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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

20 May 1988

Dear Paul,

NHS REVIEW

I attach a copy of my Secretary of State's Paper (HC21) for the NHS Review Meeting on Tuesday 24 May.

Copies of this letter and its attachment go to the Private Secretaries to the Chancellor, the Chief Secretary, 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

HC 21

NHS REVIEW: SELF GOVERNING HOSPITALS

Note by the Secretary of State for Social Services

My attached paper examines key aspects of our approach to self governing hospitals.

2. Underlying these key aspects are a range of secondary, but important, issues on which working papers are being prepared. These cover:

* the constitution of providers

* the management of capital assets and investment

* manpower planning and supply, and the financing of medical and nurse training

* ensuring that contracts between buyers and providers give the right incentives

* the timescale of change and the programme of action for achieving it

* resource implications

* improving information, including information on costs

* a balance sheet of how the changes we propose would affect consultants, GPs and nurses.

3. Colleagues will clearly want to consider the main points arising from these papers. But the best way of making progress might be for them to be looked at first by the Cabinet Office Group of Officials. The main points that arise from that work can then be brought to us. If that is agreed, I will arrange accordingly.

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SELF GOVERNING HOSPITALS: KEY ASPECTS

Note by the Secretary of State for Social Services

1. This paper examines two key aspects of self governing hospitals - role of the buyer; and how the new approach would work in practice from the point of view of the patient, the GP and the consultant. We are, I think, clearer about the virtues of "self-governing hospitals" themselves, but Annex 1 sets out some further thoughts on "health care providers".

I The role of the buyer

(a) Separation of buying and provision

2. The essential step we have to take if we are to establish self governing hospitals is to separate the buying and provision of health care.

* The major disadvantage of the present monolithic system, in which there is little choice and competition, is that the interests of the patients can take second place to those of the provider. In turn this has reduced the incentive for managers to improve services and the scope for people to spend more of their own money on health care.

* By contrast, the advantage of separating the purchase from the provision of care is that it will open up the system to competition. The patient would come first, not second.

3. The key to this will be the role of the buyer, or local health agency. The agency's starting point should be the needs and interests of the community, not those of the provider. This is a crucial change - we must not dilute its impact.

4. We shall want to consider the evolutionary route towards this goal, on which I set out some proposals in Annex 2. In deciding on the pace of change we must pay particular attention to:

* building on the progress we have already made in the NHS - for example in the successful introduction of general management and our initiatives on competitive tendering

* maintaining the morale of those now working in the service who need to be reassured that there is a valued place for them in the reformed structure.

(b) Who will the agency be?

5. Basically, the agency will be a public sector body and the successor to the present health authorities and family practitioner committees. I deal with this in more detail in Annex 2.

(c) **What will the agency do?**

6. The agency will be responsible for ensuring that there is comprehensive health care for the population for which it is responsible. In particular it will:

* identify present and future health needs, taking account of consumer demand

* invite tenders from providers of particular services or groups of services, and negotiate and award contracts

* monitor the performance of providers against key quality, outcome and cost targets, ensuring that patients, family practitioners and consultants are fully informed.

7. The size of population covered will depend on a number of factors, including the extent to which the agency is responsible for community care as well as health care. But I expect these factors to point towards a typical population of around 500,000, resulting in about half as many agencies as there are now district health authorities. This would be about the same size as now covered by family practitioner committees and interestingly the same size as proposed in New Zealand for their equivalent body. We should not, however, aim to move to this size overnight, as Annex 2 explains.

(d) **How will agencies be funded?**

8. Buyers would receive cash-limited allocations calculated according to

* population size, weighted for age profile and other relevant characteristics; plus

* the cost of servicing the capital assets employed by service providers (both existing stock and new investment), which would be charged within contract prices.

There should be no need to compensate for cross-boundary flows, as RAWP does at present, since each buyer's boundaries would be irrelevant to the location of the services it bought.

(e) **How will money follow patients?**

9. The way in which money follows the patient would depend on the nature of the work for which the agency was contracting. In patient hospital care covers

<u>immediate treatment</u> such as accidents and other medical and surgical emergencies

<u>urgent treatment</u> such as cancer surgery, for which admission must be prompt when required

<u>treatment for chronic illness</u> such as geriatrics and mental illness

non-urgent ("elective") treatment, such as hip replacements and hysterectomies, for which timing can be a matter of choice.

10. Most hospital treatment falls into the first three categories. An agency's concern for these will be to secure treatment when required, but within a fixed budget. This points to

* a capitation contract, where the money would go in advance of the patient. Such a contract would involve a set annual fee for the number expected to use the service whether or not they actually do. Where a non-resident was treated there could be cross charging or a knock for knock arrangement. A capitation-based contract might also apply to out-patient referrals.

11. For most "elective" treatment it should be possible for the money to follow each patient, through

* an average cost contract, for a given number of treatments.

12. A third alternative, which incorporates elements of the first two forms of contract, would be

* a retainer plus marginal cost contract, under which a set annual fee would be paid so that the capacity was available. There would then be a price per patient based on marginal costs: for that part of the contract, the money would follow the patient. This might be a useful approach for, say, maternity services.

II How the approach would work in practice

(a) How the patient would see it

13. The patient would

* retain a direct, personal relationship with the doctor responsible for his (or her) treatment.

* continue to look to his GP both for primary health care and for advice on, and referral to, hospital services.

* continue to enjoy access, and entitlement, to a comprehensive range of health services, free at the point of delivery.

* enjoy a better informed, and therefore more real, choice - exercised through his GP - between different consultants and different hospitals. He could for example make his own decisions on the balance of advantage between shorter waiting and less travelling. Administrative boundaries would not determine to the location of treatment.

* benefit from the impact of competition on the standards of service offered by providers.

* be able to look to a single body - the local health agency - as being responsible for ensuring that his health care needs can be met.

(b) How the GP would see it

14. The GP's primary responsibility would still be to the patients on his (or her) list. He would retain full clinical responsibility for those patients. And he would continue to refer them, as necessary, direct to consultants.

15. The main changes would be to the circumstances in which those referrals took place. At present GPs are theoretically free to refer a patient to whichever consultant they wish, although this is limited in practice. Under the new arrangements I am proposing there would be - and should be - a trade-off between

* the local health agency's decision on where to place its contract or contracts for any given service, a decision which must be taken with cost-effectiveness as well as choice in mind; and

* the GP's clinical judgement as to what is best for his (or her) patient, which may be to refer him to a specialist at a hospital with which the buyer does not have a relevant contract.

16. The effect of this trade-off, without any modification, would be to constrain a GP's freedom of referral, and the profession would no doubt object to this. It is essential, therefore, that we modify it to preserve the GP's ultimate clinical freedom and enhance his ability to exercise it in practice. I believe that the arrangements I propose would do this, for the following reasons:

* in practice, a GP's freedom of referral is already constrained - by inadequate information; by the reluctance of some district health authorities to accept patients from elsewhere; and by the resources available in hospitals. In future the information available to him would be much better; DHA boundaries would be irrelevant; and local health agencies would be shopping in a more efficient provider market.

* in practice, too, GPs may take referral decisions on the basis of which consultants they happen to know, or of longstanding habit. The approach I propose would both prompt and help GPs to question such referral patterns and exercise a better informed choice.

* GPs collectively would be able to influence, though not determine, where local health agencies placed their contracts for hospital and other services. For example, each agency's decisions would need to take account of "their" GPs' preferred patterns of referral, and would need to offer GPs the maximum range of choice consistent with cost-effectiveness.

* GPs would retain the right to make referrals additional to those for which "their" agency had already contracted, whether to the same or to different providers. This right would be

- financed by a cash-limited "back pocket" held by each local health agency for this purpose.
- supported by a process of peer review, so that competing demands on these reserve funds could be resolved by the profession itself.

17. Annex 3 summarises the different geographical circumstances in which GPs would be exercising the choices open to them.

(c) **How the consultant would see it**

18. Like the GP, the consultant would find his (or her) basic clinical responsibility, and his relationship with his patients, fundamentally unaffected. But there would be a number of changes which, whilst welcome to government, might not be welcome to many in the profession. In particular:

* consultants would no longer be employed by Regions or teaching Districts. Instead they would either be self-employed or, like other staff, employed by individual providers.

* whilst the principle of clinical freedom would be untouched, the consultant would find what was expected of him (or her) more tightly constrained by the terms of the contracts which local health agencies had entered into with the provider for whom he was working.

* there could be no security of tenure beyond the term of current contracts for the services for which he was responsible.

19. Against this there would be much in what I propose that would be attractive to consultants, especially to the majority who are committed to working hard for a better service. In particular:

* a more competitive form of provision should enable consultants to do more work - as so many tell us they would like to - without their services incurring the financial penalties which are inherent in the present system.

* consultants would have much greater influence in the management of their business - the delivery of the services in which they specialise - and much more scope to develop and market new ideas.

* there would be the prospect of higher earnings for the best consultants as providers compete for their skills.

Conclusion

20. My further work since our last meeting has satisfied me that we are still on the right track. I invite colleagues to agree that we should continue the development of the self governing hospitals approach.

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Annex 1

Health Care Providers

1. Under the "self-governing hospitals" model, public sector providers would be freer than they are now to consider what services they wish to offer and how to improve them. They would compete among themselves and with private sector providers on both the quality and the cost of the various services they offered. They would be free to sub-contract particular services and to subject their support services to competitive tendering.

2. It would be a mistake for government to decide in advance exactly how many providers of what kind would be needed, or to impose a rigid format on what such a market would generate by way of a longer term pattern of provision. Just as we have successfully embraced different models in our approach to privatisation, so we should recognise in our approach to the provision of health care the variety of circumstances we have to encompass. In particular:

* there is a spectrum of hospital care ranging from metropolitan areas with several teaching hospitals; through conurbations with a wide choice of acute services; suburban areas with a single district general hospital; to at the other end rural areas with substantial travel to district hospitals and a greater potential role for cottage hospitals. Annex 4 sets this out in more detail.

* there are over 1,800 NHS hospitals in England, of which 750 have fewer than 50 beds. Many are in practice closely interdependent. It would not be economic for every one of these hospitals to become "self-governing" - employing their own staff, negotiating their own contracts, and so on. Instead, it would make better management sense for some of them to work together when bidding for contracts, as they do now to provide a wider range of care.

* not all public sector providers would be based on mainstream acute hospitals. Of the 611 management units only 195 are solely "acute". The rest provide community health services, mental illness or mental handicap services, or a combination of different services. These are delivered partly through hospitals but also at patients' homes and through clinics, health centres and GPs' surgeries. GPs themselves would also be "providers" - seeing far more patients than are seen in hospitals.

3. We should therefore put in place a sufficiently flexible market framework to enable a variety of providers to emerge, and develop this framework in an evolutionary way. This suggests a three-stage programme:

* Stage 1: prepare the way by continuing to devolve responsibility to existing management units, involve doctors in hospital unit management, and develop information systems.

* Stage 2: allow units to float free of Districts and become "self-governing", probably at the same time as district health authorities and family practitioner committees are re-formed into the new buying agencies (Annex 2, paragraph 4).

* Stage 3: leave the market to generate new subdivisions and combinations of providers, perhaps with some providers opting out of the public sector entirely (for example through management buyout).

4. Providers who remain in the public sector will need to be accountable for their stewardship of public assets. We shall need to explore, and perhaps to experiment with, different models for satisfying the requirements of accountability and for dealing with related matters such as investment in capital and training. We need also to explore ways in which provider management could itself be franchised competitively: this could be especially valuable where there was little or no scope for alternative providers to enter the market, or where a hospital's failure in the market did not justify the closure of a valuable, or even essential, facility. We shall need to consider further papers on these issues in due course.

Annex 2

Local Health Agencies

Local health agencies would be accountable to the Secretary of State for Social Services who would in turn be accountable to Parliament.

2. Broadly, such agencies could be based on one of three models:

elected bodies, like the proposed New Zealand regional health authorities.

appointed bodies, akin to the present health authorities and family practitioner committees. (Regional health authority and family practitioner committee members are all formally appointed by the Secretary of State, though nominations are drawn from various groups. District health authority members are appointed by regional health authorities or local authorities, though the chairman is appointed by the Secretary of State.)

government agencies, without any outside members.

3. In considering these models, we need to bear in mind:

first, that the agencies will be funded by central government money, not local. It would be important to have an organisation which focussed on value for money rather than becoming a pressure group for more resources. The New Zealand model does not seem appropriate for that reason.

second, we need to make the best use we can of existing management resources and to avoid the cost of unnecessary turbulence.

third, our experience of managing the NHS has shown the need for good oversight of work of district health authorities and the value for this purpose of an effective regional tier.

fourth, we want to leave room for alternative buying agencies to develop if there is a demand for them.

4. Taking these factors together, the quickest way to make progress will be to adapt the existing structure rather than introduce an entirely new one. On this basis, the stages of development might be:

Stage 1. prepare the way by continuing to devolve responsibility from region to district, by implementing key aspects of the Primary Care White Paper, and by further developing the necessary information sytems.

Stage 2. re-form district health authorities and family practitioner committees into local health agencies, probably at the same time as providers begin to be floated free.

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Stage 3. consolidate the skills and systems needed to make the new approach work.

Stage 4. in due course - allow competing buyers to emerge and review the role of the regional tier.

5. As part of this process we shall want to consider the continuing role of nominated members.

Annex 3

Geographical Variations

1. This note describes the different types of area in which GPs would refer their patients to hospital.

2. Admission to hospital would continue to be by three main routes:

* directly via accident and emergency departments
* emergency referrals by GPs
* by a GP referral for an out-patient appointment followed if necessary by a decision by the consultant to admit for treatment as an "elective" patient or to refer the patient on for more specialised care.

All local health agencies, regardless of size or geographical coverage, would need to ensure that their contracts provided for access to hospital through these routes.

3. In deciding with which hospital to place a contract, local health agencies would need to judge the cost, quality and accessibility of services. The weightings given to these criteria would be influenced by the kind of area in which the agency operated. Broadly, the range would be:

i. areas including a teaching centre

By definition, these will be metropolitan areas, often with several teaching hospitals. About 15% of the population currently live in a district served by a teaching hospital. In these areas:

* GPs and patients currently have a wide choice of core and specialist acute services: contracts might appear to restrict this.

* except to the extent that separate provision is made for medical training, local health agencies would need to balance costs (which are high in teaching hospitals), the public's desire for the "best", and the need to ensure that teaching hospitals have sufficient numbers of routine cases to carry out their education function.

* there might be alternative private sector provision.

The net effect would be likely to be little change in public perception. There should be ample scope for placing contracts with several provider units. By raising awareness this should increase real choice.

ii. conurbations

In addition to those living in an area which includes a teaching centres, about 25% of the population live in heavily built up areas. In these areas:

* there would be a wide choice of core acute services. There should therefore be no difficulty in placing contracts with efficient providers while retaining some choice. The balance might be more difficult to strike where there was a high degree of consumer awareness, for example with maternity services.

* some choice would also be likely in specialist services. Greater competition might be encouraged where there was a teaching centre nearby and alternative private sector provision.

iii. mixed urban/rural areas with one district general hospital

About 45% of the population live in Districts of this kind which do not have a teaching hospital. In these areas:

* patient choice might be increased for some treatments depending on the accessibility of neighbouring units and the scale of private sector provision.

* the scope for competition in the provision of core acute services would be relatively limited.

* there would be unlikely to be significant change in the pattern of specialist referrals or of referrals from one consultant to another.

iv. rural/sparsely populated areas

About 15% of the population live in "rural" Districts. In these areas:

* there would be unlikely to be significant changes in the choice of core or specialist acute services. Accessibility would continue to be a major criterion.

* the new model might encourage more imaginative use of cottage hospitals. Contracts could be negotiated directly with GPs.