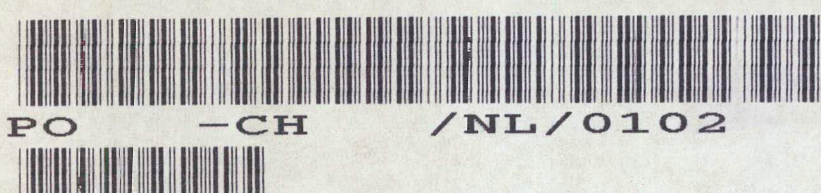
PO-CH/NL/0102
PART I

Part J.

SECRET

(Circulate under cover and notify REGISTRY of movement)

Begins: 29/6/88.
Ends: 6/7/88.



PO -CH /NL/0102
PART J

Chancellor's (Lawson) Papers:

THE NATIONAL HEALTH SERVICE REVIEW

Disposal Directions: 25 Years

10/8/95.

29.6.2

covering SECRET

FROM: D P GRIFFITHS

DATE: 29 June 1988

1. MR PHILLIPS

2. CHANCELLOR

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

NHS REVIEW: 1 JULY

I attach a revised brief and line to take on Mr Moore's paper on consultants' contracts.

2. I have pursued the question of the proportion of company-paid health insurance schemes which are open to all employees. We do not have any definitive information available but an Income Data Services study in February 1987 found that only about 15% of the company schemes in its sample were open to all employees. (This was in line with the findings of a 1985 survey by Audience Selection.) It is doubtful whether the position has altered significantly since then. Company-paid schemes open to all employees are costly and hence unattractive to the generality of firms.

D P GRIFFITHS

SECRET

CONSULTANTS' CONTRACTS

Points to make

Essential objectives of change in this area are to ensure more flexibility in the use of consultants and have them properly accountable to general management.

2. Fully support proposals to introduce reviewable job descriptions, new disciplinary procedures, participation by managers in consultant appointments, moving contracts to districts and reform of distinction awards, though too costly both financially and politically to alter the position of existing award holders.

3. Introduction of short term contracts probably necessary to ensure that our objectives are achieved. Consider these contracts can be introduced for new consultants without offering any financial compensation: we are abolishing tenure for new university academic appointments without increasing salaries. Doubt that it would be cost-effective or desirable to try to end tenure for existing consultants.

4. Should also consider scope for promoting more part-time work by NHS consultants to prevent any supply constraints affecting growth of private sector health care.

Background

5. 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 consultants' posts; and greater recognition of and financial incentives for the resource management responsibilities of consultants.

Short-term Contracts

6. However, we consider that these benefits can only be fully realised by the introduction of short term contracts. Otherwise, whatever may be prescribed in performance targets and provision for review of appointments, the difficulties of actually getting rid of a consultant caused by the inertia of the system and the support from his peers may result in management's having no more control over consultants than at present. As the 'Trafford Group' noted, "once the concept is accepted... that doctors have no more right to a specific job or jobs for life than any other member of the community, manpower problems become easier".

7. Ending the tenure of existing consultants would be very controversial and could certainly only be achieved by offering substantial financial compensation:- DHSS have estimated the costs at £108m a year. We doubt whether it is sensible to pursue this option. However, there is no compelling reason why these contracts should not be introduced for new consultants. DHSS estimate that this would cost some £7m in year 1 with similar increases in subsequent years. But we question whether any additional salary need be offered in compensation. In the case of university academics, legislation is being introduced to end tenure for new appointments but they would not receive any more money. Unfortunately there is an opposite precedent in the NHS. When the new pay structure for general managers was introduced in 1986 it included an element (some £2000-3000) to reflect the fact that they were now on short-term contracts (whether the appointments were new or old).

Merit Awards

8. More work needs to be done on the reform of distinction awards - who will make the awards, size of the awards, pensionability and likely number of recipients. Larger awards may be necessary in return for making them reviewable, although we would want to minimise any additional funding which might be required for this purpose. The main question addressed by Mr Moore concerns treatment of existing awards. The profession would

fiercely resist making these awards reviewable. We doubt whether it would be politically practicable to proceed with the change without offering a level of compensation which would be highly unattractive from a public expenditure standpoint.

Part-time Practice

9. The paper still does not mention the question of part-time practice or the opportunity for creating more 'junior' consultant posts. We consider it is worth examining the possibility of abolishing the "maximum" part-time contract (of 10/11 full time) and promoting more genuine part-time work. This could encourage more consultants to take the latter option, increasing their availability for private practice. (But note that Mr West, the DGM for Portsmouth, felt that part-time contracts were not cost-effective because consultants then, after carrying out research, teaching and audit, had little time left for actual patients.)

ST2

week.27.6/mr.4

SECRET

FROM: H PHILLIPS
DATE: 29 June 1988

CHANCELLOR

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

Ch/ Your minute on supply + demand has gone round. [With other circulated papers behind]. Full Trafford text is in background pps at back.

NHS REVIEW: 1 JULY

MPW.

Attached is revised briefing on consultants' contracts, and, in Mr Griffiths' note below the best information we have so far been able to obtain about company schemes open to all employees. Perhaps I could add a few comments on each.

2. On consultants' I agree with the views expressed in paragraphs 6 and 7 of the brief that short term contracts for new entrant consultants are probably a necessary way to break in to the existing system, and that it is reasonable not to accept that additional money is necessary to achieve this. But you should know that

a. the analogy with ending tenure for academics is not as complete as we would wish as the authorities can appoint for as long as they like, albeit with clearer provision from now on for sacking. But the new arrangements do include short term contracts; and

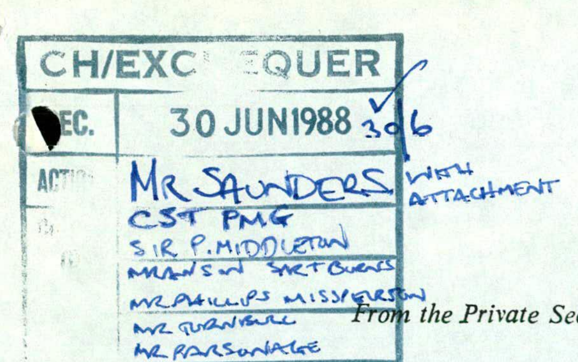
b. the precedent for NHS general managers is not as bad as might appear because in covering old as well as new appointments, changes were made to actual conditions of employment as well as to expectations of tenure on promotion.

3. You mentioned this morning the possibility of a fall back concession of an exemption for company paid health insurance

schemes which were open to all employees. Inland Revenue have already said that they would need to look at this in more detail, if it became a runner, to see if it was workable. But the figure of 15 per cent of company schemes is quite a bit lower than I had imagined it would be. I suppose cost is the main factor. If an exemption could be made to work I imagine, however, it will be difficult to say how much impact it might have as the incentive it would provide would be for the individual employee rather than the company so any boost to demand would come about rather indirectly. I fear an exemption might mean a great deal of effort for very little reward.

HP

H PHILLIPS



10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

29 June 1988

Dear Geoffrey,

I enclose for the information of members of the NHS Review Group a submission by the King's Fund College.

I am copying this letter and enclosure to Alex Allan (H.M. Treasury), Jill Rutter (Chief Secretary's Office), Jenny Harper (Minister for Health's Office), David Crawley (Scottish Office), Jon Shortridge (Welsh Office), David Watkins (Northern Ireland Office), Sir Roy Griffiths, Trevor Woolley (Cabinet Office) and Richard Wilson (Cabinet Office).

Yours,
Paul

Paul Gray

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

ps2/66M SECRET

FROM: MISS M P WALLACE
DATE: 30 June 1988

CHANCELLOR

NHS REVIEW

Hayden reports the following gossip on how others are being briefed for this afternoon's meeting.

2. The Prime Minister saw Richard Wilson's Steering Brief over the weekend. Lots of question marks beside the passage on tax relief, apparently. Hayden's feeling is that there may be a rough ride on marginal rate versus basic rate, but that the outlook may be a little more optimistic on the benefit in kind question, particularly after your minute. Briefing from the Policy Unit is likely to say that the CST's top-slicing scheme is not grand enough, and will "freeze the awfulness of RAWP, regions etc.". Hayden will be having a word with the Chief Secretary about this before the meeting. For what it's worth, Mr Moore is being briefed not to oppose our top-slicing paper, as a quid pro quo for our stance on self-governing hospitals.

3. We have also been doing some thinking about the quadrilateral meeting which is in the diary for Monday. This ought to discuss the "package" paper: as you know, Hayden has done a first draft. Mr Moore has seen this, and is apparently a littled miffed that it has been drafted by Treasury rather than DHSS, and is therefore "minimalist". Hayden thinks we can recover from this bad start: the plan is that he will get together with Richard Wilson and Strachan Heppell tonight and tomorrow morning to produce a tripartite official draft, which Ministers could then discuss on Monday, with no commitment on any side. We could also use that meeting to have another go on the Audit Commission front.

MPW.

MOIRA WALLACE

... **PS:** Useful piece in today's Independent, attached in case you missed in the cuttings.

week.27/6/mr.7

SECRET

Ch/ as foreshadowed

FROM: H PHILLIPS
DATE: 30 June 1988

CHIEF SECRETARY

MPW

cc Chancellor
Miss Peirson
Mr Saunders - o/r

NHS REVIEW: MEETING TODAY

As it may not be easy for you to fit in a conversation before the Prime Minister's 4.30pm meeting today I thought I should let you have a brief additional note.

2. It is possible that your paper on financing hospitals may be criticised as blocking off more radical reform and going too much with the grain of RAWP and the existing allocation system.

3. There is a robust response to this:-

a. RAWP is not about rewarding or improving performance but about equalising provision across the country - hence your proposal to reward, and encourage, efficiency;

b. you intend it to be a bridge across to the way in which self-governing hospitals (if agreed) might be financed as they progressively develop;

c. it is designed to inject faster change into the existing system and to be capable of implementation quickly.

4. No one has yet come up with a better scheme for rewarding performance that looks workable; and I doubt if anyone will this afternoon. If the Prime Minister feels that a 'dead hand' in the regions would effectively undermine our objective then you can say you have already indicated an open mind on whether or not the DHSS should do it.

HP.

H PHILLIPS

30.6.3

Ch/ I'm not sure I would fret about either of these, in the circs. [Save our powder for his speech in the House] MPW.

FROM: D P GRIFFITHS

DATE: 30 June 1988

1. MISS PEIRSON MP

2. PS/CHANCELLOR

cc PS/Chief Secretary
Mr Phillips
Mr Saunders
Mr Call

Agree

MR MOORE'S NHS SPEECH 4 JULY 1988 [To the CPS]

There are a couple of points worth taking up on the draft speech. In paragraph 15 there is the statement that "each and every family contributes over £1600 a year to the NHS". [That is untrue.] Mr Moore is, of course, talking about the cost of the NHS to the notional family of 4 and this should be made clear. I suggest re-drafting the latter part of paragraph 15 as follows:-

> "Apart from social security ..... aspect of Government. Well over £22 billion will be spent on the NHS this year - equivalent to £1600 per family of four."

2. In paragraph 36 Mr Moore attacks the need to clear "with Whitehall" certain staff promotions. This is going too far: we would not want to see a system in which all NHS appointment and promotion issues were at the complete discretion of managers. I suggest the last sentence of paragraph 36 is deleted or replaced by something more general such as:-

> "Managers must be allowed to get on with the job of managing."

[signature]

D P GRIFFITHS

mjd 3/186m

UNCLASSIFIED

BF 4/7 pmp.

FROM: MISS M P WALLACE
DATE: 1 July 1988

MR GRIFFITHS

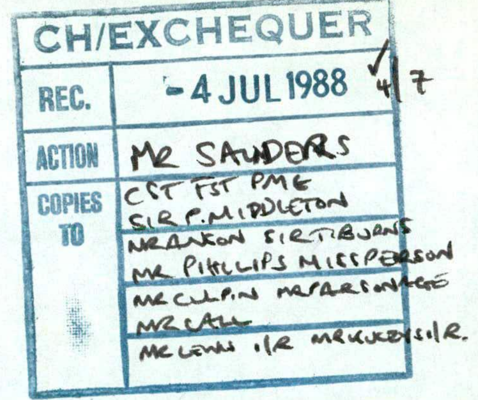
cc PS/Chief Secretary
Mr Phillips
Miss Peirson
Mr Saunders
Mr Call

MR MOORE'S NHS SPEECH 4 JULY 1988

The Chancellor was grateful for your note of 30 June. On balance, he is not inclined to intervene at private office level on this one. But he has commented that we will want to have an advance look at the Moore/Newton speeches for the debate next week. This request has already been registered with Mr Moore's office.

mpw.

MOIRA WALLACE



10 DOWNING STREET

LONDON SW1A 2AA

1 July 1988

From the Private Secretary

Dear David,

NHS REVIEW

The Prime Minister thought that your Secretary of State, and the Secretaries of State for Wales and Northern Ireland, might find it helpful to see some of the recent papers considered by the Review Group before the 8 July meeting that they will be attending.

I therefore now enclose:-

i) a report submitted by Lord Trafford on 1 June

ii) notes by the Chancellor of the Exchequer on tax relief and supply and demand

iii) a note by the Chief Secretary on the financing of hospitals

iv) notes by the Secretary of State for Social Services on contracting out, self-governing hospitals, consultants and medical audit

v) minutes of the meeting of the group held on 30 June.

Before the 8 July meeting the Cabinet Office and Sir Roy Griffiths will be circulating further papers.

I should be grateful if you and copy recipients would ensure that this material is shown only to those with an operational need to see it.

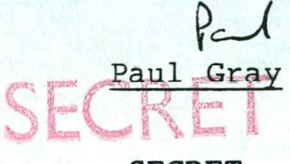
I am sending copies of the letter and the enclosures to Jon Shortridge (Welsh Office), David Watkins (Northern Ireland Office), and of this letter only to Alex Allan (HM Treasury), Jill Rutter (Chief Secretary's Office), Geoffrey Podger (Department of Health and Social Security), Jenny Harper (Minister for Health's Office), Sir Roy Griffiths (NHS Management Board) and Trevor Woolley and Richard Wilson (Cabinet Office).

Yours,

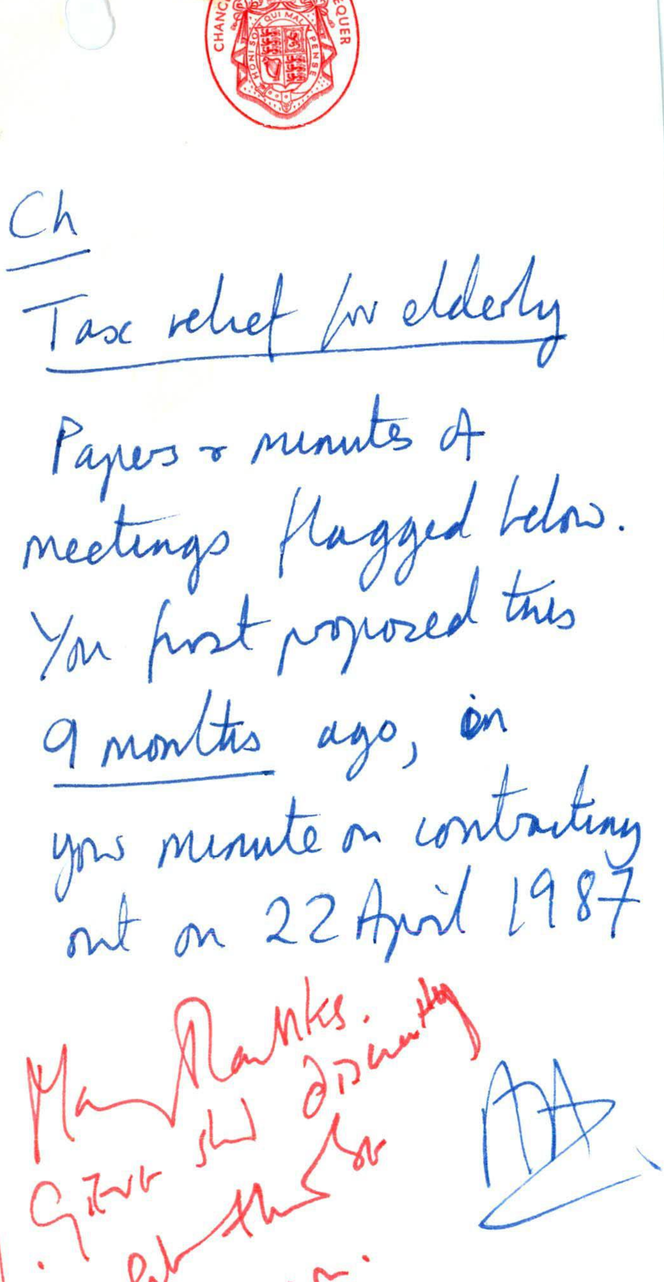
Paul

Paul Gray

David Crawley Esq
Scottish Office.



SECRET



Ch

Tax relief for elderly

Papers & minutes of meetings flagged below. You first proposed this 9 months ago, in your minute on contracting out on 22 April 1987

AA

Many thanks. [illegible] [illegible] [illegible] [illegible] known.

SECRET

Inland Revenue

Policy Division
Somerset House

FROM: P LEWIS
EXT: 6371
DATE: 1 JULY 1988

CHANCELLOR

Ch/ NB this option is trailed in the LSE pamphlet trailed in yesterday's Independent — behind (p15 para 4)

MPW 1/7

Many thanks. V. helpful. AA: ...

NHS REVIEW: BENEFITS IN KIND

1. I understand that, following the meeting of the Prime Minister's group yesterday, you asked for urgent advice on an "all employee" benefits-in-kind exemption. This note gives our preliminary views.

Proposal

2. The proposal is that, rather than exempting all employees who get medical insurance provided by their employers, the exemption should only run if the employer gives medical insurance benefits to all his employees.

Main policy considerations

3. This approach seems to have the following advantages

- It much reduces the deadweight cost. The information we have about which schemes cover all employees is very patchy, but the indications are that the cost would be reduced from about £100m to something of the order of £20m.

---

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

Chairman
Mr Isaac
Mr Beighton
Mr Corlett
Mr Lewis
Miss Rhodes
Mr Kuczys
Mr Farmer
Mr Evershed
Mr Northend
Mr Hodgson
Mr Eason
PS/IR

Spoke to IR — no need for all of them

Lewis → Chex 1/7

- It should be more effective in encouraging employers who already provide some medical insurance, but not to all employees - the majority of those giving insurance - to provide it more widely to gain the tax exemption. It should therefore do more to bring uninsured employees into existing company schemes.

- It would make the relief less open to criticism as benefiting in practice mainly directors, managers and senior employees.

- It would be more in keeping with the approach adopted elsewhere in the tax system where substantial tax reliefs are available, for example, in the (long-standing) exemption of canteen meals, and the more recent specific tax reliefs under the all-employee share and share option schemes and for profit-related pay.

- While it would not eliminate the unfairness for employees whose employers do not provide medical insurance, and the self employed, it would at least prevent the additional unfairness within any particular employer between those who get (tax-free) insurance and those who do not.

4. The main disadvantages are

- The relief would have more rules, with additional compliance costs for employers and administrative costs for the Revenue.

- For employers who at present give no medical insurance at all - the great majority - an "all employee" limitation would mean a bigger "entry fee" to get into tax relief. Employers who, with a general benefits exemption, might have given medical insurance to some employees might not be prepared to give insurance to everyone.

yes, but only bigger than with general benefits-in-kind exemption

Overall Effectiveness

5. It is difficult to make an overall assessment of the effectiveness of an "all employee" exemption in encouraging additional private medical insurance as compared with a general exemption. In both cases the effect is indirect since the employee gains from the relief but the employer continues to pay the cost.

6. For employers who already have schemes with limited coverage, there should be a stronger incentive to extend them to other employees. For some employers who give no medical insurance at present, the need to cover all employees to qualify for tax relief may be too daunting to get them interested. But others who, if there had been a general relief, would have started a scheme with limited coverage may be prepared to start an all employee scheme.

but no worse off than at present

7. A general exemption would be likely to encourage the spread of limited "top hat" schemes. An all employee scheme would not have that effect - the quality of the response should be better.

8. Overall our initial impression is that an "all employee" scheme might provide a stronger and more satisfactory incentive. But even with further work it may be difficult to say with much confidence what the net effect might be.

How the relief would work

a. Qualifying policies

9. Relief would only be given in respect of the same kind of qualifying policies as would be eligible for relief in the case of the elderly. So no additional vetting procedures would be required. Since an "all-employee" scheme would encourage general rather than "top-hat" schemes, it would be less likely to encourage the introduction of "qualifying" policies into which a lot of non-medical benefits had been squeezed.

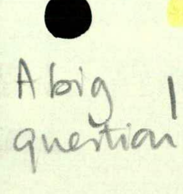
b. <u>All employees</u>

10. The share scheme and PRP concepts of "all employee" coverage exclude (or at the employer's discretion may exclude) casual, temporary and part-time workers and employees who have recently joined the employer. How we define "all employees" in this context would depend to some extent on just how comprehensive "group" cover would normally be. The reasons for allowing employers to exclude new employees from share schemes and PRP do not really run for medical insurance. But there may be a similar need to allow employers to exclude casuals/part-timers; and to disregard people who - for whatever reason - opt out, if that is possible.

?

c. <u>Similar terms</u>

11. Again, as in the share scheme and PRP legislation, there would probably need to be a "similar terms" requirement. This would mean that it would not be possible to give favoured employees very extensive cover, and others minimal cover in order to qualify. Similarly, if cover for senior management extended to their families, the same would be necessary for other employees. (It would, of course, be possible if you wished to be even more restrictive and make family cover obligatory in all cases).


A big question

d. <u>Groups - baby syndicates</u>

12. It would be necessary to prevent employers complying with the letter but not the spirit of the legislation by putting a small number of senior employees into a separate company which met the conditions as a separate employer. Again the share scheme legislation tackles this problem by disqualifying schemes which, looked at in a group context, apply only to directors and higher paid employees.

<u>Administration</u>

13. There has not been time to consider this in any detail. In outline, I think what would be required would be some kind of

Revenue "approval" of the circumstances in which the employer provided medical insurance which would be his passport to leaving medical insurance payments off his P11D returns and for similarly excusing employees from including medical insurance benefits on their returns. It would be for decision whether the employer "approval" would need to be fairly formal and centralised - as for share schemes - or rather less formal and decentralised - as for dispensations.

14. Whether, overall, there would be an addition to or reduction in employer and Revenue work on medical benefits is unclear at present. On the one hand we would have special rules for medical insurance, and the work of "approving" employer schemes would need to be done at a fairly senior level. On the other hand, once an employer was approved, both he and the Revenue would have less work at a more routine level.

15. To set up an exemption we would need to review, manually, all PAYE codes including medical insurance benefits. For an "all employee" scheme we could not begin to do so until employers had established with us that exemption was due. So an "all employee" scheme might take rather longer to get started.

Rate of tax at which relief given

16. The administrative and compliance arguments are different for a benefits-in-kind exemption. Whereas for the elderly paying their own premiums it would be much simpler to give relief only at the basic rate because we would be operating through MIRAS and higher rate relief would have to be handled individually, the reverse is true for a benefits exemption.

17. If the exemption were limited to the basic rate, employers would have to continue to return the benefit so that we could deal with the higher rate liability cases; and we would have to collect, through awkward coding adjustments and assessments, the difference between basic rate and higher rate tax for higher rate taxpayers.

18. The administrative arguments therefore point strongly to an outright exemption, not one limited to the basic rate. But that would make it more difficult to restrict relief to the basic rate for the over-60s paying their own insurance. Apart from anything else, it would mean the position of the over 60s would differ depending on whether the employer, or someone else, paid their premiums.

Direct medical payments by employers

19. Some employers do not insure their employees, but pay medical bills if treatment is required. Under a general benefits exemption these would be exempt even if the employer only paid for senior people (the usual case). Under the "all employee" approach the relief might be extended to cases where the employer was ready to pay for any employee (as part of his terms of employment), if coverage of the scheme was comparable to "approved" policies. So however we end up on benefits, we shall have to aim for comparable treatment in these direct payment cases.

If employers were prepared to meet these criteria, they might as well insure.

Summary

20. A scheme of this kind would, inevitably, be more complicated than a straight exemption; though many of the rules would be reasonably familiar to employers through similar provisions in the share scheme and PRP legislation.

21. The initial deadweight cost would be decisively lower though there would be additional deadweight over the years as employers already giving some medical benefits switched to all employee schemes.

22. The incentive effects can be argued both ways. Our initial view is that on balance an all employee scheme would produce a ? stronger incentive - and that the response (all employee rather than "top-hat" schemes) would be more satisfactory.

23. An all employee relief would be fairer and less controversial. It would be more consistent with the Government's stance on benefits in kind, and in particular the share scheme and PRP reliefs.

24 . A benefits-in-kind exemption points, administratively, to exemption at marginal rather than basic rate.

25. An all employee scheme might take rather longer to get started than a general benefits exemption.

P LEWIS

week.4.7/m.1

SECRET

FROM: H PHILLIPS

DATE: 4 July 1988

CHANCELLOR

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

Mr Kuczys - IR

X The changes Mr Phillips suggests are essential. I have also marked some other improvements on the draft paper.

Ch/ The first version of package paper. HP's amendment will remove some of unfairnesses, but still quite skewed – no "square-bracketing" of some still v. dangerous and unagreed ideas in part III. On tactics, would it be better for the disagreement to be made explicit? ["DHSS say X, HMT say Y"] – at the moment the brackets make it look as if agreement will come in due course. Any comments to feed in at this stage? MPW

NHS REVIEW: THE OVERALL PACKAGE

Attached is the first Cabinet Office draft of this paper which I discussed this evening with Mr Wilson and Mr Heppell. It will be revised in the light of that discussion and we shall give you the revised version tomorrow.

2. The paper is in three parts. Part 1 - the Broad Direction of Long Term Change is designed to help Mr Moore feel that a genuine strategy is emerging. Part II - Package of Immediate Measures - is essentially a shortened version of our earlier paper. Part III - Possible Measures for the Longer Term - is there to respond to the No.10 Policy Unit's concern to see more radical issues addressed.

3. I should record the main points we agreed to change this evening.

Paragraphs 1-3

4. I said that the first three paragraphs should incorporate the fact that unlike most other advanced Western nations we had not lost control over NHS expenditure and therefore health costs. The

key to any reform was not to jeopardise this advantage but to build on its strength. If the new draft starts from here it will be very useful.

Part I

5. We agreed to

(a) bring the point about patients (5(vii)) to the top of paragraph 5;

(b) delete "major" in 5(iii), and say only that DHA's "might" act as buying authorities;

(c) revise the last sentence of 5(iv) to read:

"Hospitals should be funded in relation to the work which they perform ....."

(d) revise the first sentence of 5(v) to read:

"There should be a major expansion of the private sector in the provision of healthcare based on the removal of supply side rigidities......"

(This will also be reflected in paragraph 6 where "matched by" will read "based on".)

6. I hope that these, and some other minor amendments, will make the drafting of Part I tolerable for us. Buyers and providers are still lurking there but in a distant long term way.

Part II

7. This part uses square brackets where key decisions have yet to be taken. In relation to the section on a Better Deal for Patients, I asked that both 8(iv) (tax relief for the elderly) and 8(v) (company schemes) should be more neutrally expressed ie

decisions have yet to be taken on the rate for any relief and on whether further action in relation to company schemes is desirable.

8. I said that paragraph 9, Better Use of NHS Resources, was broadly acceptable, provided

(a) in 9(iii) the qualification "value for money" to audit was deleted; and

(b) 9(v) (the Chief Secretary's proposal) read, in its second sentence,

> "They will be linked to the introduction of market mechanisms eg for selected independent hospitals, etc"

9. The much shortened section on consultants (paragraph 10) looks all right provided the idea of short-term contracts for new entrant consultants is added in paragraph 10(ii).

10. The passages on a better organised NHS (paragraph 11) still suffer from not having been worked out. This is especially true of paragraph 11(ii) which is intended to summarise Mr Moore's recent self-governing hospitals paper. But I think we can live with it provided it is clear that the design has still to be worked up and that this is the area of experiment rather than of a national plan. I asked for a new 11(v) to be included saying it would be necessary to review the role of the regions and of the NHS Management Board in this context (as opposed to doing this at the very end of the paper, paragraphs 16 and 17).

Part III

11. The final section, paragraphs 13-16, contains ideas on buyers and providers, and relations between financing and provision which are untested, even in theory. I said we might not be against bringing DHA's and FPC's together (or of cash limiting primary care) and we liked the idea of a hospital having to qualify for independence but argued that for the mode in paras 15 and 16 to

work a great deal of GP freedom would have to be curtailed. I can see why Mr Wilson feels he has to include something along these lines (a lot of this comes from Lord Trafford) but I said I thought our view would be against saying any of this in a White or indeed Green Paper. Apart from any other considerations to set out such a vision of the future, without detail or timescale would simply induce a level of uncertainty which would undermine the effectiveness of the main early reforms.

Conclusion

12. We shall have to see how tomorrow's version turns out, and will let Mr Wilson know your reactions. More generally this seems the sort of paper which could create a useful agenda for the meeting on Friday. In particular Annex B brings home the incredibly tight timetable to which we are now working.

pp M L Reader.

HAYDEN PHILLIPS

SECRET

NOTE OF A MEETING HELD AT NO.11 DOWNING STREET
AT 4.00pm ON MONDAY 4 JULY

Those present: Chancellor
Chief Secretary
Sir T Burns
Mr Anson
Mr Phillips
Mr Culpin
Mr Parsonage
Mr Saunders
Mr Griffiths
Mr Call

Mr Kuczys - IR

NHS REVIEW

The Chancellor said that he had found Mr Lewis's note on "all employee" benefits-in-kind exemption most interesting: it inclined him to the conclusion that, if a fall-back had to be conceded, this was the most logical of the options, and the best value for money.

2. The Chancellor said he had also been struck by some of the points made in the Barr/Glennerster/Le Grand paper. It made a number of very telling points: in particular, its focus on the wastefulness of some preventive and curative medicine; its rejection of demand-boosting/opting out schemes; and its distinction between private health care provision and finance. Some of the statistics quoted were quite striking - particularly the comparison of public health spending per capita in the US and UK. The UK also came out well, by international standards, on the various health indices, and this was used, helpfully, to knock down the argument that more resources were required for health. However, there were some less helpful strands in the paper which would need careful handling: the enthusiasm, albeit lukewarm, for a

SECRET

hypothecated health tax; the emphasis placed on local authorities as cost controllers; and the assertion that competition between hospitals could serve to increase costs. No attempt was made to explain this last phenomenon, although Mr Parsonage noted that it could happen if hospitals competed on the basis of quality, in a situation where there was insufficient cost control.

3. Mr Saunders said that the paper's concerns about the effect on costs of boosting the private sector had been echoed in officials' recent discussions with Bill Roper, of the US Medicare/Medicaid agency. He had emphasised his view that the UK Government should ensure that any reforms did not result in the NHS losing control of costs. He had also said that in the US, moves to evaluate the effectivess of health care were only just beginning. Mr Saunders added that, as far as the UK was concerned, it could be argued that the great gains in life expectancy had been largely the result of immunisation progammes, and cleaner water. The effectiveness of other areas of health expenditure might be more questionable but any progress in re-targeting was bedevilled by lack of adequate information systems. Mr Parsonage noted that another problem with a redirection of resources of this kind was that clinical practice and research were often very closely linked, and treatments that had first appeared high cost and not very effective could in the end turn into great success stories - kidney transplants were example of this phenomenon.

4. The Chancellor said that he thought there was wide-spread public support for a retargeting of health expenditure, towards the treatments which were widely known to be effective - hip replacements, pace-makers etc - and away from those treatments which doctors might want to pursue simply because they were interesting. The analysis of waste in the health service set out in the LSE paper could be drawn on to strengthen the case for the various "micro" efficiency improvements and supply side reforms which we would want to see included in the package. We would need

SECRET

to give further thought to the presentation of the measures on this checklist: it could be difficult to sell within Government, and publicly, as the radical shake-up people expected as the outcome of the Review.

5. It was agreed that, rather than circulating the paper and having it formally put on the Review Agenda, it would be preferable to feed in some of its more helpful ideas by other means. The first step was to inject as much as possible into the package paper, being drafted under the Cabinet Office's Chairmanship. Mr Phillips noted that the Chancellor's minute on supply and demand had looked forward to a cost-benefit analysis of the emerging package. The useful points from the LSE paper could be brought out in this analysis, or in a covering note. It was agreed that officials would prepare a draft which Ministers could look at during the course of Wednesday: a decision could then be reached as to whether this could be circulated before or after the next No.10 meeting.

MPW.

MOIRA WALLACE

Circulation

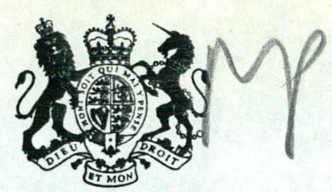
Those present
PS/Financial Secretary
Miss Peirson
Mr Turnbull

Mr Lewis
PS/IR

THE WELFARE STATE PROGRAMME

DISCUSSION PAPER SERIES

Number	Author	Title
WSP/1	Julian Le Grand	*Inequalities in Health : the Human Capital Approach* (out of print)
WSP/2	Meghnad Desai and Anup Shah	*An Econometric Approach to the Measurementment of Poverty* (out of print)
WSP/3	Paul Johnson	*The Historical Dimensions of the Welfare State 'Crisis'* (out of print)
	(published in the Journal of Social Policy, 15, 4, 443-465)	
WSP/4	Howard Glennerster	*Research Directions on the Future of the Welfare State : a View from Social Administration* (out of print)
WSP/5	A B Atkinson	*Income Maintenance and Social Insurance : A Survey*
WSP/6	Julian Le Grand	*On Researching the Distributional Consequences of Public Policies* (out of print)
WSP/7	Gunnar Persson	*The Scandinavian Welfare State : Anatomy, Logic and Some Problems* (out of print)
WSP/8	Edgar Cahn	*Service Credits : A New Currency for the Welfare State* (out of print)
WSP/9	A B Atkinson J Hills and J Le Grand	*The Welfare State in Britain 1970-1985 : Extent and Effectiveness*
WSP/10	Robert E Goodin Julian Le Grand	*The Middle Class Infiltration of the Welfare State : Some Evidence from Australia*
WSP/11	A B Atkinson	*Social Insurance and Income Maintenance* (out of print)
WSP/12	Raymond Illsley Julian Le Grand	*Measurement of Inequality in Health*
WSP/13	John Hills	*When is a Grant not a Grant? The Current System of Housing Association Finance* (out of print)
WSP/14	Julian Le Grand David Winter	*The Middle Classes and the Welfare State*
WSP/15	Maria Evandrou	*The Use of Domiciliary Services by the Elderly : A Survey*



10 DOWNING STREET

LONDON SW1A 2AA

CH/EXCHEQUER
REC. 6 JUL 1988
ACTION Mr Saunders
COPIES TO CST, Sir P. Middleton, Sir T Burns, Mr Anson, Mr Phillips, Mr Culpin, Mr Turnbull, Miss Peirson, Mr Parsonage, Mr Call, Mr Kuczys I/R

From the Private Secretary

5 July 1988

I enclose for information for the members of the NHS review group copies of evidence submitted by COHSE and by the Society of Family Practitioner Committees. These have been acknowledged and no immediate further action is called for.

I am copying this letter and enclosures to Moira Wallace (HM Treasury), David Crawley (Scottish Office), Jon Shortridge (Welsh Office), David Watkins (Northern Ireland Office) and Richard Wilson (Cabinet Office).

Ch/
COHSE paper, on a brief skim, looks completely predictable. SFPCs just want a look for table at X, and sets face against amalgamation of DHAs/FPCs at Y

Paul Gray

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

Glen House
High Street
Banstead
Surrey SM7 2LH

Telephone: Burgh Heath
(07373) 53322
Telex: 944245

Our ref: KO/TC/JMG

Your ref:

29 June 1988

The Rt. Hon. Margaret Thatcher MP,
Prime Minister
10 Downing Street
London W1

Dear Prime Minister

We welcome your decision to review the financing of the National Health Service, and I take this opportunity to submit our proposals for improving and enhancing the service provided by the NHS.

We look forward to the results of your review and trust that the proposals will build upon the existing structure, and use the dedication and skills of all NHS workers to the full.

Yours sincerely

Hector MacKenzie
General Secretary

enc.

Confederation of Health Service Employees

General Secretary: Hector MacKenzie

CONFEDERATION OF HEALTH SERVICE EMPLOYEES

COHSE'S EVIDENCE TO THE GOVERNMENT REVIEW ON RESOURCING THE NATIONAL HEALTH SERVICE

Glen House,
High Street,
Banstead,
Surrey.
SM7 2LH

General Secretary:
H. U. MACKENZIE.

FUTURE FUNDING FOR THE NHS

PREAMBLE

1. The Confederation of Health Service Employees is Britain's major Health Service Union. It represents 220,000 Health Service staff. COHSE's members work in all jobs and occupations within the NHS, local authority social services, and voluntary and private sector health care provision.

2. At the same time as Health Authorities are facing acute shortages of funds and there are a barrage of complaints about inadequate hospital services, the Government claims it is spending more than ever before on Health.

3. How is this possible? It is true that between 1978/79 and 1986/87 Government funding to the NHS increased 25.7% above the general level of inflation. However, set against NHS inflation (taking into account the actual rise in prices faced by the NHS) this meant a real increase in resources of 10.4% over eight years.

4. At the same time the number of people waiting for treatment by the NHS has risen for the last three years, and now stands at 799,760. Of that number 207,938 have waited over a year. Health Authorities are in such a bad financial position that by the end of last year 3,100 acute beds had been closed purely because of lack of funds (BMA Consultants Survey).

5. How is it that the 10.4% real increase in resources has not brought down waiting lists and left health authorities in a healthy financial position? There are two reasons for this. First, the major part of the increase in resources for the NHS occurred between 1979 and 1981, mainly due to the Clegg awards. In the six financial years from 1980/81 to 1986/87 the cumulative growth was only 3.2%. Indeed, in the most recent four financial years (1982/83 to 1986/76) the cumulative growth was a mere 0.4%. To begin with, waiting lists fell from the all time high of 752,000 in 1979, but they have now risen for the last three years in a row.

6. Secondly, as the Minister of State at the DHSS confirmed to the Social Services Committee (on Public Expenditure on the Social Services) in 1986 "Health Authority Services need at present to grow by about 2% a year in order to meet the pressures they face. 1% is needed to keep pace with the increasing number of very elderly people (although this pressure is now at a peak and will decline into the 1990s); medical advance takes an additional 0.5%, and a further 0.5% is needed to make progress towards meeting the Government's policy objectives

(for example to improve renal services and develop community care)".

7. By applying the 2% growth target to the period 1980/81 to 1987/88 the Social Services Committee reported that even after taking account of cash releasing cost improvements, the cumulative underfunding of the Hospital and Community Health Services (HCHS) amounted to £1.9 billion at 1987/88 prices. Health Authorities estimate that for the financial year 1988/89 the Government have underfunded them by £235 million.

8. It is clear that despite increases in money terms the NHS is badly underfunded and the situation is getting worse. The Government have in effect conceded this point by releasing a further £101 million for the last financial year to try to cut waiting lists.

INTERNATIONAL COMPARISONS

9. The real scale of the problem can be seen by comparing UK spending on health with other countries. The UK spends 5.9% of Gross Domestic Product (GDP) on health. The US spends 10.7% of GDP, Sweden 9.4%, France 9.1% and West Germany 8.1%. The only country in the EEC that spends less than the UK is Greece, who are currently setting up a national health service and increasing their spending on health. In 1982 France spent $996 per person on health care, the Netherlands spent $851, Germany spent $883, but the UK only spent $539. The UK is also increasing spending at a much slower rate than the rest of the EEC. From 1960 to 1983 the UK increased its share of GDP spent on health by 2.3%, compared to 5.0% in France, 3.4% in West Germany and 4.9% in the Netherlands.

10. The result of this underfunding is that the UK scores poorly on international rankings for everything from tooth decay to heart disease. In fact, mortality rates, an often-used measure of a nation's health, are higher only in Portugal, Greece and Italy of all EEC countries (source: Social Trends). Indeed, standard mortality ratios of death by all causes (source: OPCS), which has been falling for years, actually rose for both men and women in the UK in 1985 (the most recent year for which data is available).

11. It is a credit to the NHS, and the people who work for it, that given the persistent underfunding over many years, such that spending on health in Britain as a share of GDP is now 50% less than the European average, the health of people in Britain is no worse than it is.

COHSE'S PROPOSALS

12. It is now widely accepted that the NHS needs more funds in order to cope properly with the demands put on it. However COHSE do not believe that the problems of the NHS will be solved simply by throwing money at it. What is needed is a carefully drawn up strategy to provide a stable planning environment for Health Authorities to the end of the century.

13. We propose that:

i. There should be an immediate cash injection of £2.5 billion into the NHS. £2 billion should be used to make up for the shortfall in funding since 1979, and be devoted to improving patient-care. £500 million should be used as a matter of urgency to improve the conditions of the thousands of dedicated workers in the NHS, such as extending paid maternity leave, providing child care facilities on a 24 hour basis and enabling people to choose more flexible work patterns.

ii. Funding to the NHS should increase in line with the growth in Gross Domestic Product (GDP) in real terms (taking into account higher NHS inflation for goods and services).

iii. In addition to this, funding should be increased by 2.5% per annum so that UK spending on health as a share of GDP will rise to the current EEC average (9%) by the year 2000.

iv. All pay awards to NHS staff should be fully funded by Central Government.

v. The NHS should continue to be funded via general taxation.

vi. Health care should be provided free at the point of delivery.

14. If the economy is booming as the Government claims, and certainly tax revenues are pouring into the treasury, then there is extra money that can be devoted to the NHS. All evidence suggests that there is majority support for this throughout the population.

15. Why move towards the EEC average spending on health? Certainly the UK is above average in terms of wealth, and there is no reason to believe that Britons have different preferences over health from their counterparts in Europe. Therefore to bring healthcare in the UK just up to the European average is a modest demand.

16. Why all pay awards fully funded? Any award which is not fully funded means arbitrary cuts in patient care forced on health authorities, which makes it impossible to plan a proper service.

17. Why funded through general taxation? As with other services funded by the state, such as defence, the health service should be funded through a progressive tax system so that those in a position to pay more contribute to the general health of society. Proposals to set up lotteries or give tax relief to those opting out undermine the NHS. No-one proposes funding Trident through a lottery and pacifists have never been given tax relief on taxes going to arms expenditure.

18. Why free at the point of delivery? First, we hold to the principle that in an advanced industrialised country, everyone, regardless of their ability to pay, should have equal access to the very best healthcare that can be provided. The only way to ensure this is by providing healthcare free at the point of delivery. Indeed many countries have grafted a public health service on to their inadequate (but expensive) insurance-based systems. Some countries, notably Italy, Greece and Portugal are moving towards a national health service with equal access, free at the point of delivery.

19. Secondly, it is much more cost-effective than a system where every patient has to be individually billed for treatment. A recent OECD study showed that far less of the NHS annual budget is used for administration costs (less than 5%) compared to insurance-based systems such as in the USA (more than 20%). A steady stream of right-wing US economists have come to examine the NHS to discover the flaw in tax-based public health systems, to which they are ideologically opposed. These would-be critics have left after studying the NHS, singing its praises.

20. Why should the NHS be funded and run on a national basis? First, as a bulk buyer of drugs and medical equipment the NHS has been able to keep much better control of medical costs than in many other countries. Secondly, through central planning the NHS is able to direct funds into priority areas such as services for mentally ill people, people with learning difficulties and elderly people. Thirdly, because of being a national service the NHS is in a position to even out regional differences through the RAWP and SHARE procedures.

ALTERNATIVE SYSTEMS

21. Some people, because of their ideological position, have tried to use the current crisis in the NHS to put forward a host of alternative ways of financing and delivering healthcare in this country. An idea that is currently fashionable is that with a system that delivers free healthcare, demand for that care is infinite and therefore the Government can never hope to fund it adequately and private health care should be expanded. COHSE do believe that the National Health Service is having to deal with the results of disastrous policies in other areas such as unemployment, poverty and homelessness. But demand for healthcare free at the point of delivery is not infinite. Health is fundamentally different from services such as sports centres or under fives' nurseries. To claim that demand is infinite is to suggest people will deliberately injure themselves in order to take advantage of free health care. It is true that people will feel more able to seek medical attention if it is free at the point of delivery. This is the purpose of primary health care, since it means that in many cases illness will be detected early and expensive treatment can be avoided.

22. Most of the proposed changes to the structure of the NHS are based on the view that it is desirable to separate provision of care from the financing of it. COHSE would dispute this. Once such an artificial separation is made, money is linked to treatment rather than treatment to medical need. We believe that the result would inevitably be higher administrative costs and more unmet need. This would lead the NHS to be less effective and efficient. Equality of access to treatment would also be compromised.

HMOs/MHUs

23. The proposal to introduce American style HMOs into the NHS is likely to lead to less effective health care at higher cost. In an American context where health care costs are spiraling out of control because of the inefficiencies of private markets, HMOs make some sense. In a British context where costs are controlled and administrative costs are less than 5% they have little or no relevance.

24. Four main types of HMOs have emerged in America:

i) **Public Sector HMOs** - These are like mini NHSs. They pay doctors a salary, own their own hospitals and allocate funds centrally.

ii) **Capitated HMOs** - They pay doctors a capitation fee of $X per patient in return for which doctors undertake to treat them for a specified period. This introduces strong incentives for doctors not to treat bad risks and suffers from many of the problems that an insurance based system would encounter. This system tends to produce over-treatment of well people and under-treatment of ill people.

iii) **Independent Practice Association HMOs** - They pay doctors a fee for service. This creates the incentives to overtreat patients which are such a widespread and inefficient feature of the American system. Administration costs are also high because HMOs that pay a fee for service have to monitor the behaviour of their doctors if they are to have any chance of keeping costs down. Only the public sector HMO could be transplanted into the British system in any form.

iv) **Social HMOs** - Much has been made of the ability of the HMO system to care for the poor and the elderly. These claims just do not stand up to close scrutiny.

25. In the USA currently only 3% of Medicare beneficiaries are enrolled in HMOs and even this low figure is declining. This is because it is not in the interests of HMOs to enroll people who are likely to have above average health care needs. HMOs who enrolled large numbers of the elderly or poor would face unpredictable costs which would adversely affect profitability. In Minnesota, United Healthcare have just dropped 15,000 over 65s from their organisation leaving them without any medical cover at all. At best HMOs offer the elderly and the poor and indeed other "bad risks" such as AIDS victims unstable health care provision with little or no security. They are no substitute for a publicly funded system which spreads risks and treats according to need.

WHY HMOS?

26. A claim is made that HMOs can cut costs. Again in an American context, where the system is outrageously expensive, this is true. HMOs have achieved cost savings by cutting the link between provision of service and doctors fees. However, this link does not exist in Britain's NHS, although it could conceivably be developing in the burgeoning private sector in this country. The disturbing thing about HMOs is that they work by reducing care. If they are reducing excess care then they can have a positive role but overtreatment is a much more significant feature of private system than it is in the NHS.

CONCLUSION

27. HMOs have nothing to offer in the British context. Their introduction would be likely to cause currently low administration costs to soar, taking scarce resources away from patient care. At the same time, HMOs can not offer coverage to "bad risks" without being heavily state subsidised. If medical treatment is to be subsidised, the most efficient and equitable way to do it is by using the current system.

INTERNAL MARKETS

28. COHSE has no objection at all to developing centres of excellence in particular specialisms. It would be inefficient and less effective to insist that every hospital must do its own open heart surgery. In so far as this could be said to be an internal market, then COHSE would approve. However, if the phrase 'internal markets' is defined as the introduction of general market functions across hospitals, then COHSE would strongly disapprove.

ADMINISTRATIVE COSTS WOULD SOAR

30. In order to introduce internal market functions, a bureaucracy would have to be established to administer the transfer of cash from the Government to the providers and across health authority boundaries. Each expense incurred in the NHS would have to be attributed to individual patients, an excessively costly administrative exercise which the NHS currently avoids. Often entire floors of American hospitals are devoted to billing patients and chasing unpaid debts. The American system spends 22% of all health care dollars on administration according to a recent study by Himmelstein and Woolhandler (Cambridge Hospital/Boston University - New England Journal of Medicine 1986). They went on to calculate that $38.4 billion could be saved by instituting a NHS in America.

29. If an internal market is instituted one of two things is likely to happen:

i) Hospitals will compete for less ill patients where profits are easier and simpler to make. They will specialise in lesser treatments;

or

ii) Hospitals will compete for lucrative sick patients offering to do kidney dialysis for example.

This type of system will introduce incentives to neglect chronically ill people, the mentally ill, the elderly, the mentally handicapped and AIDS victims.

31. The introduction of internal markets creates incentives for hospitals to treat patients in response to their own institutions' financial needs, rather than the medical needs of patients. The logical outcome of internal markets is that patients will be willing to travel the length and breadth of the country to get treatment, and that hospitals who do not treat people for profit will somehow close. This is patently absurd.

WHY ASSUME THAT COMPETITION IS GOOD?

32. In much of the current discussion on the future of the NHS, it is taken as axiomatic that competition is a good thing. In fact the evidence points to the fact that competition in a health care context is downright harmful. A recent study by S M Shortell and E F Hughes, published in the New English Journal of Medicare, April 1988, on the effects of regulation competition and ownership on mortality rates amongst hospitals found that there are:

> "Significant associations between higher mortality rates, the stringency of state programmes to review hospital rates and the intensity of competition in the market place".

Mortality rates were between 6% to 10% higher in areas of higher competition. Amongst the conclusions, Shortell and Hughes said:

> "These findings raise serious concerns about the welfare of patients who are admitted to hospitals in relatively competitive markets. Regardless of the nature of their ownership, hospitals that face severe regulatory constraints, strong competitive pressures in the local markets or both, may respond to these forces in ways associated with poorer outcomes for patients".

In other words, competition kills patients.

NEW PROPOSALS

33. COHSE believes that the founding principles of the National Health Service, as stated in the Royal Commission Report into the NHS 1979, viz:

a. Encourage and assist individuals to remain healthy;

b. Provide equality of entitlement to health services;

c. Provide a broad range of services of a high standard;

d. Provide equality of access to these services;

e. Provide a service free at the time of use;

f. Satisfy the reasonable expectations of its work;

g. Remain a national service responsive to local needs;

remain as true today as they were 40 years ago.

34. We therefore believe that any new proposals for change to the NHS structure should be measured against these principles. Only if proposals measure up to and enhance these principles should they be introduced, or it must be demonstrated that the principles no longer apply.

CONCLUSIONS

35. It is clear that the NHS is underfunded both in the Government's own terms and compared to the rest of the industrialised world. COHSE therefore propose making up the underfunding since 1979 and, by moving steadily towards the average level of funding in the EEC, provide a stable planning environment for Health Authorities from now to the end of the century. A service which is free at the point of delivery and financed through the tax system is both equitable and cost-efficient. No alternative method of providing healthcare measures up to a properly financed public health system and many countries are moving towards the UK model of health provision.

36. The alternative systems for the provision of health care currently being discussed are more bureaucratic, less cost efficient and would not provide comprehensive healthcare for the people of Britain.

37. The National Health Service is the best way to provide healthcare so long as it is given a stable planning environment by guaranteeing adequate resources now and in the future.

38. As one leading economist in the field stated "All systems of healthcare are bad, but the NHS is the least bad".

June 1988.

SOCIETY OF FAMILY PRACTITIONER COMMITTEES

75 YORK ROAD,
WATERLOO,
LONDON SE1 7NT

Tel: 01-620 1474

PRESIDENT : DR D D CRACKNELL MBE
SECRETARY : W D DAY LL.B FBIM

The Right Honourable Margaret Thatcher FRS MP
10, Downing Street
London
SW1

Our Ref: DDC1/GB

1 July 1988

Dear Prime Minister

REVIEW OF THE NATIONAL HEALTH SERVICE

On behalf of the Society which has in its membership all 98 English and Welsh Family Practitioner Committees I submit the enclosed evidence which the Society wishes to be taken into account as part of your Review of the National Health Service. I have also sent a copy to the Secretary of State for Social Services.

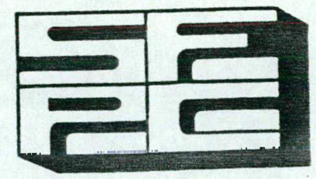
The Society is an autonomous section of the National Association of Health Authorities. It contributed to and endorses the evidence submitted by the Association under the title "The Nations Health - a Way Forward" except that relating to the Primary Health Care Services.

The Society's evidence is therefore concerned with the Primary Health Care Services and their interaction with the Hospital Services.

The Society understands that your Review is only concerned with the funding, provision and operation of hospitals and related medical services. Should the Review be extended beyond this to cover the whole of the four Family Practitioner Services provided by Family Doctors, Dentists, Community Pharmacists and Opticians, the Society wish to submit evidence thereon.

D. Cracknell

President
Enc.



SOCIETY OF FAMILY
PRACTITIONER COMMITTEES

THE FAMILY HEALTH SERVICE

Evidence to the
Prime Minister's Review
of the National Health Service

T H E   F A M I L Y   H E A L T H   S E R V I C E

THE SOCIETY OF FAMILY PRACTITIONER COMMITTEES' EVIDENCE

TO THE PRIME MINISTER'S REVIEW OF THE NHS

SOCIETY OF FAMILY PRACTITIONER COMMITTEES
75 YORK ROAD, WATERLOO
LONDON SE1 7NT

© SOCIETY OF FAMILY PRACTITIONER COMMITTEES 1988

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without prior permission of the Society of Family Practitioner Committees.

INDEX

1. Introduction 1

2. The White Paper - Primary Health Care Proposals 3

3. Interaction of the Hospital Services with the Primary Health Care Services 6

4. Family Practitioner Committees 10

5. Primary Health Care Services - The Way Ahead 13

Summary of Key Points 15

Annex 1 18

Annex 2 19

1. INTRODUCTION

1.1 The Society of Family Practitioner Committees has in its membership all 90 English and eight Welsh Family Practitioner Committees. It is an autonomous section of the National Association of Health Authorities (to which FPCs also belong) and, on behalf of FPCs, deals amongst other matters, with;

- the four Family Practitioner Services;
- Primary Health Care;
- the interface with both the Secondary Health Care Services and Private Care;
- the Department of Health and Social Security

1.2 The Society, on behalf of FPCs, was involved in the preparation of the evidence recently submitted by NAHA to the Prime Minister's review of the NHS - 'The Nation's Health - A Way Forward'. It endorses those sections of the evidence which deal with the financing of the NHS, and the possible implications in terms of range and quality of services which would be provided for all using them (i.e. the NHS' customers). The Society generally supports the proposals relating to the Hospital Services. It does not therefore wish to submit further evidence on these issues.

1.3 The Society however, wishes to submit its own evidence on the Primary Health Care services. The views expressed in paragraph 111 of the Association's evidence are, as there indicated, made on behalf of Health Authorities. They are not shared by the 98 Family Practitioner Committees or the Society.

1.4 It is understood that the main concerns of the Prime Minister's review relate to the Hospital Services (particularly the Acute Services) and their interaction with the other medically related services of the NHS. The Society on behalf of FPCs therefore wishes to comment on the following:

- The White Paper - Primary Health Care proposals
- The Interaction of Hospital Services with the Primary Health Care Services
- Family Practitioner Committees
- Primary Health Care - The Way Ahead

1.5 Should the Review be extended at any stage to the non medical parts of the NHS, the Society would wish to have the opportunity to submit evidence thereon.

1.6 The basis of the Society's evidence is a commitment to a comprehensive health service for the nation with genuine equity of access irrespective of means, locality, social or ethnic status. This principle appears to have virtually universal support within the country.

1.7 "Equity of access irrespective of means" can only be achieved if general funding rather than specific charges continues to be the principal source of financing the various services. Also, where charges are made full account needs to be taken of any potential deterrent effect when fixing the level of charges.

1.8 Despite imperfections, the NHS has played a key role in improving the nation's health, and has relieved individuals from worry about the personal costs of being ill.

1.9 Paragraph 4 of NAHA's evidence draws attention to the popularity of the NHS and the high degree of satisfaction amongst those receiving treatment and their immediate family. Local and national surveys amongst users of the four Family Practitioner Services and the immediate families of those users also show very high levels of satisfaction as well as belief that the services are provided efficiently.

2. THE WHITE PAPER - PRIMARY HEALTH CARE PROPOSALS

2.1 The Primary Health Care Services (i.e. those provided outside hospitals) cover the four Family Practitioner Services provided by family doctors, dentists, community or retail pharmacists and opticians and their staff, and the District Health Authority Community Health Services provided by community nurses, midwives, health visitors and other professions allied to medicine (such as physiotherapists and chiropodists). Collectively they provide the 'front-line' day-to-day health care of the Health Service. This represents more than 90% of the nation's contact with the NHS.

2.2 The Secretary of State, in paragraph 2 of the consultative paper 'Primary Health Care - An Agenda For Discussion' (command 9771) published in 1986, at the start of the Government's review of Primary Health Care, said:

> "Primary Health Care Services are more fully developed in the United Kingdom than in other countries, where patients have more direct access to specialist care and rely less on General Practitioner and Community Health Services. Our services are generally provided to a high standard and are well appreciated by the public. The Government considers that British primary care arrangements have made an important contribution to both the quality and cost-effectiveness of our health care system, and this view is widely held by commentators both in this country and abroad."

2.3 It is generally recognised that these services, even before that review, provided the most comprehensive and probably the most cost-effective Primary Health Care cover in the western world (Western Europe, North America and Australasia). Notwithstanding this, the Government felt that more could be achieved through these services in terms of providing a **Family Health Service**, with an increasing emphasis on promotion of good health rather than merely on the treatment of illness. The Society shares this view.

2.4 The White Paper 'Promoting Better Health' published in November 1987 sets out the Government's plans for the future, based on the six objectives identified by it in the earlier discussion document, viz:

- to make services more responsive to the needs of the consumer

- to raise standards of care;

- to promote health and prevent illness;

- to give patients the widest range of choice in obtaining high quality primary care services;

- to improve value for money;

- to enable clearer priorities to be set for Family Practitioner Services in relation to the rest of the health service;

and the themes which emerged as a result of the consultation process (for details see Annex 1).

2.5 Listed at Annex 2 are the main changes the Government is seeking. In paragraph 1.8 of the White Paper, the Government set out three inter-related ways of achieving its aims, namely;

- no opportunity should be lost to increase fair and open competition between those providing Family Practitioner Services;

- to that end, consumers should have readier access to much more information about the services provided;

- and the remuneration of practitioners should be more directly linked than at present to the level of their performance."

The Society, on behalf of FPCs, has strongly supported the thrust of the Government's approach and the main changes envisaged.

2.6 In its view, the proposals for actively promoting good health and preventing ill-health; for enhancing the treatment of illness; for raising the quality of services and facilities, and for increasing value-for-money will further improve the Primary Health Care Services as well as making them more cost-effective. The enhanced managerial and monitoring roles envisaged for FPCs are welcomed and will raise standards, improve services and help to contain costs for the benefit of the NHS as a whole. Collectively the proposals, coupled with the improving collaboration between DHAs and FPCs, will have an impact on the use made of the Acute Hospital Services and their resources - albeit some of the impact will be in the longer term. With the caveats mentioned later, the Society hopes that the various proposals will be implemented as quickly as possible.

2.7 FPCs are concerned to ensure that the cash-limiting proposals in relation to ancillary staff and premises, are operated in such a way as usefully to increase the range and numbers of ancillary staff employed by GPs and likewise improve standards of accommodation, taking the existing best practices as the base lines for further improvements. FPCs and the Society have expressed elsewhere reservations as to whether a small number of the changes set out in the White Paper are not counter-productive to its overall aims. However, these are not germane to the present review.

2.8 The Society, in connection with implementation of the White Paper, proposes to explore with the Department of Health and Social Security ways in which greater flexibility in resourcing can be given to FPCs to achieve improved value for money and containment of costs within FPS expenditure.

3. INTERACTION OF THE HOSPITAL SERVICES WITH THE PRIMARY HEALTH CARE SERVICES

3.1 There are three main interactions between the Primary and the Hospital Services:

- GP referrals to, and use of, hospital facilities;
- reduction in the time patients spend in hospital and changing treatment patterns;
- care in the community.

3.2 Access to specialist services and secondary care is normally obtained only on referral by the General Practitioner who performs the functions of gatekeeper, adviser and co-ordinator/mobiliser of secondary care.

3.3 Paragraph 3.61 of the White Paper draws attention to the very substantial costs incurred through family doctors' decisions to refer patients to hospital and the need to ensure that these expensive facilities are used in the most cost-effective way. The White Paper also draws attention to the variation in referral rates and to the work already being done in some areas by family doctors and specialists to examine the criteria used in making referral decisions.

3.4 It is generally considered that the GPs' filter and referral roles (even allowing for the variations mentioned) are already very effective in ensuring patients obtain the treatment (whether primary or secondary) most appropriate to their needs, and reduce the level of hospital admissions which might otherwise occur. The following table based on OECD data shows that the United Kingdom has one of the lowest hospitalisation rates amongst OECD countries:

TABLE - HOSPITAL ADMISSION RATES (1983 OR NEAR DATE) IN RANK ORDER (LOWEST FIRST)

COUNTRY	RATE (% OF POPULATION) / a year?!	DATE
Japan	6.7	1983
Spain	9.2	1981
Portugal	9.6	1982
France	11.8	1983
Netherlands	11.8	1983
Greece	11.9	1982
United Kingdom	12.7	1981
Switzerland	12.8	1982
Belgium	13.9	1981
Canada	14.7	1982
Norway	14.9	1983
Italy	15.4	1983
New Zealand	15.7	1983
Ireland	16.4	1982
United States	17.0	1981
Germany	18.1	1982
Luxembourg	18.1	1983
Denmark	19.2	1983
Sweden	19.2	1983
Iceland	20.2	1982
Austria	20.7	1983
Finland	20.9	1983
Australia	21.0	1980

3.5 The referral system is also an important part of the 'continuum of care' which family doctors provide for their patients through diagnosis, treatment, after care, advice and support.

3.6 The Society supports the proposal in paragraph 3.62 of the White Paper:

> "that FPCs should use independent medical advisers to encourage good practice in the referral of patients to hospital. Doctors with abnormally high or low rates of referral will be invited to take part in an assessment of their approach to help them in making effective use of hospital resources."

It also supports the linked proposal in paragraph 10.10 of the White Paper:

> "that FPCs and DHAs should act to ensure that the use of hospital facilities achieves the maximum benefit for patients, and that services are used to ensure quality of care in a cost-effective way."

3.7 Information about the size of waiting lists and likely length of any waiting period for appropriate hospitals should be automatically available to all family doctors to enable them better to advise their patients. Similarly FPCs should be given this information to assist them in their monitoring roles. GPs and FPCs should also be provided with information as to the cost of referrals (which is not currently available). The introduction of clinical budgeting should help in this connection.

3.8 Family doctors make extensive use of hospital pathology and radiology facilities in assisting them to diagnose and treat patients. These are essential aids and need to be provided locally at hours which are convenient to patients. Direct access by family doctors helps to avoid the need for more expensive hospital based diagnosis and should be encouraged. Given the extensive use also made of the pathology and radiology facilities by hospitals themselves, it seems that in general they are most cost-effectively located within the hospitals.

3.9 The shorter periods spent in hospital by patients, as well as changes in treatment methods for a number conditions, such as peptic ulcers and diabetes, have resulted in a greater involvement of the Primary Health Care Services in the management of treatment and in after care for a wide variety of patients. Changing methods of diagnosis are also having an impact on referrals/non-referral patterns. Diagnosis and treatment within the community setting is much preferred by patients to hospital referrals and, generally speaking, also is considerably cheaper. On both grounds the Society believes these trends (which are in keeping with the White Paper's aims) should positively be encouraged where-ever practical.

3.10 The Society supports the trend towards care in the community of the elderly, the mentally-ill, the mentally-handicapped and the physically-handicapped wherever it is in their interests and adequate support services can be provided both for the patients and their carers so as to ensure equal or improved quality of life to that which can be provided by "in hospital" care. This involves a shift in resources from Hospital Services. Evidence suggests the overall costs for the nation of care in the community may be higher than at present.

3.11 "The Nation's Health - The Way Forward" draws attention to the potential implications for patients and their family doctor advisers, of health maintenance organisations, health care vouchers and internal markets. These need to be taken fully into account in any evaluation of the implications of such arrangements so as to ensure that the

choice, quality and accessability of care which patients receive is not eroded whilst also ensuring hospital facilities are used cost-effectively.

3.12 Should any of these three proposals find favour as a result of the review, the Society would wish to have the opportunity of commenting in more detail. However, it is important at this stage to express particular concern regarding the internal market approach. If the concept is carried too far it could result in patients having less immediate access to hospital treatment. Specialisation by hospitals should not detract from their ability to provide the kinds of immediate treatment needed by a large proportion of patients for the more routine types of acute surgery and illness as well as accident and emergency cases.

3.13 The proposal in paragraph 3.63 of the White Paper to encourage family doctors to undertake minor surgery is welcomed. It will provide a more convenient service to patients and reduce the calls on out-patient departments. It will also help to prevent out-patient facilities being used inappropriately and aid in the containment and marginal reduction of hospital costs. The G.P. manpower implications will need to be carefully monitored.

4. FAMILY PRACTITIONER COMMITTEES

4.1 The future management and administration of the four Family Practitioner Services was the subject of detailed consultation and consideration in 1981. As a result the Government decided to separate FPCs from the then Area Health Authorities and make them autonomous. This was seen as the best means of developing the Family Practitioner Services; ensuring that these meet local needs; increasing value-for-money; streamlining the management process, and ensuring better collaboration with other sections of the NHS to provide effective and economic health services for the nation.

4.2 Since the grant of autonomy in 1985, and notwithstanding considerable resource and staffing difficulties, FPCs have shown that they are well suited to plan and manage the Family Practitioner Services and take full account of the customer aspects of those using the services. No longer reactive, FPCs are increasingly monitoring and where appropriate challenging individual contractor's standards and ensuring better value for money. In so doing, they are building on the very constructive relationship with the contractors, which has always been one of the strengths of FPCs.

4.3 Last November's White Paper, which included the Government's response to the House of Commons Social Services Committee Report on Primary Care, confirmed that the Government too believes that the separation of FPCs from DHAs has provided the base and impetus for better planning, development and management of the Family Practitioner Services. The additional responsibilities and functions proposed for FPCs and the changes proposed for practitioner's contracts will significantly help FPCs to ensure more sensitive services of a high quality; wider consumer choice; improved value-for-money; better Primary Health Care Services and improved collaboration with DHAs.

4.4 FPCs and the Society believe that the unification of FPCs and DHAs suggested by NAHA in paragraph 111 of its evidence would in fact stultify the progress being made and prove seriously detrimental to the provision of effective Primary and Secondary Health Care Services.

4.5 NAHA, in its evidence, rightly says that 'good foundations should not be undermined'. It draws attention to the fact that 'an effective Primary Health Care System can absorb and cushion demands which would otherwise be made on the more expensive hospital service' and that 'collaboration between the two sectors is therefore vital'. However, it produces no evidence to support its claims that the unification of such services

under the District Health Authority would enhance such collaboration and that 'all the Primary Health Care Services should be brought within the jurisdiction of District Health Authorities'. Past experience, up to 1985, tends to refute both NAHA's assertions and its conclusions. Evidence available suggests that at present the Primary Care Services may be suffering at the expense of secondary care in a number of DHAs.

4.6 The Society believes there are eight main reasons against any such unification:

(1) The Acute Hospital Services account for some 58% of the NHS budget, whilst the DHA Community Services account for a further 6%. This is big business, which needs effective management. It is probable (indeed, probably inevitable) that given the proportion spent on Acute Hospital Services these will continue to demand most of the time and expertise of DHA members and senior staff.

(2) FPCs are very largely concerned with health services in the community, which are becoming increasingly important. Both elements (FPS and CS) need full consideration and effective management.

(3) Given the breadth of services involved, it is likely that any unification of responsibilities along the lines envisaged by NAHA, would result in too diverse a range of services under one Authority and too wide a span of control for effective and efficient management.

(4) Authority Members of both DHAs and FPCs already find significant demands on their time. It is unlikely that the two bodies could be merged without making impossibly heavy demands on Member's time, thus leading to increasing difficulties in recruiting and retaining persons of the right calibre - a problem which already exists in some areas.

(5) If, on the other hand, NAHA envisages that at Member level there should continue to be a separate Family Practitioner Committee, this would seem to be little different from the 1974 re-organisation which was intended to bring about a closer working relationship between the 'managed' predominantly hospital services and the 'independent' family practitioner services. It proved unsatisfactory and led to FPCs becoming wholly independent in 1985.

(6) As already indicated, autonomy has led to increasingly effective planning and management of the Family Practitioner Services and to improvements being made to them and the other Primary Health Care services. The separation of FPCs and DHAs enables both to question constructively the services provided by themselves and each other so as to bring about the most effective arrangements for NHS users.

(7) Paragraph 7 of the Government's discussion document on Primary Health Care drew attention to the significant differences between the Family Practitioner Services provided by independent contractors and the Hospital Services which are employee based.

(8) The management costs of District Health Authorities are some 4.5% of their budgets. Those of FPCs are currently around 1%. Whilst these are not wholely comparable the type of unification envisaged by NAHA is likely to result in significant additional expenditure in providing continuing management of the Family Practitioner Services.

4.7 The Society shares NAHA's view (expressed at para 111) that family doctors need to be more involved in the managerial and planning processes. The White Paper envisages new contracts between GPs and Family Practitioner Committees, which will ensure that the family doctor services are more sensitive to national policies and local needs. Given the independent contractor status of GPs (an arrangement which as the Government has repeatably confirmed, helps to ensure user orientated and cost-effective services) the type of contract envisaged by NAHA would not be appropriate. The GP services, unlike most acute hospital treatments, are not about separate incidents, but about providing a continuing Family Health Service. There needs to be a long-term commitment to patient understanding and relations and development of the doctor's practice. However, GPs should provide their services within the framework of nationally and locally determined needs, which are regularly reviewed and updated. Their contract should clearly specify the functions and obligations of both parties (i.e. FPC and GP) and enable performance to be appropriately monitored and guaranteed. Where services prove unsatisfactory there needs to be speedy, fair means of rectifying this so as to ensure that the patient/ customers receive the standard of care to which they are entitled.

5. PRIMARY HEALTH CARE SERVICES - THE WAY AHEAD

5.1 Both the Government's discussion document 'Primary Health Care' and the recent White Paper 'Promoting Better Health' draw attention to the fundamental importance of the Primary Health Care Services in meeting the non-hospital health needs of the country's population. These are naturally focused around the Family Practitioner Services. The Cumberlege Report; the Government's response to it; and the Edwards Report each underlines the need to provide comprehensive Primary Health Care Teams, and for the Community Nursing Services to be linked to General Practice Services.

5.2 The Society believes that implementation of the White Paper; creation throughout the country of effective Primary Health Care Teams linked to General Practices, and their further broadening out to include appropriate allied paramedical services should be the immediate objective.

5.3 The Edwards Report for Wales further recommends that the four Family Practitioner Services managed by FPCs, together with the Community Nursing Services managed by District Health Authorities should be combined within a Primary Health Care Authority.

5.4 The Society in principle supports such a concept as the way ahead. A Primary Health Care Authority makes a more logical division of the health services; would better reflect patients' and users' needs; would create two better matched and manageable ranges of services; would help to give impetus to the Government's wish for a Family Health Service with appropriate emphasis on promotion of good health, screening and other measures to prevent illness as well as the treatment of illness. It should be responsible for identifying and meeting the personal health needs of local communities. It would work with District Health Authorities, local authorities and the private and voluntary sectors in ensuring that these needs are met in appropriate, practical and cost-effective ways. It should also have responsibility for providing health education with the Health Education Authority continuing to act as the national specialist body. The Society believes that such arrangements would be in keeping with the approach of both the White Paper and the Griffiths Report on Community Care.

5.5 However further study needs to be given to a number of aspects, including so far as England is concerned the differing patterns of DHAs and FPCs that exist. Also studies are needed into the financing of PHCA's, their staffing and the most appropriate management arrangements.

The objective would be to ensure sensitive cost effective Primary Health Care Services to which the Hospital Services are closely linked so as to jointly provide personalised comprehensive health care and treatment for all who use the NHS. Consideration should also be given to how Primary Health Care Authorities can best contribute to effective Care in the Community facilities and services.

5.6 Because the Primary Health Care Services are naturally focused around the Family Practitioner Services, the Society believes that FPCs are well-placed to play a leading role in the creation of Primary Health Care Authorities.

SUMMARY OF KEY POINTS

(i) The Society has in its membership all 98 English and Welsh FPCs and is an autonomous section of the National Association of Health Authorities.

(ii) The Society on behalf of Family Practitioner Committees, endorses the evidence submitted by the Association in relation to the future financing of the National Health Service, and the implications for all who use the services. It also generally supports the Association's proposals relating to the Hospital Services.

(iii) The views put forward by the Association on behalf of Health Authorities regarding Primary Health Care, are not shared by Family Practitioner Committees and the Society.

(iv) There appears to be total support within the nation for a comprehensive health service with genuine equity of access irrespective of means, locality, social or ethnic status. "Equity of access irrespective of means" can only be achieved if general funding rather than specific charges continues to be the principal source of financing the services and full account is taken of any potential deterrent effect when fixing the level of charges.

(v) Despite imperfections, the NHS has played a key role in improving the nation's health and has relieved individuals from worry about the personal cost of being ill.

(vi) At the forefront are the services provided by Family Doctors, Dentists, Community (Retail) Pharmacists and Opticians who handle over 90% of the calls made on the NHS. Local and national surveys show very high levels of satisfaction with these Services.

WHITE PAPER PROPOSALS FOR PRIMARY HEALTH CARE

(vii) The Primary Health Care Services in the United Kingdom are the most comprehensive amongst the western nations and are probably the most cost-effective. The White Paper 'Promoting Better Health' published last November, outlines proposals for further improvements. With a few caveats the Society strongly supports the proposals and believes they offer the best way ahead for creating a cost-effective **Family Health Service**. When implemented they will also help to reduce demands on the Acute Hospital Services and contain those costs.

(viii) The Society believes that greater flexibility in resourcing would assist in achieving better value for money and the containment of costs.

INTERACTION OF PRIMARY HEALTH CARE SERVICES WITH ACUTE HOSPITAL SERVICES

(ix) The referring role of family doctors is on the whole already very effective in ensuring patients obtain the treatment most appropriate to their needs, and reduces the level of hospital admissions (and costs) which might otherwise occur. The Society supports the White Paper proposals to make this role even more effective. Additionally all family doctors (and FPCs) should be provided with up to date information on waiting lists and length of waiting time so that they can better advise their patients. Information about the cost of referrals should also be made available to family doctors and FPCs.

(x) The changing diagnostic and treatment patterns with shorter stays in hospital and the greater involvement of the Primary Health Care Services (including after care) are preferred by patients and are more cost-effective. On both grounds these trends should be positively encouraged wherever practical.

(xi) The trend towards increasing 'Care in the community' for the elderly, mentally-ill, mentally-handicapped and physically-handicapped is supported where it is in the patients' own interests and adequate support can be provided for them and their carers. This means a shift in resources away from hospital services. Evidence suggests that the overall costs for the nation may be higher than at present.

(xii) The pathology and radiology services provided by hospitals are essential in aiding family doctors to diagnose and treat their patients. Direct access should be increased and can help to contain costs.

(xiii) Proposals to encourage family doctors to undertake minor surgery will provide a more convenient service to patients, reduce calls on out-patient departments and reduce hospital costs.

FAMILY PRACTITIONER COMMITTEES

(xiv) The Society shares the Government's view that the Family Practitioner Services can be more effectively managed by FPCs which are independent of DHAs. In the three years since autonomy, significant advances have been made and more are planned as a result of the White Paper.

(xv) Close collaboration between all the health groups in the NHS is essential in ensuring the effectiveness of the NHS. The Society believe that NAHA's suggestion for DHAs to take over responsibility for the four Family Practitioner Services would result in poorer, and not better, primary and secondary health care services. Also it is anticipated that costs would increase.

PRIMARY HEALTH CARE SERVICES - THE WAY AHEAD

(xvi) The White Paper and other recent reports have confirmed the fundamental importance of the Primary Health Care Services in meeting all the non-hospital health needs of the country's population.

(xvii) Implementation of the White Paper proposals; the creation throughout the country of effective Primary Health Care Teams linked to General Practices and their further broadening out to include appropriate allied paramedical services should be the immediate priority.

(xviii) The Edwards Report 'Nursing in the Community' suggests that the four Family Practitioner Services together with the Community Nursing Services, should be combined within a Primary Health Care Authority. The Society in principle supports such a concept as the 'way ahead', but recognises that a number of issues need first to be the subject of detailed studies, including for England the differing patterns of FPCs and DHAs which exist.

(xix) Because the Primary Health Care Services are naturally focused around Family Practitioner Services, FPCs are well-placed to play a leading role in the creation of PHCAs.

THEMES IDENTIFIED IN PARAGRAPH 1.7 OF THE WHITE PAPER AS ARISING FROM THE CONSULTATION PROCESS ON THE DISCUSSION DOCUMENT

- concern about the extent of preventable disease;
- the value which consumers - whether individuals or families- place on accessible, effective and sympathetic Family Practitioner and Community Health Services;
- the need of consumers for better, more detailed, and more accessible factual information about practitioners and the range and pattern of services they provide;
- the need to meet the varied requirements of elderly people, whose numbers are increasing;
- a growing interest in the promotion of good health;
- the need to improve services in deprived areas, particularly inner cities and isolated rural areas.

ANNEX 2

MAIN CHANGES WHICH THE GOVERNMENT IS SEEKING TO FAMILY PRACTITIONER SERVICES (PARAGRAPH 1.15 OF THE WHITE PAPER)

- Agreed targets for achieving higher levels of vaccination and immunisation and screening for cervical cancer;

- more health promotion sessions in general practice (to advise and assist on, for example, prevention of heart disease, on how to give up smoking, and on diet);

- regular and frequent health checks for particular sections of the community (for example children and some elderly people);

- more information for consumers to enable them to choose the doctor who best meets their needs;

- a wider range of services for the consumer at the doctor's surgery (for example interpreter services, counselling, chiropody, minor surgical operations and more nursing services);

- a new contract for dentists which will encourage prevention and promote the quality of treatment provided;

- measures to improve the distribution of dentists;

- a dental health campaign to promote an awareness of the value of regular check-ups among the young;

- free spectacle repairs for the handicapped and a domiciliary sight-testing service for the housebound on low income;

- an extended use of the pharmacist's skills;

- an enhanced role for Family Practitioner Committees (FPCs) in England and Wales in administering these changes.

FHS (June 1988)

ANNEX 1

THEMES IDENTIFIED IN PARAGRAPH 1.7 OF THE WHITE PAPER AS ARISING FROM THE CONSULTATION PROCESS ON THE DISCUSSION DOCUMENT

- concern about the extent of preventable disease;

- the value which consumers - whether individuals or families- place on accessible, effective and sympathetic Family Practitioner and Community Health Services;

- the need of consumers for better, more detailed, and more accessible factual information about practitioners and the range and pattern of services they provide;

- the need to meet the varied requirements of elderly people, whose numbers are increasing;

- a growing interest in the promotion of good health;

- the need to improve services in deprived areas, particularly inner cities and isolated rural areas.

ANNEX 2

MAIN CHANGES WHICH THE GOVERNMENT IS SEEKING TO FAMILY PRACTITIONER SERVICES (PARAGRAPH 1.15 OF THE WHITE PAPER)

- Agreed targets for achieving higher levels of vaccination and immunisation and screening for cervical cancer;

- more health promotion sessions in general practice (to advise and assist on, for example, prevention of heart disease, on how to give up smoking, and on diet);

- regular and frequent health checks for particular sections of the community (for example children and some elderly people);

- more information for consumers to enable them to choose the doctor who best meets their needs;

- a wider range of services for the consumer at the doctor's surgery (for example interpreter services, counselling, chiropody, minor surgical operations and more nursing services);

- a new contract for dentists which will encourage prevention and promote the quality of treatment provided;

- measures to improve the distribution of dentists;

- a dental health campaign to promote an awareness of the value of regular check-ups among the young;

- free spectacle repairs for the handicapped and a domiciliary sight-testing service for the housebound on low income;

- an extended use of the pharmacist's skills;

- an enhanced role for Family Practitioner Committees (FPCs) in England and Wales in administering these changes.

FHS

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

CH/EXCHEQUER 6/7
REC. -6 JUL 1988
ACTION Mr Saunders
COPIES TO CST, Sir P Middleton, Sir T Burns, Mr Anson, Mr Phillips, Mr Culpin, Mr Turnbull, Miss Peirson
Mr Parsonage Mr Call
Mr Kuczys I/R

SECRET

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

5 July 1988

Dear Paul,

NHS REVIEW

I enclose Sir Roy Griffiths' paper on Consultants for the meeting of the Prime Minister's Group on the NHS Review which is to take place on 8 July.

Copies of this letter and enclosure go to the Private Secretaries to the Chancellor, the Chief Secretary, the Minister for Health, and the Secretaries of State for Scotland, Wales and Northern Ireland; to Professor Griffiths and Mr O'Sullivan at the Policy Unit and to Richard Wilson at the Cabinet Office.

Yours sincerely,

Geoffrey Podger

GEOFFREY PODGER
Private Secretary

CONSULTANTS' CONTRACTS

This note summarises the points on consultants' contracts which I was making at the last meeting.

Before moving to change the contracts, either as to tenure or other terms and conditions, and deciding whether to extend these changes to all consultants or simply to new appointments, we should decide:-

1. what it is we are seeking to achieve;

2. to what extent this is possible under the existing contract;

3. if it is not possible, what changes to the contract are necessary;

4. what dangers we are running in making changes only to contracts for new appointments.

We are looking to the consultants to provide high quality of care, more efficiently, more expeditiously and more conveniently to the patient (the right product at the right time at the right price). We should not underestimate the extent to which improvements are being made under the various management initiatives (there are many hospitals, including Guy's which have taken on effectively the messages from the Management Inquiry and are producing results.) The involvement of the clinicians comes not from any road to Damascus enlightenment or from any stroke of the legislative or contractual pen, but from an understanding by management and clinicians that the running of hospitals is like the running of any other business and depends on clear responsibilities, clear targets, a good budgetary system and a system of appropriate rewards and incentives (not all personal).

Have these successes been exceptional and do we require any change in contract to make them the norm and to facilitate and accelerate progress?

The starting point is that the contracts with consultants are contracts of employment and not like those of GP's, contracts with independent contractors for services. There

is always in any contract of employment a vast middle ground between absolute employer rights under a contract and absolute employee rights - in other words how far does management prerogative cover the middle ground? In areas of the private sector over the last 10 years the middle ground has as a matter of will, been largely reclaimed. We should do it in the Health Service. The nature of the contract is that consultants can be required then to perform those activities which are at the heart of the contract, whether expressed or implied. The specific obligations are generally set out in terms of sessions etc. I believe that consultants can be required to take part in management processes such as budgetary cost control, clinical review and a quality audit as being integral and being implied in their contract of employment. Other flexibilities such as a requirement to move to day surgery (which might be regarded as requiring a change to clinical practice) can be controlled by allocating the money and resources for day surgery as distinct from in-patient surgery. In short I believe that most of our requirements are achievable with the present consultants' contract. Their active co-operation would of course be positively sought, but if refused the consultant would run the risk of dismissal.

There remains two substantive issues which are not covered by contract. Existing contracts are generally quite specific that the appointment is to a particular position at a particular hospital. This should be changed in any new contracts if it is thought desirable. Secondly, it is clear that if a consultant is asked to take on duties substantially different from his existing duties, such as in any organisation would be regarded as a new job, then this would have to be re-negotiated in the individual case, e.g. if asked to take on substantive management duties such as a part-time general manager outside the normal implications of his work. Against this background we have to consider the three issues which, many suggest, have to be addressed if we are looking for real advance.

1. Moving the contracts from region to district.

2. A new reward system to replace the distinction rewards.

3. Short term contracts.

A common factor in the background of all three is that management aspects have not been regarded as part of the basic contract. In 1. above the Management Inquiry made it quite clear that it did not matter legally where the contract was held (in most companies it is held by the company itself). The real question is who has the management authority, subject to the appropriate appeals procedure, to discipline. It should be made quite clear that the regions should, providing the district have exercised discretion within reasonable limits, accept the district's recommendations on disciplinary matters and that the district in effect should be seen to have the appropriate management authority vis-a-vis consultants.

Under 2. there are already proposals in HC29 for a new reward system. It should be made clear that no award should be made where, whatever the professional merits, there have been reservations as to the consultant's participation in the management tasks implicit in his contract. Additionally some awardsshould be given for special excellence in the areas of management.

On the question of tenure the legal position is as set out in paragraph 14 of HC29, i.e. contracts are subject to 3 months notice, with the expectation by custom and practice that they will continue. The justification for this practice is that it simply reflects the fact that the NHS is a monopoly employer and a consultant has a right to expect that his employment will be for life. The reality is that the consultants' contracts, like the GP's contracts, have rarely been managed by anyone and the contracts rarely terminated except for the most flagrant breach. To effect substantive change it has to be made clear that performance in terms of quality audit, and participation in management processes such as budgeting and resource allocation, are part of a consultant's job and to go for any kind of change in the overall contract without tackling these matters will be to ossify the contract even more. The suggestion of a 7 year renewable contract would become by custom

and practice again a life contract. In any case it is almost laughable to suggest that a 7 year contract will give flexibility. It has no precedent other than biblical; even company law expressly forbids Directors more than 5 year term contracts without shareholder approval and, in any case, term contracts are most exceptional in the private sector. Term contracts will in any case probably have a ratchet effect on costs, with the cost for renewal escalating.

I am not under-estimating the strong passions aroused everywhere by considerations of tenure and the holding of the contracts by districts. Both have become regarded as symbolic pre-requisites of change. We should seek the appropriate change by management action within the contracts and only go for changes of tenure and to district contracts if they can be achieved without tremendous extra cost. If politically it is adjudged necessary to move on these matters, then it should be appreciated that the moves are not for managerial reasons. We should also expect, if we make these moves, consultants to put many other issues on the table; payment for 24 hour cover and possibly overtime, where currently we get away quite cheaply.

Revised disciplinary procedures and the right to move doctors within the Health Service are flexibilities worth negotiating. The former is in any case under review and I would simply add into contracts with new consultants the right to move them at least anywhere within the region or district. Otherwise I would be careful in being absolutely explicit in contracts for new consultants about quality audit involvement in management, unless we make it quite clear that we are merely being quite explicit about what is already the implicit in existing contracts.

In short to contemplate making large payments to buy out tenure or move contracts from regions is playing with the form without tackling the substance of the problem. It is a change in behaviour by management process and not a change in contract by legal process that we should be seeking to achieve. Our position is essentially that the contract is subject to 3 months notice. Consultants have a right to expect from a monopoly employer

that they will continue in employment with the NHS, but this can only be on the basis that they are doing what can reasonably be demanded, i.e. provide good quality care at a reasonable cost and will take part in the management process, including medical audit, which will achieve and evidence this.

If we are prepared to spend large amounts of money (estimated at least £100M.) to achieve changes in tenure and holding of the contract at district level - that is if negotiable at all - I think that money would be better spent on tackling directly some of the major problems such as waiting times etc. For a figure of £10M. per annum we could appoint say 200 new consultants specifically to those districts and specialties where waiting times are long - this would if specifically targetted, have a dramatic effect on changing the behaviour of consultants everywhere. We could appoint 50 - 100 immediately from the ranks of Senior Registrars and others who are queuing for appointment; the rest would take longer, 2 - 4 years. This would have the added advantage of containing costs by an improvement in the supply side to meet any growth in the private sector. If we added to this the putting out to competitive tender of clinical services, as a first priority in the districts and specialties where the waiting times are long, we could transform the position.

4th July, 1988
ERG/0370v

NH6/29M

SECRET

FROM: MISS M P WALLACE

DATE: 5 July 1988

MR PHILLIPS

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

Mr Kuczys IR

NHS REVIEW: THE OVERALL PACKAGE

The Chancellor was most grateful for your minute of 4 July, covering the first draft of the package paper. He agrees that the changes you suggest are essential. He had a number of other points on the draft:

(i) In paragraph 4, he has queried the assertion that rationing is "the main means of controlling costs" - this could also mention the role of cash limits;

(ii) he feels that the two sentences of the current paragraph 5 (vii) are two distinct points, and should be separated. He would prefer the second toned down to read "those who wish to buy medical care for themselves and their families should be <u>able</u> to do so";

(iii) in paragraph 8 (iv) he has commented that the final sentence (benefits in kind exemption for the elderly employed) should also be square bracketed : it was offered <u>conditionally</u> on the proviso that nothing else was done for benefits in kind;

(iv) in paragraph 10 (ii) he agrees that it is essential we have short-term contracts added to the list;

(v) again, the Chancellor thinks that paragraph 12 (vi) overplays what has been agreed, and he would rather see this in square brackets.

mpw.

MOIRA WALLACE

SECRET

FROM: R B SAUNDERS
DATE: 5 July 1988

CHANCELLOR

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

Mr Kuczys - IR

[Red manuscript annotation: Thanks. As you say, not too bad. Re para 3, I am not too fussed about the "buyer-provider" theme, since [illegible] contract [illegible] positive [illegible] for the longer term. I am [illegible], however, [illegible] contracting [illegible] [illegible] criticism of buyers & providers, [illegible] contracts [illegible]]

NHS REVIEW: THE OVERALL PACKAGE

I attach Richard Wilson's redraft of this paper.

2. It is broadly satisfactory from our point of view. The references to tax relief are much more tentative. There is an early reference (para 2) to the success of the NHS in keeping costs down. And your and Mr Phillips' other points have been taken on board [with no square brackets].

3. The main worry is that Part I and - more particularly - Part III still lean quite heavily towards "buyers and providers", but with no further clues as to how they would work. This is inevitable, in view of the outcome of the last No 10 meeting. But if - as is quite likely - the concept collapses before the autumn, we shall have to be careful that it is not replaced by something equally half-baked, like contracting out.

4. We shall let you have detailed briefing for Friday's meeting, including an analysis of costs and benefits of the package, which Mr Parsonage and Mr Sussex are producing. A draft minute to the Prime Minister, reflecting yesterday's discussion, will follow tomorrow.

RBS

SECRET

Draft of 5 July

REVIEW OF THE NATIONAL HEALTH SERVICE

THE OVERALL PACKAGE: A SUMMARY OF CONCLUSIONS SO FAR

Note by the Cabinet Office

1. We were asked to prepare a paper summarising the main ideas and conclusions emerging from the Review so far, as a basis for the discussion on Friday 8 July.

2. A paper for this purpose is attached. It has been prepared on the basis that the proposed White Paper will announce firm Government decisions on the broad direction of long-term reform of the National Health Service (NHS) and the immediate steps to be taken in that direction (Parts I and II of the paper); but that it will discuss the details of the long-term reform more tentatively, in the manner of a Green Paper, as a basis for consultation and discussion (Part III of the paper).

3. The paper is not intended to be the text of a White Paper. Presentation will need to be considered carefully when the policy has been decided.

4. The Group is invited to consider:

i. whether it is content with the overall package described in the note and, if not, what changes should be made and what further work needs to be done;

ii. whether more work is needed on issues not so far covered in the Review (possibilities are listed in Annex A);

iii. what the timetable for the rest of the Review should be (a possible outline is in Annex B).

Cabinet Office
6 July 1988

SECRET

REVIEW OF THE NATIONAL HEALTH SERVICE

THE OVERALL PACKAGE: A SUMMARY OF CONCLUSIONS SO FAR

1. The Government is firmly committed to ensuring that a high standard of medical care is always available to all, regardless of income. It has demonstrated this commitment by increasing net expenditure on the National Health Service (NHS) from £7.8 billion in 1978/79 to £22.6 billion now. The Government intends to maintain this commitment and preserve what is best in the NHS.

2. The Government is also determined to modernise and improve the NHS, where it is weak. The present system of centralised control has enabled the NHS to escape large increases in costs and expenditure experienced elsewhere in major Western countries. Nevertheless, the NHS does not always provide as high a standard of care for the patient, or as good a level of value for money for the taxpayer, as it could; and the private sector in health care is still relatively small. The Government believes that the law of diminishing returns will apply to every increase in money granted to the NHS, unless it is accompanied by a programme of reform directed at greater efficiency, greater choice and better quality of care.

3. In the following sections, Part I outlines the main direction which the Government believes that the long-term development of the NHS should take. Part II sets out a first package of measures which the Government will implement to begin this process of change, building on the management reforms of recent years. Part III suggests further steps which might be taken later on to develop the process of change, as a basis for consultation and discussion.

PART I: BROAD DIRECTION OF LONG-TERM CHANGE

4. At present the NHS is a planned and centralised bureaucracy which uses cash limits as the main means of controlling costs and rationing to cope with ever-growing demand. Doctors have no incentive to be cost-conscious: many cling to the belief that they should not be involved in the management of resources. Budgeting and information systems are ill-designed. Those who commit resources are not financially accountable and are not given adequate information on the costs of what they are doing. Those who use resources efficiently are often not rewarded for doing so. Indeed, hospitals may be penalised for efficiency.

5. The Government believes that the long-term aim should be to develop the NHS on the following lines.

i. Hospitals, either singly or in groups, should be given much greater independence in running their own affairs, with corresponding responsibility for the results.

ii. As part of this process, the medical profession should accept that they have important management responsibilities, as distinct from their clinical responsibilities.

iii. There should be a slimming-down of the present structure of regional and district health authorities. The eventual role of many District Health Authorities should be to act as the buying authorities for their districts.

iv. These organisational reforms should lead to much greater competition and trading of services between health authorities and between the public sector and the private sector. The funding of hospitals should be based on the work which they perform, and those which are efficient should be rewarded correspondingly.

v. There should be a major expansion of the private sector in the provision of health care, matched by the removal of supply-side rigidities, inefficiencies and restrictive practices. The private sector should provide competition in those areas where it is the most efficient supplier. It should also be encouraged to co-operate more closely in the operation of the public sector (eg through contracting out or the purchase of spare capacity) wherever this is the most cost-effective approach.

vi. There should be more effective arrangements for medical audit, directed at monitoring the use of resources and securing improved quality of health care.

vii. Those who wish to buy medical care for themselves and their families should be able to do so.

The net result should be a better service and greater choice for patients.

6. These changes cannot all be implemented immediately. They involve major organisational reform, which will need careful management. Moreover, the demand for health care exceeds the supply: future growth in supply needs to be based on the removal of inefficiencies and restrictive practices, if an explosion of costs is to be avoided. There therefore needs to be a first package of measures which prepares the way for later reform.

PART II: PACKAGE OF IMMEDIATE MEASURES

7. There are five main ingredients in the package of measures which the Government proposes to introduce now.

8. First, a better deal for patients. The Government's proposals for increased efficiency will mean that patients will benefit from a more responsive NHS and a thriving mixed economy in health provision. But there will also be more specific benefits in the package.

i. GPs will have better information about waiting lists so that they can send their patients more quickly for a consultation or operation.

ii. New "top-sliced" financing arrangements will be directed partly to cutting waiting times, based on a hospital's performance in tackling waiting-list cases.

iii. GPs will be given incentives to carry out more minor surgery (Primary Care White Paper).

iv. People over the age of 60 will get tax relief for private health insurance taken out by on their behalf. [A decision needs to be taken on whether there should be tax relief at the higher rate for those paying tax at this rate.] [Those still in employment could get parallel relief from the benefits-in-kind charge on corresponding premiums.]

[v. A decision needs to be taken on tax relief for company health insurance schemes.]

vi. There are to be more schemes under which patients can pay for optional extras or more "topping-up". This will generate income for the NHS and provide extra services for patients.

9. Second, better use of NHS resources. There has been good progress with management improvements in recent years. The Government intends to build on this as follows.

i. Better information is essential. The Resource Management Initiative will be accelerated, by extending it next year from five experimental sites to the whole country. This will enable proper clinical budgets and monitoring to be introduced. It will also provide doctors with more detailed information about each other's practices as a basis for medical audit.

[ii. Better use of capital is also important. Discussions between Treasury and DHSS in hand.]

iii. Independent outside scrutiny is an essential counterpart to better internal systems. Performance indicators are now in place. New arrangements for independent audit of Value For Money will be introduced: legislation will be needed.

iv. Arrangements for medical audit will also be strengthened. Consultants can at present refuse to participate: in future they will be contractually bound to do so.

[v. The new "top-sliced" financing arrangements will be designed to provide greater incentives to efficiency. They will be linked to the introduction of market mechanisms, eg for selected independent hospitals, and the pursuit of local experiments.]

10. Third, full involvement of consultants. There is growing acceptance by the medical profession that they have a management role complementary to their clinical duties. Responsibility for the use of resources will go hand in hand with accountability for the stewardship of them. This will not affect clinical accountability which will continue to be to the patient and to the doctor's professional peers.

i. The Resource Management Initiative is directed at involving doctors in management systems.

ii. Contractual arrangements will be revised. [Paper by Sir Roy Griffiths will explore this further. Proposals so far include the transfer of contracts to District Health Authorities, short-term contracts for new entrants, reviewable job descriptions, mobility between hospitals, reform of the merit award system and encouragement of part-time contracts.]

11. Fourth, a better organised NHS. A key feature of the proposed long-term reforms is greater independence for hospitals to enable them to operate within market mechanisms rather than top-down controls. This will require legislation in due course. In the meantime, the first steps towards this aim at greater devolution of responsibility to hospitals (or groups of hospitals) within the existing framework of the NHS, including the following:

i. making clinicians, who are the main users of NHS resources, accountable for the use which they make of those resources. This ties in with the proposals for better information systems and for revising consultants' contracts;

ii. requiring District Health Authorities to agree with hospitals under their control what their performance targets are, both for local 'baseload' services such as accident and emergency departments and for elective surgery. Hospitals which meet their performance targets will be guaranteed an agreed level of funding. There will also be agreed arrangements covering the provision of services to other Districts or the private sector, and tertiary referrals;

iii. giving hospitals more freedom to determine local pay and conditions, and to deploy staff flexibly, within a reformed Whitley system;

iv. setting up pilot experiments (eg for teaching hospitals) to try out new arrangements for independence, leading towards autonomy on the lines of paragraph 14, at an early date;

v. revision of the role of the NHS management board, to take account of these changes.

12. Finally, a thriving mixed economy of health care. The private sector is an integral part of the nation's health care. A strong private sector is good for the NHS, and vice versa, as a source both of competition and co-operation. The Government welcomes the joint ventures which have begun to take place. It will encourage the growth of an efficient private sector by:

i. encouraging more joint ventures;

ii. extending contracting-out to clinical work as well as laundry cleaning and catering. Competitive tendering will initially cover clinical support services such as pathology but the scope for further extension (eg to certain types of elective surgery) will also be considered;

iii. asking all NHS hospitals to review the scope for selling spare capacity to the private sector;

iv. encouraging more pay beds in NHS hospitals, particularly the introduction of new private wings (eg in accommodation which becomes surplus following rationalisation);

v. tackling medical restrictive practices to free up the supply of key personnel, especially consultants;

[vi. introducing tax relief to encourage some forms of private health insurance (see above).]

PART III: POSSIBLE MEASURES FOR THE LONGER TERM

13. Taken together the measures in Part II are in themselves a formidable programme of change. But they need to be part of a programme for the longer-term development of the NHS, designed to give a better deal to the patient and the taxpayer. The details of this programme will be decided in the light of further consultation and discussion. But the Government's present thinking is as follows.

14. The process of devolving responsibility to hospitals should lead to the establishment of self-governing hospitals with statutory independence. To qualify for independence each hospital would need to demonstrate to the satisfaction of the Secretary of State a record of sound financial, professional and management competence. New hospitals would provide a particularly good

opportunity for experiments in autonomy. Once independent, hospitals would be separate legal entities, free for instance to:

i. grade, deploy and pay staff - including consultants who would be hospital employees - as their management board thought fit;

ii. enter joint capital ventures with the private sector;

iii. develop new services to meet demand or reflect new technology;

iv. sell their services to whichever District Health Authorities, or private sector health insurance companies wished to buy them.

15. General Practitioners would continue to act as the gateway to hospital services. They would continue to have freedom to refer patients to consultants: indeed they would have better information about where to refer patients. DHAs would need to set aside funds to cover special or ad hoc referrals to hospitals not covered by their main contracts. The present functions of Family Practitioner Committees could be transferred to DHAs, and cash-limited funds for primary care could be channelled through DHAs. GPs would remain independent contractors, but their contracts would be with DHAs. The provision or otherwise of their contracted services could be used as performance indicators (eg the rate of referrals to consultants, home visiting, the carrying out of minor surgery and prescription rates).

16. As operational management responsibilities shifted to hospitals, there would be a corresponding change in the role of District and Regional Health Authorities. DHAs would be the buyers of services and would place contracts with whichever hospitals could provide the best package of services. Contracts would be contestable by other public and private sector hospitals. The constitution of DHAs would be revised to end their existing exposure to local political and other pressures. The shift in responsibility to hospitals would mean that the size - and perhaps the number - of DHAs could be greatly slimmed down. So too could the size and number of Regional Health Authorities, perhaps to the point where they could become regional offices of the DHSS. Funding would then flow direct from the DHSS to the Districts.

Cabinet Office
6 July 1988

ANNEX A

POSSIBLE AREAS ON WHICH FURTHER PAPERS MAY BE NEEDED

1. Restrictive practices in professions other than consultants.
2. Manpower and Training Issues.
3. The role of the NHS Management Board.
4. Private Sector: action plan.
5. Competitive tendering.
6. Information technology and the Resource Management Initiative.
7. Independent Audit: report by Treasury and DHSS.

ANNEX B

TIMETABLE FOR COMPLETION OF REVIEW

26 July	:	Meeting to consider further work commissioned on 8 July.
Week beginning 12 September	:	Meeting to consider first draft of White Paper.
Week beginning 3 October	:	Meeting to consider second draft of White Paper.
Week beginning 9 October	:	Party Conference.
November/December	:	Publication of White Paper.
January 1989 onwards	:	Consultations followed by legislation in 1989-90 Session.

HEALTH

Ch/ Latest version of Cabinet paper behind.
Two other points:

(i) Do you want briefing meeting before Friday? Hayden thinks it wd be useful - by then we will have Griffiths paper on consultants. And cd also discuss - if still unresolved - whether you should minute Group before Friday. Shall we fix something pre-Cabinet or later in Thursday afternoon perhaps?

(ii) Friday's session does include lunch - and the intention is that discussion should continue at the table. You have to leave for Leicestershire, so will have to miss this, I suppose.

Yes

MPW.
5/7

MC6.28

CONFIDENTIAL

FROM: MARK CALL
DATE: 5 JULY 1988

CHANCELLOR

cc Chief Secretary

LSE PAPER ON NHS

Although many interested parties do agree on the need to reform consultants contracts, I'm sure the BMA do not. The LSE paper, given its pedigree, could be tactically useful in dealing with BMA objections. Yes, it supports their view of the need for financing to remain substantially based on general taxation, and the general soundness of the NHS strategy, but the quid pro quo is the reform of consultants contracts. It will be more difficult for them to dismiss such a paper than those of the Adam Smith Institute or contributions by politicians.

MARK CALL

ph7.9

SECRET

6/7/88.

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

PRIME MINISTER

YOUR MINUTE ON HEALTH OUTCOMES

NHS REVIEW

My minute of 28 June about the supply and demand for health care concluded that we need to concentrate on improving the supply side. I should like to develop that thought further in this note.

Too much of the public debate has been about inputs - in particular the proportion of GDP devoted to health care, but also such statistics as the numbers of doctors and nurses, etc. What really matters, however, is health outcomes. The following table is interesting in this context.

Country	Health expenditure as % of GDP (1985)		Life expectancy (latest available year)		Infant mortality (1986)
	Public	Total	Male	Female	Per 100 live births
UK	5.2	5.7	71.4	77.2	0.95
USA	4.4	10.7	70.5	78.2	1.06
Australia	5.4	7.3	72.0	78.9	0.99
France	6.8	8.6	70.4	78.5	0.80
Germany	6.4	8.2	70.2	76.8	0.86
Italy	5.4	6.7	69.7	75.9	1.01
Sweden	8.5	9.4	73.0	79.1	0.59

Source : OECD

It is clear that there is little relationship between the amount of health spending and performance as measured by these indicators. Although the UK spends less of its GDP on health than the rest, we are comfortably in the middle of the range of the indicators. The USA spends more than all the rest, but has the highest infant mortality. In short, other countries do not seem to be getting good value for money from their higher expenditures.

This is less surprising when one recalls the great difficulty most other countries are experiencing in getting the costs of health care under control in either the public or the private sector. Indeed, they envy our ability to keep costs down. It is clearly important that we do nothing to erode our advantage: indeed, we should be seeking ways of getting even better value for money.

One reason for this loss of cost control in other countries is the practice of payment per item of service, which among other things leads to considerable numbers of unnecessary operations. There are surprisingly ~~very~~ large variations in the amount of treatment given, for example up to four-fold differences in some operations (eg Caesarean sections, appendectomy, tonsillectomy and hysterectomy). All in all, it is evident that there is no validity in arguments based on the proportion of GDP spent on health care.

This leads to a more general point. We know far too little about the effectiveness of different forms of treatment. We are in no position to say which represent the best value for money and so are most deserving of extra resources. There have been major success stories, such as the immunisation programmes, kidney transplants, and hip replacement operations, which have had a dramatic effect on either mortality rates or the relief of pain. But there is equally evidence of money being spent to little effect, and of extra spending yielding diminishing or even negative returns:

- some past studies in this country showed that then long standing and costly types of treatment - coronary care units, freezing of duodenal ulcers and hormone treatment of viral hepatitis - did little to increase survival rates, and even sometimes decreased them.

- Studies in the USA and Germany have shown that, even though prevalence of the disease is much the same, those areas with the highest rates of appendectomy operations also have the higest rates of death from appendicitis, no doubt as a result of the risks attached to operating on patients.

- One of the top ten causes of hospitalisation in the USA is adverse reactions to drugs administered for medical reasons.

Other countries now recognise the need to tackle these problems. For example, in the USA, the Health Care Financing Administration, which is responsible for federal expenditure on Medicare and Medicaid,is about to start a programme of assessing the effectiveness of particular types of treatment.

We too need to tackle these problems. While we have a system which successfully controls hospital expenditure, thus helping to keep costs down, we have not yet got the incentives right at the clinical levels. We can start with a number of supply-side measures which are already in prospect, like improving the information available to doctors and managers and encouraging medical audit. We can go further by new measures, some of which we have already discussed, like involving doctors more closely in

management and improving value for money audit. And we most certainly need to take further steps to improve the supply-side by far greater private sector provision of health care. But this is quite different from seeking to expand private sector finance, which risks the damaging consequences I outlined in my earlier note.

While there are detailed elements which we shall need to discuss, I commend the approach in the Cabinet Office note on the overall package. Taken with the action we need to take on consultants' contracts and restrictive practices in the medical profession, I believe that this provides us with the outline of a coherent set of proposals which can be put into effect quickly and would not rule out more radical change in the longer term.

I am copying this minute to John Moore, John Major, Tony Newton, Malcolm Rifkind, Tom King, Peter Walker, Sir Roy Griffiths, Sir Robin Butler, Richard Wilson and John O'Sullivan.

A C S Allan

PP N.L.
6 July 1988

[approved by the Chancellor and signed in his absence]

6.7.1

SECRET

FROM: R B SAUNDERS

DATE: 6 July 1988

CHANCELLOR

cc Chief Secretary
Financial Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Sussex
Mr Call

DISC ATTACHED CONTAINING DRAFT LETTER

NHS REVIEW

I attach a draft minute to the Prime Minister on the lines we discussed at your meeting on Monday.

2. First, a few points on the minute itself:

- the table in paragraph 2 is the same as in the LSE paper, except that we have added Australia, and updated the expenditure and infant mortality figures.

- The examples quoted in paragraph 5 can be put forward with confidence. All result from well known and respectable academic research. While some are now a bit out of date - eg ulcers are nowadays treated with drugs rather than by freezing - that does not detract from the general point that we should be asking the same questions about all treatments.

- It may be suggested that your emphasis on health outcomes sits ill with your scepticism about Mr Moore's Health Index. This is not so. We are simply saying that it makes no sense to look only at what is spent. The Health Index is a very woolly idea, which carries the risk that it would be used to set unrealistic health outcome targets with open-ended expenditure consequences.

Also, we were mainly objecting to the way he announced it as if it was something decided in Review.

SECRET

3. You will wish to consider what use to make of this draft. There are three alternatives:

a. Send it in quickly before Friday's meeting.

b. Hold it back until after the meeting, so that it can take account of the discussion there.

c. As b., but expanding it to incorporate some of the material in the note which Mr Parsonage is putting to you today about the costs and benefits of the "package". (not yet here)

4. Whether to put it in before the meeting is largely a tactical judgement. There is something to be said for getting these points onto the table before Friday's meeting, which is likely to be a crucial one. On the other hand, you may think that a further note following so soon on your earlier one would be counterproductive. If you decide to delay this note, there would be something to be said for working in our conclusions on overall costs and benefits. The next meeting will not be for another 2½ weeks, and so we shall have a little time to refine this work further. I suggest therefore that the choice is between a. and c. above.

RB

R B SAUNDERS

14/1417/ar

SECRET

DRAFT MINUTE FROM THE CHANCELLOR TO THE PRIME MINISTER

NHS REVIEW

My minute of 28 June about the supply and demand for health care concluded that we need to concentrate on improving the supply side. I should like to develop that thought further in this note.

2. Too much of the public debate has been about inputs - the proportion of GDP devoted to health care, numbers of doctors and nurses, and how to encourage more private spending. It is a mistake however to concentrate on this without also considering health outcomes. The following table is interesting in this context.

3. There are two points to make about this table. First, most of the other countries in it are experiencing great difficulty in getting the costs of health care under control in either the public or the private sector. They envy our ability to keep costs down, for example by avoiding the ruinously expensive "fee for service" mechanism.

4. Second, there is little evident relationship between health spending and performance as measured by these indicators. There are also large variations in the amount of treatment given, for example up to fourfold differences in some operations (eg Caesarean sections, appendectomy, tonsillectomy and hysterectomy). Although the UK spends less of its GDP than the rest, we are comfortably in the middle of the range on the indicators. The USA spends more than all the rest, but has the highest infant mortality. In short, other countries do not seem to be getting good value for money from their higher expenditures and more frequent operations.

5. This leads to a more general point. We know too little about the effectiveness of different forms of treatment. We are in no position to say which represent the best value for money and so are most deserving of extra resources. There have been major success stories, such as the immunisation programmes, hip replacements, and kidney transplants, which have dramatically improved mortality rates, and the quality of people's lives. But there is equally evidence of money being spent to little effect, and of extra spending yielding diminishing or even negative returns:

- some past studies in this country showed that then long standing and costly types of treatment - eg coronary care units, freezing of duodenal ulcers and hormone treatment of viral hepatitis - did little to increase survival rates, and even sometimes decreased them.

- studies in the USA and Germany have shown that areas with the highest rates of appendectomy also have the highest rates of death from appendicitis, even though prevalence of the disease is much the same, no doubt as a result of the risks attached to operating on patients.

- one of the top ten causes of hospitalisation in the USA is adverse reactions to drugs administered for medical reasons.

6. Again other countries face similar problems. For example, in the USA, the Health Care Financing Administration, which is responsible for federal expenditure on Medicare and Medicaid, are about to start a programme of assessing the effectiveness of particular types of treatment.

7. We too need to tackle these problems. While we have a system which successfully controls hospital expenditure, thus helping to keep costs down, we have not yet got the incentives right at the clinical level. We can start with a number of supply side measures which are already in prospect, like improving the information available to doctors and managers

and encouraging medical audit. We can go further by new measures, some of which we have already discussed, like involving doctors more closely in management and improving value for money audit. And we need to take further steps to improve the supply side by greater private sector provision. But, as I argued in my earlier note, the case for increasing demand by measures aimed at private sector finance is weak.

8. Taken with the action we need to take on consultants' contracts and restrictive practices in the medical profession, I believe that this provides us with the outline of a coherent set of proposals which can be put into effect quickly and would not rule out more radical change in the longer term, if that emerged as desirable. While there are detailed elements which we shall need to discuss, I commend the approach in the Cabinet Office note on the overall package.

9. I am copying this minute to John Moore, John Major, Tony Newton, Malcolm Rifkind, Tom King, Peter Walker, Sir Roy Griffiths, Sir Robin Butler, Richard Wilson and John O'Sullivan.

SECRET pse.jf/mp/mp.4M

FROM: M A PARSONAGE
DATE: 6 JULY 1988

1. MR PHILLIPS
2. CHANCELLOR

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

Mr Kuczys - IR

NHS REVIEW: COSTS AND BENEFITS OF THE PACKAGE

I attach a paper giving our preliminary assessment of the costs and benefits of the emerging package of proposals. Attached is a summary reference table. The detailed Annex will follow.

2. The paper concentrates on the "immediate measures" listed in Part II of the Cabinet Office paper circulated yesterday by Mr Saunders. It does not therefore include any analysis of "possible measures for the longer term" such as "buyers and providers".

3. A broad conclusion is that, with further work, the package looks to have the makings of a coherent and concerted attack on supply side deficiencies, but that it is short on measures offering immediate and tangible benefits to consumers. If you agree, it might be worth considering whether there are any proposals which could be worked up to fill this gap (the attached paper makes a passing reference to guaranteed maximum waiting times as one such possibility), not least as a means of heading off more damaging suggestions.

M A PARSONAGE

163/32

NHS REVIEW: COSTS AND BENEFITS OF THE PACKAGE

Detailed assessments of the costs and benefits of the main individual proposals in the package are given in the attached Annex. Table 1 provides a highly summarised overview.

2. The main points to be drawn from the analysis are as follows:

(i) some key elements in the package remain ill-defined, so limiting the scope for detailed evaluation. This particularly applies to the measures concerned with eliminating restrictive practices and other manpower inflexibilities. These measures need to be worked up and given greater prominence if the package is to be presented as a coherent whole;

(ii) the main emphasis of the package is rightly on improving supply performance. There is no shortage of demand for health care, but there are constraints on its cost-effective supply. Apart from small well-targeted changes on tax relief for private health insurance, none of the elements in the package is therefore aimed directly at increasing demand. Reforms which serve to improve the quality and effectiveness of services may indirectly stimulate greater demand. For example, measures to reduce waiting lists may encourage GPs to place more patients on those lists. However, these indirect effects look manageable;

(iii) many of the proposals for improving supply performance are in the nature of investments, ie the costs are incurred now but the benefits take time to come through. Examples are the measures to improve information systems, to involve clinicians in management and to encourage efficiency through rigorous auditing and peer review. Such measures are highly desirable and - in the long term - offer perhaps the greatest potential of all for

COSTS + BENS OF THE PACKAGE

improved performance. But it will be important to keep up the pressure for the benefits to be realised as quickly as possible. This implies setting and enforcing demanding timetables;

(iv) the greatest immediate impact of the package is likely to flow from action on waiting lists. This would directly relieve some of the most obvious pressure points in the system. Top-sliced financing to reward the most efficient hospitals should also offer early benefits, particularly by reducing the need for temporary closures of wards and operating theatres where higher than expected throughput threatens to breach hospital budgets. Implementation of this should be possible by 1 April 1989;

(v) over a slightly longer timescale, the extension of contracting out, via competitive tendering, to clinical services seems to promise the most by way of direct cash savings;

(vi) as well as improving supply performance, the package should also be designed to offer benefits in terms of a greater responsiveness to patients' preferences. There are one or two proposals which are directed towards this objective, but it is open to question whether these go far enough. More generally, the package is relatively weak in offering the consumers of health care an immediate and obvious improvement in the services with which they are provided. There is nothing in the package which carries the punch of, say, guaranteed maximum waiting times;

(vii) the package largely preserves the effectiveness of existing controls on public expenditure. The proposal for giving greater independence to hospitals, including freedom to determine local pay and conditions, will need to be looked at carefully from the control perspective, but this measure is not for early implementation except on a pilot basis. (One reform which offers the potential for improving expenditure control, ie the merging of DHAs and FPCs and so allowing FPS expenditure to be brought within cash limits, has been dropped from the package of immediate measures and moved in to the longer term. It could be reinstated);

(viii) Table 1 attached includes rough estimates of the additional Exchequer costs of the various proposals in the package. Where information is available, these are linked to DHSS Survey bids. Some proposals cannot be costed at all precisely at this stage, being dependent on Ministerial decision and negotiation with the professions. The overall cost of the package is therefore subject to wide margins of uncertainty, but looks to be of the order of several hundred millions a years.

3. Taken as a whole, the package represents a reasonably coherent and wide-ranging attack on supply side inadequacies while leaving the present arrangements for financing health care largely untouched. Its aim is to maintain the present highly effective macro control of public expenditure on health while at the same time promoting greater efficiency and responsiveness at the micro level. If the package is implemented in full, the supply benefits should come through - but only over a period of years. The attractiveness of the package would therefore be greatly increased if it could offer more in the way of immediate and tangible benefits to patients. But this would have to be in ways which did not jeopardise the longer term efficiency gains.

SECRET

TABLE 1

Summary of benefits and costs of the package of proposals

PROPOSAL	MAIN BENEFIT	ADDITIONAL EXCHEQUER COST
1.Waiting times: information for GPs	Reduced average waiting times	£m 5/10/10 in DHSS Survey bid
2.Further action on waiting lists	Reduces excessive waiting times	More than £25m pa (current level)
3.GPs doing minor surgery	Shorter waits; better use of hospitals	Small
4.Tax relief for the over-60s	Expanded use of private sector	£25m-£30m dead-weight cost
5.More for-payment "optional extras"	Enhanced consumer choice	Self-financing
6.Accelerated resource management initiative	Cheaper (at least £50m pa) and better provision	£m 90/180/145 in DHSS Survey bid
7.Capital and asset accounting	More efficient use of HCHS capital assets	Investment of few tens of £m
8.Independent value for money audit	More efficient provision	Approx. £10m pa
9.Medical audit	Better quality of clinical treatments	Order of £10m pa
10.Financing efficient hospitals	Lower costs per case	Depends on Ministerial decision
11.Revised consultants' contracts	Better integration of doctors in management	£0m-£150m pa
12.Hospital performance targets	Lower costs per case and higher throughput	None necessarily
13.Self-governing hospitals	Managerial freedom to innovate	Depends on financial flexibilities
14.Revised role for NHS Management Board	Facilitation of other proposals	None
15.More public/private sector joint ventures	Lower cost and higher quality treatment	None necessarily
16.Contracting out clinical support	Savings on present £700m pa cost	Small admin. cost offset by savings
17.More HCHS income generation schemes	Fuller use of NHS capacity	Self-financing or net excheq. gain
18.Tackling medical restrictive practices (other than 11. above)	Lower costs in both NHS and private sector	Dependent on negotiation

Total? £200m + 6?

6.7.4

SECRET

FROM: D P GRIFFITHS
DATE: 6 July 1988

1. MR PHILLIPS

2. CHANCELLOR

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

NHS REVIEW: CONSULTANTS' CONTRACTS

I attach a brief on Sir Roy Griffiths' paper on consultants' contracts. It is generally a good paper (Sir Roy's support for competitive tendering for clinical services is particularly welcome) but Sir Roy may be inclined to over-estimate what can be achieved under the existing system. We consider that measures such as the introduction of short-term contracts for new consultants may have a part to play if significant changes are to be carried through. But Sir Roy is right to emphasise the need to evaluate the costs of any contractual changes and whether this money might be spent to better effect elsewhere.

2. At the 30 June Review meeting it was suggested that the solution to the problem of consultants would be to make them independent and self-employed, selling their services to hospitals under contract. We would not recommend that this idea be pursued. It has dangerous implications both for cost and managerial control. If consultants were self-employed, there would be an inevitable tendency for them to adopt a fee-for-service approach. Certainly it is highly unlikely that they would continue to work overtime as they do now without additional remuneration. Medical manpower costs could easily spiral. Similarly, if consultants are self-employed and independent, hospital managements will have less rather than more control over them - viz the very limited control which Family Practitioner Committees have over GPs. Moreover, there would be less incentive for consultants to participate fully in the management of hospital resources.

D P GRIFFITHS

154/32

SECRET

CONSULTANTS' CONTRACTS: PAPER BY SIR ROY GRIFFITHS

Points to Make

1. Agree that our objectives are to achieve greater involvement of consultants in management and greater management control over consultants.

2. Accept we should not make changes in contracts just for form's sake and that more could be achieved by firm management. But question whether our objectives can be fully met under the existing contract.

3. Introduction of short-term contracts might ensure the necessary behavioural changes, but could be costly. Costs and benefits do need careful consideration.

4. Support view that participation management tasks must be taken into account in new merit awards system.

5. Interested in Sir Roy's idea for appointing additional consultants in selected areas. Should consider this in context of promoting more part-time work by NHS consultants. Fully support extension of competitive tendering to clinical services.

Background

6. In Sir Roy's view the objective of change is that consultants should provide a high quality of care more efficiently, more expeditiously and more conveniently to the patient. He believes that this can mostly be achieved under the present contract by management's taking a firmer line and holding consultants to the implied as well as the explicit terms of the contract. Sir Roy does not think it advisable to introduced short-term contracts (which he believes would have a ratchet effect on costs with no real benefits in terms of management control). Nor does he think moving consultants' contracts from Regions to districts is necessary. However, he does consider that tighter disciplinary procedures and greater ability to move consultants within the NHS

are worthwhile. He also supports a closer linkage between distinction awards and management performance. Finally, he suggests that the targeted appointment of new consultants and the introduction of competitive tendering for clinical services could have a dramatic effect on consultants' behaviour.

7. Sir Roy is right that, by themselves, the introduction of short-term contracts and moving contracts from Regions to districts will not produce a sea-change in consultants' behaviour. And he correctly draws attention to the cost implications of such changes - hence our concern that short-term contracts should only be considered for new consultants where there is a precedent (university academics) for abolishing tenure for new appointees without salary increases.

8. But we consider Sir Roy is taking too optimistic a view of how much change can be achieved under the present contract. Progress towards greater management control over consultants has so far been rather slow. Management's ability to manage would be reinforced by changes such as the introduction of short-term contracts and moving contracts to districts. These measures would have more than a symbolic importance in establishing a more management-orientated culture within the NHS.

9. We fully support the extension of competitive tendering to clinical services. This is due to be discussed later in the Review and we shall also be taking it up in the Survey. Sir Roy's ideas for appointing extra consultants to areas and specialities where waiting lists are particularly long are worth further consideration, particularly in the context of promoting more part-time consultancies in the NHS to prevent any supply constraints affecting the private sector.

6.7.2

SECRET

FROM: R B SAUNDERS

DATE: 6 July 1988

1. MR PHILLIPS

2. CHANCELLOR

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

Mr Kuczys - IR

NHS REVIEW: THE OVERALL PACKAGE

We assume that the Cabinet Office paper will be used as an annotated agenda for the Prime Minister's meeting on Friday.

Part I: Broad direction of long term change

2. Paragraph 5, which sets out the long term aims, is the key one here. These are broadly acceptable to us, as are the points in paragraph 6 about the pace of change. In writing up the longer term relationship between more independent hospitals and district health authorities (which is mentioned in paragraph 5(i) and (iii) and developed further in Part III) it will be important not to be too prescriptive. It is going to be difficult to devise a detailed and workable scheme now, without going through some internal market experiments first.

3. It might be better, therefore, to state the aim as being to introduce new mechanisms for better alignment of financial and clinical decisions, without being too specific about the means other than saying that experimental schemes would be set up.

151/30

SECRET

Part II: Package of immediate measures

4. This is based largely on the work we have done here. The proposals are grouped under the same five headings that we originally proposed.

5. On the first, a better deal for patients, what is conspicuously missing is any idea of how to improve the way the NHS treats its customers. It is the little things - inefficient appointment systems, scruffy waiting areas, inflexibility over the timing of operations - which cause most resentment. Trent regional health authority have recently received some publicity for their initiative over the last couple of years to improve the ways in which they handle patients. We need to include here a new central initiative - perhaps a DHSS-led scrutiny - to build on the Trent initiative and seek further ways of improving the service to patients. You may wish to raise this if Mr Moore does not.

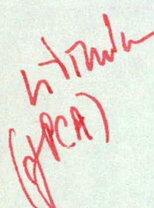
6. At Mr Moore's request, a reference to contracting out has been added to paragraph 8(v). The only part of this nexus of issues not in square brackets is tax relief for the elderly who pay their own premiums.

7. The key proposal on the better use of NHS resources is the extension of the resource management initiative across the country. This is the subject of a very large Survey bid (£m90/180/145). This will be a very big task, and DHSS must have a properly planned and managed programme. We shall be pressing this in our scrutiny of the Survey bid, and you could make the point to Mr Moore as well. What we have seen so far from DHSS is not encouraging.

8. The second item mentioned here is capital. DHSS have put to us a paper proposing that capital charges should be included in health authority revenue (ie current) accounts. We have had two meetings at official level, at which it became clear that the DHSS ideas were ill thought out and were seen largely as a wheeze for getting around controls on new capital investment. They are supposed to be coming back to us with a new paper shortly. Again

at Mr Moore's request, there is a new reference to this at the end of paragraph 5(v), and a new reference in 9(ii) (to which we would not object) to the need for the costs of capital to be brought home to management. If this comes up, you should simply note that we are awaiting revised proposals from DHSS, and give no commitment to including anything about this before we have been able to go through them properly.

9. VFM audit is also mentioned under this heading. Following the meeting between the Chief Secretary and Mr Moore, at which the objective of independent audit was agreed, officials have been working out the criteria to govern the relationship between the new independent body, the Secretary of State and the Accounting Officers. The relationship with the NAO and the PAC also needs to be settled. It is not agreed who the outside body should be: the Treasury strongly favours the Audit Commission with its existing track record and systematic approach, while the DHSS would prefer a new independent body. The objective is to bring the matter forward for decision at the 26 July meeting, having first consulted other interested parties, including Mr Ridley.



10. On <u>consultants</u>, there is a new paper round from Sir Roy Griffiths, on which Mr Griffiths (no relation) has provided a separate brief.

11. There are two new proposals under <u>a better organised NHS</u>. The first is greater local flexibility over pay and manpower - paragraph 11(iii). It is difficult to take a view on this without having seen the promised DHSS paper on manpower issues. But we need to be a little cautious here. In particular, greater freedom for local management needs to be accompanied by safeguards to prevent leap-frogging.

12. The second new point is that we need to reconsider the role of the NHS Management Board. As we have already noted, this is a curious body which, despite its grand title, has no management responsibilities for the NHS. This has not been looked at in the Review so far. But we need to consider how far the management board still makes sense in the light of the proposals which are emerging.

Part III: Possible measures for the longer term

13. This is the Green part of the document. It develops several points which are touched upon earlier, notably the buyer/provider distinction between health authorities and hospitals, and greater management freedom for hospitals. While, as you have noted, we do not need to get too excited about this so long as it remains suitably Green, I think the point in paragraph 2 above is still valid. We should stress the experimental nature of the approach, and not be too specific about where we think we are going to end up. The proposals as currently described look inherently unworkable - the health authorities are given a budget but somebody else (a combination of GP referrals and acceptance or rejection of them by consultants) controls how those budgets are spent - and this is likely to become painfully clear when experiments are set up.

14. Otherwise on this section, the point in paragraph 15 about amalgamating family practitioner committees and district health authorities might well be promoted to Part II. It has considerable attractions in its own right: it would allow primary and hospital care to be better coordinated; and it holds out the prospect of better financial control over the presently non-cash limited FPS. The Review should consider the issue. We are preparing a paper which we propose to circulate to officials shortly.

Annex A - Further papers

15. We think it is worth the Review considering papers on restrictive practices, manpower, the management board and audit. But it is less clear that papers are necessary on a private sector action plan, on competitive tendering and on information technology (4-6 in the list). We should just get on with these; indeed, the second and third will be considered in the Public Expenditure Survey. It might however be worth adding a paper on the amalgamation of districts and FPCs.

Annex B - Timetable

16. As the Cabinet Office paper notes, this is now extremely tight. This underlines the need for the Review not to waste time considering papers on peripheral issues.

R B SAUNDERS

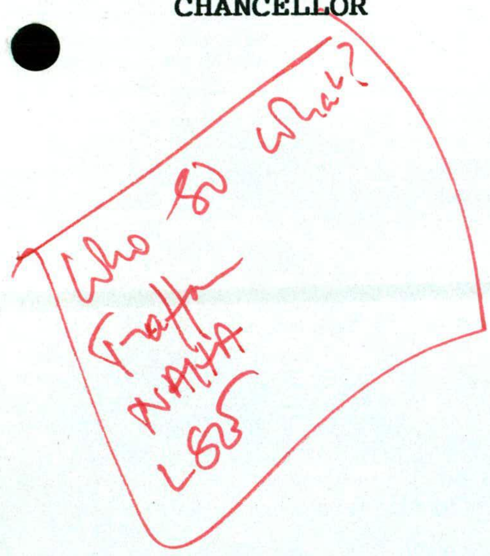
week.4.7/m.4

SECRET

FROM: H PHILLIPS

DATE: 6 July 1988

CHANCELLOR



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

Mr Kuczys - IR

PHILLIPS → CHEX 6/7

NHS REVIEW: PRIME MINISTER'S MEETING ON 8 JULY

We are meeting tomorrow morning for a discussion in advance of the Prime Minister's meeting on Friday. That meeting will be the main discussion planned before the Recess, and, as so far scheduled, gives more time to the Review than any previous discussion.

General Comment

2. You, and we, are very anxious to see practical progress made in the discussion. The Cabinet Office paper can provide a basis for that. But the No.10 Policy Unit are still searching for more radical reform than they think is implied by the proposals before you. In a brief conversation today Professor Brian Griffiths told me he was worried that the result of the review, as it now looked, would be minimal change: "much less radical than education". I told him that I did not accept that: the proposals would 'free-up' (the phrase he used in describing what he wanted) the NHS while not releasing control over costs; they recognised a distinction between short and long-term possibilities for change; and they did not try to ignore the reality of supply and demand. He is not yet convinced.

3. On Friday Mr Rifkind and Mr King will join the group. From the minutes they have sent in I expect they will go with the grain of your preferred approach.

4. The new papers for the meeting are the new Cabinet Office paper, and Sir Roy Griffiths's note on consultants. Briefs on these, from Mr Saunders and Mr Griffiths, are attached. I also attach, from Mr Parsonage, a first assessment of the costs and benefits of the emerging package. I have seen and approved these in draft.

5. Perhaps I could add the following comments:

(a) The Overall Package

It is irritating that Mr Moore has asked for contracting out to go back in when we had managed to keep it out of the last draft. I think you have concluded that if there is continuing pressure on this point, or for raising the P11D limit, you may wish to say you are prepared to consider an exemption for company schemes of medical insurance benefitting all employees (Mr Lewis's note of 1 July).

(b) Consultants' Contracts

Sir Roy Griffiths's emphasis on the need for clear objectives for change, and for costs and benefits to be spelt out, is very welcome. But the point in our brief below about the value of short-term contracts for new entrant consultants should be emphasised. Sir Roy's approach in this, and other areas, through his 'managed' route, can risk either putting off decisions or blunting their impact. The political judgement is whether to shake up the consultants' regime or ease it along.

(c) Costs and Benefits

I thought you should see Mr Parsonage's note before Friday. It is a useful checklist, and the basis for the sort of

document which I would suggest the Review Group should have for its meeting on 26 July. You will wish to judge whether you want to offer such an analysis on Friday, or simply put one in when we have the results of Friday's meeting. At the moment the note is written for internal consumption. I agree with the view it expresses, however, that the emerging proposals may not be strong enough in giving to patients enough perceived improvement for them over the next two-three years: cost effective action on waiting times may be the best approach.

HP.

HAYDEN PHILLIPS

ph7.9

SECRET

6/7/88 - pvp

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

PRIME MINISTER

NHS REVIEW

My minute of 28 June about the supply and demand for health care concluded that we need to concentrate on improving the supply side. I should like to develop that thought further in this note.

Too much of the public debate has been about inputs - in particular the proportion of GDP devoted to health care, but also such statistics as the numbers of doctors and nurses, etc. What really matters, however, is health outcomes. The following table is interesting in this context.

Country	**Health expenditure as % of GDP (1985)**		**Life expectancy (latest available year)**		**Infant mortality (1986)**
	Public	**Total**	**Male**	**Female**	**Per 100 live births**
UK	5.2	5.7	71.4	77.2	0.95
USA	4.4	10.7	70.5	78.2	1.06
Australia	5.4	7.3	72.0	78.9	0.99
France	6.8	8.6	70.4	78.5	0.80
Germany	6.4	8.2	70.2	76.8	0.86
Italy	5.4	6.7	69.7	75.9	1.01
Sweden	8.5	9.4	73.0	79.1	0.59

Source : OECD

It is clear that there is little relationship between the amount of health spending and performance as measured by these indicators. Although the UK spends less of its GDP on health than the rest, we are comfortably in the middle of the range of the indicators. The USA spends more than all the rest, but has the highest infant mortality. In short, other countries do not seem to be getting good value for money from their higher expenditures.

This is less surprising when one recalls the great difficulty most other countries are experiencing in getting the costs of health care under control in either the public or the private sector. Indeed, they envy our ability to keep costs down. It is clearly important that we do nothing to erode our advantage: indeed, we should be seeking ways of getting even better value for money.

One reason for this loss of cost control in other countries is the practice of payment per item of service, which among other things leads to considerable numbers of unnecessary operations. There are surprisingly very large variations in the amount of treatment given, for example up to four-fold differences in some operations (eg Caesarean sections, appendectomy, tonsillectomy and hysterectomy). All in all, it is evident that there is no validity in arguments based on the proportion of GDP spent on health care.

This leads to a more general point. We know far too little about the effectiveness of different forms of treatment. We are in no position to say which represent the best value for money and so are most deserving of extra resources. There have been major success stories, such as the immunisation programmes, kidney transplants, and hip replacement operations, which have had a dramatic effect on either mortality rates or the relief of pain. But there is equally evidence of money being spent to little effect, and of extra spending yielding diminishing or even negative returns:

- some past studies in this country showed that then long standing and costly types of treatment - coronary care units, freezing of duodenal ulcers and hormone treatment of viral hepatitis - did little to increase survival rates, and even sometimes decreased them.

- Studies in the USA and Germany have shown that, even though prevalence of the disease is much the same, those areas with the highest rates of appendectomy operations also have the higest rates of death from appendicitis, no doubt as a result of the risks attached to operating on patients.

- One of the top ten causes of hospitalisation in the USA is adverse reactions to drugs administered for medical reasons.

Other countries now recognise the need to tackle these problems. For example, in the USA, the Health Care Financing Administration, which is responsible for federal expenditure on Medicare and Medicaid,is about to start a programme of assessing the effectiveness of particular types of treatment.

We too need to tackle these problems. While we have a system which successfully controls hospital expenditure, thus helping to keep costs down, we have not yet got the incentives right at the clinical levels. We can start with a number of supply-side measures which are already in prospect, like improving the information available to doctors and managers and encouraging medical audit. We can go further by new measures, some of which we have already discussed, like involving doctors more closely in

management and improving value for money audit. And we most certainly need to take further steps to improve the supply-side by far greater private sector provision of health care. But this is quite different from seeking to expand private sector finance, which risks the damaging consequences I outlined in my earlier note.

While there are detailed elements which we shall need to discuss, I commend the approach in the Cabinet Office note on the overall package. Taken with the action we need to take on consultants' contracts and restrictive practices in the medical profession, I believe that this provides us with the outline of a coherent set of proposals which can be put into effect quickly and would not rule out more radical change in the longer term.

I am copying this minute to John Moore, John Major, Tony Newton, Malcolm Rifkind, Tom King, Peter Walker, Sir Roy Griffiths, Sir Robin Butler, Richard Wilson and John O'Sullivan.

ACSAllan

PP N.L.
6 July 1988

[approved by the Chancellor
and signed in his absence]

CABINET OFFICE

70 Whitehall London SW1A 2AS Telephone 01-270

CH/EXCHEQUER 6/7
REC. 6 JUL 1988
ACTION Mr Saunders
COPIES TO CST
Sir P. Middleton
Sir T. Burns
Mr Anson
Mr Phillips
Mr Culpin
Mr Turnbull
Miss Peirson
Mr Parsonage
Mr Call
Mr Kuczys I/R

SECRET

P 03171

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON SW1

6 July 1988

Dear Paul,

REVIEW OF THE NATIONAL HEALTH SERVICE

I enclose the paper which the Cabinet Office was asked to prepare on the overall package emerging from this Review so far, as a basis for the discussion on Friday, 8 July.

I am copying this letter and the enclosure to the private secretaries to the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Northern Ireland, the Secretary of State for Scotland, the Secretary of State for Social Services and the Chief Secretary, and to Sir Roy Griffiths, Sir Robin Butler and John O'Sullivan.

I would be grateful if recipients would ensure that the paper is seen only by those who need to see it.

Yours ever,

Richard.

R T J WILSON

SECRET

HC32

REVIEW OF THE NATIONAL HEALTH SERVICE

THE OVERALL PACKAGE: A SUMMARY OF CONCLUSIONS SO FAR

Note by the Cabinet Office

1. We were asked to prepare a paper summarising the main ideas and conclusions emerging from the Review so far, as a basis for the discussion on Friday 8 July.

2. A paper for this purpose is attached. It has been prepared on the basis that the proposed White Paper will announce firm Government decisions on the broad direction of long-term reform of the National Health Service (NHS) and the immediate steps to be taken in that direction (Parts I and II of the paper); but that it will discuss the details of the long-term reform more tentatively, in the manner of a Green Paper, as a basis for consultation and discussion (Part III of the paper).

3. The paper is not intended to be the text of a White Paper. Presentation will need to be considered carefully when the policy has been decided.

4. The Group is invited to consider:

   i. whether it is content with the overall package described in the note and, if not, what changes should be made and what further work needs to be done;

   ii. whether more work is needed on issues not so far covered in the Review (possibilities are listed in Annex A);

   iii. what the timetable for the rest of the Review should be (a possible outline is in Annex B).

Cabinet Office
6 July 1988

SECRET

REVIEW OF THE NATIONAL HEALTH SERVICE

THE OVERALL PACKAGE: A SUMMARY OF CONCLUSIONS SO FAR

1. The Government is firmly committed to ensuring that a high standard of medical care is always available to all, regardless of income. It has demonstrated this commitment by increasing net expenditure on the National Health Service (NHS) from £7.8 billion in 1978/79 to £22.6 billion now. The Government intends to maintain this commitment and preserve what is best in the NHS.

2. The Government is also determined to modernise and improve the NHS, where it is weak. The present system of centralised control has enabled the NHS to escape large increases in costs and expenditure experienced elsewhere in major Western countries. Nevertheless, the NHS does not always provide as high a standard of care for the patient, or as good a level of value for money for the taxpayer, as it could; and the private sector in health care is still relatively small. The Government believes that the law of diminishing returns will apply to every increase in money granted to the NHS, unless it is accompanied by a programme of reform directed at greater efficiency, greater choice and better quality of care.

3. In the following sections, Part I outlines the main direction which the Government believes that the long-term development of the NHS should take. Part II sets out a first package of measures which the Government will implement to begin this process of change, building on the management reforms of recent years. Part III suggests further steps which might be taken later on to develop the process of change, as a basis for consultation and discussion.

PART I: BROAD DIRECTION OF LONG-TERM CHANGE

4. At present the NHS is a planned and centralised bureaucracy which uses cash limits as the main means of controlling costs and rationing to cope with ever-growing demand. There is a lack of choice, and no incentive for the Service to please its users. Doctors have no incentive to be cost-conscious: many cling to the belief that they should not be involved in the management of resources. Budgeting and information systems are ill-designed. Those who commit resources are not financially accountable and are not given adequate information on the costs of

what they are doing. Those who use resources efficiently are often not rewarded for doing so. Indeed, hospitals may be penalised for efficiency.

5. The Government believes that the long-term aim should be to develop the NHS on the following lines.

i. Hospitals, either singly or in groups, should be given much greater independence in running their own affairs, with corresponding responsibility for the results.

ii. As part of this process, the medical profession should accept that they have important management responsibilities, as distinct from their clinical responsibilities.

iii. There should be a slimming-down of the present structure of regional and district health authorities. The eventual role of many District Health Authorities should be to act as the buying authorities for their districts.

iv. These organisational reforms should lead to much greater competition and trading of services between health authorities, between hospitals and health authorities and between the public sector and the private sector. The funding of hospitals should be based on the work which they perform, and those which are efficient should be rewarded correspondingly.

v. There should be a major expansion of the private sector in the provision of health care, matched by the removal of supply-side rigidities, inefficiencies and restrictive practices (problems which need to be tackled in both the public and private sectors). The private sector should provide competition in those areas where it is the most efficient supplier. It should be encouraged to co-operate more closely in the operation of the public sector (eg through contracting out or the purchase of spare capacity) wherever this is the most cost-effective approach. And there should be fair comparisons between the public and private sectors on the cost of capital.

vi. There should be more effective arrangements for medical audit, directed at monitoring the use of resources and securing improved quality of health care.

vii. Those who wish to buy medical care for themselves and their families should be able to do so.

The net result should be a better service and greater choice for patients.

6. These changes cannot all be implemented immediately. They involve major organisational reform, which will need careful management. Moreover, the demand for health care exceeds the supply: future growth in supply needs to be based on the removal

of inefficiencies and restrictive practices, if an explosion of costs is to be avoided. There therefore needs to be a first package of measures which prepares the way for later reform.

PART II: PACKAGE OF IMMEDIATE MEASURES

7. There are five main ingredients in the package of measures which the Government proposes to introduce now.

8. First, a better deal for patients. The Government's proposals for increased efficiency will mean that patients will benefit from a more responsive NHS and a thriving mixed economy in health provision. But there will also be more specific benefits in the package.

i. GPs will have better information about waiting lists so that they can send their patients where they can be dealt with more quickly for a consultation or operation.

ii. New "top-sliced" financing arrangements will be directed partly to cutting waiting times, based on a hospital's performance in tackling waiting-list cases. This will build on the present waiting-list initiative.

iii. GPs will be given incentives to carry out more minor surgery (Primary Care White Paper).

iv. People over the age of 60 will get tax relief for private health insurance taken out by on their behalf. [A decision needs to be taken on whether there should be tax relief at the higher rate for those paying tax at this rate.] [Those still in employment should get parallel relief from the benefits-in-kind charge on corresponding premiums.]

[v. A decision needs to be taken on P11D tax relief for company health insurance schemes and/or a scheme for contracting out.]

vi. There are to be more schemes under which patients can pay for optional extras or more "topping-up". This will generate income for the NHS and provide extra services for patients.

9. Second, better use of NHS resources. There has been good progress with management improvements in recent years. The Government intends to build on this as follows.

i. Better information is essential. The Resource Management Initiative will be accelerated, by extending it next year from five experimental sites to the whole country. This will enable proper clinical budgets and monitoring to be introduced. It will also provide doctors with more detailed information about each other's practices as a basis for medical audit.

[ii. Better use of capital, and recognition of it as a cost, are also important. Discussions between Treasury and DHSS in hand.]

iii. Independent outside scrutiny is an essential counterpart to better internal systems. Performance indicators are now in place. New arrangements for independent audit of Value For Money will be introduced: legislation will be needed.

iv. Arrangements for medical audit will also be strengthened. Consultants can at present refuse to participate: in future they will be contractually bound to do so.

v. [The new "top-sliced" financing arrangements will be designed to provide greater incentives to efficiency. They will be linked to the introduction of market mechanisms, eg for selected independent hospitals, and the pursuit of local experiments. Present financing mechanisms will be improved to respond more quickly to cross-boundary flows.]

10. Third, full involvement of consultants. There is growing acceptance by the medical profession that they have a management role complementary to their clinical duties. Responsibility for the use of resources will go hand in hand with accountability for the stewardship of them. This will not affect clinical accountability which will continue to be to the patient and to the doctor's professional peers.

i. The Resource Management Initiative is directed at involving doctors in management systems.

ii. Contractual arrangements will be revised. [Paper by Sir Roy Griffiths will explore this further. Proposals so far include the transfer of contracts to District Health Authorities, short-term contracts for new entrants, reviewable job descriptions, mobility between hospitals, reform of the merit award system and encouragement of part-time contracts.]

11. Fourth, a better organised NHS. A key feature of the proposed long-term reforms is greater independence for hospitals to enable them to operate within market mechanisms rather than top-down controls. This will require legislation in due course. In the meantime, first steps will be taken towards greater devolution of responsibility to hospitals (or groups of hospitals) within the existing framework of the NHS, including the following:

i. making clinicians, who are the main users of NHS resources, accountable for the use which they make of those resources. This ties in with the proposals for better information systems and for revising consultants' contracts;

ii. requiring District Health Authorities to agree with hospitals under their control what their performance targets are, both for local 'baseload' services such as accident and emergency departments and for elective surgery. Hospitals which meet their performance targets will be guaranteed an

agreed level of funding. There will also be agreed arrangements covering the provision of services to other Districts or the private sector, and tertiary referrals;

iii. giving hospitals more freedom to determine local pay and conditions, and to deploy staff flexibly, within a reformed Whitley system;

iv. setting up pilot experiments (eg for teaching hospitals) to try out new arrangements for independence, leading towards autonomy on the lines of paragraph 14 at an early date;

v. revision of the role of the NHS management board, to take account of these changes.

12. Finally, a thriving mixed economy of health care. The private sector is an integral part of the nation's health care. A strong private sector is good for the NHS, and vice versa, as a source both of competition and co-operation. The Government welcomes the joint ventures which have begun to take place. It will encourage the growth of an efficient private sector by:

i. encouraging more joint ventures;

ii. extending contracting-out to clinical work as well as laundry cleaning and catering. Competitive tendering will initially cover clinical support services such as pathology but the scope for further extension (eg to certain types of elective surgery) will also be considered;

iii. asking all NHS hospitals to review the scope for selling spare capacity to the private sector;

iv. encouraging more pay beds in NHS hospitals, particularly the introduction of new private wings (eg in accommodation which becomes surplus following rationalisation);

v. tackling medical restrictive practices to free up the supply of key personnel, especially consultants;

[vi. introducing tax relief to encourage some forms of private health insurance (see above).]

PART III: POSSIBLE MEASURES FOR THE LONGER TERM

13. Taken together the measures in Part II are in themselves a formidable programme of change. But they need to be part of a programme for the longer-term development of the NHS, designed to give a better deal to the patient and the taxpayer. The details of this programme will be decided in the light of further consultation and discussion. But the Government's present thinking is as follows.

14. The process of devolving responsibility to hospitals should lead to the establishment of self-governing hospitals with statutory independence. To qualify for independence each hospital would need to demonstrate to the satisfaction of the Secretary of State a record of sound financial, professional and management competence. New hospitals would provide a particularly good opportunity for experiments in autonomy. Once independent, hospitals would be separate legal entities, free for instance to:

i. grade, deploy and pay staff - including consultants who would be hospital employees - as their management board thought fit;

ii. enter joint capital ventures with the private sector;

iii. develop new services to meet demand or reflect new technology;

iv. sell their services to whichever District Health Authorities, or private sector health insurance companies wished to buy them.

15. General Practitioners would continue to act as the gateway to hospital services. They would continue to have freedom to refer patients to consultants: indeed they would have better information about where to refer patients. DHAs would need to set aside funds to cover special or ad hoc referrals to hospitals not covered by their main contracts. The present functions of Family Practitioner Committees could be transferred to DHAs, and cash-limited funds for primary care could be channelled through DHAs. GPs would remain independent contractors, but their contracts would be with DHAs. The provision or otherwise of their contracted services could be used as performance indicators (eg the rate of referrals to consultants, home visiting, the carrying out of minor surgery and prescription rates).

16. As operational management responsibilities shifted to hospitals, there would be a corresponding change in the role of District and Regional Health Authorities. DHAs would be the buyers of services and would place contracts with whichever hospitals could provide the best package of services. Contracts would be contestable by other public and private sector hospitals. The constitution of DHAs would be revised to end their existing exposure to local political and other pressures. The shift in responsibility to hospitals would mean that the size - and perhaps the number - of DHAs could be greatly slimmed down. So too could the size and number of Regional Health Authorities, perhaps to the point where they could become regional offices of the DHSS. Funding would then flow direct from the DHSS to the Districts.

Cabinet Office
6 July 1988

ANNEX A

POSSIBLE AREAS ON WHICH FURTHER PAPERS MAY BE NEEDED

1. Restrictive practices in professions other than consultants.
2. Manpower and Training Issues.
3. The role of the NHS Management Board.
4. ~~Private Sector: action plan.~~ ok?
5. Competitive tendering.
6. Information technology and the Resource Management Initiative.
7. Independent Audit: report by Treasury and DHSS.

Capital

ANNEX B

TIMETABLE FOR COMPLETION OF REVIEW

26 July	:	Meeting to consider further work commissioned on 8 July.
Week beginning 12 September	:	Meeting to consider first draft of White Paper.
Week beginning 3 October	:	Meeting to consider second draft of White Paper.
Week beginning 9 October	:	Party Conference.
November/December	:	Publication of White Paper.
January 1989 onwards	:	Consultations followed by legislation in 1989-90 Session.

SECRET

Draft of 4 July

REVIEW OF THE NATIONAL HEALTH SERVICE

THE OVERALL PACKAGE: A SUMMARY OF CONCLUSIONS SO FAR

Note by the Cabinet Office

1. We were asked to prepare a paper summarising the main ideas and conclusions emerging from the Review so far, as a basis for the discussion on Friday 8 July.

2. A paper for this purpose is attached. It has been prepared on the basis that the proposed White Paper will announce firm Government decisions on the broad direction of long-term reform of the National Health Service (NHS) and the immediate steps to be taken in that direction (Parts I and II of the paper); but that it will discuss the details of the long-term reform more tentatively, in the manner of a Green Paper, as a basis for consultation and discussion (Part III of the paper).

3. The Group is invited to consider:

i. whether it is content with the overall package described in the note and, if not, what changes should be made and what further work needs to be done;

ii. whether more work is needed on issues not so far covered in the Review (possibilities are listed in Annex A);

iii. what the timetable for the rest of the Review should be (a possible outline is in Annex B).

Cabinet Office
6 July 1988

HP's comments marked in green

SECRET

REVIEW OF THE NATIONAL HEALTH SERVICE

THE OVERALL PACKAGE: A SUMMARY OF CONCLUSIONS SO FAR

[Add something on NHS strength in controlling costs]

1. The Government is firmly committed to ensuring that a high standard of medical care is always available to all, regardless of income. It has demonstrated this commitment by increasing expenditure on the National Health Service (NHS) from £[ ] billion in 1979 to £[ ] billion now. The Government intends to maintain this commitment and preserve what is best in the NHS.

2. The Government is also determined to modernise and improve the NHS, where it is weak. Despite its great strengths, the NHS does not always provide as high a standard of care for the patient, or as good a level of value for money for the taxpayer, as it could. The Government believes that the law of diminishing returns will apply to every increase in money granted to the NHS, unless it is accompanied by a programme of reform directed at greater efficiency, greater choice and better quality of care.

Is low standard a problem? Quantity not quality is usually the complaint.

3. In the following sections, Part I outlines the main direction which the Government believes that the long-term development of the NHS should take. Part II sets out a first package of measures which the Government will implement to begin this process of change, building on the management reforms of recent years. Part III suggests further steps which might be taken later on to develop the process of change, as a basis for consultation and discussion.

PART I: BROAD DIRECTION OF LONG-TERM CHANGE

4. At present the NHS is a planned and centralised bureaucracy which uses rationing as the main means of [controlling costs and] coping with ever-growing demand. Doctors have no incentive to be cost-conscious: many cling to the belief that they should not be involved in the management of resources. Budgeting and information systems are ill-designed. Those who commit resources are not financially accountable and are not given adequate information on the costs of what they are doing. Those who use resources efficiently are not rewarded - indeed may be penalised - for doing so.

Not true: costs are controlled by cash limits

SECRET

SECRET

5. The Government believes that the long-term aim should be to develop the NHS on the following lines.

i. Hospitals, either singly (eg teaching hospitals) or in groups, should be given much greater independence in running their own affairs, with corresponding responsibility for the results.

ii. As part of this process, the medical profession should accept that they have important management responsibilities, as distinct from, and separately from, their clinical responsibilities.

iii. There should be a major slimming-down of the present structure of regional and district health authorities. The principal role of many District Health Authorities should be to act as the buying authorities for their districts.

iv. These organisational reforms should lead to much greater competition and trading of services between health authorities and between the public sector and the private sector. Hospitals should be paid for the work which they actually perform, and those which are efficient should be rewarded correspondingly.

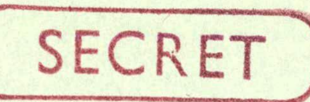
v. There should be a major expansion of the private sector in the provision of health care, matched by the removal of supply-side rigidities, inefficiencies and restrictive practices. The private sector should provide competition in those areas (eg some form of cold elective surgery) where it is the most efficient supplier. It should also be encouraged to co-operate more closely in the operation of the public sector (eg through contracting out or the purchase of spare capacity) wherever this is the most cost-effective approach.

vi. There should be more effective arrangements for medical audit, directed at monitoring the use of resources and securing improved quality of health care.

vii. The net result of these reforms should be directed at a better service and greater choice for patients. Those who wish to buy medical care for themselves and their families should be encouraged to do so.

6. These changes cannot all be implemented immediately. They involve major organisational reform, which will need careful management. Moreover, the demand for health care exceeds the supply: future growth in supply needs to be matched by the removal of inefficiencies and restrictive practices, if an explosion of costs is to be avoided. There therefore needs to be a first package of measures which prepares the way for later reform.

SECRET



PART II: PACKAGE OF IMMEDIATE MEASURES

7. There are five main ingredients in the package of measures which the Government proposes to introduce now.

8. First, a better deal for patients. The Government's proposals for increased efficiency will mean that patients will benefit from a more responsive NHS and a thriving mixed economy in health provision. But there will also be more specific benefits in the package.

i. GPs will have better information about waiting lists so that they can send their patients more quickly for a consultation or operation.

ii. New "top-sliced" financing arrangements will be directed partly to cutting wiaitng times, based on a hospital's performance in tackling waiting-list cases.

iii. GPs will be given incentives to carry out more minor surgery (Primary Care White Paper).

iv. People over the age of 60 will get tax relief for private health insurance taken out by on their behalf. [This will include tax relief at the higher rate for those paying tax at this rate.] Those still in employment will get parallel relief from the benefits-in-kind charge on correpsonding premiums.

[v. The limit below which employees escape tax liability on company health insurance schemes as a benefit in kind will be raised from £8,500 to around £20,000.]

vi. There are to be more schemes under which patients can pay for optional extras or more "topping-up". This will generate income for the NHS and provide extra services for patients.

9. Second, better use of NHS resources. There has been good progress with management improvements in recent years. The Government intends to build on this as follows.

i. Better information is essential. The Resource Management Initiative will be accelerated, by extending it next year from five experimental sites to the whole country without the three-year evaluation previously planned. This will enable proper clinical budgets and monitoring to be introduced. It will also provide doctors with more detailed information about each other's practices as a basis for medical audit.

[ii. Better use of capital is also important. Discussions between Treasury and DHSS in hand.]

SECRET

SECRET

iii. Independent outside scrutiny is an essential counterpart to better internal systems. Performance indicators are now in place. This will allow the introduction of new arrangements for independent [audit of Value For Money]: legislation will be needed.

iv. Arrangements for medical audit will also be strengthened. Consultants can at present refuse to participate: in future they will be contractually bound to do so.

[v. The new "top-sliced" financing arrangements will be designed to provide greater incentives to efficiency. They will [include] the introduction of market mechanisms, eg for teaching hospitals, and the pursuit of local experiments.]

be linked to

Doesn't 2nd sentence muddy scheme?

10. Third, a new role for consultants. There is growing acceptance by the medical profession that they have a management role complementary to their clinical duties. Responsibility for the use of resources will go hand in hand with accountability for the stewardship of them. This will not affect clinical accountability which will continue to be to the patient and to the doctor's professional peers.

i. The Resource Management Initiative is directed at involving doctors in management systems.

ii. Contractual arrangements will be revised. [Paper by Sir Roy Griffiths will explore this further. Proposals so far include the transfer of contracts to District Health Authorities, reviewable job descriptions, mobility between hospitals, reform of the merit award system and encouragement of part-time contracts.] [Add short-term contracts]

11. Fourth, a better organised NHS. A key feature of the proposed long-term reforms is greater independence for hospitals to enable them to operate within market mechanisms rather than top-down controls. This will require legislation in due course. In the meantime, the first steps towards this aim at greater devolution of responsibility to hospitals (or groups of hospitals) within the existing framework of the NHS, including the following:

i. making clinicians, who are the main users of NHS resources, accountable for the use which they make of those resources. This ties in with the proposals for better information systems and for revising consultants' contracts;

ii. requiring District Health Authorities to agree with hospitals under their control what their performance targets are, both for local 'baseload' services such as accident and emergency departments and for elective surgery. Hospitals which meet their performance targets will be guaranteed an agreed level of funding. There will also be agreed arrangements covering the provision of services to other Districts or the private sector, and tertiary referrals;

If our top slicing scheme square bracketed this shd be too!

needs more working up
Must make clear experiment not plan

SECRET

SECRET

iii. giving hospitals more freedom to determine local pay and conditions, and to deploy staff flexibly, within a reformed Whitley system;

iv. setting up pilot experiments to try out these new arrangements at an early date.

[v - review role of Regions + of NHS management board]

12. Finally, a thriving mixed economy of health care. The private sector is an integral part of the nation's health care. A strong private sector is good for the NHS, and vice versa, as a source both of competition and co-operation. The Government welcomes the joint ventures which have begun to take place. It will encourage the growth of an efficient private sector by:

i. encouraging more joint ventures;

ii. extending contracting-out to clinical work as well as laundry cleaning and catering. Competitive tendering will initially cover clinical support services such as pathology but the scope for further extension (eg to certain types of elective surgery) will also be considered;

iii. asking all NHS hospitals to review the scope for selling spare capacity to the private sector;

iv. encouraging more pay beds in NHS hospitals, particularly the introduction of new private wings (eg in accommodation which becomes surplus following rationalisation);

v. tackling medical restrictive practices to free up the supply of key personnel, especially consultants;

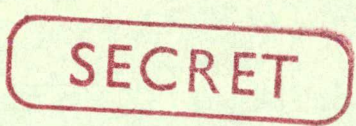
vi. introducing tax relief to encourage some forms of private health insurance (see above).

PART III: POSSIBLE MEASURES FOR THE LONGER TERM

13. Taken together the measures in Part II are in themselves a formidable programme of change. But they need to be part of a programme for the longer-term development of the NHS, designed to give a better deal to the patient and the taxpayer. The details of this programme will be decided in the light of further consultation and discussion. But the Government's present thinking is as follows.

14. The process of devolving responsibility to hospitals should lead to the establishment of autonomous self-governing hospitals with statutory independence. To qualify for independence each hospital would need to demonstrate to the satisfaction of the Secretary of State a record of sound financial, professional and management competence. Once independent, such hospitals would be separate legal entities, free for instance to:

SECRET



i. grade, deploy and pay staff - including consultants who would be hospital employees - as their management board thought fit;

ii. enter joint capital ventures with the private sector;

iii. develop new services to meet demand or reflect new technology;

iv. sell their services to whichever District Health Authorities, or private sector health insurance companies wished to buy them.

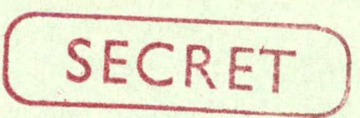
15. The role of General Practitioners would continue to be to act as the gateway to demand in the NHS. They would continue to have freedom to refer patients to hospitals: indeed they would have better information about where to refer patients. DHAs would need to set aside funds to cover special or ad hoc referrals to hospitals not covered by their main contracts. Alternatively, the present functions of Family Practitioner Committees could be transferred to DHAs, and cash-limited funds for primary care could be channelled through DHAs. GPs would remain independent contractors, but their contracts would be with DHAs. The provision or otherwise of their contracted services would be used as performance indicators by which to assess their results: and such information could include the rate of referrals to hospitals and consultants, the amount of domiciliary and home visiting, the hours of service, the level of screening activity, the carrying out of minor surgery and prescription rates. Add point on need for GP freedom to be curtailed.

16. As operational management responsibilities shifted to hospitals, there would be a corresponding change in the role of District and Regional Health Authorities. DHAs would be the buyers of services and would place contracts with whichever hospitals could provide the best package of servicesf. Contracts would be contestable by other public and private sector hospitals. The contribution of DHAs would be revised to end their existing exposure to local political and other pressures. The shift in responsibility to hospitals would mean that the size - and perhaps the number - of DHAs could be greatly slimmed down. So too could the size and number of Regional Health Authorities, perhaps to the point where they could become regional offices of the DHSS. Funding would then flow direct from the DHSS to the Districts.

17. Finally, the role of the NHS management board would need to be reviewed to take account of these changes.

Cabinet Office
6 July 1988

SECRET

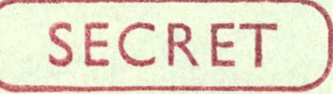


ANNEX A

POSSIBLE AREAS ON WHICH FURTHER PAPERS MAY BE NEEDED

1. Restrictive practices in professions other than consultants.
2. Manpower and Training Issues.
3. The role of the NHS Management Board.
4. Private Sector: action plan.
5. Competitive tendering.
6. Information technology and the Resource Management Initiative.
7. ~~VFM~~ Independent Audit: report by Treasury and DHSS.

SECRET



ANNEX B

TIMETABLE FOR COMPLETION OF REVIEW

26 July	:	Meeting to consider further work commissioned on 8 July.
Week beginning 12 September	:	Meeting to consider first draft of White Paper.
Week beginning 3 October	:	Meeting to consider second draft of White Paper.
Week beginning 9 October	:	Party Conference.
November/December	:	Publication of White Paper.
January 1989 onwards	:	Consultations followed by legislation in 1989-90 Session.

SECRET

NH6/32M

SECRET

MP

FROM: MISS M P WALLACE

DATE: 6 July 1988

MR SAUNDERS

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

Mr Kuczys IR
Mr Lewis IR

NHS REVIEW: THE OVERALL PACKAGE

The Chancellor was most grateful for your minute of 5 July.

2. He agrees with you that the paper is not too bad. He has also commented that he is not too concerned about the "buyer-provider" theme since it is set clearly in the context of "possible measures for the longer-term". He is, however, utterly opposed to contracting-out, which would be highly damaging and could not be kicked into the long grass of the longer-term. So he thinks that it may be tactically better to soft-pedal our criticism of buyers and providers, provided that it continues to be set in the longer-term context.

MPW.

MOIRA WALLACE