~~CONFID~~ SECRET.

710.

4.

12 B

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

SECRET

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

22 April 1988

Dear Paul,

NHS REVIEW

I attach a copy of my Secretary of State's Paper for the NHS Review meeting on 27 April.

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

Yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

SECRET

NHS REVIEW: CHARTING THE WAY AHEAD HC 18

NOTE BY THE SECRETARY OF STATE FOR SOCIAL SERVICES

Introduction

1. Our work so far has identified three main elements of a health care system:

- buying health services
- providing health services
- financing these transactions

My paper focuses primarily on the first two elements. It deals with the third only where it is directly relevant to the other two.

Summary of approach

2. The table below summarises the key aims I believe we have agreed on and the key changes which I consider would enable us to achieve those aims.

Key aims for improving NHS	Key changes to achieve aims
1. More choice and competition.	A. Self governing hospitals.
2. More flexible, less monolithic system, with more freedom for hospitals.	B. Separation of buying and provision. 'Buyer' contracts with GPs and hospitals, public or private, for provision of care.
3. Better incentives for good management and effective cost controls and better quality services, applying to both administrators and professionals.	C. Buyers responsible for service needs of population.
4. Encourage people to spend more of own money on health care.	D. Providers compete to deliver health care itself and to contain costs.
5. Well accepted mixed economy of public and private health care.	E. Retain expenditure control through cash limits on buyers for hospital and community health expenditure.
	F. Cost control supported by a tariff of standard reference prices based on DRGs.
	G. Fiscal incentives to take out health care insurance.
	H. Better information about services, especially for GPs.

Self governing hospitals

3. Annex A summarises what the central proposal, the separation of the buying and provision of health care, might mean in practice. In broad terms hospitals would be able to run themselves, while responsibility for ensuring

SECRET

that health care was available would rest with statutory "buyers". In effect the functions currently performed by health authorities would be split and, in the case of the provision of services, dispersed.

4. The buyers would be funded by, and accountable to, Government for:

* securing comprehensive health services for their resident population in accordance with the Government's policies and priorities for better health and health care services. We shall need to give further thought to the most sensible size of population for the buyers to cover.

* ensuring that these services gave the best value for money for public funds. In particular, buyers will need to take full account of the actual health benefit to patients and the public of the services provided.

To these ends they would invite tenders which covered between them all the necessary services, placing contracts - wherever possible on a competitive basis - with whichever providers of health care could deliver most acceptably. The contracts would need to cover family practitioner, community, public and preventive health services, as well as hospital services.

5. These contracts between buyers and providers would be central to the whole approach. Each contract would specify both the price and the quality required for each service. The form of contract would need to vary from service to service, in a way which was sensitive to the needs of that service and which struck an acceptable balance between entitlement to treatment, expenditure control and the need, in some cases, for money to follow patients; some possibilities are discussed in Annex B. It might be helpful to establish a range of standard reference prices, based on DRGs, (diagnostic related groups) but subject to variation in the light of local market conditions (for example to reflect any regional or local variations in pay levels).

6. We need, correspondingly, to open up the provision of health care by encouraging more diversity and greater local autonomy. The emphasis will be on local management and responsibility; this is the best way of releasing the enthusiasm and enterprise of the people who provide services. The present NHS hospitals and other service units would remain public sector bodies, but they would be competing on equal terms both with each other, and with private sector providers, for contracts from the buyer. Public sector service providers would also be free to compete for the business of the private sector buyers of health care such as individuals, insurance companies, or employers. We would thus be giving considerable impetus to a health care "mixed economy".

1800

7. There are more than 1,800 NHS hospitals, varying in size from around 20-30 beds to over 1,000. It would not make practical sense for every one of these hospitals to be "self-governing" and responsible for its own contracts. A better starting point would be the 600 or so management units into which hospitals and community health services are currently grouped, although most of these units would contract separately for different groups of services, and often with different buyers.

8. Each providing unit would be autonomous, employing directly the staff necessary for their business. They would have considerable freedom to determine what kinds of service they should offer to buyers. This greater autonomy raises a number of issues to which we would need to give further thought. For example:

(i) We would need to ensure that adequate mechanisms were in place to manage capital assets and capital investment. We would not want providers to duplicate facilities extensively in an attempt to compete; nor - conversely - buyers to find themselves unable to secure adequate local services because of a failure by providers to invest in good time. To ensure that public providers offered fair competition and that all costs were properly allowed for, the cost of servicing capital would have to be met through contract prices.

(ii) We would also need mechanisms for securing an adequate, but not over-sufficient, supply of doctors, nurses and other skilled manpower, and for meeting the overhead costs of in-service training incurred by teaching hospitals and other service providers. Some of these aspects inevitably involve long lead times - for example the training of consultants.

(iii) Autonomy implies not only the employment of staff but also - at the very least - greater flexibility over pay and conditions of service. We should need to address the implications of such further relaxation of central control.

9. An important corollary of this approach is that some hospitals may fail to secure sufficient contracts to remain viable, either for the whole of their services or for a substantial sub-set. Each buyer would need to ensure that its population had adequate access to local services where such access was important, but politically sensitive closures of public sector hospitals or wards could result nonetheless. We shall need to consider how far it would be feasible in practice for Ministers to distance themselves from such decisions under the approach I envisage.

10. The position of GPs under the new arrangements would be crucial, both as providers of services themselves and as "gatekeepers" to hospital and other services. As providers GPs could remain contractors as now, but with the new buyers taking over the functions of Family Practitioner Committees. As gatekeepers GPs would retain their right of referral, but the freedom to refer wherever they wished could in practice be constrained by the relevant buyer's decisions on the placement of contracts. It would be essential to ensure that such constraints did not limit unreasonably the GP's - and hence the patient's - choice. For example:

* the range of contracts needed to secure adequate choice would need to be discussed between buyers and "their" GPs;

* each buyer would need to make some budgetary provision for GPs to make referrals additional to those contracted for, either to the same or to different providers; and

* the necessary contractual and budgetary arrangements could usefully be supported by peer review of referral practices and, perhaps, of difficult individual cases.

11. We shall want to bear in mind the parallel between what is said here about the buying and provision of health care and the proposals Roy Griffiths has made about the buying and provision of community care services.

Financing health care

12. We will be in a better position to reach decisions on the financing of health care when we have settled the main structure of buying and providing care. But the elements are closely interlinked:

first, because we can only go so far in developing competition and choice through internal restructuring we need a better mixed economy. To achieve that we need a better means of encouraging more people to put more of their own money into health care, particularly those aspects where personal choice can be an important element like elective surgery. In my judgement, to make a real impact on this we need to introduce more fiscal incentive for individuals.

second, the cost of health care needs to be better understood not just by those buying and providing it but by those receiving it. One way of doing this is for people to know how much they are contributing to the cost of health care.

13. Taken together, these factors underline the advantages of paying for health care through a modified version of the national insurance scheme, which includes a rebate for those who contract out of certain NHS services into an approved private or occupational health care scheme. The existing national insurance arrangements would not be entirely suitable. We would have to look in particular at the contribution structure so that it did not worsen work incentives, especially for the lower paid, or add significantly to the burden on employers; and also at the rebate arrangements, so that they were fair to older as well as younger people. But the overall attraction of this approach remains.

14. Contracting-out would apply only to certain services - for example to elective surgery, the area in which waiting lists build up most heavily. Buyers would continue to place contracts for such services, for those who do not contract out. But those who contract out would have an opportunity of greater choice and could elect to spend more of their own money than the buyer would have spent on their behalf.

Implications of the new structure

15. We should not under-estimate the scale of the changes implied by the model I have described. The NHS would look much the same to the patient, who would continue to go to the GP and hospital for free treatment, but the structure underlying it would be very different. The present hierarchical structure would go. The basis of employment would change. And the introduction of contracts and competition would make life look very different from the inside. All in all, the changes would be much greater than any of the reorganisations since 1949. As such they would attract opposition from those working in the NHS at all levels who felt threatened by those changes or who simply disagreed with them.

16. I feel bound to say, too, that I would expect the upward pressure on public expenditure on the NHS to be, if anything, increased by these changes. By forcing buyers to make explicit what services they judge their

population to need, any gaps between those judgements and the services available would become more open and measurable. The better information which would be essential to make the system work could supply ammunition to those who believed their services to be inadequate. Some spare capacity might be needed for competition to work effectively and for money to follow the patient. And competition and greater autonomy among providers could drive up labour costs. We shall need to look carefully at ways in which we can offset the effects of such pressures: for example, by developing more incentives to greater efficiency and cost-effectiveness.

17. The role of Government would change, but not fundamentally. We would still set the policy objectives and strategic direction within which we expect buyers to operate, and would still allocate their revenue. Buyers would be accountable to us for their purchasing decisions, and hence for the quality, comprehensiveness and cost-effectiveness of the services contracted for. Under the new structure, the Government would need to secure effective means for regulating and auditing health care services, both public and private sector. Government would also need to ensure the quality and quantity of education and training for medical, nursing and paramedical professions. In all these areas, accountability to Parliament would continue.

Approach to change

18. Overall a health care system along the lines sketched out in this paper would be fundamentally different from the present one. The changes involved would have to be phased in over a period of years. We would need to move towards our goals in a way which

- is incremental, so that we are able to modify our approach as we go
- minimises the impact on patients, so that they do not feel they are losing what is now valued in the NHS, especially the ready access free of charge
- recognises and seeks to reduce as far as possible the concern about turbulence that will be felt by those working for the NHS.

19. These factors all point to an approach which opens up the NHS to organic change. We need a rolling programme of improvement which leaves scope for adjusting the detail of longer-term changes as we learn from experience. Pushing down budgetary responsibility, and making related changes in information systems, is one example of an essential early reform. We must also seek ways of testing out key aspects of our reform proposals where existing experience - here or overseas - is an inadequate guide to how they will work out in practice. The timing of any organisational change - notably to the present health authority structure - would need careful thought, but we could fairly present our proposals as a continuing process of consultation and change, allowing reform to be taken at an acceptable pace.

Conclusions

20. My objective in this paper has been to carry forward our thinking, particularly in giving hospitals greater freedom to run themselves, in introducing more scope for competition and choice in developing a better mixed economy of health care, and in involving doctors more in the management of resources.

21. The model that has been set out is not intended to be a full or final blueprint, but to give us an opportunity to gauge the strengths and weaknesses of the general approach. We shall clearly need to do more work on the detailed implications. We shall also want to compare the pros and cons of this approach to the other approaches set out in the HC 15, particularly the "NHS refurbished" model.

attached for reference. d Flag A/CC6. C.

22. If colleagues are content with the general approach I have outlined, I will put the follow up work in hand. I will also arrange for the approach to be compared to the other models we have considered.

April 1988

ANNEX A

SELF-GOVERNING HOSPITALS

How it might work

1. Patients would in general see an unchanged, though improved, NHS. In particular they would continue:

- to be entitled to a comprehensive range of health care, free at the point of use.
- to have access to the system mainly through GPs and specialists.

2. Buyers would

Who are the buyers?

- be responsible and accountable to Government for

  a. ensuring that the service needs of their resident population were adequately met, and

  b. staying within cash-limited revenue allocations.

- put each service, or group of services, out to tender.
- contract with providers, including GPs, for particular services over a specified period.
- monitor the providers' performance.

3. GPs would

- i.e. health fundholding

- retain full clinical responsibility for their patients.
- remain as independent contractors to the buyers, providing a primary health care service.
- continue to act as "gatekeepers" to specialist services through their referral of patients to specialists.
- discuss with buyers the range of referral choices open to them.

4. Consultants would

- retain full clinical responsibility for their patients.
- be either full or part-time employees of hospitals or clinics.
- be able to assemble "service packages" for their hospitals to offer to buyers.

DC1.8/9

5. Hospitals and clinics would

- be self-governing, with a management board, individually or in groups.
- employ professional and lay staff.
- seek to attract services for their local communities.
- offer specialist facilities to other providers on a sub-contract basis.

6. Providers generally would

- offer to provide particular services, or groups of services (not necessarily based wholly within a hospital or clinic), to NHS buyers.
- be free also to bid for private sector business.
- buy in any additional facilities they needed from other NHS hospitals and clinics or from the private and voluntary sectors.
- be accountable through contracts with buyers for meeting cost, volume and quality standards.
- bid for capital investment from public funds.

7. The DHSS would

- work primarily through buyers in setting policy objectives, allocating revenue and securing accountability.
- encourage development of clinical audit (including peer review).
- ensure that adequate capital funds were available (see below).
- publish DRG-based costs for contract pricing purposes.
- ensure effective regulatory and audit arrangements.

8. In addition, mechanisms would be needed to

- look after capital assets and capital investment matters, and in particular to:
  - be responsible and accountable for funding short-term and long-term investment plans, eg buildings and equipment.
  - acquire, hold and dispose of capital assets, consistently with public policy and accountability.
- ensure that there were adequate levels of trained manpower, and that the professional training overheads of providers (including those of teaching hospitals) were funded.
- ensure that service and resource plans were properly integrated.

Annex B

CONTRACTS BETWEEN BUYERS AND SELF-GOVERNING HOSPITALS

1. All services would be procured under contracts which explicitly set out the services and standards to be delivered and the mechanisms for cost control and quality assurance. Contracts would not necessarily be with hospitals, but with other providers or consortia of providing units. In this way contracts could be secured to provide integrated hospital and community services where appropriate. Competitive tendering would not be feasible in many parts of the country, for some services: a buyer will often be faced with only one provider for large parts of its population; and a provider with only one customer for its services.

2. To provide stability for both the hospital and the buyer, contracts would need to span a reasonable period of time and a clearly defined range or type of service. Three basic approaches to pricing the services under a contract are used:

Average cost - charges to the buyer would be raised on each patient served, priced according to DRGs. The provider would need to know expected volumes during the contract period before fixing the average cost, and the contract could be subject to an overall volume limit. The contract could also contain agreed prices for units of service beyond the volume initially contracted for.

Retainer plus marginal cost - the buyer would pay a retainer fee to ensure that a facility of a given size was kept available, and would pay the marginal cost of each patient treated in it, priced according to DRGs.

Capitation - the buyer would pay the provider a set annual fee for the number of patients expected to use the services offered by the provider, regardless of whether the patient actually uses these services. This is effectively an extreme case of the "retainer" type contract, where the population to be served is known, and their costs are sufficiently uniform to be rolled together.

3. There are three policy objectives which will help determine the choice of contract method:

Money following patient - money would follow patients as a group, in the long term, if the buyer places the service contract with another provider. In the short term, and in relation to the individual patient, it is achieved only by the average cost contract. This is because the whole amount of the money passes with the patient.

Expenditure control - requires that the maximum possible expenditure under a contract be known in advance. Thus capitation provides control, but a contract with a variable cost element would also need to be subject to a volume limit.

Immediate entitlement to treatment - this cannot be achieved if there is any volume limit on the contract such that a patient may have to wait, or simply not get service. However, any contract with a variable cost element and no volume limit allows no expenditure control. Capitation would provide both for immediate entitlement, and for expenditure control.

4. Possible contract regimes for each of the main services are described in the following paragraphs.

Family practitioners

5. GPs already work along the lines of the model: they are independent contractors to Family Practitioner Committees, which act as "buyers". This relationship would continue, but the FPCs would be replaced by the buying authorities. The buyers would contract with such practitioners as were conveniently located to serve the buyer's resident population (not necessarily practitioners located within the buyer's boundary). Buyers would need to include in their contracts with at least some practitioners a provision for treating visitors from other areas, such as holidaymakers, migrant workers, etc.

6. As the main access point to health services, GPs should be under a contract which ensures immediate entitlement to service. Contracts for GPs' services would therefore continue to be on the basis of capitation. If it is not intended to disturb the patient's view of the GP service, it might be appropriate also to continue to provide for certain specified services (such as family planning) to be contracted on the average cost basis. Dentists' and opticians' services would continue to be purely on the average cost basis.

Accident and Emergency

7. Each buyer would need contracts for the provision of accident and emergency services, even though the patients concerned might live outside the buyer's area. One approach might be for a buyer to make contracts with each of the hospitals to which a patient injured within that buyer's area might be taken. These would not necessarily be hospitals within the buyer's area. The contract would need to specify the range of conditions to be dealt with, so that only genuine accident cases were charged to the buying authority. But the contract would also need to preserve the "open door" policies of A & E departments, without encouraging over-use.

8. The hospital would pass an invoice for the additional patient charges to the buyer responsible for the area in which the emergency originated. The buyer would either pay, or refer the invoice on to the patient's home buying authority. Buyers could make reciprocal agreements to absorb such invoices on a "knock for knock" basis.

9. Patients referred on from A & E for immediate admission, together with other emergency cases referred by GPs (which may or may not enter hospital via the A & E department), would be treated under the contracts for the specialties concerned.

10. Both these types of admission must be provided on the basis of immediate entitlement. If demand within a buyer's area were sufficiently predictable, contracts could be on a type of capitation basis. This approach would give complete control of expenditure. Further consideration would be needed as to whether it would be realistic for buyers and providers to negotiate contracts on this basis. If not, and the variability of demand were too great, leading to an excessive fixed charge, the contract could be on the basis of a retainer plus the marginal cost of individual patients. For most emergency referrals these additional charges would be based on the DRG(s) applicable for each case referred.

Outpatients

11. Provision would be needed for immediate entitlement to an out-patient appointment where the GP considers this to be necessary. As with A & E, a type of capitation might be appropriate; otherwise, according to the economics of the situation, either an average cost contract, or a retainer plus marginal cost contract, neither with volume limits, would apply. GPs might be given incentives to reduce unnecessary referrals to outpatient departments and to provide directly treatment which is given unnecessarily in outpatient clinics. The contract pricing would need to cover the cost of any diagnostic services used.

Diagnostic services

12. GPs could arrange their own contracts (provided they were given their own budgets), or call off services under global average cost contracts arranged by buyers, for diagnostic services provided by hospital departments (eg radiography, pathology), which did not require referral to a consultant.

Elective admissions

13. Non-urgent cases are also referred to the hospital by the GP, usually for surgery, but sometimes for medical treatment. These cases would be subject to waiting list arrangements specified in the contract. These procedures need not be uniform across all services or treatments. This is discussed further in paragraph 22.

14. For these services, immediate entitlement is not relevant, but it is desirable for money to follow the patient. This points to a contract on the average cost basis, with charges according to the DRG of the patient. The contract would specify precisely which procedures and treatments were covered, and the maximum number of patients to be handled during the contract period. Contracts might encourage day- rather than in-patient procedures wherever possible.

Maternity

15. The volume requirement for maternity services is fairly predictable, and the services should be subject to immediate entitlement. However, individual costs vary according to the nature of

each case (eg straightforward delivery, caesarian, etc), so that a capitation approach might not be easy to negotiate. Maternity is also a service in which it may be desirable for money to follow the patient. Since demand is relatively predictable and inelastic, the risk to expenditure control in adopting an average cost contract without volume limit might be acceptable.

Other non-acute

16. Some "acute" episodes of mental or geriatric illness would logically fall under the equivalent of the emergency arrangements described in paragraph 10, or those for elective admissions in paragraph 14.

17. Other mental illness, mental handicap and long-stay geriatrics are relatively predictable, inelastic in demand and uniform in cost. There is little alternative to immediate entitlement. It would be desirable for money to follow the patient, but any movement would take place on a slow timescale in any event. A capitation contract might therefore be appropriate for these services.

Community services and public health

18. Community services are less subject to the requirement of immediate entitlement. Money could, to a limited extent, follow the patient. Capitation might therefore be inappropriate, and it should be possible for these services to be contracted on the basis of average cost. The main constraint on expenditure would not so much be a formal volume limit in terms of patients served, as a limit on overall resources available; the contract could limit the number of staff available.

19. Services which were not patient-specific, such as general prevention and public health, could be contracted on a fixed capitation type basis.

Expenditure control

20. Expenditure control is easiest where costs are fixed in advance, and do not vary with patient throughput. Hence capitation contracts offer the buyer greatest certainty. Where volume limits can be applied, as for elective surgery and non-urgent general medical cases, expenditure is equally firmly fixed. Contracts providing a retainer plus marginal cost charges are less controllable, and open-ended average cost contracts, least of all. Lack of a volume limit is less important for some services such as maternity, where demand is relatively predictable and inelastic. In others, the main constraint will be the waiting list for in- or day-patient services, and the simple rationing of visits for community services (as in paragraph 18).

21. Where expenditure control is firm, the task of control of costs falls squarely on the provider. Where expenditure control is imperfect, buyers might need to rely on the audit (clinical and financial) of a random sample of individual cases. Buyers could maintain a small professional staff to carry out the audit process, perhaps with access to medical records.

22. Waiting lists would be an essential part of expenditure control in non-urgent services. The maintenance of an agreed waiting list regime might be included in the contract for the relevant services. For example, the contract might provide for the buyer to direct the hospital as to the rate of flow of waiting list cases, within set limits.

23. Most expenditure on family practitioners has hitherto been demand-led. Under the contracting regime proposed the presumption might appear to be that it would be cash-limited, but there should be no difficulty in principle in releasing that tranche of buyers' expenditure from cash limits.

Quality control

24. Quality control would be an essential feature of the contract. It would be enforced by clinical audit procedures, and by the discipline of the eventual removal of the contract. In some cases, contracts could provide incentives for improving quality of service.

Penalties

25. The main penalty for failure by a buyer to meet contract conditions would be loss of the contract when renewal is due. However, in addition, particularly where there is little or no competition, financial penalties under the contract might be appropriate. Ways of dealing with contract failure without detriment to patient services require further thought.

NAT HEALTH
Expenditure
pt 11