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

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COVERING SECRET

Ms Carys Evans
Private Secretary to the
Chief Secretary to the Treasury
HM Treasury
LONDON SW1

20 January 1989

Dear Carys

NHS REVIEW: WHITE PAPER SUMMARIES

As promised, I enclose a copy of the two summaries of the White Paper - a popular version for the public which would be in leaflet form and a version for NHS staff. The drafts will need to be updated to ensure consistency with the White Paper as editorial changes are made there (today's summary versions are based on yesterday's White Paper draft!).

We would be grateful if the Chief Secretary could consider the drafts in relation to his wider role concerning Government publicity. We could also be glad to know if you think the drafts include any errors or depart from the substance of the White Paper.

As requested, I am also sending a copy of this letter and enclosures to Paul Gray (No 10) and Richard Wilson (Cabinet Office).

Yours

A J McKEON
Principal Private Secretary

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DRAFT - 20/1/89

DRAFT PoP VERSION OF WHITE PAPER

The Health Service today

All in all, Britain's Health Service is ~~the best system of its kind~~ unsurpassed anywhere in the world. It has a highly skilled and dedicated staff, backed by huge and growing resources. There are well over 6,000 more doctors and dentists and 70,000 more nurses and midwives than in 1978. Spending has shot up - from £8 billion in 1978 to £26 billion in 1989 (£154 million each week in 1978 compared with £500 million each week in 1989). And, to take just one example, the NHS now cares for $1\frac{1}{2}$ million more in-patients each year. [illegible] 1½ million a year

There is a lot to be proud of. Today, the Health Service is helping people in Britain to live longer and enjoy a better quality of life. But despite those successes, the performance of the NHS still varies greatly from place to place:

- people have to wait for operations much longer in some places than in others. A patient who has to wait several years in one District could have the same operation within a few weeks in another;

- drug costs in some places are nearly twice as high per head of population as in others.

- some GPs refer twenty times more patients to hospitals than others.

- the average cost of treating someone in hospital varies by as much as 50% between different health authorities.

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Of course, the NHS is not a business run for profit, but it can certainly become more business-like. What the Government now wants to do is to take all that is best in the NHS, and raise the rest of it to that very high standard. An NHS that is run better will be an NHS that can care better.

The Way Ahead

Over the last year, the Government has been looking at ways of strengthening the Health Service. That review is now over, and its conclusions have just been announced. Some of them will need the approval of Parliament. They all have a simple aim - a service that puts patients first. But while some of them will require major reforms in the way the NHS is run, the basic principles that have guided it over the last 40 years will continue to guide it into the next century. As now, the Health Service will continue to be available to everyone, regardless of income, and paid for mainly out of general taxation.

The proposals are all designed to enable those who work in the NHS to give you even better care. In future:

* as much power and responsibility as possible will be taken from central and regional administration and given to those working to provide care at a local level;

* resources will go more directly to those hospitals which offer the best service - popular hospitals which attract more patients will attract more money. Rewarding the best will increase the quality of patient care, and encourage all hospitals to improve their standards;

* major hospitals will be able to choose to run their own affairs. Known as "NHS Hospital Trusts", those self-governing hospitals will still be part of the NHS, but will have much more freedom to take their own decisions. In order to earn income, they will have to provide the kind of service that patients want. They will of course continue to provide emergency treatment to anyone who needs it;

* large GP practices will be able to buy a range of services direct from hospitals. They will be able to "shop around" to get the best possible care for their patients. This means that they will, for example, be able to send patients to hospitals where waiting times are shortest. All GPs will also be encouraged to offer a better service, because their pay will be increasingly related to the number of patients they attract. It will be easier for patients to choose (and change) their GP;

* there will be 100 new consultants over the next three years. This will help keep up the attack on waiting times and on the long hours worked by some junior doctors.

Putting Patients First

All these reforms will improve the quality of the service that the NHS provides. Some of them will however take time to work through. So there will be other initiatives to tackle the areas of greatest public concern more immediately:

i. the Waiting List Initiative will be continued. Over the last two years, a special £60 million fund has allowed an extra 220,000 people to be treated. Half of all waiting list patients are now admitted from the list within 5 weeks or less. Another £40 million will be spent on this initiative next year.

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ii. To make sure that patients are treated more sensitively, each hospital will be expected to offer:

- individual and reliable appointment times;
- more attractive waiting areas, with proper facilities for parents with children;
- counselling for family and friends;
- clear and sensitive explanations of what is happening when someone is in hospital;
- rapid notification of the results of diagnostic tests.

iii. In addition, so that patients can feel more at home and exercise more choice, they will in future be able to pay for a number of optional extras such as a choice of meals, a single room, a telephone or a television.

Timetable for Change

Taken together the Government's proposals will bring major change for the NHS. They are too important to rush into, so 1989 will be a year of preparation. By 1990, the new NHS will be taking shape, and the new method of funding hospitals will start. By 1991 the first NHS Hospital Trusts will be up and running, and some GPs will be buying hospital services for their patients. In the nineteen-nineties the new NHS will provide the country with a more modern and effective service, working for patients even better than before.

YA/0613t [3rd DRAFT - 20/1/89]

SUMMARY OF NHS REVIEW WHITE PAPER - FOR NHS STAFF

INTRODUCTION

1. The Government has published a White Paper: ["Working For Patients"] (Cm 555) setting out its plans to reform and strengthen the National Health Service.

2. Underlying every proposal in the White Paper is a simple aim - a service that puts patients first. The achievements of the NHS - in helping increasingly large numbers of people to enjoy a better quality of life and to live longer - will be the foundation from which an even better service can be built. All that is best in the NHS will be retained. The Government supports and will not change the principles on which it was founded - it will continue to be open to all, regardless of income, and financed mainly out of general taxation.

THE ACHIEVEMENTS OF THE NHS

3. The NHS is growing at a truly remarkable pace. There are over 6,000 more hospital doctors and dentists and 70,000 more nurses and midwives than in 1978. Spending has increased massively - up from £8 billion in 1978/79 to £26 billion in 1989/90, an increase of 40 per cent after allowing for general inflation. All this, coupled with improved productivity, means that - to give one example - NHS hospital staff now treat over $1^{1}/2$ million more in-patients a year than in 1978.

THE NEED FOR CHANGE

4. So the NHS has expanded enormously since 1978. The quality of its medical care and its ability to respond to emergencies remain among the best in the world. But increasingly people recognise that rising demand and an ever-greater range of treatments mean that more needs to be done. And that the injection of more and more money is not, of itself, the answer.

5. The organisation of the NHS - the way it delivers care to individuals - needs reform. The Government has already taken a series of measures to improve the way the Service is managed, notably the introduction of general management. Their success points the way ahead.

6. The performance of all hospitals and GP practices needs to be raised to the level of the best. How to do so has been the main question for the Government's review. There is clear evidence of wide variations at present. For instance, in 1986-87, the average cost of treating acute hospital in-patients varied by as much as 50 per cent, even after allowing for the complexity and mix of cases. In the same way, waiting times for operations vary sharply and there are great differences in the referral rates and prescribing habits of GPs.

7. To achieve its aims the Government intends to provide a framework in which the talent and enterprise of all those working in the NHS can flourish. It wants much more delegation of power and responsibility to those who deliver care to patients - mainly the GP and the local hospital. The best run services are those where local staff are given as much responsibility as possible for responding to local needs and are held to account for doing so.

8. The White Paper proposals are a programme of action designed to secure two objectives:

* to give patients, wherever they live, better health care and greater choice of the services available; and

* to produce greater satisfaction and rewards for NHS staff who successfully respond to local needs and preferences.

THE KEY PROPOSALS

9. The White Paper contains seven key measures:

* More delegation of responsibility to local level

To maximise responsiveness to patients' needs, functions will be delegated from Regions to Districts and from Districts to hospitals. All hospitals will be given much more responsibility for running their own affairs, enabling local commitment, energy and initiative to flourish.

* Self-governing hospitals

To stimulate a better service to patients, major hospitals will be able to apply for a new self-governing status within the NHS as NHS Hospital Trusts. These Trusts will be given more freedom to take the decisions which most affect them, such as offering their services to the NHS and private sector, determining the pay of their own staff and (within limits) borrowing capital.

* New funding arrangements

To enable hospitals which best meet patients' needs to get the money to do so, the money required to treat patients will be able to cross administrative boundaries. In future, all NHS hospitals - whether run by health authorities or self-governing - will be free to offer their services to different health authorities or to the private sector. In this way money will go more directly to where the work is done and health authorities will be better able to use their funds to secure a comprehensive range of services.

* Additional consultants

To reduce waiting times and improve the quality of service, 100 new consultant posts will be created over the next three years. These will be over and above the already agreed rate of expansion and will also help reduce the long hours worked by some junior doctors.

* GP practice budgets

To help the family doctor improve his service to patients, large GP practices will be able to apply for their own budgets to buy a defined range of services direct from hospitals. GPs will be encouraged to compete for patients by offering better services and it will be easier for patients to choose (and change) their GP.

* Reformed management bodies

To sharpen the efficiency and accountability of NHS management, regional, district, hospital and family practitioner management bodies will be reduced in size and reformed on business lines. They will have executive and non-executive directors. Community Health Councils will continue to act as a channel for consumer views.

* More rigorous audit arrangements

To ensure that all who deliver patient services make the best use of resources, quality of service and value for money will be more rigorously audited. Arrangements for "medical audit" will be extended throughout the NHS. And the Audit Commission will audit the accounts of health authorities and other NHS bodies and undertake wide-ranging value for money studies. It will report to Ministers and its reports will be published.

10. The Secretary of State for Health will shortly publish a number of working papers explaining in detail how major aspects of these proposals are to be implemented in England.

CONFIDENTIAL

[TO BE IN A SEPARATE BOX]

SELF-GOVERNING HOSPITALS

The Government wants to create a number of "self-governing" hospitals within the NHS in order to:

* make the most of the energy, commitment and ability of hospital staff, by setting them free from many of the current constraints.

* encourage a stronger sense of local pride in hospitals, many of which are substantial organisations spending £10-50 million a year.

* enable them to offer their services throughout the NHS and to the private sector, which should lead to more patient choice, greater efficiency and encourage other hospitals to do even better. As a result patients should receive better services.

The powers and responsibilities of each self-governing hospital will be vested in a new body, known as an NHS Hospital Trust. They will be run by small Boards of Management operating like a commercial Board of Directors, with executive and non-executive members and a General Manager.

Self-governing hospitals will get their money from selling their services, mainly to health authorities. A hospital which is good at its job and attracts increasing numbers of patients will see its income rise.

A simple procedure will apply for establishing an NHS Hospital Trust. A variety of groups will be able to start the ball rolling, such as the hospital management team or the senior medical staff, with the Secretary of State for Health taking the final decision. Initially, major acute hospitals will be the most suitable candidates but in due course other hospitals may come within the scope of the proposals.

Self-governing hospitals will be free to determine the pay and conditions of their own staff. And they will have greater freedom (within limits) to borrow capital.

The first self-governing hospitals should be established from April 1991, subject to the necessary legislation.

CONFIDENTIAL

[TO BE IN A SEPARATE BOX]

NEW FUNDING ARRANGEMENTS

At present, NHS funds are allocated from central Government to individual hospitals (via Regions and Districts) through a complicated and remote process. Regions get their money through the RAWP formula. RAWP has largely achieved its purpose of equalising the resources available to each Region. But it has disadvantages. It's highly complex and slow to compensate those Regions which take many patients from elsewhere. District funding too is slow to reflect these flows of patients across administrative boundaries. This means funding and workload may be out of step. As for hospitals, they are at present subject to the perverse effects of a system which can penalise success.

The Government wants to change all this. So it proposes to:

* change the method of funding Regions and Districts to a simpler one based on population numbers and weighted for the health and age of that population. The cost of treating patients from other Regions and Districts will be reflected in budgets much more quickly than now. The Thames Regions will get slightly higher funding per head - some three per cent - to reflect their populations' higher use of services. The transition to the new system should be complete by April 1992 for Regions and [April 1994] for Districts.

* place the funding of hospitals on a new footing. The objective is a system where the money goes more directly to where the work is done and done best.

At the hospital level there is a clear distinction to be drawn between services where guaranteed immediate access is necessary, such as Accident and Emergency, and those where the patient and his GP have some choice about when and where to be treated. Some immediate access (or "core") services will be funded through a management budget by which the DHA sets clear performance targets for its own hospitals. DHAs will also be able to buy such services from other Districts or from self-governing hospitals.

Where there is some choice over the time and place of treatment, services will be obtained through a contract, specifying the cost and amount of treatment. DHAs will be able to place contracts with their own, directly managed, hospitals, or with self-governing, private or other DHAs' hospitals. [GPs will still be able to refer a patient to whichever hospital or consultant they think best.]

CONFIDENTIAL

[TO BE IN A SEPARATE BOX]

GP PRACTICE BUDGETS

The GP service is one of the great strengths of the NHS. The GP is the patient's key adviser about the best hospitals and specialists. But it can take a long time for good and popular hospitals - which treat more patients - to receive more money. So GPs have little incentive to offer patients a choice of hospitals.

The Government wants GPs in large practices to hold their own budgets with which they can buy hospital services for their patients. These budgets will cover:

* out-patient services;

* a defined group of in-patient and day case treatments, such as hip replacements and cataract removals;

* diagnostic tests, such as X-rays and pathology tests.

And budgets will be bigger and more flexible (at least £600,000-700,000) by also including:

* the 70% of the cost of employing staff which the Government already reimburses;

* money for improving premises; and

* the costs of prescribing drugs.

At first only practices with lists of at least 11,000 patients (twice the national average) will be eligible to join this voluntary scheme. Over 1,000 UK practices could join, covering about 25% of the population. The details of each practice budget will be settled by the RHA with the practice, within national guidelines to ensure consistency and fairness. Savings will be available to finance further improvements in the care delivered. And a fee will be provided to cover the costs of participation. The scheme should start from April 1991.

SCOPE OF THE PROPOSALS

11. Everyone is entitled to better health services with higher quality and more choice, regardless of where they live. So the White Paper proposals apply throughout the UK. The way they are implemented in each country will need to reflect each one's particular organisation of health care, as well as its distinctive needs and circumstances.

PUTTING PATIENTS FIRST

12. People sometimes have to wait too long for treatment and may have little, if any, choice over the time or place of treatment. The Government has already done much to tackle this problem. Over the past two years, £60 million has been spent on a new initiative to reduce waiting lists and times, allowing over 230,000 additional patients to be treated. As a result, half of all waiting list patients are now admitted from the list within five weeks or less. In 1989/90, another £40 million will be spent on this initiative.

13. The changes in the White Paper seek to improve further the quality of services offered by the NHS. At present the service provided on admission to hospital is sometimes too impersonal and inflexible. The Government intends to improve matters by ensuring that, like the best hospitals now, every hospital provides a service which considers patients as people, by offering:

* appointment systems which give people individual and reliable appointment times.

* quiet and pleasant waiting and other public areas.

* clear information leaflets about the facilities available and what patients need to know when they come into hospital.

* once someone is in hospital, clear and sensitive explanations of what is happening.

* clearer, easier and more sensitive procedures for making suggestions for improvements and, if necessary, complaints.

* rapid notification of the results of diagnostic tests.

* a wider range of optional extras and amenities, such as single rooms, televisions and choice of meals, for those prepared to pay for them.

THE BEST USE OF RESOURCES

14. A quality Service - which provides not only clinical excellence but also makes patients feel valued - requires a quality management and organisation. To provide the best possible service from its resources, particularly as demands continue to grow, the NHS must always seek to make the best use of the resources available.

15. [There will be no wholesale administrative reorganisation of the NHS.] But local managers must have more freedom to manage. And those whose decisions affect the use of resources must be more accountable for that expenditure. For some time the Government has been concentrating on giving more responsibility for taking decisions to those actually working in hospitals. The White Paper aims to take this process much further by:

* effecting a clearer distinction at national level between Ministers' policy responsibilities and the operational duties of top management.

* continuing the drive towards better information systems for local managers, enabling them to improve their budgeting and monitoring.

* ensuring that hospital consultants - whose decisions about treatment commit substantial sums of money - are more directly involved in hospital management; accept responsibility for their use of resources and are encouraged to use those resources more effectively. Proposals here include agreeing up-to-date job descriptions and modifying the distinction awards scheme.

* ensuring that GPs too take greater responsibility for their use of resources. Additional resources will be made available for developing computer systems for general practice.

* obtaining further improvements in the cost information available to managers, doctors and other professionals by extending the Resource Management Initiative - to up to 50 more acute hospitals in 1989/90, with the aim of covering all 260 major acute units by the end of 1991/92.

* introducing a system of accounting for capital which encourages managers to balance the need for new investment against the maintenance of older stock. Limits on the size of new projects needing central approval will be raised and joint ventures with the private sector encouraged.

* ensuring that drug prescribing costs are kept within reasonable limits.

* ensuring that services are carried out as cost-effectively as possible by contracting out more functions.

* re-examining the work of nurses and other professional staff so as to secure the most cost-effective use of their skills.

* making the reconstituted FPCs accountable to Regional Health Authorities.

PUBLIC AND PRIVATE SECTORS WORKING TOGETHER

16. The NHS and the independent health sector should be able to support each other and provide services for each other, to the benefit of patients. Those who choose to buy health care outside the Health Service take pressure off the NHS and add to the diversity of provision and choice. The Government expects to see further increaes in the number of people wishing to make private provision. But many who do so during their working life find the cost of higher premiums difficult to meet in retirement. The Government therefore proposes to allow tax relief on private medical insurance premuims paid by retired people or, for example, by their families on their behalf.

MANAGING THE FAMILY PRACTITIONER SERVICES

17. Primary care provided by GPs and the work of hospitals are closely intertwined. The Government intends to build on the proposals in its White Paper on primary care services, "Promoting Better Health", by:

* encouraging GPs to take greater responsibility for their use of resources. One objective is to introduce a national framework for medical audit whereby GPs would systematically review their work, supported by a special committee in each FPC.

* pressing ahead with plans to let consumers have more information about GP services and to make it easier to change doctor.

* increasing competition between GPs by raising the proportion of their pay derived from the number of patients on their lists from 46% to at least 60% as soon as possible.

* taking steps to control the total cost of the GP service whilst ensuring that sufficient opportunities remain in general practice. So the Government will seek reserve powers to control, if necessary, the number of GPs in contract with the NHS. It will also seek to reduce the retirement age of GPs from 70 to 65.

* reducing the rate of increase in spending on drugs through a new budgeting scheme whereby RHAs will give FPCs budgets for drug spending and GP practices will receive indicative budgets for their prescribing costs. There will be special arrangements to deal with over- and under-spends at both the practice and FPC level. People will still be able to get the medicines they need.

PROGRAMME FOR REFORM

18. The White Paper proposals will enable a higher quality of patient care to be obtained from the resources devoted to the NHS. They represent a wide-ranging opportunity to put the interests and wishes of patients at the forefront of decision-making at all levels.

19. They also offer a new and exciting challenge to all those who work in the NHS. The proposals amount to a substantial body of change, which must be implemented with determination and commitment.

20. The provision for health in the coming financial year, 1989/90, includes the likely costs of preparing for the reforms. Over time, any extra costs should be offset by the improved efficiency which will stem from the changes. The total provision for health will take account of progress in implementing the reforms, including the increased efficiency savings. The costs of implementation in future years will be considered in the annual public expenditure surveys.

21. Throughout the programme of reform the Government will hold to its central aims:

to extend patient choice; and

to delegate responsibility to those best placed to respond to patients' needs and wishes.

The result will be a better deal for the public, both as patients and taxpayers. The Government will build further on the strengths of the NHS, but will not flinch from tackling its weaknesses. This is the way to ensure that the NHS continues working for patients.

[TO BE IN A SEPARATE BOX]

A TIMETABLE FOR CHANGE

Legislation will be introduced at the earliest opportunity to give effect to the proposals. The programme of reform will have three main phases:

PHASE 1: 1989

* The Secretary of State for Health will establish a new NHS Policy Board and reconstitute the NHS Management Board.

* The Health Departments, and RHAs in England, will identify the first hospitals to become self-governing as NHS Hospital Trusts, and plan for their new status; will devolve further operational responsibility to Districts and hospitals; and will begin preparing the ground for GP practice budgets.

* The Government will introduce regulations to make it easier for patients to change their GP.

* The first additional consultant posts will be created; Districts will begin agreeing job descriptions with their consultants; and a new framework for medical audit will begin to be implemented.

* The resource management initiative will be extended to more major acute hospitals.

* Preparations for indicative drug budgets for GPs will begin.

* The Audit Commission will begin its work in the NHS.

PHASE 2: 1990

* The changes begun in Phase 1 will gather momentum. Devolving operational responsibility, changing the management of consultants' contracts and extending medical audit throughout the hospital service will near completion.

* "Shadow" Boards of the first group of NHS Hospital Trusts will start to develop their plans for the future.

* RHAs, DHAs and FPCs will be reconstituted, and FPCs will become accountable to RHAs. Regions will begin paying directly for work they do for each other.

PHASE 3: 1991

* The first NHS Hospital Trusts will be established.

* The first GP practice budget-holders will begin buying services for their patients.

* The indicative drug budget scheme will be implemented.

* District Health Authorities will begin paying directly for work they do for each other.