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HC 37

NHS REVIEW

THE OVERALL PACKAGE

Note by the Secretary of State for Health

1. I have studied the outcome of the Ministerial Group's work so far. There is much that I welcome, but in one or two respects - especially on structure and funding - I would suggest a different approach. This note outlines my initial views on some central issues.

Structure and Funding

Long-term aims

2. I support the Group's main proposals for funding hospital services: provision for money to follow the patient for elective acute services; clearer responsibilities for budgets and cost control; and a simpler financial allocation system. I also agree that the review has correctly identified the need to tackle the elective acute services as being a major political priority.

3. I do however see two key weaknesses in the current proposals:

* an over-dependence on District Health Authorities as "buyers". Some will never be capable of rising above the parochial interests of "their" hospitals and "their" staff. And the public would not see DHAs as acting on behalf of individual patients.

* the administrative upheaval proposed does not produce enough benefits to patients or enough impact on the behaviour of doctors to make it worthwhile. I do not believe it to be either necessary to achieve our objectives or desirable in itself. It would distract management effort.

4. I see our central purpose as being to get better value for money in ways which expand patient choice and improve the quality of the service patients receive from the hospitals to which they are referred for treatment.

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5. In my opinion the best way to achieve this would be to make resources flow to those GPs who were most responsive to the needs of their patients, and to those hospitals that were most efficient and cost-effective in providing treatment. In other words, patients would effectively bring a budget with them that the GP would then spend with the hospital that offered the best value for money.

6. Such a scheme would build on the particular strengths of our GP service, with which the public readily identify. It would encourage GPs to offer potential and actual patients the best service possible, and would also - by promoting competition for business between GPs and between hospitals - raise standards. Three key changes would be required:

i. elective acute services to be funded from budgets held by GPs.

ii. DHA-run, self-governing and private sector hospitals to compete for the custom of GPs.

iii. responsibility for implementing change to be held at regional level.

7. The adoption of GP budgets would be fundamental. It would inject greater flexibility, competition and responsiveness in three ways:

* patients would choose their general practitioner partly in the light of his policies and performance in "buying" elective surgery. This would tie in well with our moves to improve information for patients and permit advertising. Successful GPs would attract more income through capitation payments.

* GPs would be free to choose with which hospitals to contract for their elective surgery "business". Money would then follow the patient. Consultants offering a good service would do well, and their hospitals would be rewarded for success.

* consultants would try to build up their practices, in competition with each other, by attracting the custom of GPs.

Experiment

8. We would clearly need to experiment in how best to make GP budgets work, for example to test

* the ability and willingness of enough GPs to operate effectively in this way.

* the precise scope of the services to be covered by the budget, and how we ensure that essential, urgent treatment is not denied.

* how the budgets would be managed, so as to minimise the risk of GPs running out of money in-year and/or building up unacceptable waiting lists of their own.

* how the budgets would be calculated. I envisage capitation-based budgets, but with an allowance for extra costs, such as the number of elderly people, and perhaps some incentive to medical quality and cost-effectiveness.

* the form of the necessary contracts between GPs and hospitals. GPs would need to control expenditure within their budgets and to preserve some flexibility in-year.

9. I envisage these and other practical issues being put to the test for selected medical conditions in a carefully defined geographical area, perhaps the whole or part of a relatively small Region. East Anglia might be suitable. A principal criterion for judging success at the end of the experiment would be whether the patients and their GPs wished to continue with the new system.

10. The same experiment should also test out the idea of self-governing, NHS hospitals. As providers of elective acute services self-governing hospitals would compete with DHA and private hospitals for GP business. I do not believe that hospitals should be made to become self-governing unwillingly - this is the kind of organisational upheaval we should avoid. But we could try out the possibility of giving them the option. We should need, for example,

like opting out schools.

* to establish precisely what "self-government" means. How would they be managed, and to whom would they be accountable? What freedom would they have over, say, levels of pay or capital investment? Would they employ their own consultants?

* to develop and test the criteria against which a hospital would be permitted to opt out of DHA management.

* to monitor the effects of self-government on neighbouring hospitals.

* to establish who should act on behalf of a hospital, both before and after "self-government".

11. We would need to take statutory powers to experiment in these ways. I recommend that the White Paper should foreshadow such legislation, preceded by a period of consultation. I also believe the pace of change should be dictated by the outcome of the experiments and not prescribed or prejudged now.

Capital

12. I am convinced that complementary changes are needed in the management of capital. I see four key aims:

i. clear responsibilities for decisions on the opening and closing of hospitals and hospital units, devolved as far as is compatible with securing a cost-effective distribution of capital stock.

ii. the maximum possible devolution of responsibility for the management of capital programmes, with health authorities buying in expertise as they need it.

iii. some form of charging for the use of capital assets, so that capital costs are fully reflected in management decisions and public and private hospitals can compete on a "level playing field".

iv. access to private capital as well as public capital for self-governing hospitals.

13. Treasury and DH officials are discussing a number of practical issues which bear on capital management. I hope this work can be progressed quickly so that we can include in the White Paper firm - if outline - proposals for giving effect to the aims I suggest.

Revenue allocations

14. I support the current proposals for a simpler system of allocating revenue to Regions and Districts. I suggest that they are adopted for those services which are not funded from the GP budgets I propose.

Organisation

15. The organisation of the Service would need to be adapted in three ways, each of which falls well short of major structural change:

i. FPCs would remain separate from DHAs - reflecting the distinct roles of GPs and hospitals - but would be responsible for administering GPs' contracts with hospitals. We would need to consider altering the composition of FPCs - to reduce the domination of the professions - and strengthening their management. I should also like to consider further the implications

for controlling the numbers and distribution of GPs, and how far and how quickly we can move in the direction of cash-limiting the family practitioner services.

ii. DHAs would become one of the providers of services, in competition with others. This would strengthen the case for changing the composition and reducing the size of the authorities themselves, by removing political and trade union nominees for example.

iii. Regions would be more clearly Ministers' agents of change. There may be advantage in making them regional arms of the Department in the long run, but I am not yet convinced that this structural change is really necessary or desirable. We would certainly streamline their composition and staffing.

Consultants

16. I support the broad thrust of John Moore's most recent paper on consultants and consultants' contracts (HC36). In particular, I am convinced that our strategy should be to make the present contract work and not try to negotiate (or impose) a new one. We must avoid an unnecessary and expensive row with the profession over this; and we shall need their co-operation with the resource management initiative, which is central to our wider objectives.

17. As to the details, I agree with the proposals in section A of HC36 on job descriptions and mobility. I agree, too, that we must make major changes to the distinction awards system, but I should like to give further thought to how we might best achieve this.

18. I am attracted by the idea of increasing the number of consultants, although in my judgement HC36 if anything underestimates the likely costs. If colleagues agree I should be happy to work up a scheme along the lines proposed.

Other issues

19. I have concentrated in this paper on the political heart of the review. I am taking it as read that the many other issues addressed by the Group will need to be covered in the draft White Paper, and worked up in more detail, as appropriate.

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Conclusion

20. I invite colleagues to endorse in principle the ideas set out in this paper and to agree that I should now work them up in more depth.

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From the Secretary of State for ~~Social Services~~ Health

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Paul Gray Esq
Private Secretary
10 Downing Street
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2 September 1988

Dear Paul,

NHS REVIEW

My Secretary of State has been reading the key review papers during August and would be grateful if he could take the opportunity afforded by the Ministerial Group meeting on 6 September to share his thoughts with colleagues.

FLAG B | He suggests that the Group might begin by considering the enclosed note (HC37). The main part of this note - its discussion of structure and funding - takes into account the earlier Cabinet Office paper on "Funding Arrangements" (HC35), but is broadly self-contained.

FLAG C

The note touches also on "Consultants". This part of the paper needs to be read in conjunction with Mr Moore's earlier note on this subject (HC36).

FLAG D

I am copying this letter and its enclosures to the Private Secretaries to the Chancellor of the Exchequer, to the Secretaries of State for Wales, Scotland and Northern Ireland, to the Chief Secretary and to the Minister of State and to Sir Roy Griffiths in this Department. Additionally I am copying these papers to Professor Griffiths and Mr Whitehead in the Number 10 Policy Unit and to Mr Wilson in the Cabinet Office.

Yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary