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SUBJECT

cc MASTER

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

7 September 1988

Dear Geoffrey,

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister held a further meeting on 6 September to discuss the review of the National Health Service, the tenth in the present series.

I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with the CMO arrangements.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Northern Ireland, the Secretary of State for Health, the Chief Secretary, the Minister of State, Department of Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson (Cabinet Office) and Mr. Whitehead (Policy Unit).

The meeting had before it papers by the Secretary of State for Health on the overall package (HC37) and by his predecessor on consultants (HC36). A paper on funding arrangements (HC35), co-ordinated by the Cabinet Office, was also circulated.

Introducing his paper on the overall package the Secretary of State for Health said his main proposal was that GPs should be responsible for purchasing elective acute services on behalf of their patients and should be given budgets for the purpose. He believed that this would build on what had already been agreed in the group, particularly the need for money to follow the patient. He was concerned that relying on District Health Authorities (DHAs) as buyers for all services might not bring the benefits which were intended, because DHAs would feel loyalty to their staff rather than to patients, and patients would find it difficult to identify with them. If GPs were given budgets as he proposed, they would be able to act in effect as the customer choosing between DHA hospitals, independent hospitals and private hospitals, as they judged best. Consultants would come under pressure to compete for contracts to treat patients. DHAs would have an incentive to make sure that their hospitals were well managed and successful in winning business. Regional

Health Authorities (RHAs) would have a continuing role, managing the change. Once the necessary legislation was through he proposed that there should be an experiment in a suitable region, possibly East Anglia. He did not rule out the possibility of experimenting with different versions of the scheme in different parts of the country. If the idea of GP budgets succeeded and was popular, it could be extended throughout the country.

In discussion the following main points were made:

a. The idea of giving responsibility for purchasing certain hospital services to GPs and their patients had attractions in principle, but it was not clear that it would be workable in practice. Some GP practices would be too small to bear the risk of a lot of patients all needing operations at the same time. It would be highly undesirable for GPs to run out of money half way through a financial year. There would need to be a move to sizeable group practices, with professional managers to operate them, in order to create a big enough pool of patients to bear the risks. This would be a move in the direction of US-style Health Maintenance Organisations (HMOs) which the group had already rejected, without some of the advantages which HMOs offered. There would also be a risk that GPs would in practice not be able to control their budgets because consultants in hospitals would prescribe treatment and take key decisions which influenced expenditure.

b. These problems could in part be avoided if charging by hospitals was based on a system of <u>average</u> costs for each particular kind of operation. A doctor running a small practice of his own would then be able to contract with his local hospital that they would take all his cases at a specified level of service. But this might be seen as a reduction in the right of patients to have a say in where they were treated, and be considered less satisfactory than the present position where the GP was seen as independent.

c. One of the main arguments for the scheme was that GPs would come under pressure from their patients to make the best use of their budgets. They would have a real incentive to attract patients, for instance by shopping around hospitals for shorter waiting times and offering attractive deals on particular kinds of operation. A GP who did not do so would lose his patients to other GPs who did. Similarly if a GP was inefficient, consistently prescribing the most expensive treatment for his patients or referring too many to hospital instead of treating them himself, he would run out of money, build up longer waiting lists than other GPs in his area and start losing patients.

d. Against this, it could be argued that the incentives might not work in this way. Patients might seek out those GPs who offered the most expensive treatment. If

those GPs ran out of money, they would complain that their budgets were too small to enable them to buy their patients the treatment which in their medical opinion was essential. The effect might be greatly to increase the lobby for more money for the NHS, and to create two tiers of waiting lists, one with hospitals and one with GPs. In rural areas where there was only one hospital within reasonable distance the idea of GPs shopping around for shorter waiting times might be impracticable. More generally, for most GPs the proposed budgets would be their first experience of cash limiting. Even if they did not exceed their budgets there would be a natural inclination to spend up to the limit. For all these reasons, there would be the potential for cost explosion. There would therefore need to be sophisticated monitoring of each GP's financial programme during the course of a year. This would be administratively cumbersome.

e. On consultants, the group were agreed that the aim should be to achieve the Government's objectives within consultants' existing contracts. This was subject to the need to achieve major changes in the distinctions award system. The group also wished to keep open the possibility of taking on additional consultants, some on short term appointments, as discussed on 12 July. The important thing was to motivate hospitals to manage their consultants properly. Money following the patient was critical in this context. The present system paid hospitals and consultants for being there: the aim should be to fund them in a way which reflected the work which they actually did. If a consultant failed to carry out the number of operations expected of him, the hospital would not receive the money which it needed to employ him and would not be able to afford to keep him.

f. The key question was how the funding should be handled. It was common ground that the GP, with the patient, should choose the hospital where the treatment was to be carried out. Giving the GP a budget as well, with direct responsibility for funding the hospitals, would encourage consultants to build up a practice of GPs and to be responsive to their patients' needs. On the other hand it would have the monitoring and other problems already identified. The alternative was to build on DHAs (incorporating Family Practitioner Committees), as envisaged in the group's work hitherto. Hospitals would operate on performance-related budgets and would have to tender for 'top-sliced' money to reduce waiting lists. They would still have the incentive to get the best out of their consultants.

g. The Secretary of State's proposals implied a timetable in which legislation would be passed in the 1989/90 Parliamentary Session followed by an appropriate period for experiment. This would have the advantage of allowing time for the further development of the Resource Management Initiative. On the other hand, legislating for an experiment would convey the impression that the

Government did not know where it was going, and there would be nothing to show for the Government's policies at the next Election. The issues had to be faced and decided now. It might however be possible to put forward the idea of GP budgets, not as a main plank in the immediate package of measures, but as a possible further development for experiment in the longer term.

Summing up the discussion, the Prime Minister said that the group were agreed on a number of important points. The funding of hospitals needed to be changed to reflect their performance and to enable money to follow the patient. Consultants needed to be properly managed. GPs and their patients should be able to choose where the patient was treated. There needed to be more detailed work however on who would do the funding and how the arrangements would work. Patient choice, which the Secretary of State emphasised in his paper, was important but the group was not convinced that it would be right to give budgets to GPs because of the monitoring and other problems which would be involved. It was essential that whatever solution was adopted should be administratively practicable. The Secretary of State should consider the options further in the light of the discussion and provide a paper for the group's next meeting on 14 September. In the meantime it would not be possible to make progress with the drafting of a White Paper until the main lines of policy had been decided.

The Prime Minister also agreed that it would be helpful if your Secretary of State could discuss the issues on capital, outlined in paragraph 12 of his paper, with the Chief Secretary and let the group have a paper on them in due course.

I am sending copies of this letter to the Private Secretaries of the Ministers at the meeting, and of the Secretary of State for Scotland, and to the others present.

Yours,
Paul

(PAUL GRAY)

Geoffrey Podger, Esq.,
Department of Health.