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PRIME MINISTER

REVIEW OF THE NHS
Meeting of Ministers on 6 September

Paper by the Secretary of State for Health: The Overall Package (HC37). (The Cabinet Office Paper on Funding Arrangements (HC35) is also relevant.)
Paper by the Secretary of State for Social Services: Consultants (HC36)

DECISIONS

1. The main task for the Group is to decide whether it endorses the Secretary of State for Health's proposal in HC37 that GPs should act as buyers for certain hospital services which he calls "elective acute services". This is an important change from the approach which the Group favoured in July, which was that District Health Authorities (DHAs) should buy the health care for people in their districts.

2. Making GPs buyers has big attractions in principle, and a neat logic. But its implications need to be thought through and the Group will wish to be sure that it is workable in practice. The Chancellor in particular may be sceptical. You may wish to handle the meeting by inviting general reactions and then working through Mr Clarke's paper, paying attention in particular to the following points:

i. practicability. Mr Clarke argues that this could be decided by experiment. But you will want to decide whether the Government should be reasonably sure that the idea is workable before going public on it;

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ii. expenditure control. The Chancellor will be especially concerned about the effect on expenditure control. There will need to be good answers to his questions;

iii. scope of services to be covered. If GP budgets are only to cover some categories of treatment, it is important that these categories can be clearly defined and that the distinction between them and other forms of treatment does not lead to anomalies;

iv. effect on rest of package. It is not completely clear how Mr Clarke's proposal fits in with other parts of the package agreed so far: for instance, the role of regional health authorities and district health authorities and the funding of self-governing hospitals.

If the Group is broadly content with Mr Clarke's approach, the way forward may be to ask him to provide a further paper, setting out in more detail how his ideas would work out in practice. This will need to be prepared urgently, given the tightness of the timetable for the Review.

3. The other main task for the meeting is to consider the position of consultants. Paper HC36 was submitted by Mr Moore but Mr Clarke broadly endorses it. The Chancellor may argue for a tougher approach and in particular that there should be a change in existing contracts.

ISSUES

The case in principle

4. There are strong arguments in principle for making GPs buyers of hospital services:

i. it would bring the choice of services nearer the patients, and make GPs more responsive to their wishes. This is central to the whole exercise and a major advantage over other approaches which the Group has considered;

ii. it would reduce the role of the DHA bureaucracy, which may have interests of its own which are quite different from those of the patients;

iii. it would increase the responsibility of GPs and give them an incentive to use resources efficiently, a constant theme of the review;

iv. it would eliminate the conflict between the role of the DHA as buyer and the GPs' freedom of referral, a problem which has dogged other approaches.

Making sure the approach is workable

5. Mr Clarke's paper is (understandably) only a sketch at this stage. The main question is whether it can be made to work in practice. Mr Clarke proposes an experiment to test this out and says that a principal criterion of success would be whether at the end of the experiment patients and their GPs wished to continue with the new system. The implication seems to be that if they were not, the Government might drop the idea. The group will need to decide whether it is content with this approach or whether it needs to be reasonably sure now that it can be made to work. You might wish to ask:

i. How embarrassing would it be to make such an experiment, and argue the case for the necessary legislation, if in the event it were to fail? What would the Government then do?

ii. What timetable does Mr Clarke have in mind? Presumably he envisages that the experiment could not start until the summer of 1990 because of the need for legislation, and that there would then have to be a period of a year or 18 months while the experiment took place. If decisions of principle have to wait for the result, they will be put off to the next Parliament. Is that satisfactory?

iii. Mr Clarke says that the test for judging success will be whether patients and their GPs are satisfied. If they like it, there may be no turning back. But the Government is also concerned with the effect on expenditure. It needs to be sure before going public that the system is consistent with proper expenditure control.

6. The way forward might be to conclude that:

i. the idea is attractive in principle;

ii. but before going public the Government needs to be reasonably sure that it is practicable;

iii. Mr Clarke should now prepare urgently a paper setting out in more detail how it would work.

7. This further paper might cover the points in the following paragraphs, dealing with expenditure control, the scope of services to be covered by GPs' budgets and the effect of the proposals on other elements of the package so far agreed.

Expenditure control

8. The Chancellor may argue that making the GP the buyer would risk an explosion in health expenditure. There need to be good answers to his points. For instance, he may ask:

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i. whether GPs would be competent - and willing - to manage budgets. The more enterprising and efficient GPs might adapt to budgets fairly readily. For many it would be a very new experience. There would presumably need to be arrangements to make sure that they kept proper records and accounts, and adequate monitoring (without introducing a bureaucratic paperchase) to check that they kept within budget. How would this work, and who would run it?

ii. whether there is a risk that GPs would prescribe unnecessarily expensive treatments, perhaps to attract patients;

iii. what would happen if GPs were to run out of money before the end of a year. It would be highly undesirable if the size of GP budgets became another source of media stories about the need for money in the NHS.

There may well be good answers to these points. But they need to be worked up.

Scope of services to be covered

9. Mr Clarke proposes that the GP should buy only elective acute services. Further work might cover these questions:

i. whether this category of treatment can be clearly defined and ringfenced. It would be important not to have disputes between GPs and DHAs about whose budget should fund a particular patient's treatment. It would also be important not to give GPs an incentive to shift patients between categories, for example to reduce the burden on their budgets;

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ii. how much of GPs' work would in practice be covered by budgets. Under the earlier structure, the Department of Health thought that only one-third of expenditure was "non-core" treatment. If this is so, the arrangements for funding treatment not covered by budgets needs to be spelled out. Would it be complicated for GPs to have to deal with two categories of treatment and two methods of funding?

iii. more fundamentally, whether in the long run it would be simpler for GPs' budgets to cover all medical treatment. If GPs are to have budgets for elective acute services, it is hard to see why they should not also have budgets for all hospital services and all the resources which they deploy (including drugs and prescriptions). It would avoid boundary problems. It would strengthen the need for GPs to be responsive to patients. And it would prepare the way for slimming down DHAs, which might not be necessary at all.

Effect on rest of package

10. You might ask Mr Clarke to set out how much of the rest of the package so far agreed would survive his change of approach. Important questions are:

i. Self-governing hospitals. GPs would buy only cold elective surgery from self-governing hospitals. It is not clear where such hospitals would get their other business from, given that DHAs might well want to support "their own" hospitals and be reluctant to give business to hospitals which had become independent;

ii. Funding. The Cabinet Office paper (HC35) proposes that RAWP, the present system for allocating funds to regions, should be terminated. Mr Clarke's paper implicitly agrees with this. But the arrangements for funding those hospital

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services which are not covered by GP budgets needs to be spelled out. So do the arrangements for funding tertiary referrals, where one hospital refers a patient to another;

iii. The role of RHAs, DHAs and FPCs. Mr Clarke sketches these in but they need to be spelled out. For instance, it is not clear what Regional Health Authorities would do as "agents of change", or what Family Practitioner Committees would actually do when "administering GPs' contracts";

iv. Capital. There are still major issues on capital to be worked through by the DHSS and Treasury. For this meeting, the main question is whether the Group is content with the four key aims in paragraph 12 of Mr Clarke's paper. It is clearly essential that public sector hospitals should have to compete on an equal basis with private sector hospitals when trying to win business from GPs. This means that there has to be some form of charging for the capital assets which public sector hospitals deploy;

v. The number and distribution of GPs. Mr Clarke proposes to consider further the implications of controlling the number and distribution of GPs. The thinking behind this is not clear. You may wish to explore what he has in mind.

Consultants

11. Mr Clarke says he broadly agrees with Mr Moore's proposals on consultants. The main questions arising on these are:

i. Is it right to reject the idea of negotiating or imposing a new contract? The argument here is that to do so would be controversial and expensive, and that the present contracts provide scope for detailed job descriptions which

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can then be used to get the necessary changes. The Chancellor may however argue that a new contract should be considered.

ii. Is it right to reject the idea of short-term contracts for new consultants? Mr Moore argued that this would be controversial, and expensive because pay would have to be raised. You might ask why this need be so if the change applies only to new contracts.

iii. Should the Government be "generous" to the profession if it makes the package of changes? The proposal to indicate this to the Review Body (paragraph 12 of Mr Moore's paper) may be especially contentious.

iv. Should we retain the right of a consultant to appeal to the Secretary of State against dismissal? This is a major disincentive to dismissing a consultant. Mr Moore proposed to retain it, but with a time-limit.

v. Should whole-time and maximum part-time contracts be merged? This is a complicated subject which you may want to ask Mr Clarke to consider. The simple question is: if consultants work x% of their time for the NHS why should they not receive x% of the full-time salary, like anybody else?

vi. What major changes should be made to the distinction award system? Mr Clarke wants to reconsider this, and you might invite him to do so.

vii. Should there be a new central funding initiative to increase the number of consultants? Mr Moore put forward a scheme but did not suggest the limit on the cost. You might ask Mr Clarke to work up a scheme in detail, in agreement with the Chancellor.

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Next Steps and timetable

12. A further meeting of the group has been arranged for 14 September. It was to have discussed a first complete draft of the White Paper but this will be impractical, given that the main lines of policy are still being worked out. The meeting on 14 September might instead consider:

i. any papers which you commission from Mr Clarke on how his ideas would work in practice;

ii. a brief two-page outline from Mr Clarke of the White Paper, so that there can at least be a first discussion of its structure and style.

If practical, the next stage would be consideration of a full draft White Paper from Mr Clarke at a further meeting in the first week of October. This would ensure that the group kept to the timetable of publishing a White Paper towards the end of November. But this can be decided at the meeting on 14 September.

R T J WILSON
Cabinet Office

2 September 1988

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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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