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PRIME MINISTER

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N H S REVIEW

Kenneth Clarke's paper "NHS REVIEW - THE OVERALL PACKAGE" is a most welcome development. The responsibility for buying hospital elective acute services would be devolved from the DHAs down to the GPs. The GPs would then arrange contracts with public and private hospitals, on behalf of their patients. The adoption of this model would provide a number of benefits:

- GP freedom of referral would need to be reconciled with financial responsibility.

- Money would truly follow the patient.

- GPs would be rewarded for attracting and retaining patients.

- GPs would have an in-built incentive to carry out minor surgery.

- A mixed economy of health care would emerge. Self-governing hospitals, DHA-run hospitals and private hospitals would compete for contracts. The cross border flow of patients could not be restrained by DHAs.

- GPs will merge together if there are sufficient economies of scale. The resulting health centres will provide a broader range of specialist local services for their patients.

Treasury objections

The Treasury will object to the paper on two main grounds. First, they will argue that GPs will be less efficient than DHAs. Costs will escalate and demands for an increase in the capitation fee will abound. Yet surely GPs will have a major incentive to manage costs more efficiently. And they will provide a more professional service to their patients to retain them. Inefficient GPs will be weeded out.

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Second, they will argue waiting lists will still grow, placing further upward pressure on the capitation fee. But this model could incorporate mechanisms to alleviate this problem. One option would be to permit patients to voluntarily top-up their capitation fee. The GP could then obtain private insurance coverage on behalf of those patients. Patients could be offered a plethora of options.

The top-up payments would have a number of benefits:-

- GPs would have a natural incentive to minimise the payments to attract and retain patients;

- Low income families should be able to afford the much smaller top-up fee compared with today's high cost of private insurance.

Alternatively, a GP may decide to set aside a small percentage of his budget in a reserve pool to protect against a sudden increase in demand.

Fine-tuning

The pragmatic approach of the paper should provide a better deal for patients. But a number of areas may need to be fine-tuned:

(1) Paragraph 6 - GP budgets would exclude accident and emergency services. After all, there is little opportunity here for competition between hospitals. But there may be a cost advantage in separating the buying and providing functions. Why not include all hospital and community health service costs in the GP budget? GPs would be required to arrange annual contracts with a nearby hospital to provide all accident and emergency services for their patients. If an accident occurs in another part of the country, the nearest hospital would be required to respond immediately. Costs incurred would be billed to the home hospital.

(2) Paragraph 15 suggests a limitation on the number of GPs. This should not be necessary. A GP will not survive if his practice is too small. Fixed costs would not be covered by the capitation fees.

(3) Paragraph 15. The paper makes no reference to the organisation at the centre; only to RHAs, DHAs and FPCs. As a new member of the Policy Unit, I have not had the opportunity to review organisational aspects in any depth. But my experience in the financial sector in London and New York has shown me that lines of accountability must be clearly defined from the top. Initiative and managerial risk-taking must be permitted to thrive within the line constraints. And success is rewarded and failure penalised. But management is often fudged in the NHS. The Supervistory Board has become largely an unknown quantity and the NHS Management Board operates as a consultant to the NHS.

The Institute of Health Services Management made the following statement in its recent submission:

> "The Management Board role and membership has become increasingly multi-faceted; part-political, part-executive and part-civil service. If public accountability is to be served in the future, it will be important as a first step to separate out these three legitimate but totally different functions, since merging them in one single body means that none is satisfactorily achieved."

Management decisions are often taken outside the purview of the Board. This weakness will continue to stifle leadership.

The public service ethos is more concerned with prospective accountability than with retrospective accountability. Civil servants should be chiefly concerned with policy, monitoring and assessment; not day-to-day management. The Department may well argue that a high profile centrally funded service should be

managed by civil servants. But this argument simply hides the real issues; bureaucratic hierarchy and fudged management.

(4) Health Centres could take more direct responsibility for community care. GPs and Health visitors are already involved in many non-health issues. For example, GPs often request Social Services Departments to provide 'Meals on Wheels' or 'Home-Helps' for their elderly patients recovering from an operation. The age-weighted capitation fee paid to GPs could include an element for community care, particularly for the elderly. Additional payments could be made for the mentally and physically disabled.

Summary

Kenneth Clarke's recommendations should be embraced in most respects. The benefits of a GP-based capitation fee are considerable. Yet you may wish to raise a number of points:-

(1) Include accident and emergency services in GP budgets (Para. 6).

(2) Do not place a ceiling on the number of GPs (Para. 15).

(3) Remove the civil servants from the NHS Management Board and give it real management responsibility for running the service, perhaps as a separate corporate body. RHAs and DHAs could become area offices of the new entity.

(4) Give health centres more responsibility for providing and, where appropriate, buying community care services.

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