Audit Commission about accepting the proposed relationship with the Secretary of State, then we would have to consider establishing a new

CST TO CH/EX 17 JUN

independent body. Our final fallback would be a Next Steps agency, but I hope there is no real risk of having to adopt that solution.

6 Either the use of the Audit Commission, or the creation of a new independent body, would require primary legislation. (John Moore suggested that a possible vehicle might be a DOE Bill, but another would be any legislation required to introduce other aspects of the health review.) That is of course the reason for getting on with the proposal, and he and I agreed that we should bring the matter back to the Prime Minister's group quickly: it is at present on the agenda for 30 June.

JOHN MAJOR

cc:
Sir Peter Middleton
Mr Anson
Sir A Wilson
Mr H Phillips
Mr Beastall
Mrs Case
Mr Turnbubull
Miss Peirson
Mr Parsonage
Mr Potter
Mr Saunders
Mr Call

NH6/10M

SECRET

1. Tue
2. BF 10 m 20/6 21/6 22/6

PS/CHIEF SECRETARY

FROM: MISS M P WALLACE

DATE: 17 June 1988

cc PS/Financial Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Mr Parsonage
Mr Saunders

NHS REVIEW: THE NEXT THREE WEEKS

We spoke this morning about the programme of NHS meetings for the next few weeks, and I undertook to pass on the Chief Secretary's views to the Chancellor. I have now done so, and this is to record the Chancellor's agreement that we should fix the two "quadrilaterals" with Messrs Moore and Newton, ideally on Friday 24 June, and Monday 4 July. The Chancellor also agrees that we should not, at this stage, schedule any additional internal pre-meetings. And he has confirmed that he is content with the cast list of the four Ministers, plus Messrs Heppell, Phillips, and Wilson. This office will now proceed to fix the meetings.

2. I should also record that Geoffrey Podger rang me today to ask if the Chancellor would be writing to Mr Moore setting out his views on how we should handle the papers for the next two No 10 meetings. The Chancellor agrees that we did pick up a remit to do this, and is happy either to look at a draft on his return from Toronto on Wednesday, or for the Chief Secretary to write in his absence. I have alerted Mr Phillips to this, and he will be in touch with you about it. In the meantime, the Chancellor agrees that I should tell Mr Moore's office that (a) they will be getting a response, before the quadrilateral, but not immediately, but (b) in the meantime the working assumption should be that drafts of their papers and ours will be circulated on Thursday afternoon.

MPW.

MOIRA WALLACE

CHANCELLOR OF THE EXCHEQUER

Ch/ You asked if there was any precedent for relief at basic rate only. Tony Kuczys says the nearest is the old life assurance relief, at half the basic rate.

mgpw
17/6

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

MP

D J Watkins Esq
Private Secretary to
The Rt Hon Tom King MP
Secretary of State for Northern Ireland
Northern Ireland Office
Whitehall
LONDON
SW1A 2AZ

17 June 1988

Dear David

Thank you for your letter of 3 June in response to mine of 11 May about the changes my Secretary of State is proposing to make in the management arrangements for the Special Hospitals Service.

I note what you say about the long-standing arrangements under which patients from Northern Ireland are admitted to the English special hospitals. I can confirm that the proposed management changes will not affect these arrangements.

I am copying this letter to the Private Secretaries to the Chancellor of the Exchequer, to the Lord Chancellor, the Home Secretary, the Secretary of State for Scotland, Wales, and to Trevor Woolley.

Yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

ps2/52M

CONFIDENTIAL

FROM: MISS M P WALLACE
DATE: 20 June 1988

PS/CHIEF SECRETARY

cc Sir P Middleton
Mr Anson
Sir A Wilson
Mr H Phillips
Mr Saunders
Mr Call

NHS REVIEW: AUDIT

The Chancellor was most grateful for the Chief Secretary's minute of 17 June. He has noted that DHSS officials continue to be unhelpful on this issue: and he has commented that he would be grateful if Sir P Middleton could have a word with Chris France about this.

MOIRA WALLACE

WALLACE TO PS/CST 20 JUN

20.6.5

SECRET

FROM: R B SAUNDERS

DATE: 20 June 1988

CHIEF SECRETARY

cc Chancellor
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

NHS REVIEW: FINANCING HOSPITALS

I attach a draft of a paper to go into the Prime Minister's next meeting on "top-sliced" allocations to the most efficient NHS hospitals.

2. It proposes a relatively small incremental change to the existing system. It does not require a major structural reform. But it could be adapted to, and made consistent with, reforms which may be agreed for other reasons.

3. There are three main elements to the scheme.

a. A small proportion (perhaps 2%) of the HCHS current budget would be held back for allocation to those districts who had most improved their efficiency in the latest 12 month period for which data were available. The system would be based on the performance indicator package, and money would be disbursed to districts, who could then apply it so as to improve efficiency further or otherwise to meet local priorities. The additional funding would not necessarily continue beyond the first year, but would be contingent on securing further improvements in efficiency.

b. There would also be a small allocation based on improvements in activity in the areas where waiting times are longest. This would replace the present rather ill-directed "waiting list initiative", substituting a clearer system, based on performance in actually getting waiting lists down.

c. Self-governing hospitals would be outside the system, at least initially. They would instead be financed partly by an internal market or "money following the patient" mechanism, under which they would be paid for referrals from consultants in other hospitals. By confining the internal market to transactions between hospitals, the problem on which the earlier DHSS "buyer/provider" scheme fell apart - the relationship of GPs to the system - is avoided.

4. We are keeping officials in other departments in touch as our thinking develops. I am anxious that we should devise a scheme which is workable, and will be discussing it with DHSS on Wednesday. I suggest we should aim to show it to Mr Moore, perhaps under cover of a note by you or the Chancellor, in time for your quadrilateral meeting on Friday.

Any view?

R B SAUNDERS

SECRET

FINANCING HOSPITALS

Note by the Treasury

This paper examines the scope for rewarding the best performing parts of the NHS through a "top-sliced" element of the health budget. It is intended to tackle quickly the problems that exist now. It therefore assumes, first, that the present structure of the NHS is left broadly intact, and, second, that the bulk of health authority revenue budgets continues to be allocated through the RAWP system. But the principle of "top-slicing" can be adapted to meet an evolving NHS structure. So the paper indicates at various points how it might develop in the future, while concentrating on what can be done quickly and within the existing structure.

The problem

2. The present resource allocation system is based on need, as measured by the RAWP formula. It takes no account of efficiency or performance. Thus, in principle, the main incentive to improve efficiency is that it enables a hospital to provide a greater volume of services within a fixed budget. But in practice this turns out to be only partially true, because treating extra patients of itself generates increased costs. In general, if throughput is improved so that more patients can be treated within existing capacity at existing staffing levels, unit costs do not fall commensurately, so that the improved treatment rates cannot be achieved without increased funding. So the incentives to improve efficiency are not as great as they could be.

Top-slicing

3. In outline, the system would be quite simple. Most current expenditure would be allocated as now: distributions to regions, based on RAWP, in the previous December; allocations by regions to districts (based in some cases on "sub-regional RAWP") completed by late February. The amount allocated under RAWP might be equal in real terms to the total of health authority budgets the previous year. The balance of "growth money" (typically 1-2% in recent years, before taking account of pay awards to doctors and nurses) could then be allocated on the basis of performance.

4. This would be in February, so that hospitals would go into the year in full knowledge of their budgets. The total available for distribution would have been determined in the previous public expenditure survey. If, for the sake of argument, it was 2% of the total, the extra performance-based allocations might vary between 0 and 5% of initial allocations. A number of questions need however to be addressed:

- to whom would the performance-based allocations be made: hospitals or districts?

- how would their performance be measured?

- would the objective be to reward activity or efficiency?

- would performance be measured against some external standard, or would the criterion be improvement in measured performance?

District or unit?

5. Allocations direct to ~~units~~ hospitals, or even to departments within hospitals, would provide the most direct incentives to improve efficiency. Money would be diverted to the best performing parts of the health service in a very direct way. The main problem is the inadequacy of information at this level of detail. When the resource management initiative is firmly established and extended throughout the service, this may change. But, for the moment, information is not available to enable resources to be allocated other than at local level; even if it were, there might well be difficulty in interpreting it other than locally.

6. Performance-based allocations to districts could, in principle, be introduced much quicker. The new district-level performance indicator package, based on the Korner report, was introduced from 1 April 1987. In principle, the information produced from this system could be adapted for the purpose of top-slicing. Giving the money to districts would enable them to allocate it both in accordance with local priorities and so as further to improve efficiency, in the knowledge that this could be expected to result in further financial rewards.

7. Distribution of the performance-based element should be separated from the main allocation, lest adjustments are made - consciously or unconsciously - to offset the performance rewards. Also, it would probably not be reasonable to expect the DHSS to deal directly with ~~600 units (or~~ 2000 hospitals~~)~~. Taking these two points together would suggest that, if allocations were to ~~units~~ hospitals, they should be made by regions, and if they were to districts, they should be made by the department.

How to measure performance?

8. Ideally, an objective measure would be devised, based initially on performance indicators for districts. Later on, more sophisticated measures for ~~units~~ hospitals or for departments within hospitals could be developed, building on the resource management initiative. The measure would obviously need to be as up-to-date as possible. If allocations are to be made in the February before the start of the financial year, the aim should be to base them on performance in the 12 months to the previous 30 September.

9. Officials will need to do more work urgently on the development of measures based on performance indicators, if Ministers wish to pursue this route.

Activity or efficiency?

10. This depends on the area being considered. Where waiting times are excessive, increasing activity levels - and maintaining the increase - is the only way to get them down. But increased activity is not a good measure of performance in other areas - for example, psychiatry. And concentrating on activity may introduce a bias towards low cost surgery at the expense of other priorities which may be more important in terms of the health of the population generally. It may also discourage hospitals from treating difficult cases.

11. This suggests a two-pronged approach. In order to introduce the right incentives and to deal with the problems identified in paragraph 2 above, the general criterion for distributing the top-sliced money should be efficiency. But the concept could be imported into the present efforts to tackle excessive waiting

times for routine procedures. A separate top-sliced allocation, replacing the present waiting list initiative, could be distributed to those who had done most to increase activity in certain defined areas, thus reducing waiting times, in order to encourage them to go further, if necessary taking patients from waiting lists in other nearby districts.

Absolute performance or improvement in performance?

12. Any attempt to devise a "standard" performance measure would be very complicated. The formula would have to take account of hospital size, the range of specialties covered, the characteristics of the local population. Managers would argue that it should also cover factors like the physical concentration of sites which affect efficiency but are beyond the control of the local management. No matter how sophisticated the formula, many would continue to argue that they were subject to special factors which were not given their due weight.

13. Such problems would be avoided by measuring performance over the most recent 12 months and comparing it with the previous period. It would be much more difficult to argue that there were special factors which inhibited improvement in performance, as opposed to the absolute level of that performance. Rewards based on improved performance would also offer more immediate incentives to management. Those who started well down the league might need to spend several years improving their efficiency before qualifying for extra money if the criterion were absolute level of performance. Management might get discouraged in such circumstances, whereas they could start to benefit immediately if it was improvement in performance that was being rewarded.

14. But there are incentive effects going the other way. Assuming that the awards are not built into the baseline for future years, higher levels of funding could be maintained only by continued improvement in performance faster than the average. There is likely to be some natural limit to this process, so that the most efficient would be unable to rely on a continuing high level of funding. Managers would have to take this into account in committing the money. The rewards might tend to be concentrated among the least efficient, where most scope for improvement existed.

Yes. This v. difficult. What's the answer?

SECRET

rather depends on conclusions of other work

Implications for self-governing hospitals

15. The system would need to be adapted for self-governing hospitals, independent of districts. It is likely that the first self-governing hospitals would be the teaching hospitals, which were independent of the NHS structure before the 1974 reorganisation. Teaching hospitals tend to serve two functions in addition to their teaching role: they provide a service to their local communities, just like other district general hospitals; but they also act as centres of excellence, to which difficult cases are referred. The latter is particularly true of the post-graduate teaching hospitals (Gt Ormond Street, Royal Marsden, Hammersmith, Queen's Square, etc), to whom between 30 and 70% of admissions are referrals by consultants in other hospitals.

16. This suggests that these hospitals could be financed in part by an internal market mechanism under which other hospitals who referred patients to them would pay for the cost of the treatment. Previous attempts to devise workable internal market systems have tended to founder on the relationship of GPs to the system and their freedom to refer patients to any consultant. The difficulties are very much reduced, however, if the payment mechanism is confined to referrals from one consultant to another in a different hospital: all the costs are thereby within the control of the hospital and the health authority who have to meet them.

17. In this way, self-governing hospitals could receive a direct allocation reflecting their DGH-type role (including the basic load of referrals by GPs), which they would seek to top up by attracting patients referred by consultants in other hospitals and other health authorities. It would be for consideration whether the main allocation, which would cover the fixed costs of the hospital, should be made by the department or by the region; this would in part depend on the precise constitution of the self-governing hospital and its relationship with its region. It would have to be specified precisely what was covered by the direct allocation, and care taken to avoid duplication between the two sources of funding.

18. As time went by, it might become possible to develop systems which would enable the main allocation to these hospitals to reflect performance as proposed for the rest of the service. This would probably need to be preceded by full implementation of resource management in these hospitals. But if more hospitals became self-governing over time, performance-related funding would become essential, lest the system proposed earlier in this paper become diluted to an unacceptable degree.

CONFIDENTIAL

NHS REVIEW: OUTSTANDING PAPERS (8.6.88)

Paper	Subject	Lead	Meetings		
		Dept	Offic. Grp	Chancellor/ S of S	Min'l Grp
1.	Tax Relief	Tsy	21/6		30/6
2.	Contracting out	DHSS	21/6		30/6
3.	Financing hospitals	Tsy	14/6		30/6
4.	Contracts and self-Governing hospitals	DHSS	14/6		30/6
5.	Consultant contracts and medical audit	DHSS	14/6	?	?*
6.	Other professional/ manpower issues	DHSS	?21/6	?	?*
7.	VFM audit	Tsy	?		?*
8.	Private sector: action plan	DHSS	?		?
9.	RMI and information	DHSS	?	?	?*
10.	Competitive tendering	DHSS	?	?	?*
11.	Strategy paper	DHSS	?		?

*taken in Prime Ministerial Group as agreed Treasury/DHSS paper, if possible.

CST with

020/3291

FROM: JILL RUTTER
DATE: 20 June 1988

MISS PEIRSON

cc:
2- Chancellor
Sir Peter Middleton
Sir Terence Burns
Mr Anson
Mr Phillips
Mr Turnbull
Mr Parsonage
Mr Saunders
Mr Call

HEALTH REVIEW: VIEWS OF A DISTRICT HEALTH AUTHORITY MANAGER

The Chief Secretary was most grateful for your minute of 16 June about the views of Mr West. He recalls that this is the man that Mark Call suggests as a possible new chief executive for the NHS. In the light of the views expressed in your minute the Chief Secretary thinks he certainly sounds a promising candidate.

JILL RUTTER
Private Secretary

week.20.6/mr.3

SECRET

Looks OK

FROM: H PHILLIPS
DATE: 20 June 1988

CHIEF SECRETARY

cc Chancellor
Financial Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Mr Turnbull
Miss Peirson
Mr Parsonage
Mr Saunders

Mr Kucys - IR

Tony L
apologies for wild goose chase. Found.....
.....pnp. APS.

NHS REVIEW: THE NEXT THREE WEEKS

We need to write to Mr Moore about our views on how to handle the papers for the next two meetings of the NHS Review Group. I attach a draft for you to consider.

2. There is an enormous problem, in terms of the issues that remain unresolved, but there can be a manageable way through. The meeting on 30 June should take separate papers on the critical subjects - tax relief, and contracting out; self-governing hospitals and top slicing (now called, in a neutered way, financing hospitals); and consultants' contracts. Decisions on how to handle these will enable us to make a good paper for 8 July.

3. For 8 July (a whole morning and lunch, and when you will be joined by the three territorial Secretaries of State) I think you should take a single paper on the package of emerging proposals and avoid a string of papers on subsidiary issues. The package should be enough to swallow and could mop up any key differences of view on the remaining issues.

4. In the papers taken on 30 June and in the 'package' paper we are, in practice, settling some of the key parameters of the Health PES, as well as longer-term expenditure decisions.

HP.

H PHILLIPS

SECRET

DRAFT LETTER TO THE SECRETARY OF STATE FOR SOCIAL SERVICES

At our meeting on 10 June you handed to Nigel Lawson and me the attached note of papers to be prepared for the review. We have considered these and this letter sets out the way we suggest they be handled in the two meetings fixed for 30 June and 8 July.

Your note listed four papers firmly for 30 June: tax relief (ours), contracting out (yours), financing hospitals (ours) and contracts and self-governing hospitals (yours). We agree with this list but think we should also take a paper on consultants' at the same time. I understand that your officials will be ready with this. These five papers are more than enough for 30 June, and I hope we can go through the drafts in our own meeting on 24 June.

I think we should aim to try to take some pretty firm decisions on these issues on 30 June. If we do (and it will help that we can report that we are agreed on an independent vfm audit of the NHS) then I suggest that we concentrate on 8 July on the 'package' of emerging proposals - listed as "strategy paper" in your note. I hope this could be an agreed paper, but, where it is not, one that identifies any remaining differences between us.

I hope we can proceed in this way because the work that is left is on issues on which I believe we are either agreed that action must be taken (and where we should submit agreed papers) or where it is

important that we try to submit agreed papers. In the first - agreed - list I would put

a. medical audit;

b. RMI and information; and

c. competitive tendering.

In the second - aim to agree - list I would put

d. other professional/manpower issues;

e. private sector: action plan (insofar as these remain separately identifiable issues); and, a point not mentioned in your list;

f. how to handle capital allocations, generally, and in relation to self-governing hospitals.

On these six issues I suggest we should ask our officials to try to settle papers for our joint decision (at our planned 'quadilateral' on 4 July). I think this is the only way we can produce a 'package' paper that prompts decisive collective discussion.

Perhaps we can discuss this plan at our meeting on 24 June.

Copies of this letter go to Nigel Lawson and Tony Newton.

CST

CONFIDENTIAL

NHS REVIEW: OUTSTANDING PAPERS (8.6.88)

Paper	Subject	Lead	Meetings		
		Dept	Offic. Grp	Chancellor/ S of S	Min'l Grp
1.	Tax Relief	Tsy	21/6		30/6
2.	Contracting out	DHSS	21/6		30/6
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4.	Contracts and self-Governing hospitals	DHSS	14/6		30/6
5.	Consultant contracts and medical audit	DHSS	14/6	?	?*
6.	Other professional/ manpower issues	DHSS	?21/6	?	?*
7.	VFM audit	Tsy	?		?*
8.	Private sector: action plan	DHSS	?		?
9.	RMI and information	DHSS	?	?	?*
10.	Competitive tendering	DHSS	?	?	?*
11.	Strategy paper	DHSS	?		?

*taken in Prime Ministerial Group as agreed Treasury/DHSS paper, if possible.

CST with

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

NP

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

20 June 1988

Dear Paul,

REVIEW OF RAWP

Thank you for your letter of 6 June. My Secretary of State has now considered the terms of a statement on the publication of the Report on the RAWP Review. He proposes to handle this, as happened on the Interim Report, by way of an inspired PQ, and I enclose a draft of the reply he has in mind. Given the media interest, an accompanying press statement will be needed, couched in the same terms as the parliamentary reply.

It was agreed that the Minister for Health would also give further thought to the resource assumptions to be issued to health authorities as a basis for their 1989-90 plans. These will need to be determined on the basis of the existing formula. Ministers propose also to continue the approach of asking each Region to plan within a range of possible resource increases. Final decisions on allocations within these ranges could then be taken in December, in the light of all the relevant developments including progress on the NHS Review and any consequent decisions on the formula.

My Ministers would like to proceed with an early announcement. It would be helpful therefore to have your response as soon as possible.

I am copying this letter to John Shortridge (Welsh Office), David Watkins (Northern Ireland Office), David Crawley (Scottish Office), Miss Rutter (Office of the Chief Secretary to the Treasury) and to Trevor Woolley (Cabinet Office).

Yours sincerely,
Geoffrey Podger

GEOFFREY PODGER
Private Secretary

[Question: to ask the Secretary of State when he plans to publish the Report on the Review of the RAWP formula, and if he will make a statement.]

SUGGESTED REPLY

1. I am today publishing the NHS Management Board's final Report on its review of the Resource Allocation Working Party (RAWP) Formula, which is used to calculate funding targets for Regional Health Authorities in England. [Copies of the Report are available in the Vote Office].

2. The NHS Management Board were asked to explore the scope for improving the way in which the national RAWP formula measures relative need for health care across the country. The Board's Interim Report, published in December 1986, considered each element of the formula, identified aspects where there was scope for improvement, and recommended a programme of analysis and research. That work programme is now complete, and its results are set out in the final Report. I am grateful to the Management Board for this comprehensive study.

3. The Review of the RAWP Formula was already close to completion when the Government began its wide-ranging review of the NHS. The Government will consider the Report within the context of the wider review of the NHS.

week.20.6/mr.11

SECRET

FROM: H PHILLIPS
DATE: 21 June 1988

CHANCELLOR

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

Mr Corlett)
Mr Lewis) IR
Mr Kucys)

NHS REVIEW: A PACKAGE OF EMERGING PROPOSALS
SUPPLY AND DEMAND FOR HEALTH CARE

I attach two draft papers we have prepared. The first is our first version of what the package of emerging proposals looks like. The second, which I have discussed with Sir Terence Burns, sets out a basic analysis of supply and demand in the provision of health care.

2. I should like to let the senior officials concerned with the Review in the Cabinet Office and DHSS see the first of these on the understanding that it had not been endorsed by you or by the Chief Secretary, and with the objective of ensuring that work by officials goes forward on the basis of our draft. A paper along these lines is required for the Prime Minister's meeting on 8 July. The second is in the form of a minute from you to the Prime Minister. Subject to your views on its content and style I suggest you might like to send it in time for the meeting on 30 June.

The Emerging Package

3. As you will see we have not concentrated on the beauty of drafting in this paper but on setting down, and hopefully setting limits to, the content and size of the package. I am afraid that the paper is a mixture of assertion, prescription, and questions about issues yet unresolved. That is to some extent inevitable but I hope it reflects the stance you would like to take on major issues. I would add three comments, namely

a. we have added in three new points which have not explicitly surfaced in the review so far: doing something about the non-clinical treatment the patient receives (eg waiting room, waiting time, treatment by receptionists etc); tackling the top structure of the NHS Management Board; and possibly bringing together districts, and Family Practitioner Committees;

b. as you know DHSS want still to be more ambitious in relation to restructuring and are taking the opportunity of the Prime Minister's enthusiasm for self-governing hospitals to recreate a "buyer/provider" system;

c. the first section of the paper, 'a better deal for patients' is a confection of disparate items but it seemed worthwhile to try to put something together which appeared to put the patient first.

4. We are working up a note on the costs and benefits of the package.

Supply and Demand

5. We decided that we would write the draft minute in non-technical language but you will wish to consider whether it is worth building up the technical examples in more detail.

6. There are two related points which I might record. First, we have been told that Mr Moore has not yet decided on whether to

circulate his paper on contracting out and I judge that he wants to wait to hear from you, at your meeting on Friday 24 June, what you propose to say about tax relief for the elderly at marginal rates and a higher PIID threshold for private medical insurance. We have assumed that you do not want to table a demand/supply paper for discussion on 24 June although you have told Mr Moore that you intended to put one in.

7. Second, at an IEA 'health' lunch discussion last week I was subjected to a lot of demand boosting arguments and was relieved to find that rather than having to reply myself (which would have been injudicious) the attack was effectively led by another guest, Mr Mills-Webb, Finance Director of AMI Health Care. He argued, very persuasively, that the limiting factor on private sector expansion was people and that until the strangle-hold of the consultant establishment was released, tax relief or contracting out measures would simply drive up costs and prices. He gave an example of a joint project which his firm wished to do with an NHS hospital, where he said the NHS managers were keen, but the consultants stopped it. He also argued strongly that the private health insurance industry was ill equipped to respond to any big boost in demand and was full stretched by what he described as a staggering growth (25 per cent so far this year) in take up, and an estimated doubling in the number of subscribers in the next two years. If this information is even nearly right, and true across the private health sector, then any approach other than that commended in the demand/supply paper would be extremely dangerous.

Conclusion

8. Are you content for me to circulate our draft package at official level as proposed, and to send a minute on demand and supply to the Prime Minister before 30 June?

H PHILLIPS

SECRET

NHS REVIEW: THE PACKAGE

Objectives

To ensure that considerable (and growing) resources devoted to ~~health care~~ the NHS ~~- both public and private -~~ get directed to best effect. Means building on best management practice and current initiatives in NHS. And, ~~where the private sector does something more cost-effectively, letting it do it. And the overall result must be a better deal for patients.~~ alongside this, creating conditions in which private sector will expand.

A better deal for patients

2. Our proposals for increased efficiency will mean that patients face a more responsive and effective NHS and a thriving mixed economy in health provision. But what most immediately affects the patient will be

- better information for GPs about waiting lists so that the local doctor can send his patient more quickly for a consultation or operation;

- new "top-sliced" financing to cut waiting ~~lists~~ (this will be based on a hospital's performance in tackling waiting list cases);

- health authorities making waiting areas more acceptable and comfortable, partly as a part of the income generation initiative, partly to make life more bearable for patients and their families;

- more schemes under which patients can pay for optional extras, generating income for the NHS and providing extra services for patients;

- GPs doing more minor surgery (as in Primary Care White Paper)

- taking steps to encourage availability of more "topping-up" services to patients willing to pay for them.

(visible)

3. These steps will have an immediate impact but what is also required is a series of major changes which underpin for the future the most effective NHS and value for money for the tax payer. How is this achieved? There are four steps;

- better use of NHS resources
- a better organised NHS
- a new role for consultants
- a thriving mixed economy of health-care

Better use of NHS resources

4. The firm Government commitment to the NHS is exemplified in the massive increase in resources which has taken place. Great strides in recent years in making system more efficient (cost improvement programmes, improved productivity through shorter stays etc, competitive tendering, performance indicators, income generation). Now time to capitalise on the new attitudes and the new tools becoming available, so as to ensure that the growing resources are allocated to best effect.

5. Resource management initiative is a key development. Will make vital information about patient care and use of hospital resources available to both management and doctors. Will enable proper clinical budgets to be introduced, and detailed costs to be monitored against them. Will provide doctors with more detailed information about each other's practices, giving a firmer base on which to build procedures for medical audit. Now proposing to begin extension from 5 experimental sites to whole country from next year, doing without previously envisaged three-year evaluation period.

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8. Also tackle mechanisms for financing hospitals so as to build in right incentives to greater efficiency, and to tackle disincentives in present system. Includes introduction of internal market mechanisms, eg for teaching hospitals, and pursuit of local experiments.

A Better Organised NHS

9. The impression must be of the NHS always being reorganised with no outward and visible improvement for the patient and taxpayer. Therefore no reorganisation for its own sake. But begin steps towards self-governing hospitals to release management energy. Start by re-examining 1974 absorption of teaching hospitals into NHS structure. Need to define:

- the relationship of these hospitals with local districts
- how they are to be financed
- how decisions on capital expenditure will be taken
- control of expenditure (both capital and current).

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11. Pay and manpower. Greater independence for hospitals implies more delegation of these functions. We need to define their freedoms and how control over costs will be exercised. What will be the future of review bodies and Whitley negotiation?

(as many with NI pressure advocates)

12. Should we amalgamate districts and FPCs as part of move to more self-governing hospitals? Re-open 1985 reorganisation? Bringing districts and FPCs together could open the way to cash limits on the whole structure.

13. In the light of the changes described the future role of NHS management board will need appraisal.

A new role for consultants

14. Growing acceptance by the medical profession that they have a management role complementary to their clinical duties. Responsibility for the use of resources must go hand in hand with accountability for stewardship of them. Important to recognise that this does not cut across clinical accountability, which always has been, and will continue to be, to the patient and to the doctor's professional peers.

15. Resource management recognises this by involving doctors intimately in the systems - with the result that doctors get better information about how treatments they are giving and their use of hospital resources. But other consequences flow from this recognition:

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- encourage part-time contracts

SECRET

A thriving mixed economy of health care

16. Role of private sector complementary to NHS, not in competition with it. Strong private sector benefits NHS, and vice versa. Welcome recognition of this by health managers, and joint ventures which have begun to take shape recently. Will encourage this process by:

- extending contracting out to clinical areas. So far confined to laundry, cleaning, catering. Will initially introduce competitive tendering for clinical support services, notably pathology. Consider scope for competitive tendering for, eg, certain types of elective surgery

- encouraging more joint ventures, such as have been seen in [examples]. This brings public and private sectors closer; emphasises symbiotic relationship; each benefits from the other's expertise

- inviting all NHS hospitals to keep under review spare capacity which could be sold to private sector

- encouraging more pay beds in NHS hospitals, particularly introduction of new private wings (eg in accommodation becoming surplus following rationalisation).

- any changes on pharmacists

17. Better integration of public and private sectors will of itself encourage growth of a healthy and expanding private sector, as image of privilege falls away. But further measures to encourage this process:

- tackle medical restrictive practices to free up the supply of well qualified doctors; and grant

- tax relief for private health insurance taken out by or on behalf of people over age 60.

DRAFT

pl type up, keep as draft

PRIME MINISTER

NHS REVIEW: SUPPLY AND DEMAND

As the work of the review moves forward we shall need to examine the emerging proposals against the objectives we have set ourselves, and an economic analysis of the supply of and demand for health-care. I hope it will be useful to you, and such other colleagues if I set out the essential points of this approach. An analysis.

Our main objectives in the review are:

(a) to make the NHS more cost-effective; and

(b) to increase the contribution of the private sector.

We shall also want to ensure that when we come to look at the results of our reforms, some success has been achieved in meeting specific pressure points in the system.

2. These primary objectives will not be met by simply making available more resources to expand demand. Indeed, the problems we are seeking to address would in all likelihood be made worse. The key to lasting success must be better performance on the supply side.

3. This is of course a lesson we have learned and applied in many other areas of policy. There is no reason

why health should be different in this regard. Indeed, there are features of the supply and demand for health care which make it especially important that we should get the design of our reforms right in this area.

4. First, on the demand side, we must acknowledge the almost complete absence of the price mechanism as a means of regulating the level of output. This is most obviously the case in the state sector, where prices or charges play a negligible role, particularly in the hospital service. Patients tend to judge the standard of treatment by its cost, and will always press for high cost options. But even in the private sector, where patients have to pay in full, the price mechanism works in a very muted way.

5. Private treatment is mainly financed out of insurance. This effectively means that at the point of use services are free to the individual patient, just as they are in the NHS. Once services are required, there is no financial reason for the patient to limit his demands. In time higher expenditure on hospital and other services will be reflected in higher premiums, but this is a weak and indirect check, especially on those in company schemes whose premiums are paid by a third party. As experience in the United States has shown, the effect would be even more attenuated if private insurance were underpinned by general tax relief.

6. The lack of an effective price mechanism working on consumers is reinforced by a lack of cost consciousness

among doctors and other suppliers. As we have noted many times in the course of the review, budgeting and information systems in the NHS are ill-designed for the purpose of encouraging cost-effectiveness and economy. Those who commit resources are not financially accountable for their decisions, nor are they given adequate information on the costs of what they are doing. Systems are better in the private sector, but doctors everywhere cling to their outmoded tradition of non-involvement in the management of resources. Under present arrangements, the demands of patients are more likely to be amplified than constrained by the decisions of doctors.

7. The absence of price signals for both patients and doctors has resulted in a chronic tendency towards excess demand. Some of this demand is suppressed, for example by controls on expenditure in the NHS, and remains latent as only because patients are put off by ~~excessive~~ lengthy waiting ~~times~~.

8. An increase in effective demand in any market can have two effects, depending on the supply response. It can call forth extra output, or it can push up costs. It goes without saying that the split between these two effects is of some importance. There is nothing to be said for boosting demand if supply does not respond and it simply leads to a bidding up of pay and prices.

9. Without fundamental changes to the incentives faced by hospitals and other suppliers, ~~there are reasons for~~

thinking that the supply of health output will only adjust slowly to increases in demand, at least in the short to medium term.

10. The starting point is the availability of skilled manpower - doctors, nurses, therapists, technicians etc. The supply of these resources cannot be turned on and off like a tap. There are inevitable lags in the system resulting from the requirement to recruit and train specialist staff.

11. In addition, these constraints are compounded by institutional and other rigidities stemming from the way in which we presently organise our affairs. The problems here are well known and have been discussed in earlier papers. Particularly important in my view are inflexibilities on the manpower side: restrictive practices, overspecialisation, promotion blockages, reward systems unrelated to performance, national pay rates, and so on. But there are rigidities throughout the system resulting from weak or perverse incentives and the absence of market forces.

12. Finally, even within the limits imposed by these constraints, there are failures to use resources efficiently and to direct them towards the uses where they will have maximum effect. The scope for improving supply performance is amply demonstrated by the evidence of substantial variations in efficiency and output between different units within the NHS.

13. ~~I am thus led to the conclusion~~ It is clear, therefore, that there is little to be said for measures which simply affect the demand for health care and have little impact on supply behaviour. The likely effect would be higher costs, not higher output. This is true whether the extra demand is directed towards the public or the private sectors. One part of the market cannot be isolated from the rest; for example, a large increase in the demand for specialist staff in the private sector would inevitably have repercussive effects in the NHS, not least on wage levels.

14. It follows that I recognise that some measures to increase demand will in time lead to desirable supply side consequences. Indeed, it is largely for this reason that we are seeking to expand the contribution of the private sector. But the scale and timing of any such measures will be crucial, and in my view there is little case for any early introduction of wide-ranging demand measures. Our strategy for reform should instead focus more directly on the supply side, with the aim of promoting a much more flexible and responsive supply capability. There is much to be done in tackling the problems I have mentioned of manpower and other inflexibilities. Only then can we be sure that additional demand will be ~~fully~~ translated into additional provision, rather than simply dissipated in higher costs.

15. I started by referring to our main objectives in the review. In the course of our work we have identified a wide range of measures which might help to secure these aims. The next step is to put together a credible and coherent

package of reforms, and in doing so we must test each individual proposal against the analysis I have set out in this paper, working through the supply and demand consequences. There is no need for me to remind colleagues of the importance of getting this right.

16. Copies of this minute go to John Moore and Tony Newton, John Major, Sir Roy Griffiths and Sir Robin Butler.

SECRET

COPY NO 3 OF 3 COPIES

cc:
Chancellor
FST
Sir Peter Middleton
Sir Terence Burns
Mr Anson
Mr Turnbull
Miss Peirson
Mr Parsonage
Mr Phillips
Mr Saunders

Mr Kucys - IR

Treasury Chambers. Parliament Street. SW1P

The Rt Hon John Moore MP
Secretary of State for Social Services
Department of Health and Social Security
Richmond House
79 Whitehall
London
SW1A 2NS

21st June 1988

Dear Secretary of State,

NHS REVIEW: THE NEXT THREE WEEKS

At our meeting on 10 June you handed to Nigel Lawson and me the attached note of papers to be prepared for the review. We have considered these and agree with them. This letter sets out the way we suggest they be handled in the two meetings to be chaired by the Prime Minister on 30 June and 8 July.

Your note listed four papers firmly for 30 June: tax relief (ours), contracting out (yours), financing hospitals (ours) and contracts and self-governing hospitals (yours). We agree with this list but think we should also take a paper on consultants' contracts at the same time. I understand that your officials will be ready with this. These five papers are more than enough for 30 June, and I hope we can go through the drafts in our own meeting on 24 June.

I think we should aim to try to take some pretty firm decisions on these issues on 30 June. If we do (and it will help that we can report that we are agreed on the objective of an independent vfm audit of the NHS) then I suggest that we concentrate on 8 July on the 'package' of emerging proposals - listed as "strategy paper" in your note. I hope this could be an agreed paper, but, where it is not, one that identified any remaining differences between us.

I hope we can proceed in this way because the work that is left is on issues on which I believe we are either agreed that action must be taken (and where we should submit agreed papers) or where it is important that we try to submit agreed papers. In the first - agreed - list I would put:

a. medical audit;

b. RMI and information; and

c. competitive tendering.

SECRET

In the second - aim to agree - list I would put

d. other professional/manpower issues;

e. private sector: action plan (insofar as these remain separately identifiable issues); and, a point not mentioned in your list:

f. how to handle capital allocations, generally, and in relation to self-governing hospitals;

g. the practical arrangements for value for money audit by the Audit Commission.

On these six issues I suggest we should ask our officials to try to settle papers for our joint decision (at our planned 'quadilateral' on 4 July). I think this is the only way we can produce a 'package' paper that prompts decisive collective discussion.

Perhaps we can discuss this plan at our meeting on 24 June.

I am copying this letter to Nigel Lawson and Tony Newton.

Yours sincerely,

for JOHN MAJOR

(Approved by the Chief Secretary and signed in his absence)

CONFIDENTIAL

NHS REVIEW: OUTSTANDING PAPERS (8.6.88)

Paper	Subject	Lead		Meetings	
		Dept	Offic. Grp	Chancellor/ S of S	Min'l Grp
1.	Tax Relief	Tsy	21/6		30/6
2.	Contracting out	DHSS	21/6		30/6
3.	Financing hospitals	Tsy	14/6		30/6
4.	Contracts and self-Governing hospitals	DHSS	14/6		30/6
5.	Consultant contracts and medical audit	DHSS	14/6	?	?*
6.	Other professional/ manpower issues	DHSS	?21/6	?	?*
7.	VFM audit	Tsy	?		?*
8.	Private sector: action plan	DHSS	?		?
9.	RMI and information	DHSS	?	?	?*
10.	Competitive tendering	DHSS	?	?	?*
11.	Strategy paper	DHSS	?		?

*taken in Prime Ministerial Group as agreed Treasury/DHSS paper, if possible.

week.20.6/mr.11

SECRET

FROM: H PHILLIPS
DATE: 21 June 1988

CHANCELLOR

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

Mr Corlett)
Mr Lewis) IR
Mr Kucys)

NHS REVIEW: A PACKAGE OF EMERGING PROPOSALS
SUPPLY AND DEMAND FOR HEALTH CARE

I attach two draft papers we have prepared. The first is our first version of what the package of emerging proposals looks like. The second, which I have discussed with Sir Terence Burns, sets out a basic analysis of supply and demand in the provision of health care.

2. I should like to let the senior officials concerned with the Review in the Cabinet Office and DHSS see the first of these on the understanding that it had not been endorsed by you or by the Chief Secretary, and with the objective of ensuring that work by officials goes forward on the basis of our draft. A paper along these lines is required for the Prime Minister's meeting on 8 July. The second is in the form of a minute from you to the Prime Minister. Subject to your views on its content and style I suggest you might like to send it in time for the meeting on 30 June.

The Emerging Package

3. As you will see we have not concentrated on the beauty of drafting in this paper but on setting down, and hopefully setting limits to, the content and size of the package. I am afraid that the paper is a mixture of assertion, prescription, and questions about issues yet unresolved. That is to some extent inevitable but I hope it reflects the stance you would like to take on major issues. I would add three comments, namely

a. we have added in three new points which have not explicitly surfaced in the review so far: doing something about the non-clinical treatment the patient receives (eg waiting room, waiting time, treatment by receptionists etc); tackling the top structure of the NHS Management Board; and possibly bringing together districts, and Family Practitioner Committees;

b. as you know DHSS want still to be more ambitious in relation to restructuring and are taking the opportunity of the Prime Minister's enthusiasm for self-governing hospitals to recreate a "buyer/provider" system;

c. the first section of the paper, 'a better deal for patients' is a confection of disparate items but it seemed worthwhile to try to put something together which appeared to put the patient first.

4. We are working up a note on the costs and benefits of the package.

Supply and Demand

5. We decided that we would write the draft minute in non-technical language but you will wish to consider whether it is worth building up the technical examples in more detail.

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circulate his paper on contracting out and I judge that he wants to wait to hear from you, at your meeting on Friday 24 June, what you propose to say about tax relief for the elderly at marginal rates and a higher PIID threshold for private medical insurance. We have assumed that you do not want to table a demand/supply paper for discussion on 24 June although you have told Mr Moore that you intended to put one in.

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H PHILLIPS

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DRAFT

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10. The starting point is the availability of skilled manpower - doctors, nurses, therapists, technicians etc. The supply of these resources cannot be turned on and off like a tap. There are inevitable lags in the system resulting from the requirement to recruit and train specialist staff.

11. In addition, these constraints are compounded by institutional and other rigidities stemming from the way in which we presently organise our affairs. The problems here are well known and have been discussed in earlier papers. Particularly important in my view are inflexibilities on the manpower side: restrictive practices, overspecialisation, promotion blockages, reward systems unrelated to performance, national pay rates, and so on. But there are rigidities throughout the system resulting from weak or perverse incentives and the absence of market forces.

12. Finally, even within the limits imposed by these constraints, there are failures to use resources efficiently and to direct them towards the uses where they will have maximum effect. The scope for improving supply performance is amply demonstrated by the evidence of substantial variations in efficiency and output between different units within the NHS.

13. I am thus led to the conclusion that there is little to be said for measures which simply affect the demand for health care and have little impact on supply behaviour. The likely effect would be higher costs, not higher output. This is true whether the extra demand is directed towards the public or the private sectors. One part of the market cannot be isolated from the rest; for example, a large increase in the demand for specialist staff in the private sector would inevitably have repercussive effects in the NHS.

14. I recognise that some measures to increase demand will in time lead to desirable supply side consequences. Indeed, it is largely for this reason that we are seeking to expand the contribution of the private sector. But the scale and timing of any such measures will be crucial, and in my view there is little case for any early introduction of wide-ranging demand measures. Our strategy for reform should instead focus more directly on the supply side, with the aim of promoting a much more flexible and responsive supply capability. There is much to be done in tackling the problems I have mentioned of manpower and other inflexibilities. Only then can we be sure that additional demand will be fully translated into additional provision.

15. I started by referring to our main objectives in the review. In the course of our work we have identified a wide range of measures which might help to secure these aims. The next step is to put together a credible and coherent

package of reforms, and in doing so we must test each individual proposal against the analysis I have set out in this paper, working through the supply and demand consequences. There is no need for me to remind colleagues of the importance of getting this right.

16. Copies of this minute go to John Moore and Tony Newton, John Major, Sir Roy Griffiths and Sir Robin Butler.

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

CONFIDENTIAL

Paul Gray Esq
10 Downing Street
LONDON
SW1A 2AA

CH/EXCHEQUER
REC. 22 JUN1988 22/6
ACTION MR SAUNDERS
COPIES TO CST
SIR P. MIDDLETON
SIR T. BURNS
MR ANSON MR PHILLIPS
MISS PEIRSON
MR TURNBULL MR PARSONAGE
MR CALL

MP

21 June 1988

Dear Paul,

NHS REVIEW

Thank you for your letter of 14 June.

My Secretary of State will be happy to join the Ministerial Group on the NHS Review from next month.

Mr J Hamill (Grade 3) will represent the Scottish Office on Richard Wilson's Official Group. (In his absence Mr W K Reid, Secretary of the Scottish Home and Health Department, would attend.)

I am sending copies of this letter to John Shortridge (Welsh Office), David Watkins (Northern Ireland Office), Alex Allan (HM Treasury), Jill Rutter (Chief Secretary's Office), Geoffrey Podger (Department of Health and Social Security), Miss Jenny Harper (Minister for Health, DHSS), Trevor Woolley and Richard Wilson (Cabinet Office).

Yours sincerely,

David Crawley

DAVID CRAWLEY
Private Secretary

HMP173F5

~~BF to m 22/6~~ 23/6

CONFIDENTIAL

[show to CLW agenda RPS]

cc:
Chancellor
Sir Peter Middleton
Mr Anson
Sir A Wilson
Mr H Phillips
Mr Beastall
Mrs Case
Mr Turnbull
Miss Peirson
Miss Parsonage
Mr Potter
Mr Saunders
Mr Call

Treasury Chambers, Parliament Street, SW1P 3

Ms Flora Goldhill
Private Secretary to the
Secretary of State for Social Services
Department of Health and Social Security
Richmond House
79 Whitehall
London
SW1

Tony D pl add this to pps for folder tomorrow

21 June 1988

Dear Flora,

NHS REVIEW: AUDIT

The Chief Secretary had a meeting with your Secretary of State to discuss the paper by officials on NHS audit. Present were Mr France, Mr Mayne and Mr Lillywhite from DHSS and Mr Phillips, Miss Peirson and Mr Call from the Treasury.

The Chief Secretary said he was grateful to officials for producing the paper. It was common ground that more effective value for money audit was needed and that that audit should be independent and its results should be publicised. At present there were three tiers of audit for the NHS - the National Audit Office, DHSS external audit and health authority internal audit. The paper set out options for beefing up the second tier . The Treasury position was clear. Its view was that the Audit Commission should take over from the DHSS, i.e. should undertake the same sort of role for the NHS that it had undertaken in local government. The Audit Commission had a pretty good track record, experience and expertise. The Chief Secretary believed that the Audit Commission would put a real drive behind value for money audit in the NHS. He had been impressed by the positive suggestions they had produced for savings in local government, many of which were in areas relevant to the NHS. He also noted that the Audit Commission were experienced in producing comparative performance statistics. He thought it would be wise to build on the proven track record of the Audit Commission.

Your Secretary of State said he agreed that whatever new arrangements were put in place must have the appearance of independence. He shared the Chief Secretary's respect for the Audit Commission but he was concerned about introducing independent audit into the NHS through the Audit Commission route. He saw a considerable difference between the present relationship of the Audit Commission to local authorities and their use of money and the prospective relationship to DHSS and the Secretary of State and to Parliament in respect of NHS expenditure. He was concerned that it might be difficult to construct criteria governing the latter relationships which would be acceptable to the Audit Commission. He saw problems if an Audit Commission study recommended higher public expenditure. He thought that it might be better to achieve the agreed objective by setting up an agency that was independent of the DHSS but which reported to the Permanent Secretary as Accounting Officer and whose freedom to publish its reports could be subject to Ministerial control. He also believed that such an agency might also implement medical audit and exercise an inspectorate role.

Expanding, Mr France said that in the NHS ultimate responsibility lay with the NHS management board and DHSS Ministers. It was a different matter for the Audit Commission to compare the performance of two independent and separate local authorities and to compare the performance of two health authorities who reported to the same line of command. In the one case the Secretary of State for the Environment was free to criticise the laggard authority for its poor performance. In the other case criticism would inevitably eventually rebound on Ministers. He believed this could be another source of pressure for increased public expenditure and the government could regret setting up an organisation outside its control. Your Secretary of State said he was more concerned about the second point. He was unclear how the government could react if the Audit Commission would - as would be within its rights - say significant additional spending was required.

The Chief Secretary said he did not see any great difference in this respect from a public report by an independent audit agency. It would of course be essential to define the precise relationship between the Secretary of State and the Audit Commission, which would be different from that between the Secretary of State for the Environment and the Audit Commission. It would obviously be essential to ensure that the criteria set out were acceptable to the Audit Commission. He believed it would be legitimate for the Commission to highlight misallocation of resources between health authorities. He thought the risks of a recommendation of higher expenditure were small; the Audit Commission reports were largely about economy and efficiency. He saw drawbacks in the approach outlined by your Secretary of State. Without the publicity inherent in the Audit Commission approach the benefit of local pressure on individual health authorities to improve their management would be lost. Moreover he saw disadvantages in not building on the expertise and experience that was available in the Audit Commission.

Mr France said that he was not convinced that the Audit Commission were the right body to carry out audit in the NHS. The cost improvment savings delivered by internal NHS management had realised more savings than the Audit Commmission had achieved in local authorities. There was also the question of how medical audit could be plugged into financial audit. He noted that the Audit Commission route would require primary legislation whereas an independent agency set up on the lines of "Next Steps" proposals would not. It was pointed out however that if the agency were to be genuinely independent from the Government, its establishment would require legislation. Your Secretary of State said he was concerned about the issue of accountability. There was a clear conflict between accountability and independence which would have to be resolved. He was concerned that the body would be able to publish a report without reference to him. The Chief Secretary said that if it could not, it would not have genuine independence. Your Secretary of State cited the example of the Health Education Authority which was independent but over which he had powers of direction. Mr Mayne said that he believed that the private sector independent auditors acted under certain rules. It was necessary to find a workable system for regulating the publication of findings.

Summing up the discussion, the Chief Secretary said that he and the Secretary of State agreed on the basic objective of independent audit. They agreed that the first priority was to work out the relationship between the Secretary of State and the Audit Commission, and to see if criteria could be drawn up which were acceptable. If the Audit Commission route proved unworkable the second best choice to be looked at was an independent audit authority outside the DHSS. The third, but quite different option, was a "Next Steps" agency. He asked officials to undertake the necessary work of clarifying the relationships. Your Secretary of State said that he was content to proceed on that basis, though he believed the Government must go into this with their eyes open. He also wished to stress the importance he laid on medical audit and establishing an inspectorate which were both gaps in the present system. He noted that his power to direct the HEA had proved a useful fallback. Miss Peirson noted that it would be necessary to bring in the Secretary of State for the Environment at some stage because of his responsibilities toward the Audit Commission. The Chief Secretary continued that the aim should be to produce a proposal which could be put to the Prime Minister's group for endorsement on the 8 July.

Yours sincerely,

JILL RUTTER
Private Secretary

22.6.3

SECRET

FROM: R B SAUNDERS

DATE: 22 June 1988

CHIEF SECRETARY

cc Chancellor
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/ This overtakes (in a few respects) the version you already have. OK for CST to circulate?

Ok Subject to v. few changes now suggested.

NHS REVIEW: FINANCING HOSPITALS

Following our discussion earlier today, I have revised the paper attached to my minute of 20 June, and attach the result. I have also done a covering note under which you might circulate it.

2. The next step is to discuss it at the meeting with Mr Moore on Friday. Since we spoke, I have had a further run through it with DHSS officials. They welcomed the general principle of introducing better incentives to efficiency, but were concerned that the system should not be too mechanistic and that it should incorporate a reasonable degree of discretion for health authority management. This suggests that there are unlikely to be serious difficulties with the DHSS, so long as we express willingness to consider suggestions for improving the scheme. A particular concern was that RAWP redistribution money should come out of the "growth money" - in other words, RAWP losing regions should not start from a lower base in real terms; I have accordingly left this question open in the paper (paragraph 6).

3. At the meeting on Friday, you might make the following points in introducing the paper.

a. It is not intended to be the be all and end all of the Review. It is a modest proposal designed to improve the present system of allocating resources by building in the right incentives and tackling the present disincentives to improving efficiency.

SECRET

b. We are not wedded to the precise structure of the proposals set out in the paper. If DHSS believe they can be improved in ways which make them more practical and more saleable to health authorities, we should be very happy to consider these.

c. It will be important to consider how the scheme can be adapted to meet ideas evolving elsewhere in the Review, notably self-governing hospitals. But until conclusions have been reached on those ideas, we cannot map this out in much detail yet. Nevertheless, the principle of the scheme is simple and capable of adaptation to most structures.

d. While recognising that the scheme is not perfect - eg the danger of inefficient allocation of resources if it came to play more than a marginal role in the system - the advantages identified at the end of the covering note seem to make it well worth a go.

R B SAUNDERS

22.6.2

SECRET

NHS REVIEW: FINANCING HOSPITALS

Note by the Chief Secretary, Treasury

At our meeting on 25 May, I was invited to prepare a note about how the system of allocating resources to health authorities might be improved to reward hospitals which attracted more patients by greater efficiency. I attach a note which my officials have prepared on how a scheme of this sort might work.

2. The real growth in HCHS expenditure - which, realistically, we must expect to continue for the foreseeable future - would be earmarked for allocation on the basis of performance. Regions would be given funds for distribution to districts on broadly the same basis as now, based on inflation-adjusted total their districts received the previous year. The remainder would be allocated to the best performing.

3. On the specific points raised in the paper, my views are as follows:

a. I think it makes sense, initially at least, to build on the present performance indicator system and make allocations to districts rather than trying from the centre to target the best-performing hospitals.

b. I have no strong views on whether the allocations should be made by regions or by the DHSS, and would welcome the views of colleagues on this.

c. I hope our officials can be invited to draw up a suitable indicator or set of indicators quickly. Clearly, the measure should not be so crude as to meaningless, but it should also not be so sophisticated that there is a long time lag before it is available.

d. I agree that the bulk of the money should be allocated on the criterion of improved efficiency. But I see attraction in allocating some of it (say £50m a year) on the basis of increased activity in the areas where waiting lists are longest, replacing the present waiting list initiative.

e. When we have reached conclusions on the Secretary of State's paper on self-governing hospitals, we can consider how to adapt this system for them. But this should not present overriding difficulties.

4. I believe a scheme of this nature has a number of attractions. It would:

- provide real incentives for health authorities to improve their efficiency

- direct resources towards those areas where efficiency was being given priority; and

- thereby allow money to flow to those who improved their capacity to treat patients.

SECRET

FINANCING HOSPITALS

Note by the Treasury

This paper examines the scope for rewarding the best performing parts of the NHS through a "top-sliced" element of the health budget. It is intended to tackle quickly the problems that exist now. It does not necessitate structural change in the NHS and involves only relatively modest change at first. But it could be adapted readily to an evolving NHS structure.

The problem

2. The present resource allocation system is based on need. Money is distributed to regions on the basis of the relative priorities revealed by the RAWP formula, and then from regions to districts. The criteria applied by regions in allocating funds to districts vary, and by no means all follow RAWP-style methods. But in general the system takes no account of efficiency or performance.

3. In theory, the main incentive to improve efficiency is that, ~~in principle,~~ it enables a hospital to provide a greater volume of services within a fixed budget. But in practice this turns out to be only partially true, because treating extra patients of itself generates increased costs. In general, if throughput is improved so that more patients can be treated within existing capacity at existing staffing levels, unit costs do not fall commensurately, so that the improved treatment rates cannot be achieved without increased funding. So the incentives to improve efficiency are not as great as they could be.

Top-slicing

4. In outline, the system would be quite simple. Most current expenditure would be allocated as now: distributions to regions in the previous December; allocations by regions to districts completed by late February. The amount allocated in this way might be equal in real terms to the total of health authority budgets the previous year, leaving the balance to be allocated on the basis of performance. Typically, after allowing for pay awards, notably to doctors and nurses, this has left room for real growth of around 2%, or £250m.

5. This would be in February, so that hospitals would go into the year in full knowledge of their budgets. The total available for distribution would have been determined in the previous public expenditure survey. If, for the sake of argument, it was 2% of the total, the extra performance-based allocations might vary between 0 and 5% of initial allocations. The distribution within the total sum available for these allocations could be settled only when the overall performance of all health authorities had been assessed.

6. The interaction between the system and that for allocating resources generally would be complex, but it should be possible to ensure that rewards were carried forward into baselines for future years, and were not lost at the end of the year. Initial allocating to regions would equate in real terms to the previous year's total allocation (including performance awards). If there were to be further movement to RAWP targets, allowance would have to be made: either (and this would be very controversial in RAWP-losing regions) by adjusting these allocations up or down; or by using some of the growth money for RAWP adjustment rather than rewarding performance. Regions would be asked, in their allocations to districts, to take full account of previous performance awards, alongside the other criteria they apply. So a district's allocation should reflect the carrying forward of previous awards, possibly with some adjustment for other factors.

7. A number of questions need however to be addressed:

- to whom would the performance-based allocations be made: hospitals or districts?

- how would their performance be measured?

- would the objective be to reward activity or efficiency?

- would performance be measured against some external standard, or would the criterion be improvement in measured performance?

SECRET

District or ~~unit~~ hospital?

8. Allocations direct to ~~units~~ hospitals, or even to departments within hospitals, would provide the most direct incentives to improve efficiency. Money would be diverted to the best performing parts of the health service in a very direct way. But it would be difficult for the ~~department~~ DHSS to interpret sensibly information coming forward from ~~unit level~~ individual hospitals. Moreover, such information is not yet available in the required detail.

9. Performance-based allocations to districts could, in principle, be introduced much more quickly. The new district-level information system, based on the Korner report, was introduced from 1 April 1987. In principle, this could be adapted for the purpose of top-slicing. Giving the money to districts would enable them to allocate it both in accordance with local priorities and so as further to improve efficiency, in the knowledge that this could be expected to result in further financial rewards. Districts could be asked to link allocations to units on performance and efficiency targets. This would be a first step towards a more contractual style of management.

10. Whether allocations to districts should be made by regions or by the department is a matter for judgement. Regions would have considerable scope to undermine the effect of the performance-based allocations by offsets in their disbursements to districts. On the one hand, it could be argued that separating the two processes by the department making the performance-based allocations would minimise the scope for this. On the other, it could be argued that the commitment of the regions to the new system would be best secured by giving them responsibility for allocating the money. Ministers are invited to consider the balance of argument between giving the function to regions or the department.

How to measure performance?

11. Ideally, an objective measure would be devised, based initially on performance indicators for districts. The measure would obviously need to be as up-to-date as possible. If allocations are to be made in the February before the start of the financial year, it might be possible to base them on performance

mjd 3/178m

SECRET

FROM: MISS M P WALLACE
DATE: 23 June 1988

MR PHILLIPS

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

Mr Corlett IR
Mr Lewis IR
Mr Kuczys IR
PS/IR

NHS REVIEW: PAPERS ON THE PACKAGE AND HEALTH SUPPLY AND DEMAND

The Chancellor was most grateful for your minute of 21 June.

2. He is content for you to show the first paper (the "package") to Messrs Wilson and Heppell, subject to a number of detailed amendments recorded below, and any comments the Chief Secretary may have. The Chancellor will then concentrate on the second paper (health supply and demand) which he will look at over the weekend.

3. His detailed comments on the "package" paper are as follows.

First paragraph, first sentence - replace "health care - both public and private -" with "the NHS".

Replace present third sentence with: "and, alongside this, creating conditions in which private sector will expand."

Paragraph 2, second tiret - "waiting times" rather than "waiting lists".

Paragraph 12, to open "Should we, as many within the profession avdocate, amalgamate districts and FPCs..."

Paragraph 16, third tiret - replace "inviting" with "asking".

Paragraph 17, first tiret - amend to read: "(Crucially important) tackle medical restrictive practices to free up the supply of key personel, especially consultants."

MOIRA WALLACE

in the 12 months to the previous 30 September, although this would involve speeding up considerably the present timetable for producing the performance indicators.

12. Officials will need to do more work urgently on the development of measures based on performance indicators, if Ministers wish to pursue this route.

Activity or efficiency?

13. This depends on the area being considered. Where waiting times are excessive, increasing activity levels - and maintaining the increase - is the only way to get them down. But increased activity is not a good measure of performance in other areas - for example, psychiatry. And concentrating on activity may introduce a bias towards low cost surgery at the expense of other priorities which may be more important in terms of the health of the population generally. It may also discourage hospitals from treating difficult cases.

14. This suggests a two-pronged approach. In order to introduce the right incentives and to deal with the problems identified in paragraph 2 above, the general criterion for distributing the top-sliced money should be efficiency. But the concept could be imported into the present efforts to tackle excessive waiting times for routine procedures. A separate top-sliced allocation, replacing the present waiting list initiative, could be distributed to those who had done most to increase activity in certain defined areas, thus reducing waiting times, in order to encourage them to go further, if necessary taking patients from waiting lists in other nearby districts.

Absolute performance or improvement in performance?

15. Any attempt to devise a "standard" performance measure would be very complicated. The formula would have to take account of the size and distribution of hospitals within the district, the range of specialties covered, the characteristics of the local population. It might also have to cover factors like how many

sites hospitals are spread over, and their layouts, which affect efficiency but are beyond the control of the local management. No matter how sophisticated the formula, many would continue to argue that they were subject to special factors which were not given their due weight.

16. Such problems would be avoided by measuring performance over the most recent 12 months and comparing it with the previous period. It would be much more difficult to argue that there were special factors which inhibited improvement in performance, as opposed to the absolute level of that performance. Rewards based on improved performance would also offer more immediate incentives to management. Those who started well down the league might need to spend several years improving their efficiency before qualifying for extra money if the criterion were absolute level of performance. Management might get discouraged in such circumstances, whereas they could start to benefit immediately if it was improvement in performance that was being rewarded.

17. One difficulty with rewarding improvement in performance is that it might be the least efficient authorities with most scope for improvement (eg because they had been slow to introduce competitive tendering) who would benefit most. But once the system had been running for a few years, the best authorities should have found ways of improving their efficiency as well over time. So long as the system ensured that the allocations were built into baselines for subsequent years, the best districts should be able to reap suitable rewards.

Implications for self-governing hospitals

18. The system would need to be adapted for self-governing hospitals, independent of districts. It is difficult to say what form this would take, without clear decisions on the nature and structure of such hospitals. Among the questions to be considered are:

- whether their allocations should distinguish "baseload" functions (service to the local community, just like any other district general hospital, referrals by GPs etc) from any functions as "centres of excellence", eg the referral by consultants in other hospitals of particularly difficult cases

- whether the financing of their "baseload" services should be able to share in the growth money given out to the rest of the system in performance-based allocations

- if so, whether they too should be subject to the same regime of performance measurement

- whether the "centre of excellence" functions could be financed differently, eg by direct payments from the budgets of other hospitals whose consultants referred their patients on.

PRIME MINISTER

NATIONAL HEALTH SERVICE REVIEW 23/6/88.

I welcome the opportunity to offer a short paper to the Review of the National Health Service. My comments refer largely but not entirely to Northern Ireland circumstances.

NORTHERN IRELAND BACKGROUND

The health service in Northern Ireland is based on the principles and policies of the National Health Service in Great Britain, and like the NHS it has great public support and sympathy. A significant structural difference here is that hospital, community health and personal social services are integrated under 4 Health and Social Services Boards which deliver them as agents of the Department of Health and Social Services. There are no Family Practitioner Committees and GPs are contracted to the Boards.

My Strategy has for its priorities a reduction in acute beds, the development of health promotion and a shift in the balance of care to community services. The integrated structure is helpful in driving forward those policies.

Unemployment and overall social deprivation are high in Northern Ireland. GDP and personal disposable income per head is lower in Northern Ireland than the rest of the UK, while we seek every opportunity to expand private provision or increase charging, that exist elsewhere in the country. Also, Northern Ireland is at or

near the top of various tables of ill health in the UK and Western Europe. So inevitably the level of need for health services is proportionately higher than in England and Wales, with consequential higher levels of expenditure.

Getting value for money is all the more important. We have done a great deal to strengthen management and improve the quality of the service. More remains to be done and can be done in the present framework; and I am giving improvements in managerial efficiency and quality of service equal priority with the strategy objectives.

AREAS TO BE TACKLED

I do not believe there is enough choice for consumers. More competition in provision would result in a better quality of care and services and, together with improved management control, would sharpen up efficiency. The Health Boards should not be the only providers. The power of the trade unions and of professional interests needs to be diluted. The services need to be loosened up and encouraged to enter into partnership with the private sector and with the voluntary sector. Doctors are the key people who commit resources and general practitioners, as well as consultants, need to become more conscious of Value for Money considerations and involved in management.

In Northern Ireland, because of its unique integrated structure, any strategy for Health automatically and rightly covers primary care. The strategy for the NHS in Great Britain needs to overcome organisational separation to ensure the requisite development of primary care and community care.

THE PRIVATE AND VOLUNTARY SECTORS

The private sector of acute medicine is very small in Northern Ireland and is not likely to develop substantially given the limited size of the market and the lack of wealth of the region. Any model based on partnership with the private sector should allow for regional variations in the balance between public and private hospital care. The only market in which the private sector is substantial is that of residential and nursing home care for the elderly and other vulnerable groups. These homes are a valuable adjunct to public provision, but I am keen to make sure that the public funds involved - largely social security payments - are properly targetted and that the people who are admitted to these homes are those who need that type of care. This would point to linking payments to professional assessment of need.

The voluntary agencies, which are relatively strong in Northern Ireland, should be further supported. That is essential if the policy of caring for people in the community is to succeed, but would also draw on the private rather than the public purse. We are conducting a review in the province of our grants to voluntary agencies with a view to securing better value for money. In addition we have provided special opportunities for the long-term unemployed to work in the voluntary health and personal social services.

FINANCIAL CONSTRAINTS

In Northern Ireland, as in Great Britain, more money for health care is needed because of demographic changes and advances in medicine. Spending on health has, as in Great Britain, steadily increased each year but has levelled out in real terms. There is a widespread view

as in Great Britain that the services are under-funded but I am sure that more can be done to secure further cost improvements and income generation. Boards would be reinforced in this effort if they were clearly assured that income generated would be additional to public funds.

The handling of pay settlements remains, however, a continuing problem of financial management. The present system negates sensible planning. Bringing forward the annual Review Body settlements helps, but leaves half the pay bill unresolved until some months into the financial year. This is more of a problem in Northern Ireland because pay for many staff in the personal social services is linked to GB local authority rates. Any scope for bringing forward these other awards should be explored. Also, annual settlements made sense in times of high inflation but inflation is now firmly under control. If settlements covered a period of 2 or 3 years and if the level of funding were decided and announced in advance, health bodies would have a stable base on which to plan.

There is not enough private wealth in Northern Ireland to support large increases in private health care. There is unlikely to be a major expansion of the private health care sector in Northern Ireland in the near future, though no doubt a limited expansion of the market could be stimulated by increased tax incentives. I have also been considering how best to encourage other sources of finance for existing public health provision. Irrespective of how the NHS Lottery in Great Britain fares, I would like to encourage the Boards and/or the voluntary sector to organise lotteries here as a source of additional money. The specific reason is that the Republic of Ireland has a hugely successful national lottery and many people here buy tickets for it. I would rather they spent that money for the benefit of Northern Ireland health care.

MANAGEMENT SKILLS

Northern Ireland has taken useful initiatives in both information technology and the development of mangers but, like the rest of the UK, needs to invest further in both. Better information systems are needed as a basis for decision-making and for costing. Health managers will need considerable flexibility and skill in developing and selecting choices for the consumers, in generating additional sources of finance and acting in an entrepreneurial way. We have established a training programme for existing and aspiring managers including practising clinicians, which is proving highly successful with all professions; but opportunities exist for further improvements to management control and structure. Consultants in particular need to be involved in and committed to management decisions at every level.

Managers need to be backed up by Boards which have managerial rather than representational membership. There is a real problem here in Northern Ireland where the Boards are over-large and ill-equipped to deal with change and the reorganisation of services to improve cost-effectiveness. I would advocate ideally small supervisory bodies with more limited representation from professional groups and local authorities. This change would need very careful handling, as all else in health service affairs, but is, nevertheless, necessary to the proper functioning of the Health Service.

NORTHERN IRELAND ASSETS

Northern Ireland has much to offer in the field of health care. It is already offering nurse training and other services to English regions and I am setting up arrangements for the export of health services overseas. We could also provide services for GB health authorities, in areas where staffing difficulties exist, such as

information technology, particularly computer software, and architectural and engineering design services. While our geographic isolation presents some difficulties in terms of treating a regular flow of patients from Great Britain, I am pursuing cross border trade in health care with the Republic of Ireland. I anticipate that the outcome of the NHS Review will support such developments.

CONCLUSION

I hope you will find these brief observations helpful. I look forward to the opportunity of commenting on the recommendations of the Review as they will affect Northern Ireland, before it is finalised.

Copies of this note go to Nigel Lawson, John Moore, Malcolm Rifkind and Peter Walker.

TK

23 June 1988

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

23/6

SECRET

Miss M P Wallace
Assistant Private Secretary to the
Chancellor of the Exchequer
Parliament Street
LONDON
SW1P 3AS

23 June 1988

Dear Moira,

NHS REVIEW

I enclose 4 papers in advance of tomorrow's "quadrilateral":

i "A New Framework for Self Governing Hospitals".

ii "Consultants".

iii "Medical Audit": Although the Chief Secretary's letter of 21 June includes this among the list of papers for a further "quadrilateral" on 4 July, my Secretary of State thought it worth circulating now as the paper is quite short and closely related to that on "consultants".

iv "Contracting Out": This is a note prepared by officials and has not yet received final Ministerial clearance here. It is provided essentially as background at this stage.

I am copying this letter and its enclosures to the Private Secretaries to the Chief Secretary, the Minister for Health, Sir Roy Griffiths and to Richard Wilson at the Cabinet Office.

Yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

ANNEX: A
CONTRACTING OUT
BRIEF

23.6.1

SECRET

A

CONTRACTING OUT

Line to take

The proposals in the paper are little different from those which the Prime Minister's group discussed on 11 May and rejected. They suffer from exactly the same drawbacks:

- They will not succeed in getting more private money into health care; this will be outweighed by the deadweight cost, even if the number of subscribers increases significantly.

- There are higher priorities for extra public money on health care. Mr Moore's PES bid is for £2bn next year. Which of his bids would he drop in order to make room for the cost of his scheme?

- The scheme is likely to be seen as divisive, promoting "two-tier" health care.

- It would boost the demand for health care without doing anything to promote the supply side.

Background

Hypothecation - Pros. Cons.

2. We believe Mr Moore is not anxious to push his scheme too hard, particularly if - as is likely - it gets a rough ride at the Prime Minister's next meeting. His private secretary's covering letter is careful to distance him from it. He appears to see it as a bargaining counter, in return for whose withdrawal he would achieve some further concession on tax relief. You have a separate paper from the Revenue on tax relief. In general, there seems no need to give anything away on DHSS's account: given the weaknesses in their case, their negotiating hand is weak.

← in front

3. The proposals in the paper are, in summary:

- To hypothecate a greater proportion of national insurance contributions to the NHS, with the resulting deficit in the national insurance fund made up by an increased Treasury supplement, on the lines suggested in your earlier paper.

- People would be able to contract out of "cold elective surgery". Your earlier paper suggested that contracting out would be in respect of whatever the private insurance scheme covered. But most treatment provided under private insurance is elective surgery, and so this suggestion is not much different in practice from your paper.

- An age-related rebate (ranging from about £15 for children up to £54 for those aged 55-64). You proposed a flat rate rebate of around £50. It is unlikely that the variations in the rebate proposed by Mr Moore would lead to substantially different behavioural effects.

4. The key is the elasticity of demand. With 6 million people already covered by private insurance, the deadweight cost would be perhaps £200-300m. To recoup that, several million more people - perhaps a 50% increase in the numbers presently covered - would have to take out private insurance. On the face of it, that seems an unlikely response to the relatively small subsidy on offer.

ANNEX: B
SELF-GOVERNING
HOSPITALS
BRIEF

23.6.2

SECRET

B

SELF-GOVERNING HOSPITALS

Line to take

The paper is ill-argued. It does not say what are the objectives of the change, nor how its proposals would achieve them. Instead, it proposes that a large number of existing disciplines should be removed, with no clear idea of what should go in their place. It also effectively resurrects the ideas in the earlier "buyers/ providers" paper, without addressing the serious practical difficulties on which the previous proposal foundered. In short, while there are some possibly interesting ideas in the paper, DHSS have again failed to offer convincing evidence that they have really thought through how the proposal will work.

Background

2. The paper makes a series of proposals:

a. Hospitals would be established as legal entities independent of health authorities, run by boards of management.

b. They would be financed by contractual agreements with health authorities (principally their local one, but also others and possibly with private sector bodies too).

c. Much greater delegation of responsibility for negotiating pay and conditions.

d. Freedom from existing controls over capital spending, including the rules on unconventional finance.

3. Taking each of these in turn, the first is relatively unexceptional. At the moment, hospitals have no independent legal existence; the legal unit is the health authority. Constitutional and legal change is therefore a necessary precursor of making them self-governing.

4. The second (contracts) is however very unclear. Paragraph 4 of the paper tells us very little about what these contracts would look like and how they would work. But there is a distinct possibility, on the face of it, that this would be resurrecting "buyers and providers", with health authorities supposedly paying hospitals for the treatments they give. The paper makes no attempt to address the fundamental dilemma that patients are referred to hospitals by GPs, not by health authorities. Health authorities would be given budgets which they would be unable to control properly, since GPs would in practice be responsible for spending them. Responsibility and accountability would not be aligned. The only attempt to address the question is the reference at the end of the paragraph to freedom of referral, which is distinctly reminiscent of the earlier paper, which referred to a "back pocket" out of which referrals out-of-district would be financed. Quite apart from how this would work, however, this is not the whole problem. How are health authorities going to control the flow of patients within the district, and to different hospitals with whom they have separate contracts? None of these problems is addressed satisfactorily. The paper appears to be no advance over the earlier one.

5. On the third, it is certainly logical that there should be more local negotiation of pay and conditions. We are keen generally to make the public service pay systems more responsive to local market forces. There are also potential advantages in breaking up national negotiating systems and reducing the influence of - if not abolishing - the Review Bodies. But we are given no indication of how the new system would work, nor of how the risk of bidding up professional pay rates would be handled.

6. On the fourth (capital), an initial discussion with DHSS officials has already taken place. DHSS appear to have in mind some radical changes: the introduction of capital charges into income and expenditure accounts (a proposal which has recently been examined and rejected in the context of the PSA); major relaxation of the unconventional finance rules, including an apparent wish to get away from the fundamental criterion of value for money; and further erosion of the separate controls applied to

current and capital spending. All these present major problems for the Treasury, and we are not convinced that DHSS have properly thought through the full implications of their ideas. So this general work has some way to go before it can be put to Ministers.

7. Clearly, however, a method of allocating capital to self-governing hospitals has to be devised if the model is to work. While DHSS have not yet come up with anything practical so far, they will need to do so before very long.

ANNEX C
CONSULTANTS
CONTRACTS
BRIEF

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C

CONSULTANTS' CONTRACTS

Objectives

1. The essential objective is to ensure that consultants are fully involved in the management of the resources they use and are properly accountable to general management in respect of their contractual commitments and stewardship of resources.

Benefits and Costs of the DHSS Proposals

2. The reforms the DHSS propose would produce significant benefits in the form of more effective use of consultant resources. There would be a clearer definition of the services a consultant is contracted to provide; swifter procedures for dealing with unsatisfactory consultants; improved scope for matching service needs and consultant posts; and greater recognition of and financial incentives for the resource management responsibilities of consultants.

3. But these changes will involve very real costs. DHSS's PES 'marker' bid is £50 m. But this does not reflect the cost of buying out tenure. The introduction of short-term contracts for existing consultants is likely to be very expensive in terms of higher pay. (We do not consider it is possible to make this change without compensating financial inducements). Even limiting short-term contracts to newly appointed consultants could require their receiving higher pay. We therefore need a better estimate of the likely public expenditure implications from DHSS. The wider effect of the reforms also has to be taken into account in the cost-benefit analysis. For example, will the changes make a career in the hospital service less attractive to doctors, thereby encouraging more to go into general practice.

Achievability

4. The majority of the changes proposed by DHSS should be achievable. But two issues do present real political problems. Any attempt to remove the tenure of existing

ANNEX: D
MEDICAL AUDIT
BRIEF

D.

23.6.3

SECRET

MEDICAL AUDIT

Line to take

Proposals broadly acceptable. Note reference to resources in paragraph 6. When will the PES bid be forthcoming?

Background

2. We have tended to argue up to now that the better data coming available under resource management, combined with the impetus given by VFM audit, will be sufficient to encourage the medical profession to go further in introducing medical audit. Mr Moore's paper broadly goes along with this "self-regulatory" line. The only wrinkle is that he proposes to make it a condition of the new contract for consultants that they should participate in an audit programme, hopefully overseen by the Colleges. We think this is a reasonable safeguard, and should not antagonise the medical profession unnecessarily, but rather encourage them down a path on which they are already to some extent set.

3. Paragraph 6 says that additional costs will be entailed. It is not clear whether this is subsumed within Mr Moore's "marker" PES bid of £50m, or whether this is additional.

consultants would be very controversial and could in our view only be achieved at great financial cost or a major row with the medical profession adversely affecting their willingness to co-operate in the introduction of other changes (eg the Resource Management Initiative). Frankly, we are doubtful whether it is sensible to seek to go ahead on this basis. Similarly, we anticipate that the profession would fiercely resist making existing distinction awards reviewable. Again it might not be politically practicable to proceed without offering a level of compensation which could make the change unattractive from a public expenditure point of view.

Other Points

5. The proposals on the reform of distinction awards system are commendable as far as they go but rather vague. It is not clear, for example, who will make the awards. There is certainly a case for the management performance awards be at the sole discretion of general management. Nor do DHSS say what the size of the new awards or the likely number of recipients might be. Larger awards may be necessary in return for making them reviewable. We may therefore want to consider a more explicit cash limiting of the funding available for this purpose.

6. The paper is silent on the possibility of recognising management responsibilities in the basic pay of consultants, those heavily involved in management receiving higher salaries. We consider this deserves examination. Besides providing a greater incentive for involvement in management it would offer a career progression for consultants. The creation of a two tier structure might also be developed to provide the opportunity for the creation of more 'junior' consultant posts - perhaps on a part-time basis - to overcome some of the problems identified by Mr Studd.

7. Indeed the DHSS paper does not consider the question of part-time practice. You might ask Mr Moore about the scope for promoting more part-time work. One possible change might be the abolition of the maximum part-time contract, forcing a choice between full commitment to the NHS and genuine part-time work and inducing more consultants to take the latter option.

SECRET HC ( )

DRAFT

CONTRACTING OUT

Note by Secretary of State for Social Services

At our next meeting, we are to resume our discussion on how best to encourage the growth in the private health sector.

2. The two particular options we identified in our earlier discusion were tax relief for private health insurance premiums paid by the elderly and exempting health insurance premiums paid by employers under a company scheme for tax as a benefit in kind.

3. When we look at these options in the light of the Chancellor's further paper, I thought it would be helpful to colleagues if at the same time we looked at the way in which those options might be complemented by a limited system of contracting-out.

4. I therefore asked my officials to prepare the attached note which sets out how such a system might work.

5. Basically, the proposal is that those paying National Insurance contributions would be able to contract out of NHS funded provision of cold elective surgery in return for an age related contribution rebate. It would be a condition of contracting-out that the employee concerned was covered by an appropriate health insurance policy with an approved insurer. The policy would be taken out individually, or by a company. So the model would be broadly similar to contracting-out of the additional component of the state earnings related pension scheme. The cost to the National Insurance Fund of the rebates would be matched by an equivalent increase in the Treasury Supplement, on the lines mentioned in the earlier paper circulated by the Chancellor, so that contribution rates would not be affected,

6. I accept that - taken by itself any system of contracting-out has deadweight costs: the same applied to contracting-out of the state pension scheme. I also accept there will be extra administration costs, though we can minimise these by making good use of our pension machinery, including that developed for personal pensions.

7. But these drawbacks could be substantially outweighed by the value of an effective stimulus to the development of a mixed economy of public and provide health care, with more competition and choice. If we were to implement all three options, it would provide such a stimulus, which should pay for itself in the longer if not shorter term. What is more they would be a stimulus which would complement provision under the health service rather than provide an alternative to it. It would enhance freedom of choice but not at the price of our appearing to open the door to a second class service in the NHS. It would also have the advantage of making a major impact on one of our weak spots - waiting times for cold elective surgery.

CONTRACTING OUT

Draft 2.6.88

1. This note describes a limited scheme for contracting out incorporating two key features:

- adoption of the proposal contained in the Chancellor's paper. "A scheme for contracting out of the NHS" to increase the NHS element of NICs, with an increased Treasury Supplement.

- the facility for NIC payers to "contract out" of NHS funded provision of elective surgery in return for an age related contribution rebate. This rebate would contribute to the cost of an appropriate health insurance policy with an approved insurer.

2. The way in which a scheme of this sort might operate is discussed below. A number of more technical questions are covered in the Annexes. However, the major operational consequences of the scheme would be:

- Tax and NI rates could remain unchanged. This would avoid the disadvantagous distributional effects of a wholesale transfer to NI funding, although losing the important advantage of transparency of expenditure explicit in complete hypothecation.

- There would be no question of NI contributions establishing entitlements to treatment. All who wished to do so would remain entitled to the full range of state funded NHS treatment. Only those who voluntarily chose to contract out would lose entitlements to state funded elective surgery.

- Although people would remain at liberty to insure privately against as wide a range of medical contingencies as they wished, the major stimulus of the rebate scheme would be to the new low cost policies covering elective surgery increasingly offered by the major private insurers.

Operation of the scheme

3. Finance

- The value of tax and NI revenues for the NHS and social security implied by the Treasury's contributions scheme are shown in the table in Annex 1.

4. Collection of contributions

- Employers would continue to collect health and appropriate NI contributions from employees.

- As the NHS would be only partially financed from NICs employers are not required to identify their employee's monthly health contributions separately on pay slips.

5. Contracting out

- Contributors may contract out of state funding for elective surgery on behalf of themselves and their immediate dependants.

- As a condition of the rebate individuals must arrange, at least, a minimum approved insurance cover, either through their employers or on a personal basis. The required minimum insurance would cover a defined list of the main elective surgical procedures. A number of policies covering precisely these procedures are already on the market, for example the "Budget BUPA" plan (see Annex 2).

The contracted out patient's route to treatment

6. Non-emergency admissions:

- Following consultation with a GP, a contracted out patient would be referred to either a private health care provider or for admission to an NHS pay bed.

- Both public and private health care providers would ascertain the willingness of insurers to pay for private treatment before admitting a patient.

7. Emergency admissions:

- In the case of emergency admission to an NHS hospital, the health authority concerned would be empowered to seek any payment due from private insurers. As all patients must be either privately insured or fully "contracted in" to the NHS, there could be no question of patients being denied treatment which they urgently required.

8. Pre-existing conditions:

- These will not generally be covered by private insurers.

- Patients' GPs, being aware of the existence of these conditions and any exclusions from private health cover that they involve, could make references for state funded treatment as appropriate.

- Patients in these circumstances will have a guaranteed entitlement to state funded treatment for those conditions not covered by their private policies.

9. Exclusion from state funded treatment of those contracting out

In practice, exclusion would be self policed, as non urgent treatments are those for which waiting times apply in the NHS but immediate access and treatment is available in the private sector.

10. Rejoining the state scheme

Contracted out patients could rejoin the state scheme at the end of their private insurance contract periods. Private insurers would be responsible for informing DHSS that a policy with a particular subscriber has lapsed. However insurers should be prevented from encouraging patients to return to the state scheme in the case of mid contract episodes of ill health. For this reason it may be necessary to make insurance policies offering excesses, co-insurance and no claims bonuses ineligible for the rebate.

11. The value of the contracted out rebate

- could be based on the average costs incurred by the NHS in providing elective surgery to those contracting out.

- in order to avoid the tendency for low risk individuals to contract out while high risk ones remain in the state scheme rebates would be related to both age and family size (further details are given in the annex.)

12. Payment of rebates

- Rebates would be paid annually, in arrears, direct to the insurer by DHSS. This follows the procedure for the payment of contracted out rebates in the personal pensions scheme and avoids additional burdens on employers.

- Private insurers would claim rebates by submitting a list of policy holders (with their NI numbers) and dependants covered by medical insurance direct to DHSS, guaranteeing that all those contracting out were covered by an appropriate policy.

13. Implications for health authorities

- Revenue allocations to health authorities would be adjusted to take account of the extent of contracting out in their areas.

- This strengthens the incentive of NHS hospitals to compete and win contracts from private insurers to treat those who have contracted out.

- Failure to win contracts to sell services to private insurers would make it increasingly difficult for NHS hospitals to remain at their current capacity levels.

14. Growth of the private sector

The growth in private insurance cover following the introduction of a contracting out scheme would depend on:

- the proportion of annual premiums represented by the rebate

- the responsiveness (or elasticity) of the demand for health insurance to reductions in its price.

Annex 2 examines the first of these points for a representative set of household groups and makes an estimate of the resulting increased coverage of private health insurance. The available elasticity estimates are, however, tentative and subject to wide margins. The overall effect would largely depend on the response of the private insurance industry.

Annex 1

THE NATIONAL INSURANCE FUND AND NI FINANCING 1988-89

The Chancellor's scheme to increase the NHS allocation from the NI fund proposed raising employee's NHS contributions from 0.95% to 2.4%, with additional increases in contribution rates for both the self employed and employers. The sources of NHS income which would result from this arrangement are shown in the table.

	£bn
Employees contributions	4.3
Employers contributions	2.2
Self employed contributions	0.2
General taxation	14.4
	21.1

The value of employee's contributions in this scheme would be more than sufficient to underpin a contracting out arrangement of the sort described in this paper. Total expenditure on NHS surgical acute specialties, that is, those for which contracting out is envisaged, is in the region of £2bn for 1988/89.

It should be noted that a possible feature of the scheme is that some low earners may be entitled to rebates which are in excess of their annual NHS contributions. Excess rebates this sort would score as public expenditure. In practice, however, this is unlikely to be a serious problem. A married couple in their mid 50s with two children would have earnings of less than £100 per week before being faced with rebates in excess of their health contributions.

Annex 2

THE VALUE OF REBATES AND THE EXPANSION OF PRIVATE SECTOR

Unless rebates reflect, in some way, the risks represented by groups in the population, the consequence of a contracting out scheme will inevitably be that low risk cases leave the state scheme while high risk ones remain.

Age is an important determinant of the risk of requiring elective surgery. The table below shows the value of NHS expenditure per head on surgical acute specialties.

Age Band	Expenditure per head (1988/89 prices)
All ages	41
0-4	13
5-14	16
15-24	21
25-34	24
35-44	29
45-54	37
55-64	54
65-74	88
75+	154

Eight of these specialties account for in excess of 90% of cases from the waiting list, and cover procedures typically offered by most private health insurance policies. These average cost figures would therefore form the best basis of a contributions rebate for contracting out of elective surgery.

Insurance premiums

An indication of the contribution of these rebates to the cost of private health insurance is given below. The table expresses the value of rebates as a percentage of premium costs for a variety of family types. The family rebate consists of the sum of the age specific rebates (calculated on the

basis of expenditure on people in five year age bands applicable to each family member. The costs of premiums are those applicable to BUPA's recently launched "Budget BUPA" plan. This covers 85 in-patient and 30 day care elective surgical procedures which represent the majority of operations on NHS waiting lists.

Family type	Rebate as % of undiscounted Budget BUPA premium
Single person age 20	23.5
Couple mid 20s	23.7
with 2 children	27.5
Couple mid 30s	23.2
with 2 children	26.7
Couple mid 50s	26.9
with 2 children	28.3
Couple mid 60s	29.9

Expansion of private health insurance

US experience, which has to be applied cautiously to the UK, suggests that the demand for private health care insurance rises by about ½% for every 1% fall in the cost of premiums. On this basis the number of private insurance subscribers might be expected to increase by between 12 and 15% as a result of a rebate scheme of this sort. Using estimates produced by the Institute of Health Services Management of the number of people with private health insurance in 1987 as a base, the contracting out scheme could:

- increase the coverage of private health insurance from 6 million to around 7 million people

- boost the annual value of premiums paid to between £850 and £875 million, an increase of in excess of £100 million.

SECRET

NHS REVIEW: FINANCING HOSPITALS

Note by the Chief Secretary, Treasury

At our meeting on 24 May, I was invited to prepare a note about how the system of allocating resources to health authorities might be improved to reward hospitals which attracted more patients by greater efficiency. I attach a note which my officials have prepared on how a scheme of this sort might work.

2. The real growth in HCHS expenditure - which, realistically, we must expect to continue for the foreseeable future - would be earmarked for allocation on the basis of performance. Regions would be given funds for distribution to districts on broadly the same basis as now, based on inflation-adjusted total their districts received the previous year. The remainder would be allocated to the best performing.

3. On the specific points raised in the paper, my views are as follows:

a. I think it makes sense, initially at least, to build on the present performance indicator system and make allocations to districts rather than trying from the centre to target the best-performing hospitals.

b. I have no strong views on whether the allocations should be made by regions or by the DHSS, and would welcome the views of colleagues on this.

c. I hope our officials can be invited to draw up a suitable indicator or set of indicators quickly. Clearly, the measure should not be so crude as to meaningless, but it should also not be so sophisticated that there is a long time lag before it is available.

d. I agree that the bulk of the money should be allocated on the criterion of improved efficiency. But I see attraction in allocating some of it on the basis of increased activity in the areas where waiting lists are longest, replacing the present waiting list initiative.

e. When we have reached conclusions on the Secretary of State's paper on self-governing hospitals, we can consider how to adapt this system for them. But this should not present overriding difficulties.

4. I believe a scheme of this nature has a number of attractions. It would:

- provide real incentives for health authorities to improve their efficiency

- direct resources towards those areas where efficiency was being given priority; and

- thereby allow money to flow to those who improved their capacity to treat patients.

FINANCING HOSPITALS

Note by the Treasury

This paper examines the scope for rewarding the best performing parts of the NHS through a "top-sliced" element of the health budget. It is intended to tackle quickly the problems that exist now. It does not necessitate structural change in the NHS and involves only relatively modest change at first. But it could be adapted readily to an evolving NHS structure.

The problem

2. The present resource allocation system is based on need. Money is distributed to regions on the basis of the relative priorities revealed by the RAWP formula, and then from regions to districts. The criteria applied by regions in allocating funds to districts vary, and by no means all follow RAWP-style methods. But in general the system takes no account of efficiency or performance.

3. In theory, the main incentive to improve efficiency is that it enables a hospital to provide a greater volume of services within a fixed budget. But in practice this turns out to be only partially true, because treating extra patients of itself generates increased costs. In general, if throughput is improved so that more patients can be treated within existing capacity at existing staffing levels, unit costs do not fall commensurately, so that the improved treatment rates cannot be achieved without increased funding. So the incentives to improve efficiency are not as great as they could be.

Top-slicing

4. In outline, the system would be quite simple. Most current expenditure would be allocated as now: distributions to regions in the previous December; allocations by regions to districts completed by late February. The amount allocated in this way might be equal in real terms to the total of health authority budgets the previous year, leaving the balance to be allocated on the basis of performance. Typically, after allowing for pay awards, notably to doctors and nurses, this has left room for real growth of around 2%, or £250m.

5. This would be in February, so that hospitals would go into the year in full knowledge of their budgets. The total available for distribution would have been determined in the previous public expenditure survey. If, for the sake of argument, it was 2% of the total, the extra performance-based allocations might vary between 0 and 5% of initial allocations. The distribution within the total sum available for these allocations could be settled only when the overall performance of all health authorities had been assessed.

6. The interaction between the system and that for allocating resources generally would be complex, but it should be possible to ensure that rewards were carried forward into baselines for future years, and were not lost at the end of the year. Initial allocations to regions would be based on the previous year's total allocation (including performance awards). If there were to be further movement to RAWP targets, allowance would have to be made: either (and this would be very controversial in RAWP-losing regions) by adjusting these allocations up or down; or by using some of the growth money for RAWP adjustment rather than rewarding performance. Regions would be asked, in their allocations to districts, to take full account of previous performance awards, alongside the other criteria they apply. So a district's allocation should reflect the carrying forward of previous awards, possibly with some adjustment for other factors.

7. A number of questions need however to be addressed:

- to whom would the performance-based allocations be made: hospitals or districts?

- how would their performance be measured?

- would the objective be to reward activity or efficiency?

- would performance be measured against some external standard, or would the criterion be improvement in measured performance?

District or hospital?

8. Allocations direct to hospitals, or even to departments within hospitals, would provide the most direct incentives to improve efficiency. Money would be diverted to the best performing parts of the health service in a very direct way. But it could be difficult for DHSS to interpret sensibly information coming forward from individual hospitals. Moreover, such information is not yet available in the required detail.

9. Performance-based allocations to districts could, in principle, be introduced much more quickly. The new district-level information system, based on the Korner report, was introduced from 1 April 1987. In principle, this could be adapted for the purpose of top-slicing. Giving the money to districts would enable them to allocate it both in accordance with local priorities and so as further to improve efficiency, in the knowledge that this could be expected to result in further financial rewards. Districts could be asked to link allocations to units on performance and efficiency targets. This would be a first step towards a more contractual style of management.

10. Whether allocations to districts should be made by regions or by the department is a matter for judgement. Regions would have considerable scope to undermine the effect of the performance-based allocations by offsets in their disbursements to districts. On the one hand, it could be argued that separating the two processes by the department making the performance-based allocations would minimise the scope for this. On the other, it could be argued that the commitment of the regions to the new system would be best secured by giving them responsibility for allocating the money. Ministers are invited to consider the balance of argument between giving the function to regions or the department.

How to measure performance?

11. Ideally, an objective measure would be devised, based initially on performance indicators for districts. The measure would obviously need to be as up-to-date as possible. If allocations are to be made in the February before the start of the financial year, it might be possible to base them on performance

in the 12 months to the previous 30 September, although this would involve speeding up considerably the present timetable for producing the performance indicators.

12. Officials will need to do more work urgently on the development of measures based on performance indicators, if Ministers wish to pursue this route.

Activity or efficiency?

13. This depends on the area being considered. Where waiting times are excessive, increasing activity levels - and maintaining the increase - is the only way to get them down. But increased activity is not a good measure of performance in other areas - for example, psychiatry.

14. This suggests a two-pronged approach. In order to introduce the right incentives and to deal with the problems identified in paragraph 2 above, the general criterion for distributing the top-sliced money should be efficiency. But the concept could be imported into the present efforts to tackle excessive waiting times for routine procedures. A separate top-sliced allocation, replacing the present waiting list initiative, could be distributed to those who had done most to increase activity in certain defined areas, thus reducing waiting times, in order to encourage them to go further, if necessary taking patients from waiting lists in other nearby districts.

Absolute performance or improvement in performance?

15. Any attempt to devise a "standard" performance measure would be very complicated. The formula would have to take account of the size and distribution of hospitals within the district, the range of specialties covered, the characteristics of the local population. It might also have to cover factors like how many

sites hospitals are spread over, and their layouts, which affect efficiency but are beyond the control of the local management. No matter how sophisticated the formula, many would continue to argue that they were subject to special factors which were not given their due weight.

16. Such problems would be avoided by measuring performance over the most recent 12 months and comparing it with the previous period. It would be much more difficult to argue that there were special factors which inhibited improvement in performance, as opposed to the absolute level of that performance. Rewards based on improved performance would also offer more immediate incentives to management. Those who started well down the league might need to spend several years improving their efficiency before qualifying for extra money if the criterion were absolute level of performance. Management might get discouraged in such circumstances, whereas they could start to benefit immediately if it was improvement in performance that was being rewarded.

17. One difficulty with rewarding improvement in performance is that it might be the least efficient authorities with most scope for improvement (eg because they had been slow to introduce competitive tendering) who would benefit most. But once the system had been running for a few years, the best authorities should have found ways of improving their efficiency as well over time. So long as the system ensured that the allocations were built into baselines for subsequent years, the best districts should be able to reap suitable rewards.

Implications for self-governing hospitals

18. The system would need to be adapted for self-governing hospitals, independent of districts. It is difficult to say what form this would take, without clear decisions on the nature and structure of such hospitals. Among the questions to be considered are:

- whether their allocations should distinguish "baseload" functions (service to the local community, just like any other district general hospital, referrals by GPs etc) from any functions as "centres of excellence", eg the referral by consultants in other hospitals of particularly difficult cases

- whether the financing of their "baseload" services should be able to share in the growth money given out to the rest of the system in performance-based allocations

- if so, whether they too should be subject to the same regime of performance measurement

- whether the "centre of excellence" functions could be financed differently, eg by direct payments from the budgets of other hospitals whose consultants referred their patients on.

(Draft 23/6/88)

A NEW FRAMEWORK FOR SELF GOVERNING HOSPITALS

Introduction

1. This paper outlines a framework for giving hospitals greater freedom and responsibility for managing their own affairs, building on existing initiatives within the service. The paper puts forward a model for self governing hospitals as the end-point of an evolutionary process, and outlines an action plan for getting there. The paper sets out:

- the scope within the existing system, for devolving more responsibility and freedom to hospitals, as a key precursor to self government;

- the main features of self governing hospitals compared with the existing system; and

- a practical evolutionary path.

Increased freedom and responsibility

Building up the hospitals

2. The present thrust of development in the NHS is to devolve management responsibility to the lowest level. This needs to be continued and developed along three lines:

- build up the responsibility of hospital management (including clinical staff) and ensure that they have the information they need to control the resources they use;

SELF GOVERN-ING HOSPITA / DHSS NEW

- make specific services subject to "contracts" between DHA and unit;

- introduce greater flexibility and freedom for hospital management in the access to, and deployment of, the key resources, capital and manpower.

3. The first of these developments is already under way in the resource management initiative. The information aspects of the initiative will be described in more detail in a separate paper. The fundamental aim is to give clinicians, as the main users of NHS resources, responsibility for, as well as power over, those resources. This needs to be embodied in a new contract for consultants, which is discussed in a separate paper. Clinicians will therefore be accountable for the way resources are used, and will have detailed, timely and accurate information on patients and the costs attributable to their treatment. Thus, for example:

- doctors will be answerable for providing the most cost-effective treatment regime;

- managers will be able to identify the more efficient units for expansion;

- it will be possible to decide in a more informed way whether to provide a service in-house, or to buy it from a neighbouring hospital.

4. Secondly, the introduction of a "contractual" style of management between DHA and hospital would make more explicit the respective responsibilities of the DHA and the unit. This would build upon the availability of effective management information in the hands of those who actually deploy resources. For their local "baseload" services, hospitals would be committed to agreed performance targets in terms of the level and

quality of the services they provide, including waiting times. Correspondingly, DHAs would be committed to a level of funding which reflected the targets set. "Contracts" with both the "home" and other DHAs - and with the private sector - could be introduced specialty by specialty for services beyond the "baseload", concentrating mainly on elective surgery. Thus for example:

- non-achievement of (or indeed exceeding) set performance targets would be apparent not only to managers on both sides, but also to GPs and patients; ↑ But what choices would they have?

- "contracts" would provide the basis on which hospitals, on their own initiative, could extend their services to other DHAs, or to the private sector.

- GPs' freedom of referral would be maintained within firm overall expenditure limits by retaining funds specifically for special or ad hoc referrals not covered by the main contract(s);

5. Thirdly, to match the greater control of resources flowing from better information, and the greater commitment to specific performance arising from the "contractual" approach, hospital management could be given more freedom, within a reformed Whitley system, to set local pay and conditions. Regional pay, and pay flexibility, are already under consideration; reform of the consultants' distinction awards will be discussed in a separate paper. Thus, for example:

- skilled staff could be deployed in new ways to meet service needs, and non-medical manpower could substitute for junior medical staff in supporting roles, subject to necessary professional, ethical and legal considerations;

- more flexible pay could be offered to attract or retain key staff involved in delivering important service "contracts";

- enable pay to match local labour market conditions, which might result in reduced costs.

6. [The scope for increasing hospitals' freedom over capital is subject to further discussion between Treasury and DHSS officials.]

Slimming down the health authorities

7. The devolution described in paragraphs 2 to 6 would represent a shift in responsibility from RHAs and DHAs to the hospitals themselves. As a result, DHAs would have fewer operational management responsibilities, and could concentrate more on the procurement of comprehensive hospital and community health services for their resident population - and for the GPs who refer patients to these services. This brings closer together the new functions of DHAs with the present ones of FPCs. It would therefore be possible over time steadily to reduce the number of DHAs by around a half, and to combine their functions with those of FPCs in a smaller number of geographically larger authorities. These combined authorities, referred to as "DHAs" for the rest of this paper, would contract with GPs much as the FPCs do at present.

8. RHAs too could devolve further responsibilities and contract out others. The net result might be that both RHAs and DHAs would each employ about half the number of staff. Most of the costs would devolve upon the hospitals in the first instance, but their concentration at that level, together with the scope for competitive tendering for a wide range of support services, should bring about significant net savings. RHAs would retain responsibility for health service planning and for ensuring the effective provision of specialised services, and of funds for capital investment. RHAs could ensure adequate provision of training posts by placing contracts with hospitals for specified training services, the price reflecting the overheads incurred. In addition, they would continue to

serve as a bulwark against unnecessary Ministerial involvement in operational controversy. It might be possible over time to reduce the number of RHAs, perhaps to ten.

9. The resulting management regime needs to be considered from three viewpoints:

Funding would continue to flow from DHSS via RHAs to DHAs on a population-based formula. Most hospitals, and most services, would be planned, funded and managed by the DHA on the basis of "contracts" with the hospitals.

Capital would continue to be allocated by the health authorities according to their strategic plans, but if hospitals were required to meet capital costs this would both bring economic criteria to the fore, and involve hospital management more closely in capital planning. Any development of charging for capital would imply corresponding increases in revenue allocations recovered via receipts. Hospitals would have some scope for accumulating reserves which they could apply to minor capital projects.

Accountability for the use of resources, and for delivery of services, would continue to flow up the management line to the Secretary of State.

Self government

Statutory independence

10. Most of the initiatives described above are under way to some degree. They all develop, but remain within, the existing constitutional structure of the NHS, with hospitals (other than the London Post-graduate Teaching Hospitals) as operational arms of the DHAs, both being subordinate to the RHAs. The key break with the existing pattern of health service management

would be to form each hospital into an autonomous organisation - a self governing hospital.

11. This would require the creation of a statutory Board of Management for each hospital. The Board of Management could comprise the key members of the hospital management team, plus "non-executive directors" drawn from business and the community. Further consideration would be needed to the role of the Secretary of State in the appointment of board members, in particular the chairman.

12. The board of management would be a formal legal entity which would be empowered to employ staff, enter into contracts with health authorities and private health insurance companies etc, and hold financial reserves. By comparison with the developments described above, the self governing hospital would, for example:

- be free to grade, deploy and pay its staff - including consultants, who would also be hospital employees - as the board thought fit, bound only by arrangements to safeguard training to ensure a continued supply of skilled professional staff;

- be free to enter joint capital ventures with the private sector, and to allocate the funds earned through contracts to "revenue" or "capital" expenditures at will;

- be free to develop new packages of services which take advantage of technological advance, or meet new demand.

- be free to sell their services to whichever DHAs (or RHAs, for regional specialties) needed them, or to private sector health insurance companies;

13. Thus for fully self governing hospitals:

Funding would flow from DHSS to RHAs on the basis of their resident population. RHAs would allocate funds to the DHAs according to strategic plans. At both stages, funds for supra-regional and regional contracts with self governing hospitals would be held for payment direct to the hospitals. DHAs would use funds to provide those services for which they remained operationally responsible, and to finance their contracts with whichever self governing hospitals could provide the best packages of services. Contracts would be contestable by other public and private sector hospitals.

Capital assets used by a self governing hospital would remain in public ownership. The hospital would charge through its contracts for its use of these assets. Subject to RHA approval (to prevent asset-stripping) the board of management could dispose of assets and re-invest the proceeds in new developments. Funds for new investment would be available from the RHA's capital programme, according to priority, and to meeting the capital charges from their own resources. Self governing hospitals would also be free to allocate their own resources from contract income to capital investment.

Accountability for the delivery of services would flow from the self governing hospital to the DHA or other authority which placed the contract for the services. The hospital would be subject to the usual market disciplines. As regards the hospital's use of public assets, the board of management would be answerable via the RHA to the Secretary of State.

14. Not all the 600 or so present management units would be suitable for self governing status. DHAs would be likely to retain operational responsibility for some services, perhaps especially community and public health functions and at least some psychiatric services, and would need to ensure that the necessary integration of hospital and community-based services was not undermined. The DHAs would deal with self governing hospitals on the same basis as they would with private sector hospitals: as

contractors providing a service. They would nevertheless be expected to plan local services in close cooperation with the boards of management, and might need reserve powers for use if necessary to ensure that a basic range of core, local services were maintained.

A practical evolutionary path

15. Having set out the main features of self governing hospitals, and the freedoms and responsibilities they would enjoy, the task is to plan a practical evolutionary path towards that goal. It would not be possible, nor sensible, to attempt this in one step; an evolutionary approach would be essential. This requires the staged implementation of the various changes outlined above.

16. The risks of such a staged process of change would lie in giving some hospitals additional freedoms (say over pay levels, or over selling additional services) but not others. This could harm the competitive chances of the non self governing hospital eg because they lose their key staff to competing hospitals. Careful planning and regulation would therefore be necessary during the transitional period. The risk of unfair competition would be lessened by introducing full self government in discrete "blocks". Regions would offer the most appropriate framework for such staged implementation, and RHAs would have a key role in planning region-by-region changeover.

17. Managing the transition would be made more difficult by the fact that, under the existing system, hospitals have no "personality" at all. There would therefore be no formal "body" which, at the outset of transition, could participate (on the hospital's side) in the orderly introduction of full independence. It might therefore be advantageous to introduce the Boards of Management early in the process. In this way, the hospitals could be "up and running" in a constitutional sense, during the "building up the hospitals" phase described in paragraphs 2 - 6, but before they achieved full self government. RHAs would then be dealing with experienced and semi-autonomous bodies during the region-by-region implementation of fully self governing hospitals. A further advantage of early introduction of

Boards of Management would be that it would be a visible and popular signal of change.

18. In summary, an action plan for the development of self governing hospitals might be in four overlapping phases:

Phase 1: complete the introduction of devolved management and information systems.

Phase 2: create Boards of Management for all hospitals.

Phase 3: introduce the "contractual" model of service planning and management, applying it first to "baseload" services for the "home" DHA and then extending specialty by specialty to elective surgery for other DHAs. Hospitals would win funds according to their performance under these "contracts", in line with an internal market.

Phase 4: allow regions successively to implement self governing status for their hospitals, ensuring an orderly introduction of greater freedom to deploy their resources as they judge appropriate. For these hospitals the contractual framework would become the means by which DHAs paid for hospital services.

Teaching District level. Sir Roy Griffiths's Management Inquiry suggested that what matters most is who manages the contract rather than where it is held: the management of consultants' contracts is no more successful in teaching districts than in other districts. We need job descriptions and programmes of work which are established at district level; which are regularly reviewable; on which each consultant could be called to account; and which distinguish clearly between purely professional matters and those in which consultants are no different from other staff.

Disciplinary procedures

8. I am already in discussion with the profession about disciplinary procedures, and in particular the need to provide managers with more rapid and effective sanctions for use in the relatively few cases where allegations of professional misconduct or incompetence are insufficiently serious to warrant dismissal. We are close to agreement, and I see these new procedures as an important part of the overall package.

Participation by District General Managers in Consultant appointments

9. Consultant appointments are recommended - and almost invariably confirmed by the health authority - by essentially professional Advisory Appointments Committees whose primary consideration is the professional suitability of the candidate. There is no provision for District Managers to take a full part in these proceedings so that account is taken of the willingness and ability of the candidate to adhere to district policies on resource management. I suggest that we change the Appointment Regulations to permit the participation of the District General Manager in the selection of consultants.

Moving contracts from Regions to Districts

10. Moving contracts from Regions to Districts - although unpopular with the profession - would usefully underline the authority of local management, and I suggest we do that also. For hospitals which in due course become "self-governing", this change would be a precursor to those hospitals holding consultants' contracts themselves - which many in the

Draft (23.6.88)

CONSULTANTS

Note by the Secretary of State for Social Services

Introduction

1. This paper sets out my proposals for changes in the employment and management of consultants. Some factual information about hospital medical staffing is appended.

2. My aim is to:

* clarify the relationship between professional and management responsibility.

* ensure that NHS consultants are clear about, and committed to, their service responsibilities, the resources available to them, and their accountability to management.

* make it easier for NHS management to ensure that consultants meet their contractual commitments.

* keep in view the importance of the profession's commitment to other important changes arising from the review or, for example, from the resource management initiative.

3. We must preserve both the freedom of consultants to take clinical decisions within the boundaries of accepted professional standards, and their 24-hour responsibility for their patients. The major problem is that some consultants tend to argue or assume that their accountability is only

to their patients. While this is true for individual clinical decisions, it is unacceptable for management to have little authority or influence over those who are responsible for committing most of the service's resources.

4. We must address two questions: what changes should we make to achieve these ends? And how do we implement those changes?

What changes should we make?

Summary

5. The main changes we need to consider, ranked in broad terms from the easiest to the most difficult to deliver through negotiation, are as follows:

(i) reviewable job descriptions

(ii) new disciplinary procedures

(iii) participation of District General Managers in the selection of consultants

(iv) moving contracts from Regions to Districts and, in due course, to self-governing hospitals

(v) a new reward system to replace distinction awards

(vi) short-term contracts.

6. The following paragraphs discuss each of these in turn. In addition, I am proposing in a separate paper that participation in medical audit programmes should be a condition of employment under a revised contract.

Reviewable job descriptions

7. Consultants' contracts are currently held at either Regional or

profession might prefer. If this initiative is to succeed, it will be important to ensure that more clinicians become involved in local management and that, through this and other means, management arrangements are strengthened.

Distinction awards

11. Distinction awards for consultants were introduced in 1948. Their purpose is to enable a significant minority of consultants to achieve higher earnings for distinction and merit comparable with those available in other professions. An award takes the form of a superannuable increase in salary at one of 4 levels (ranging from £6260 to £33,720 per annum) which, once awarded, remains payable until retirement. An independent Advisory Committee on Distinction Awards makes annual recommendations about new recipients: apart from the Vice-Chairman, this is a professional body which takes advice from many professional sources and Regional Health Authority Chairmen. In their April 1988 report the Doctors and Dentists Review Body expressed concern about the operation of the distinction awards system and have suggested the introduction of an upper age limit for recipients, an examination of the concept of fixed-term awards renewable after review, and a greater involvement of management in the awards process.

12. I agree with the Review Body that we need to overhaul the distinction awards system and make it more consistent with the current needs of the NHS. Our aim would be to provide a continuing incentive to consultants not only to excel in clinical terms but also to make a valuable contribution to the development and management of the service. This could be achieved, for example, by

* making awards for future award holders reviewable after, say, 5 years.

* widening the criteria for awards to encompass the consultant's contribution to the development and management of the service.

* injecting a stronger management voice into the awards process.

13. We should need to consider the position of existing award holders. The profession would argue strongly that:

* awards recognise proven distinction and merit in the past, and therefore cannot be removed without gross injustice to the individuals concerned.

* award-holders will have arranged their financial affairs on the basis that awards, once given, become part of salary and are retained until retirement; and to remove the award of a consultant with a maximum award, for example, would reduce his salary by some 50% at a stroke.

There is nevertheless a strong case for making all awards, old or new, subject to review every 5 years. Such an approach would give existing award-holders who feared its withdrawal five years' notice of that possibility - and a full opportunity to demonstrate they had earned its retention.

Short-term contracts

14. Consultants are appointed to posts without term subject to 3 months notice, and can be dismissed or made redundant. There are two major ways in which consultants differ from other employees: one is a matter of custom and practice, and the other is the availability of additional rights of appeal against dismissal.

- First, the normal expectation is that once appointed a consultant stays in the same post until retirement age - perhaps for some 30 years.

- Secondly, although consultants can be dismissed in much the same way as other NHS staff (with specific procedures which health authorities must follow before a consultant can be

dismissed on grounds of professional misconduct or incompetence), they do have the right of appeal to the Secretary of State against dismissal. This is in addition to their rights under general employment law and applies to all forms of dismissal including redundancy. Because the Secretary of State has the power to direct that employment should continue, this procedure can act as a disincentive to authorities considering redundancy, but it does not actually prevent redundancies being made.

15. Broadly speaking, we could adapt one of two approaches to dealing with these difficulties:

(i) we could use the levers which the changes outlined above would give us. Reviewable job discriptions and the management of contracts at District level would make it much easier for management to monitor and change responsibilities and, if necessary, make posts redundant. Coupled with changes to the appointments procedures, and perhaps some financial incentives to relocation, retraining and even early retirement, these changes would amount to a powerful management armoury. Changing the distinction awards system in this way would make it more akin to performance pay, especially if "awards" were made reviewable.

(ii) we could introduce short-term, reviewable contracts, with renewal perhaps dependent on the achievement of agreed levels of service. This in turn could be done either for new consultants only or for all consultants aged less than, say, 50 or 55. Introducing short-term contracts for existing consultants would be impossible to negotiate and would therefore require primary legislation; but would add significantly to a health authority's ability to dispense with the services of someone whose performance is unsatisfactory or whose services are better deployed elsewhere.

16. The choice here is partly a matter of judgement on the merits, but is also bound up with how we achieve the changes we seek as a whole.

How do we do it?

17. There are several ways in which the implementation of these changes could be handled. I see five basic possibilities: ranging from the least to the most draconian, they are

(i) to negotiate with the profession - with a realistic hope of agreement - those changes which can be accomplished broadly within the existing contract. This would effectively confine us to the first three of the changes listed in paragraph 5 (of which the third, general manager participation in appointments, would be the most difficult to secure agreement on), but would still make for a worthwhile package.

(ii) to introduce a comprehensive new contract for new consultants only, leaving existing consultants on their present contracts. The problem here is the time it would take for the change to work through: it would be 15 years before even two-thirds of consultants were covered by the new contract on this basis.

(iii) to introduce a new contract for new consultants, and also offer a substantial incentive - in terms of higher pay - for existing consultants to move on to that contract if they choose to do so. The problem here is the cost. My current PES bid includes a "marker" of £50 million against the cost of negotiating a revised consultants' contract; but, at an average of £3,000 or so for each consultant, that would scarcely be enough to "buy" short-term contracts.

(iv) to proceed as at (iii), but taking legal powers to impose the new contract on existing consultants if the take-up is inadequate. This would be a surer route to securing the

changes we want, provided that care was taken not to breach the European Convention on Human Rights (as fundamental changes in an existing contract might do); but would certainly provoke a major row with the profession.

(v) to impose a new contract by law. Subject to the same human rights proviso, this would be the surest way of implementing change. But a huge row with the profession would be a certainty.

18. My initial inclination is to go at least for option (iii), as a publicly defensible way of securing major change, but - for the reasons given in 15(i) - not necessarily to include short-term contracts in the package. Colleagues will wish to discuss the possibilities, not only in their own right but also in the context of other changes we are considering which would affect the profession or require their support.

June 1988

APPENDIX

MEDICAL MANPOWER

England and Wales 30.9.86

Sector		Number
Hospital Service (1)		38,476
Community medicine		847
Community Health Service (2)		1,385
Hospital and Community Health Services	Total	40,708
General Medical Services		28,262
Total Medical Manpower		68,970

2. Hospital medical staffing (main grades)

	Number
Consultant	14,584
Senior registrar	3,394
Registrar	6,250
Senior House Office	10,318
House Officer	2,977

Notes

1. Main grades only (i.e excluding "clinical assistants", many of whom are also GPs.

2. Whole-time staff only (to avoid double-counting).

Consultants - key facts

3. Consultants can be appointed as:

		Proportion
i.	Whole-time. Private practice must not exceed 10% of salary.	48%
ii.	maximum part-time paid at 10/11ths of whole-time salary. Can undertake unlimited private practice.	32%
iii.	other part-time	9%
iv.	honorary (normally University employees)	11%

b. Under his terms of service, a part-time consultant as well as a whole-time consultant is "expected to devote substantially the whole of his professional time to his duties in the NHS".

c. Whole-time consultants' salaries start at £27,500 rising by four annual increments to £35,500. In addition, 36% of consultants receive a distinction award of between £6,260 and £33,720 p.a. One per cent receive the highest award: their whole-time salary (on scale maximum) is £69,220. Some 68% of consultants are in receipt of an award by the time they retire.

d. Total HCHS medical and dental pay bill for 1987/88 estimated to be £1,516 million, including some £50 million for distinction awards.

Draft (23.6.88)

MEDICAL AUDIT

Note by the Secretary of State for Social Services

Background

1. Medical audit is a critical analysis of medical activity in terms of process, outcome and implications for resource management. It is a potentially powerful tool for improving the quality of care and use of resources. It encompasses measurement of clinical outcome, scrutiny of clinical efficiency and productivity, assessment of patient satisfaction and fulfilment of contractual duties. As a full understanding of medical practice is essential, much of the analytic activity in medical audit is undertaken by colleagues in the same specialty - so called "peer review".

2. There have been encouraging developments in medical audit recently. Examples are:

* the Confidential Enquiry into Perioperative Deaths, a major study of all deaths within 30 days of surgical operation in 3 regions, now to be extended nationally with DHSS funding.

* a working party of the Royal College of Physicians, which is studying ways of extending the use of medical audit.

* the development of national protocols for checking standards in several branches of pathology.

Action proposed

3. The major unresolved problem at present is that consultants most in need of audit can refuse to participate. There are two specific steps we can take to help deal with this problem, and I propose that we do so:

MEDICAL AUDIT \ DHSS NEW

* A number of medical Colleges are moving towards making participation in audit a condition of a unit being allowed to train junior doctors. We should encourage this process.

* We should make participation in an audit programme a condition of employment under a revised consultant contract.

We must also make sure that our other proposals serve to embed medical audit into the system, for example through the criteria for hospitals to become "self-governing"; and that we encourage similar developments in nursing.

4. We need to determine responsibility for undertaking and overseeing medical audit, and to establish a new national body to support and monitor the initiatives which are needed at local level. I suggest we invite the Colleges to take this on in the first instance, with suitable non-medical representation. But if they are unwilling we should be ready to set up a body ourselves, with professional assessors.

5. Associated with the process of medical audit are two other developments which I suggest we should promote:

* further work on health outcome assessment: at present there is a paucity of information on the effectiveness of medical care to back up measurements of efficiency.

* continuing education: it is crucial that consultants maintain and develop their skills throughout their careers. We need to ensure that both managers and the medical Colleges reinforce this by making clear what they expect consultants to achieve in this regard.

6. There will be some additional costs associated with an expansion of medical audit, health outcome assessment and continuing education, and we shall need to assess these and take them into account in the normal PES process.

June 1988

TAX RELIEF BRIEF

SECRET

Inland Revenue

Policy Division
Somerset House

From: A J WALKER
Date: 23 June 1988

1. MR KUCZYS
2. CHANCELLOR

AJW 23/6

[All employees]

NHS REVIEW: TAX RELIEF

1. In advance of your meeting with Mr Moore and Mr Newton, you may like a summary of how things stand on proposals on tax relief for medical insurance.

2. We suggest that your stance should be that the furthest you can go is a package of tax relief for the over-60s, to help stimulate the most under-provided - but most needy - section of the market. The package on offer goes beyond what you offered at the Prime Minister's meeting on 7 June in that it offers benefit-in-kind exemption for the over-60s only.

This would cost £35 million in a full year, compared with £25 million for the earlier proposal.

---

c.c Chief Secretary
Financial Secretary
Paymaster General
Sir Peter Middleton
Mr Anson
Sir Terence Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Culpin
Mr Saunders
Mr Parsonage
Mr Call
Mr Battishill
Mr Isaac
Mr Beighton
Mr Corlett
Mr Lewis
Mr Kuczys
Mr Walker
PS/IR

SEC AJW11

3. If, in discussion with Mr Moore, you find that any further concession on the tax front is necessary to secure his agreement in other areas, our suggested order of preference is:-

i. relief at marginal rate for the over-60s (adds to staff cost and unlikely to be worthwhile).

ii. a lower age limit - say 55 - for relief to the elderly. The main problem here is holding the line at what might seem an arbitrary point.

iii. the proposal (covered in your paper for the last meeting of the Prime Minister's group) of exempting all employer-paid insurance contributions from being taxed as a benefit-in-kind. The main problems here are the cost and the difficulty of holding the line at medical care.

iv. Sir Roy Griffiths' idea of raising the benefits-in-kind threshold for medical insurance. This is in our view worse than ii. above: although less costly, holding the line would be just as difficult as under ii., and it would call in question the whole treatment of benefits-in-kind.

I attach defensive briefing on the issues in iii. and iv. at Annex 1 (provided by Mr Lewis).

4. We will be letting you have additional briefing (eg on the basic rate/higher rate issue) for use with the Prime Minister.

A J WALKER

NHS REVIEW: TAX RELIEF

BENEFITS-IN-KIND

ANNEX 1

a. A higher threshold for medical insurance benefits

1. One of the problems with a general benefits-in-kind exemption is that it would be perceived as unfair by employees and the self employed who pay their own premiums.

2. Your draft paper suggests that there would be additional unfairness with a separate threshold for medical insurance benefits as between those above and below the threshold and directors who would not benefit.

3. It may be argued that that does not matter because the same unfairnesses are inherent in the £8,500 threshold.

4. This is not so. At the time it was introduced, in 1948, the P11D threshold was equivalent in present day earnings terms to over £50,000. At that time benefits were virtually confined to directors and the very highly paid, so there was no unfairness in making the rules apply only to them.

5. Over the years, in part because of the existence of the threshold below which benefits were tax free, and partly because of other factors such as restrictive pay policies, benefits have become much more common at all income levels. So it did become the case that the threshold was unfair as between those above and below it.

6. Partly for this reason the Government's policy has been to let the threshold wither in real terms to the point where it will, in practice, apply to virtually all (full-time) employees. So we are fast approaching the point at which any unfairness in the threshold becomes fairly residual.

7. Against that background, introducing a new threshold for medical benefits at a substantially higher level would be quite a

different matter from the existing threshold, and would introduce a new, more marked unfairness as between those above and below the new threshold.

b. Why resist a general benefits exemption when other benefits such as sports facilities and canteens are exempt?

8. It may be suggested that there is no difference in principle between exempting sports facilities and canteens and medical insurance benefits. That is not the case.

9. As far as sports facilities are concerned, they are in principle chargeable, but we would not normally pursue the charge in relation to traditional sports facilities because the amounts attributable to any employee would be too small to make it worthwhile. So that is essentially an administrative disregard.

10. Canteen benefits can be much more substantial and ought in principle to be taxed. But so far this has had to be ruled out because of the substantial compliance burden for employers in determining the level of subsidy in their canteen facilities and the amount applicable to each employee. The statutory exemption for canteens applies only for meals in a canteen in which meals are provided for the staff generally, although, as you know, that concept has been extended considerably in long standing extra statutory concessions. Nevertheless there is the central concept that, for subsidised meals to be exempt from tax, they should be available to everyone.

11. So canteen meals are not unconditionally exempt at present; and there is no good reason for building on the present exemption, which arises from employer compliance considerations, to exempt medical insurance benefits, which are among the easiest benefits to tax.

week.20.6/mr.18

SECRET

FROM: H PHILLIPS
DATE: 23 June 1988

CHANCELLOR

cc Chief Secretary
Sir Peter Middleton
Sir T Burns
Mr Anson
Mr Turnbull
Miss Peirson
Mr Saunders
Mr Parsonage

Mr Corlett) IR
Mr Kuczys)

NHS REVIEW: YOUR MEETING WITH MR MOORE

There are six draft papers for your discussion tomorrow with Mr Moore at 10.30am:-

- tax relief (the Inland Revenue draft you have amended)
- financing hospitals (the Chief Secretary's paper)

and

- contracting out)
- self-governing hospitals) papers from
- consultants) Mr Moore
- medical audit)

This is a formidable agenda.

2. Mr Newton cannot be there. Mr Moore will be accompanied by Sir Roy Griffiths and Mr Heppell. Mr Wilson (Cabinet Office) will attend. I will support you and the Chief Secretary.

Agenda

3. I suggest you might wish to take the papers in the following order

- tax relief
- contracting out

financing hospitals
self-governing hospitals
consultants
medical audit.

4. Before you conclude you will also want from Mr Moore any reactions he has to the Chief Secretary's letter of 21 June about how work on the review should be handled over the next three weeks.

Tax Relief and Contracting Out

5. Your paper on tax relief concludes (paragraph 13) that the most far-reaching tax package you would be prepared to recommend is relief for the elderly at the basic rate including benefits in kind. The paper itself sets out the cost and tax policy arguments against relief at the marginal rate and a wider exemption on benefits in kind.

6. Mr Moore may be disappointed but not, I imagine, surprised that you are not prepared to go further. He still hankers after a bigger boost to demand us something politically attractive and necessary to drive up private provision. We accept neither of these propositions. Anything much beyond your proposal would be difficult to ringfence, more likely to be seen as divisive, and presented as a step towards "two-tier" care. Any bigger boost to private provision would have greater dead-weight cost, may not succeed in getting more private money into health care, and, even if it did would, because of supply side constraints eg numbers of consultants, structure of the professions, etc simply drive up costs and prices. [Hayden confirms figure of 25% growth since beginning of yr not anypo, anecdotal, admittedly, but from reputable source — AMI]

7. Here is the link with Mr Moore's paper on contracting out, a line to take and brief on which is at Annex A. Mr Moore has carefully tabled this as a note by officials and reserved his position as he does not want to put it to the Prime Minister and have it rejected. We see his proposals as little different in effect from those which our earlier paper on contracting out rejected. The objective is to get him to draw back from contracting out and

accept your tax relief concession. Your proposed minute to the Prime Minister on supply and demand will underpin our position.

Financing Hospitals

8. You will want to ask the Chief Secretary to introduce this paper. We expect Mr Moore will find our proposals acceptable subject to more work on the practical details being done by officials.

Self-Governing Hospitals

9. A brief and line to take is attached at Annex B.

10. We are not getting very far with these grandiose schemes for 'self-government': now linked, in this paper, with a financing scheme through contractual agreements between hospitals and health authorities. The paper argues, at the end, for an evolutionary plan starting with devolved management and information systems, then creating Boards of Management, then introducing the 'contractual' model, and finally allowing self-governing status for hospitals. Even if we agreed that the proposals stood up implementation is a very long way off.

11. So far our view is that the ideas on self-government and contracts are the stuff of a Green rather than White paper approach to reform, and even if presented for discussion over a lengthy consultation period they need to be properly worked out.

12. Our objective should be to get Mr Moore to accept that the problems outlined in the brief need resolution before decision, and that it would be better to work out some practical but more limited schemes. Can something be done for a limited type of hospital or a pilot designed for trial in one or two regions?

Consultant's Contracts

13. A brief and line to take is at Annex C.

Hayden asked me to mention that they are working on the teaching hospitals as model idea. He will be doing a note. But pro tem, he says there look to be some problems & you may not want to commit yourself to this particular idea

14. This is a tougher and more radical paper than we could have expected. But if all the changes were implemented, buying out the consultants, and their opposition, could be very expensive. They will also be difficult politically - with the doctors. For this reason I think Mr Moore may argue that it would be better to take this paper only after we see the shape of the rest of the emerging package, and certainly not as early as 30 June. I think we should resist this. What we do about consultant supply, restrictive practices, and clinical involvement in management need to be examined on their merits and before a package is constructed for discussion on 8 July.

Medical Audit

15. A short brief is at Annex D.

pps in separate section behind

16. In the context of this part of the discussion it might be worth registering the agreement with Mr Moore on the related issue of the objective of independent VFM audit. It would be useful if this agreement was reported, orally, at the Prime Minister's meeting on 30 June.

Handling

pps under 'agenda' behind

17. You might ask Mr Moore whether he is content with the Chief Secretary's proposals in his letter of 21 June. We are not clear what is meant by their paper on "other professional/manpower issues". The key document for you to look at in the 'quadrilateral' planned for 4 July is the package of emerging proposals.

HP.

H PHILLIPS

007/4206

cc:
Chancellor
Sir Peter Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Saunders
Mr D P Griffiths

Treasury Chambers. Parliament Street. SW1P 3AG

Geoffrey Podger Esq
Private Secretary to the
Secretary of State for Social Services
Department of Health and Social Security
Richmond House
79 Whitehall
London
SW1

23 June 1988

Dear Geoffrey,

REVIEW OF RAWP

The Chief Secretary has seen your letter of 20 June to Paul Gray and his reply of 24 June.

The Chief Secretary too is content with the terms of the proposed statement. As regards the basis for health authorities' 1989-90 plans, he considers that the resource assumptions should not be based too rigidly on the existing formula but should be wide enough to encompass a deceleration of the RAWP redistribution process.

I am copying this letter to Paul Gray (No.10), Jon Shortridge (Welsh Office), David Watkins (Northern Ireland Office), David Crawley (Scottish Office) and Trevor Woolley (Cabinet Office).

Yours,
Jill

JILL RUTTER
Private Secretary

mjd 3/177m

SECRET

BF 28/6

FROM: MISS M P WALLACE
DATE: 23 June 1988

MR KUCZYS

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

PS/IR
Mr Lewis
Mr Corlett

NHS REVIEW: TAX RELIEF

The Chancellor was most grateful for your minute of 16 June. As you know, this has now been circulated to the "Quadrilateral Group", with the amendments we discussed. As I also mentioned, the Chancellor agrees that it might be an idea to have a word with the Prime Minister about this paper in advance of the next No.10 meeting. We have a bilateral scheduled for next Wednesday, the 29th, and the Chancellor would be grateful if you could let him have an aide memoire.

MOIRA WALLACE

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

pl attach X.

CONFIDENTIAL

Miss J K Rutter
Private Secretary to the
Chief Secretary to the Treasury
Treasury Chambers
Parliament Street
LONDON
SW1P 3AG

Miss Pearson
Cx, Sir P. Middleton
Mr Anson, Mr Sir A Wilson
Mr Phillips, Mr Beastall, Mrs Case,
Mr Turnbull, Mr Ponsonage, Mr Potter
Mr Sanders, Mr Call

23 June 1988

Dear Miss Rutter,

NHS REVIEW: AUDIT

X Thank you very much for your letter to Flora Goldhill noting the recent discussion between the Chief Secretary and my Secretary of State with supporting officials on NHS audit.

I should record a slight gloss on the final paragraph of your letter. My Secretary of State's understanding of the outcome of the meeting is that officials were tasked with drawing up a list of the criteria for an acceptable NHS independent audit authority for my Secretary of State and then with identifying whether, and if not why not, the Audit Commission could fulfil this role.

Yours sincerely,

G J F Podger

G J F PODGER
Private Secretary

ps2/56M

SECRET

MP

CC LST
FST
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Mr Culpin
Ms Peirson
Mr Turnbull
Mr Saunders
Mr Parsonage
Mr Call
PS/IR
Mr P. Lewis IR
Mr Kuczys IR

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

23 June 1988

Geoffrey Podger Esq
PS/Secretary of State for Social Services
Department of Health and Social Security
Richmond House
79 Whitehall
LONDON
SW1 2NS

Dear Geoffrey,

NHS REVIEW

As promised, I enclose our two draft papers - on tax relief, and financing hospitals - for discussion at tomorrow's "quadrilateral".

I am copying this letter to Sir Roy Griffiths, Jenny Harper, and to Richard Wilson at the Cabinet Office.

Yours,

Moira.

MOIRA WALLACE
Private Secretary

NHS REVIEW: TAX RELIEF

Paper by the Chancellor of the Exchequer

1. At the meeting on 7 June we agreed that:-

   a. the question of restricting tax relief for the elderly to the basic rate should be looked at again; and

   b. a more limited benefits-in-kind exemption, targeted on those with earnings below a specified level, should be considered.

This paper reports on both points.

Tax Relief for the Elderly

2. Providing tax relief for private medical insurance for the over-60s at basic rate only would benefit 300,000 existing policyholders at a deadweight cost to the Exchequer of about £25 million. Allowing relief at the higher rate, as well, would be of additional benefit to about one-quarter of this group - 75,000 policyholders. The Exchequer cost would rise to a little over £30 million. There would also be some additional administrative complication. That is because, while basic rate relief would be provided at source through a MIRAS-type arrangement, higher rate relief would have to be dealt with by tax offices, through individuals' PAYE codes or tax assessments.

The question is whether these additional costs are likely to be worthwhile.

3. Clearly, in principle, the higher the rate of tax relief, the greater will be the effect on behaviour of those who benefit: a 40 per cent relief is likely to bring in more new subscribers than a 25 per cent relief. But a 50 per cent increase in take-up would be needed before the extra money going into private health care exceeded the cost of tax relief, compared with an increase of 33 per cent if relief were given at basic rate only. Only those over-60s with incomes comfortably over £20,000 would benefit from this further concession: those with income below that level would gain nothing at all from higher rate relief. So, on the one hand, the additional impact of higher rate relief would be strictly limited; while, on the other, it will give further ammunition to opponents of the scheme.

4. There is a further complication with giving higher rate relief. In my previous paper I pointed out that it might be attractive to let tax relief flow to whoever paid the premiums for a person over 60, so there would be encouragement for people of working age to pay their elderly parents' BUPA subscriptions, and this was generally welcomed. But if higher rate relief were available in such a case, it could provide a strong incentive to dress up payments by the parent as payments by the son or daughter - regardless of the true position - thus adding to the cost of the relief. In order to guard against this abuse, some additional irritating safeguards would be unavoidable.

5. In conclusion, tax relief for the elderly at the higher rate would increase the complications of the scheme, and provoke unnecessary criticism. The closest precedent for health insurance premium relief, life assurance premium relief, was (and, for pre-1984

policies, still is) given at half the basic rate, for basic rate taxpayers and higher rate taxpayers alike.

Benefit in Kind Treatment

6. For company health insurance schemes, the suggestion was to raise the limit below which employees escape tax liability on this particular benefit in kind. Since company schemes at the moment are concentrated among the higher paid, this would have the advantage of reducing the deadweight cost and targetting the incentive where it is most needed.

7. I have therefore considered the possibility of raising the limit from its present £8,500 to something in the region of £20,000 - roughly the point at which higher rate income tax liability starts. It would mean that the proportion of employees who would be exempt from tax on medical insurance would go up from 17 per cent to 65 per cent at a deadweight cost of some £m25.

8. But while this approach has its attractions, it also has some further disadvantages to add to those relating to a general benefits-in-kind exemption which I described in my minute of 3 June.

9. First, having a second income limit would be a significant added complication for employers, increasing their administrative costs. The Revenue, in conjunction with the Deregulation Unit, is currently engaged in finding ways of minimising the compliance costs of taxing benefits-in-kind: this would be a move in the opposite direction.

10. Second, it would increase the pressure to raise the £8,500 P11D limit across the board. Our consistent

policy has been gradually to bring the tax treatment of payment in kind and cash into line by allowing the real value of the P11D limit to fall. The limit has not been increased since 1979. It is now widely recognised that it is anomalous to have any income limit in taxing benefits, and that it is right to let the present limit wither away. We are well on the way to success with this policy, since there are now relatively few full-time employees with cash pay plus benefits of less than £8,500. But there also continues to be pressure, as we have seen again in this year's Finance Bill debates, to increase the limit substantially. Setting a new limit for medical insurance - one of the commoner benefits-in-kind-would clearly add to this pressure, and make it more difficult to resist.

11. Third, it would add to the sense of unfairness already felt by those whose employers do not run a company health insurance scheme, or who are self-employed.

Benefits-in-kind and Relief for the Elderly

12. But if we decide to introduce a new tax relief for premiums paid for the over 60's, then we could, I believe, provide a parallel relief for the benefits-in-kind charge on corresponding premiums. The argument is exactly the same in relation to the over 60's as it is for employees and the self-employed generally - we should ensure that there is no difference in tax treatment between those who pay their premiums privately, and those who get them paid by their employers.

13. Including benefits-in-kind in the relief for the over 60s, and confining relief to the basic rate, would

increase the cost, at current levels of provision, to £35 million and would benefit 65,000 employees as well as 300,000 individual policyholders. This is the most far-reaching tax package I would be prepared to recommend.

22.6.2

SECRET

NHS REVIEW: FINANCING HOSPITALS

Note by the Chief Secretary, Treasury

At our meeting on 24 May, I was invited to prepare a note about how the system of allocating resources to health authorities might be improved to reward hospitals which attracted more patients by greater efficiency. I attach a note which my officials have prepared on how a scheme of this sort might work.

2. The real growth in HCHS expenditure - which, realistically, we must expect to continue for the foreseeable future - would be earmarked for allocation on the basis of performance. Regions would be given funds for distribution to districts on broadly the same basis as now, based on inflation-adjusted total their districts received the previous year. The remainder would be allocated to the best performing.

3. On the specific points raised in the paper, my views are as follows:

a. I think it makes sense, initially at least, to build on the present performance indicator system and make allocations to districts rather than trying from the centre to target the best-performing hospitals.

b. I have no strong views on whether the allocations should be made by regions or by the DHSS, and would welcome the views of colleagues on this.

c. I hope our officials can be invited to draw up a suitable indicator or set of indicators quickly. Clearly, the measure should not be so crude as to meaningless, but it should also not be so sophisticated that there is a long time lag before it is available.

d. I agree that the bulk of the money should be allocated on the criterion of improved efficiency. But I see attraction in allocating some of it on the basis of increased activity in the areas where waiting lists are longest, replacing the present waiting list initiative.

e. When we have reached conclusions on the Secretary of State's paper on self-governing hospitals, we can consider how to adapt this system for them. But this should not present overriding difficulties.

4. I believe a scheme of this nature has a number of attractions. It would:

- provide real incentives for health authorities to improve their efficiency

- direct resources towards those areas where efficiency was being given priority; and

- thereby allow money to flow to those who improved their capacity to treat patients.

SECRET

FINANCING HOSPITALS

Note by the Treasury

This paper examines the scope for rewarding the best performing parts of the NHS through a "top-sliced" element of the health budget. It is intended to tackle quickly the problems that exist now. It does not necessitate structural change in the NHS and involves only relatively modest change at first. But it could be adapted readily to an evolving NHS structure.

The problem

2. The present resource allocation system is based on need. Money is distributed to regions on the basis of the relative priorities revealed by the RAWP formula, and then from regions to districts. The criteria applied by regions in allocating funds to districts vary, and by no means all follow RAWP-style methods. But in general the system takes no account of efficiency or performance.

3. In theory, the main incentive to improve efficiency is that it enables a hospital to provide a greater volume of services within a fixed budget. But in practice this turns out to be only partially true, because treating extra patients of itself generates increased costs. In general, if throughput is improved so that more patients can be treated within existing capacity at existing staffing levels, unit costs do not fall commensurately, so that the improved treatment rates cannot be achieved without increased funding. So the incentives to improve efficiency are not as great as they could be.

Top-slicing

4. In outline, the system would be quite simple. Most current expenditure would be allocated as now: distributions to regions in the previous December; allocations by regions to districts completed by late February. The amount allocated in this way might be equal in real terms to the total of health authority budgets the previous year, leaving the balance to be allocated on the basis of performance. Typically, after allowing for pay awards, notably to doctors and nurses, this has left room for real growth of around 2%, or £250m.

5. This would be in February, so that hospitals would go into the year in full knowledge of their budgets. The total available for distribution would have been determined in the previous public expenditure survey. If, for the sake of argument, it was 2% of the total, the extra performance-based allocations might vary between 0 and 5% of initial allocations. The distribution within the total sum available for these allocations could be settled only when the overall performance of all health authorities had been assessed.

6. The interaction between the system and that for allocating resources generally would be complex, but it should be possible to ensure that rewards were carried forward into baselines for future years, and were not lost at the end of the year. Initial allocations to regions would be based on the previous year's total allocation (including performance awards). If there were to be further movement to RAWP targets, allowance would have to be made: either (and this would be very controversial in RAWP-losing regions) by adjusting these allocations up or down; or by using some of the growth money for RAWP adjustment rather than rewarding performance. Regions would be asked, in their allocations to districts, to take full account of previous performance awards, alongside the other criteria they apply. So a district's allocation should reflect the carrying forward of previous awards, possibly with some adjustment for other factors.

7. A number of questions need however to be addressed:

- to whom would the performance-based allocations be made: hospitals or districts?

- how would their performance be measured?

- would the objective be to reward activity or efficiency?

- would performance be measured against some external standard, or would the criterion be improvement in measured performance?

District or hospital?

8. Allocations direct to hospitals, or even to departments within hospitals, would provide the most direct incentives to improve efficiency. Money would be diverted to the best performing parts of the health service in a very direct way. But it could be difficult for DHSS to interpret sensibly information coming forward from individual hospitals. Moreover, such information is not yet available in the required detail.

9. Performance-based allocations to districts could, in principle, be introduced much more quickly. The new district-level information system, based on the Korner report, was introduced from 1 April 1987. In principle, this could be adapted for the purpose of top-slicing. Giving the money to districts would enable them to allocate it both in accordance with local priorities and so as further to improve efficiency, in the knowledge that this could be expected to result in further financial rewards. Districts could be asked to link allocations to units on performance and efficiency targets. This would be a first step towards a more contractual style of management.

10. Whether allocations to districts should be made by regions or by the department is a matter for judgement. Regions would have considerable scope to undermine the effect of the performance-based allocations by offsets in their disbursements to districts. On the one hand, it could be argued that separating the two processes by the department making the performance-based allocations would minimise the scope for this. On the other, it could be argued that the commitment of the regions to the new system would be best secured by giving them responsibility for allocating the money. Ministers are invited to consider the balance of argument between giving the function to regions or the department.

How to measure performance?

11. Ideally, an objective measure would be devised, based initially on performance indicators for districts. The measure would obviously need to be as up-to-date as possible. If allocations are to be made in the February before the start of the financial year, it might be possible to base them on performance

in the 12 months to the previous 30 September, although this would involve speeding up considerably the present timetable for producing the performance indicators.

12. Officials will need to do more work urgently on the development of measures based on performance indicators, if Ministers wish to pursue this route.

Activity or efficiency?

13. This depends on the area being considered. Where waiting times are excessive, increasing activity levels - and maintaining the increase - is the only way to get them down. But increased activity is not a good measure of performance in other areas - for example, psychiatry.

14. This suggests a two-pronged approach. In order to introduce the right incentives and to deal with the problems identified in paragraph 2 above, the general criterion for distributing the top-sliced money should be efficiency. But the concept could be imported into the present efforts to tackle excessive waiting times for routine procedures. A separate top-sliced allocation, replacing the present waiting list initiative, could be distributed to those who had done most to increase activity in certain defined areas, thus reducing waiting times, in order to encourage them to go further, if necessary taking patients from waiting lists in other nearby districts.

Absolute performance or improvement in performance?

15. Any attempt to devise a "standard" performance measure would be very complicated. The formula would have to take account of the size and distribution of hospitals within the district, the range of specialties covered, the characteristics of the local population. It might also have to cover factors like how many

sites hospitals are spread over, and their layouts, which affect efficiency but are beyond the control of the local management. No matter how sophisticated the formula, many would continue to argue that they were subject to special factors which were not given their due weight.

16. Such problems would be avoided by measuring performance over the most recent 12 months and comparing it with the previous period. It would be much more difficult to argue that there were special factors which inhibited improvement in performance, as opposed to the absolute level of that performance. Rewards based on improved performance would also offer more immediate incentives to management. Those who started well down the league might need to spend several years improving their efficiency before qualifying for extra money if the criterion were absolute level of performance. Management might get discouraged in such circumstances, whereas they could start to benefit immediately if it was improvement in performance that was being rewarded.

17. One difficulty with rewarding improvement in performance is that it might be the least efficient authorities with most scope for improvement (eg because they had been slow to introduce competitive tendering) who would benefit most. But once the system had been running for a few years, the best authorities should have found ways of improving their efficiency as well over time. So long as the system ensured that the allocations were built into baselines for subsequent years, the best districts should be able to reap suitable rewards.

Implications for self-governing hospitals

18. The system would need to be adapted for self-governing hospitals, independent of districts. It is difficult to say what form this would take, without clear decisions on the nature and structure of such hospitals. Among the questions to be considered are:

- whether their allocations should distinguish "baseload" functions (service to the local community, just like any other district general hospital, referrals by GPs etc) from any functions as "centres of excellence", eg the referral by consultants in other hospitals of particularly difficult cases

- whether the financing of their "baseload" services should be able to share in the growth money given out to the rest of the system in performance-based allocations

- if so, whether they too should be subject to the same regime of performance measurement

- whether the "centre of excellence" functions could be financed differently, eg by direct payments from the budgets of other hospitals whose consultants referred their patients on.