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REVISE:
26 July 1988

HC32

REVIEW OF THE NATIONAL HEALTH SERVICE

THE OVERALL PACKAGE: A SUMMARY OF CONCLUSIONS SO FAR

1. The Government is firmly committed to ensuring that a high standard of medical care is always available to all, regardless of income. It has demonstrated this commitment by increasing net expenditure on the National Health Service (NHS) from £7.8 billion in 1978/79 to £22.6 billion now. The Government intends to maintain this commitment and preserve what is best in the NHS.

2. The Government is also determined to modernise and improve the NHS, where it is weak. The present system of centralised control has enabled the NHS to escape large increases in costs and expenditure experienced elsewhere in major Western countries. Nevertheless, the NHS does not always provide as high a standard of care for the patient, or as good a level of value for money for the taxpayer, as it could; and the private sector in health care is still relatively small. The Government believes that the law of diminishing returns will apply to every increase in money granted to the NHS, unless it is accompanied by a programme of reform directed at greater efficiency, greater choice and better quality of care.

3. In the following sections, Part I outlines the main direction which the Government believes that the long-term development of the NHS should take. Part II sets out a first package of measures which the Government will implement to begin this process of change, building on the management reforms of recent years. Part III suggests further steps which might be taken later on to develop the process of change, as a basis for consultation and discussion.

PART I: BROAD DIRECTION OF LONG-TERM CHANGE

4. At present the NHS is a planned and centralised bureaucracy which uses cash limits as the main means of controlling costs and rationing to cope with ever-growing demand. There is a lack of choice, and no incentive for the Service to please its users. Doctors have no incentive to be cost-conscious: many cling to the belief that they should not be involved in the management of resources. Budgeting and information systems are ill-designed. Those who commit resources are not financially accountable and are

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not given adequate information on the costs of what they are doing. Those who use resources efficiently are often not rewarded for doing so. Indeed, hospitals may be penalised for efficiency.

5. The Government proposes to introduce a programme of reforms designed to produce a better service and greater choice for all patients. It believes that the aim should be to develop the NHS on the following lines.

i. Hospitals, either singly or in groups, should be given much greater independence in running their own affairs, with corresponding responsibility for the results.

ii. As part of this process, the medical profession should accept that they have important management responsibilities for the use of medical resources, as distinct from their clinical responsibilities.

iii. There should be a slimming down of the present structure of regional and district health authorities which should become non-political bodies. The eventual role of many District Health Authorities should be to act as the buying authorities for their districts. Regional Health Authorities might in time become regional offices of the DHSS.

iv. These organisational reforms should lead to much greater competition to provide health care to patients. This competition should be between health authorities, between hospitals and health authorities and between the public sector and the private sector. The funding of hospitals should be based on the work which they perform, and those which are efficient should be rewarded correspondingly.

v. There should be a considerable expansion of the private sector in the provision of health care, matched by the removal of supply-side rigidities, inefficiencies and restrictive practices (problems which need to be tackled in both the public and private sectors). The private sector should provide competition in those areas where it is the most efficient supplier. It should be encouraged to co-operate more closely in the operation of the public sector (eg through contracting out or the purchase of spare capacity) wherever this is the most cost-effective approach. And there should be fair comparisons between the public and private sectors on the cost of capital.

vi. There should be more effective arrangements for medical audit, directed at monitoring the use of resources and securing improved quality of health care.

vii. Those who wish to buy medical care for themselves and their families should be able to do so. [Inessential treatment such as cosmetic surgery should only be provided by the NHS at a charge. But charging private patients in full for their prescriptions should be reconsidered. Further work needed.]

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6. These changes cannot all be implemented immediately. They involve major organisational reform, which will need careful management. Moreover, the demand for health care exceeds the supply: future growth in supply needs to be based on the removal of inefficiencies and restrictive practices, if an explosion of costs is to be avoided. There therefore needs to be a first package of measures which prepares the way for further reforms.

PART II: FIRST PACKAGE OF MEASURES

7. There are five main ingredients in the package of measures which the Government proposes to introduce now.

8. First, a better deal for patients. The Government's proposals for increased efficiency will mean that patients will benefit from a more responsive NHS and a thriving mixed economy in health provision. But there will also be more specific benefits in the package.

i. GPs will have better information about waiting lists so that they can send their patients where they can be dealt with more quickly for a consultation or operation.

ii. New "top-sliced" financing arrangements will be directed partly to cutting waiting times, based on a hospital's performance in tackling waiting-list cases. This will build on the present waiting-list initiative.

iii. GPs will be given incentives to carry out more minor surgery (Primary Care White Paper).

iv. There will be a package of changes that could improve the treatment of patients: for example in appointments systems for outpatients, physical surroundings in hospitals, visiting hours, management of waiting lists. [Further work needed.]

vi There are to be more schemes under which patients could pay for optional extras or more "topping up". This will generate income for the NHS and provide extra services for patients.

9. Second, better use of NHS resources. There has been good progress with management improvements in recent years. The Government intends to build on this as follows.

i. Better information is essential. The Resource Management Initiative will be accelerated, by extending it next year from five experimental sites to the whole country. This will enable proper clinical budgets and monitoring to be introduced. It will also provide doctors with more detailed information about each other's practices as a basis for medical audit.

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[ii. Better use of capital, and recognition of it as a cost, are also important. Further work needed.]

iii. Independent outside scrutiny is an essential counterpart to better internal systems. Performance indicators are now in place. New arrangements for independent audit of Value For Money will be introduced: legislation will be needed. [Further work on independent audit.]

iv. Arrangements for medical audit will also be strengthened. Consultants can at present refuse to participate: in future they will be contractually bound to do so.

v. [New "top-sliced" financing arrangements will be introduced to provide greater incentives to efficiency. They will lead on to the introduction of market mechanisms, eg for selected independent hospitals, and the pursuit of local experiments. Present financing mechanisms will be improved to respond more quickly to cross-boundary flows.]

10. Third, full involvement of consultants. There is growing acceptance by the medical profession that they have a management role complementary to their clinical duties. Responsibility for the use of resources will go hand in hand with accountability for the stewardship of them. This will not affect clinical accountability which will continue to be to the patient and to the doctor's professional peers.

i. The Resource Management Initiative is directed at involving doctors in management systems.

ii. Contractual arrangements will be revised. [See separate paper.]

11. Fourth, a better organised NHS. A key feature of the proposed long-term reforms is greater independence for hospitals to enable them to operate within market mechanisms rather than top-down controls. This will require legislation in due course. In the meantime, first steps will be taken towards greater devolution of responsibility to hospitals (or groups of hospitals) within the existing framework of the NHS, including the following:

i. re-merging Family Practitioner Committees and District Health Authorities [with cash-limited funds for primary care being channelled through the Districts. Further work needed]. Community Health Councils could be retained as a focus for local politicians;

ii. making clinicians, who are the main users of NHS resources, accountable for the use which they make of those resources. This ties in with the proposals for better information systems and for revising consultants' contracts;

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iii. requiring District Health Authorities to agree with hospitals under their control what their performance targets are, both for local 'baseload' services such as accident and emergency departments and for elective surgery. Hospitals which meet their performance targets will be guaranteed an agreed level of funding. There will also be agreed arrangements covering the provision of services to other Districts or the private sector, and tertiary referrals;

iv. giving hospitals more freedom to determine local pay and conditions, and to deploy staff flexibly, within a reformed Whitley system [further work needed];

v. setting up pilot experiments to try out new arrangements for independence, leading towards autonomy on the lines of paragraph 14 at an early date;

vi. revision of the role of the NHS management board, to take account of these changes.

12. Finally, a thriving mixed economy of health care. The private sector is an integral part of the nation's health care. A strong private sector is good for the NHS, and vice versa, as a source both of competition and co-operation. The Government welcomes the joint ventures which have begun to take place. It will encourage the growth of an efficient private sector by:

i. encouraging more joint ventures [further work on treatment of capital];

ii. extending contracting-out to clinical work as well as laundry cleaning and catering. Competitive tendering will initially cover clinical support services such as pathology but the scope for further extension (eg to certain types of elective surgery) will also be considered;

iii. asking all NHS hospitals to review the scope for selling spare capacity to the private sector;

iv. encouraging more pay beds in NHS hospitals, particularly the introduction of new private wings (eg in accommodation which becomes surplus following rationalisation);

v. tackling medical restrictive practices to free up the supply of key personnel, especially consultants.

PART III: FURTHER MEASURES OF REFORM

13. Taken together the measures in Part II are in themselves a formidable programme of change. But they need to be part of a programme for the longer-term development of the NHS, designed to give a better deal to the patient and the taxpayer. The details of this programme will be decided in the light of further consultation. But the Government's general intentions are as follows.

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14. The process of devolving responsibility to hospitals should lead to the establishment of self-governing hospitals with statutory independence. To qualify for independence each hospital would need to demonstrate to the satisfaction of the Secretary of State a record of sound financial, professional and management competence. New hospitals would provide a particularly good opportunity for experiments in autonomy. Once independent, hospitals would be separate legal entities, free for instance to:

i. grade, deploy and pay staff - including consultants who would be hospital employees - as their management board thought fit;

ii. enter joint capital ventures with the private sector;

iii. develop new services to meet demand or reflect new technology;

iv. sell their services to whichever District Health Authorities, or private sector health insurance companies wished to buy them.

Enabling legislation will be needed in 1989-90 to provide for independent hospitals.

15. General Practitioners would continue to act as the gateway to hospital services. They would continue to have freedom to refer patients to consultants: indeed they would have better information about where to refer patients. DHAs would need to set aside funds to cover special or ad hoc referrals to hospitals not covered by their main contracts [see separate paper on funding]. GPs would remain independent contractors, but their contracts would be with DHAs after the merger of DHAs and FPCs. The provision or otherwise of their contracted services could be used as performance indicators (eg the rate of referrals to consultants, home visiting, the carrying out of minor surgery and prescription rates).

16. As operational management responsibilities shifted to hospitals, there would be a corresponding change in the role of District and Regional Health Authorities. DHAs would be the buyers of services and would place contracts with whichever hospitals could provide the best package of services [see separate paper on funding]. Contracts would be contestable by other public and private sector hospitals. The constitution of DHAs would be revised to end their existing exposure to local political and other pressures. The shift in responsibility to hospitals would mean that the size - and perhaps the number - of DHAs could be greatly slimmed down. So too could the size and number of Regional Health Authorities, perhaps to the point where they could become regional offices of the DHSS. Funding would then flow direct from the DHSS to the Districts.

Cabinet Office
26 July 1988

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ANNEX A

AREAS FOR FURTHER WORK

1. Funding arrangements (paper now circulated).
2. Capital for hospitals (paper now circulated).
3. Consultants' contracts (paper now circulated).
4. Merging Family Practitioner Committees with District Health authorities.
5. Charging for inessential treatment.
6. A package to improve the treatment of patients.
7. Restrictive practices in professions other than consultants.
8. The role of the NHS Management Board.
9. Competitive tendering.
10. Information technology and the Resource Management Initiative.
11. Independent Audit.

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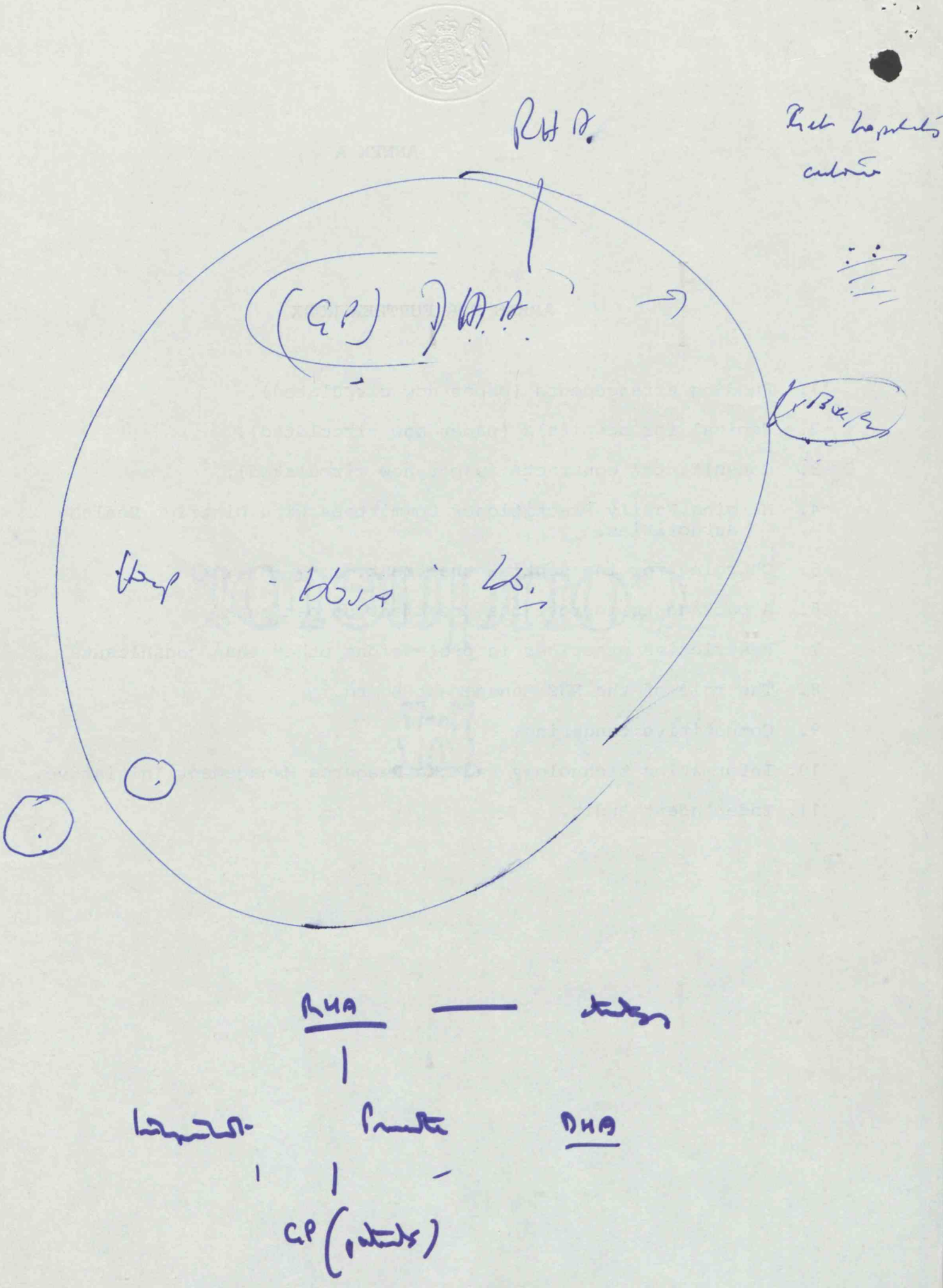

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ANNEX B

TIMETABLE FOR COMPLETION OF REVIEW

Week beginning 5 September	:	Meeting to consider further work commissioned on 8 July.
Week beginning 12 September	:	Meeting to consider first draft of White Paper.
Week beginning 3 October	:	Meeting to consider second draft of White Paper.
Week beginning 9 October	:	Party Conference.
Second half of November	:	Publication of White Paper.
January 1988 onwards	:	Consultations followed by legislation in 1989-90 Session.

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