RA

10 DOWNING STREET

PRIME MINISTER

NHS REVIEW

You may like to take a first look at Ken Clarke's latest paper over the weekend. I'm not sure it gives the sort of detail you were looking for. Policy Unit and Cabinet Office briefs will follow early next week.

RRCC

9/9

Very disappointing - shocking

MS0380t

SECRET

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~~ XXXXXXXXXXX Health

23(a-h)

9 September 1988

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

Dear Paul,

NHS REVIEW

I attach a copy of my Secretary of State's Paper on 'Funding Elective Surgery' for discussion at next Wednesday's meeting with the Prime Minister.

I am copying this letter and its enclosure to the private Secretaries to the Chancellor of the Exchequer, to the Secretaries of State for Wales, Northern Ireland and Scotland, to the Chief Secretary, to the Minister of State and to Sir Roy Griffiths in this Department, to Professor Griffiths and Mr Whitehead in the No 10 Policy Unit, and to Mr Wilson in the Cabinet Office.

Yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

SECRET

Copy No. 1/1

HC 38

NHS REVIEW

FUNDING ELECTIVE SURGERY

Note by the Secretary of State for Health

1. This note outlines some possible approaches to the main outstanding issue to be considered by the Ministerial Group, the funding of elective surgery. I have discussed the note with Sir Roy Griffiths and he tells me that he agrees with it.

Context

2. Most of the package of changes to have emerged from the Group's work - helpfully summarised in the Cabinet Office's July paper (HC 32 revised) - has now taken shape. This common ground includes substantial and important advances, such as

* scope for hospitals to become self-governing, maximising local commitment and injecting a further element of competition.

* strengthening the responsibility and accountability of consultants for their use of resources, for example through clinical budgeting and through stronger management of consultants' contracts.

* greater incentives to better performance, for example in the allocation of funds to health authorities, through performance-based management budgets, by reforming the distinction awards system, and through medical audit.

* better cost information, and better information for GPs.

3. I hope I am correct in believing that these proposals can be taken as agreed in principle and now need to be worked up in detail and set out in the White Paper. But I believe we could strengthen their impact by doing still more, if we can,

* to remove the perverse incentives of the present system whereby a hospital or clinical team may be able to do more work, because of increased efficiency, but is then constrained by its budget.

* to make the funding mechanism more responsive to GPs and their patients.

B:DC2.6/30

SECRET

C

4. Again, I believe that colleagues agree with these aims but wish to be satisfied that we have devised a practical means of moving towards them. We are, I think, agreed that we need a mechanism - compatible with cash limits - for steering money to where the work can best be done, without incurring the opposite risk of encouraging unnecessary work or inefficiency.

5. This requirement applies most clearly to elective surgery, services for which the patient has (in principle, at least) some choice of timing, location and consultant. It is for these services in particular that we need to generate additional activity, for example to reduce waiting times, without pre-empting the funds needed for emergency and other essential services. We would need to consider in more detail the precise range of conditions or treatments to be covered, but it makes sense to think primarily in terms of a mechanism for funding relatively routine elective surgery accounting for some 5% or more of the HCHS budget. We could double this figure by including out-patient services in the same arrangements, and I discuss this possibility further below.

6. I completely agree with the proposals in HC 35 for funding the bulk of hospital services, and in particular the proposals for "core" funding of services which must be available locally. I think these ideas were broadly accepted at our last meeting, and I hope I successfully explained that proposals for elective surgery were an addition and not an alternative to them. We are also agreed that any new mechanism for funding elective surgery must be introduced carefully and tested for its effectiveness and viability.

Possible approaches

7. We identified at our last meeting a number of difficulties with my proposal that we should experiment with GP budgets, and concluded that other mechanisms might be considered for experimentation either alongside or instead of GP budgets. I have given some further thought to this and have identified three basic possibilities for a new approach to funding routine elective surgery. All three methods assume that, as proposed in HC35:

* Districts would receive funding related mainly to population, but with an allowance for extra costs such as the number of elderly people.

* Each District would fix management budgets for its own hospitals, and contract with self-governing hospitals, private sector hospitals and/or other Districts for "contract-funded" services generally.

Should not be dependent on district. — self-governing hospitals must be self-governing + receive funds purely directly from dept.

B:DC2.6/30

8. Each of the three methods offers a means of giving GPs at least some influence or control over the way money flows with the patient. All three methods, or some variants of them, could be piloted at the same time if we so wished.

Method 1: Budgets held by DHAs for their resident population

9. How it would work. Method 1 is for Districts to manage the budget for elective surgery as part of their responsibility for "contract funding" generally. This is the approach proposed in HC 35. Broadly:

i. On the basis of the referral patterns of its GPs, and after consultation with them about the desirability of changing those patterns, each District would determine how much should be spent on elective surgery and, more particularly, where.

ii. If the GPs so wished, the District would hold a sum in reserve against the need for in-year flexibility.

10. Advantages:

i. Keeps financial control with Districts, whilst giving GPs some say in where the money goes.

ii. Encourages GPs to review their referral patterns without putting tight financial or other constraints on them individually.

iii. Ensures that hospitals are paid for what they do without generating additional upward pressures on expenditure or waiting lists.

11. Disadvantages:

i. Places only a limited incentive on the District to do business outside its "own" hospitals.

ii. Adds little to - and could sometimes detract from - patient choice, and adds little to public understanding of the system.

iii. GPs might find that they had little influence as individuals (the average English District has 130 GPs, although there are wide variations); and their freedom of referral might be constrained by "bureaucrats".

iv. Gives little encouragement to cost-consciousness by GPs, who would be committing someone else's budget, yet still gives them an incentive to complain about the budget's inadequacy.

B:DC2.6/30

e

Method 2: Budgets held by GP practices

12. How it would work. Method 2 is broadly the approach proposed in my last paper (HC 37):

i. Each GP practice would be given a budget for the defined range of services for its patients, calculated on a "weighted" capitation basis.

ii. Each practice would negotiate fixed-price contracts for particular services with their own choice of hospital or hospitals (DHA-run, self-governing or private), reflecting their own and their patients' preferences and keeping a proportion in reserve against the need for in-year flexibility.

iii. Each practice could enlist whatever practical assistance they needed from their FPC in negotiating bulk deals and in administering contracts.

iv. GPs would be free to plough back any surplus into their practice.

13. Advantages:

i. Gives maximum control to GPs, who are closest to the patient.

ii. Places a strong incentive on GPs to review referral patterns and to refer cost-effectively.

iii. Places strong incentives on hospitals to meet quantity, quality and price requirements of GPs, by maximising competition with other hospitals.

iv. Effects a clear separation of "customer" decisions (the GP's) from supplier interests (the DHA's).

v. Further reinforces the thrust of the Primary Care White Paper towards competition between GPs for patients.

14. Disadvantages:

i. Administratively more complex: around 9,000 practice budgets in England, assuming one for each GP practice (although much of the burden would in practice be carried by the 90 FPCs).

ii. Relatively small budgets, giving relatively little room for manoevre. (Assuming that this mechanism accounted for just 5% of the HCHS budget, about half of all practices would have budgets below £50,000 a year.)

iii. Risk of large numbers of GPs complaining of underfunding.

iv. Tendency for GPs to build up their own waiting lists.

v. Some incentives on GPs to keep high risk patients off their lists - this might need to be policed.

vi. Dependent on the ability and willingness of enough GPs to operate in this way. It would be difficult to impose even for experiments.

Method 3: Budgets held by FPCs on behalf of GPs

15. How it would work. This method makes FPCs responsible, and accountable, for the budget, but acting on behalf of their GPs collectively. (This responsibility could be given to DHAs instead, but less appropriately so.) Broadly:

i. Each FPC would be allocated a discrete, cash-limited budget for the defined range of services to its GPs' patients, calculated as for method 2.

ii. FPCs would place contracts on behalf of their GPs for the services required, rather as Districts would under method 1 but as the GPs' agents.

16. Advantages:

i. Retains separation of "customer" and "supplier" interests, with correspondingly more effective competition between hospitals than under method 1, but with far fewer budgets (90) than under method 2.

ii. GPs collectively would feel more in control than under method 1, without the responsibilities implicit in method 2.

iii. Encourages GPs to review their referral practices, as (in effect) they compete with their peers for the use of the FPC's budget, but without putting tight financial or other constraints on them individually.

17. Disadvantages:

i. GPs as individuals would in practice have little more influence than under method 1 (there are on average some 270 GPs for every FPC in England), and might still see their freedom of referral as being constrained by a bureaucracy.

ii. The budget holder would be as distant from the patient as under method 1.

9

iii. Incentives on GPs to refer cost-effectively would be less strong than under method 2.

iv. The quality of FPC management would need to be strengthened (although this is desirable anyway).

18. One possible variant of method 3 would be for GP practices to be free if they wished to take responsibility themselves for their share of the budget, as under method 2, with the prospect of FPCs handing over their budgetary responsibility to an increasing number of GP practices as and when the GPs themselves felt willing and able to take it on.

? Reconciliation at end of year of budget with performance? How do 'good' hospitals get more than poor hospitals? nr

Other services

19. We should not rule out the possibility of including other services in the same arrangements. Out-patient services, for example, would be a strong candidate. Budgets for out-patient services would need particularly careful management, since GPs would always need to be able to refer patients whose conditions might require urgent treatment. But it would also have some important advantages:

i. It would reflect the fact that GP referrals will normally be for an out-patient appointment, with the diagnosis, and the decision on the need for surgery, being taken by the consultant.

ii. It would give GPs more say in, for example, when a patient is seen.

iii. It would place GPs under a stronger incentive to undertake work which is currently done unnecessarily on an out-patient basis, encouraging the more cost-effective use of out-patient departments.

iv. It would add significantly to the amount of money available for GPs to influence or control, adding to budgetary flexibility.

I would suggest that including out-patient services is a strong candidate for careful experiment.

Conclusion

20. The methods I have set out are all variations on the theme of making money flow with the patient and allocating money to efficient hospitals according to the work they do. We could experiment in different places with any or all of the three methods, or with variants on them, depending on where we get a positive response.

B:DC2.6/30

21. We shall need legislation anyway to implement key aspects of the funding proposals in HC35, and must ensure that the relevant statutory powers are sufficiently broadly expressed to allow the flexibility necessary for experimentation. As I argued in my last paper I envisage this part of the legislation being preceded by a period of consultation on the practical issues involved. The pace of change would be dictated by the outcome of the experiments, and by the need to carry managers and the professions with us, and not prescribed or prejudged now. There may well be useful scope for more limited projects in the meantime, for example to help define, and prepare for, the likely information needs of any new budgetary mechanisms.

22. Despite the importance of making progress in this field I accept that, in presenting our conclusions, we should not make too much of any particular mechanism. We shall need to deal with the detail in the White Paper in a way which makes clear that it falls into that part of the overall package on which we propose to try out change carefully over the medium to long term. The White Paper will need to concentrate on presenting the key principles and objectives and on explaining the proposal to experiment. The rest of the package continues to offer a strong and attractive agenda for immediate action nationally.

September 1988

B:DC2.6/30