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PRIME MINISTER 29 June 1988

The NHS Review has only three meetings to run before the summer recess. Yet no firm decisions on reform have been agreed. This has created pressures which the Treasury in particular is now exploiting to push through a "minimalist" package of reforms which would (a) be greeted with derision by our opponents and dispair by our supporters and (b) postpone any serious reform of the NHS for a decade. The DHSS favours a somewhat more ambitious approach which offers some hope of evolutionary reform. Shell-shocked by its defeat in previous meetings, however, the Department has been persuaded by the Treasury (with whose officials, its papers have been written) to add intrusive centralised controls to its proposals which, as a result, are needlessly bureaucratic, complex and timid.

That is the background to the four papers before you. Two of them - those on medical audit and consultants' contracts - need not detain you for more than a moment. They are competent elaborations of previously agreed decisions. Although they present some political problems (e.g. the consultants will resist the proposed contractual charges), we should not get involved in discussing them until the broad framework of NHS reform has been worked out. Mr Moore's paper on contracting out raises many difficult qutions - but these should also best be anwered when the broad structural framework is fixed. But major problems attend the Chief Secretary's paper on financing hospitals, and Mr Moore's papers on "Moving towards self-governing hospitals" are certainly out.

b

RAWP in drag (unlawfully impersonating efficiency)

The Chief Secretary's scheme for "top-slicing" hospital budgets to reward efficiency was originally presented as a method of "the money following the patient". Tht idea has now been lost. Instead, the Treasury has cooked up a complex and intrusive system of centralised financial control in accordance with its own vague, shifting and sometimes irrelevant criteria. You are being asked to enter into a worse version of RAWP.

The scheme is explored more fully in Appendix A. For the moment, however, its defects can be summed up as follows:

(i) It is trivial. Only 2% of hospital expenditure would be directed to hospitals under top-slicing. Ninety-eight percent would be distributed on the present unsatisfactory basis.

(ii) It is bureaucratically complex, giving the DHSS, the regions and the districts two bases for allocating resources, and varying criteria for determining the best allocations. Money follows not the patient, but the bureaucrat.

(iii) It extends and intensifies centralised control of hospitals - rather than giving them greater financial autonomy.

(iv) It provides no clear or direct incentives to hospitals, doctors or health workers to improve their performance.

(v) It would be politically disastrous since, if implemented properly, hospitals in good order would receive more money and hospitals which were closing

wards and cancelling operations would receive less. That could only be sustained if it were the result of patient choice and free GP referrals. It could not continue if it were the result of a decision in Whitehall.

The scheme is without merit. It would increase the complications of the present system without achieving greater efficiency or choice. Its only real use is as a Treasury ploy to direct attention from schemes to pay hospitals in accordance with the number of patients they treat efficiently.

Our first suggestion, therefore, is that you should reject this scheme out of hand and instruct officials to work on a scheme of DRG-based direct standard payments to hospitals. [This was criticised in an earlier version of the Treasury paper as achievable only with a structural reorganisation that would risk increased bureaucracy! Perhaps because this was an admission tht the buyer/provider distinction had real usefulness, it has been dropped from the full paper]. A change of this sort should be made easier by some proposals in Mr Moore's paper on self-governing hospitals.

Babies and the Bathwater of Bureaucracy

In rejecting Mr Moore's earlier paper on "buyers" because the central system was surrounded by excessive bureaucracy, we threw out the baby with the bathwater. It would be a pity if we did so again. For Mr Moore's paper on self-governing hospitals has the central germ of a good idea - constricted by timidity and, once again, made unattractive by too much bureaucracy.

The good idea is an evolutionary movement towards self-governing hospitals by the stages of: devolved

management and better information; the creation of Hospital Management Boards; the allocation of funds via RHAs and DHAs to hospitals on a "contractual basis"; and gradual moves by regions to introduce self-governing status for hospitals.

There are, however, three drawbacks to the scheme:

(i) It is envisaged that RHAs and DHAs will remain, in slimmed-down form perhaps but keeping their present roles, through all stages of change. Given the additional tasks these bodies will perform (ie supervising and monitoring the new system, and directing many hospitals from the centre indefinitely), it is highly optimistic to forecast a reduction in staffing.

(ii) DHAs continue to own and run the hospitals in their district right up to the first stage. But in the paper they attempt to provide a sense of independence and effective autonomy by running them on a "contractual" basis.

This is self-delusion. As long as DHAs allocate resources to hospitals and are responsible for their performance (ward closures, staffing levels, cancelled operations, etc) then contracts will be an effective sanction, little more than a minor management tool. What would the DHA do if a hospital under-formed? Refuse to pay the bill?

(iii) GP's freedom of referral, as paragraph 4 (indent 3) makes clear, would be constrained in order to control costs by the new combined DHA/FPCs. The DHSS solution - which is a re-run of the mechanism advocated in Mr Moore's earlier paper and rejected then as overly bureaucratic - is to set aside funds

for "ad hoc referrals not covered by the main contracts". This solution reduces patient choice and introduces yet another bureaucratic layer - and it achieves these disadvantages without bringing about greater efficiency. It would be strongly opposed by GPs.

Taken together, these drawbacks mean that the proposed system - as agreed between the Treasury and the DHSS - would be an informational version of RAWP - a scheme for more detailed bureaucratic control of the system based upon better information.

Inherent in the paper, however, are two amendments which could make the scheme both more workable and more in line with the Review's objectives:

(A) Paragraph 8 and 9 discuss the responsibilities of both RHAs and DHAs. RHAs would retain responsibility for planning and ensuring the provision of specialised services. We should take this further.

If the RHAs were made responsible for ensuring the provision of all hospitals (as used to be the case), and made responsible for allocating resources to them, the DHAs would then become buyers. Objection (i) above would then be groundless. There would be a minimum of bureaucratic reorganisation, but the clear distinction between buyers and providers would be established. RHAs would, of course, lose their responsibility for DHAs which, with their more defined responsibilities (providing primary care, purchasing secondary care) would be directly accountable to the NHS management board. If, as Mr Moore proposes, they were fewer in number, this would be all the easier to administer.

(B) In strict theory, GPs freedom to refer can be reconciled to control of costs in only one system: that where the GPs are the budget-bidders responsible for all the patients' medical expenses. All other systems are imperfect - and Mr Moore's system has the drawback that either patient and/or GP choice is reduced or costs allowed to run unchecked.

We can solve this in part by introducing an evolutionary possibility into the scheme. GPs objections to their reduced freedom of referral will be less serious if a provision allows them to apply - singly or in groups - to "opt out" of the DHA, hold the budgets for their patients and negotiate directly with hospitals over contracts for referrals.

They would, of course, have to satisfy the NHS accrediting body of their fitness and ability to perform that role. Few might apply; those that succeeded would generally be group practices with practice managers. But the mere possibility that GPs, might opt out would be a competitive spur to DHAs in their buying role.

The proposed amendments to both papers would mean:

(a) A clear distinction between RHAs providing hospital care and DHAs purchasing;

(b) Control of costs in both primary and secondary care through cash-limited budgets;

(c) Residual freedom to refer for GPs through an "opting out" provision from DHAs;

(d) Competing hospitals - initially owned by RHAs, later self-governing - charging fees on a DRG-basis;

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(e) Therefore, competition in both supply of health care and in its financing.

I believe that if you were to press such proposals at Thursday's meeting, Mr Moore would support them.

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SECRET

APPENDIX

1. Para 4-5. The sum of 2% of total hospital spending is a trivial one - less than 1% of additional NHS spending annually.

2. Para 5. If the performance based allocations are between 0 and 5% that would mean poor performing hospitals might receive nothing, while successful hospitals might receive useful additional sums. If the poor hospitals were closing wards and cancelling operations, this would be politically unacceptable. It is only possible to punish poor performance if this is as a result of patient and GP choice reflected in GP referrals.

3. Para 6. The bureaucratic complexity of this paragraph is such that the system could only be understood by Treasury civil servants. It would therefore offer no clear incentive for better performance since most doctors and managers would be hard put to predict its operations in advance. Its complications make RAWP pale.

4. Para 9. Giving the additional money to districts to distribute in accordance with vague criteria like "local priorities" removes what little incentive to efficiency remains. Regions might make a little more sense. But if extra funds are to be directly distributed from the centre, why should they not go directly to hospitals. It is hospitals which treat the patients. Why pay someone else?

5. Para 12. The advantage of money following the patient is that it compels hospitals to present bills which in turn provides them with an inescapable obligation to acquire relevant information. The Chief Secretary's system requires them to collect an enormous amount of unspecified information without the incentive of making up a bill. The

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record of the NHS in collecting vast quantities of useless information is not such as to make one very confident that this will succeed.

6. Paras 13-14. These two paragraphs suggest that the Chief Secretary's scheme will in the end boil down to a variation on the waiting list initiative.

This could well have some very perverse effects. A system of paying more to districts that have low waiting lists in order to persuade them to take in patients from outside will have the effect of relieving pressures on other districts and reducing waiting lists there. Would that not reduce incentives to efficiency in the second district? Might it not reward the second district on the basis that its lists had improved? Unless the information system distinguishes carefully between the causes of the decline in waiting lists, some such effect could well result. In other words, the system would have to be very carefully and expensively policed.

7. Para 15. This paragraph demonstrates the difficulties that lie in wait for any scheme that distributes resources in accordance with centralised criteria. The next paragraph fails to overcome these difficulties satisfactorily. The essential point here is that hospital performance should not be judged by some abstract general test of efficiency, but by its ability to perform a given operation at the lowest cost. If we have prices, we do not need complicated schedules of relative efficiency. A system based on money following the patient achieves this.

The Treasury scheme is essentially an administrative gain. It does not matter to society at large if a particular hospital has triumphed over great odds if it can still do no more than provide medical treatment at excessive cost. To reward an improvement in its performance in a way that

persuades the hospital to take in more customers in order to treat them inefficiently is the same logic as growing bananas in Scotland.