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PRIME MINISTER

REVIEW OF THE NHS

Meeting of Ministers on 14 September

Paper by the Secretary of State for Health
"Funding Elective Surgery", HC 38

DECISIONS

1. Mr Clarke's paper indicates that there is a large area of common agreement emerging from the Review as a whole. It then concentrates on who should hold the budgets for the relatively narrow area of elective surgery, listing arguments for and against three options: GPs, District Health Authorities (DHAs) and Family Practitioner Committees (FPCs). The paper does not go into detail on how the funding arrangements would work under these options, and makes no firm recommendations. The emphasis is on the idea of experiments.

2. Discussion seems likely to pick up where it left off last time. Treasury Ministers will probably continue to be sceptical, saying that they are still not clear how GP budgets or FPC budgets would work in practice. You may wish to concentrate the discussion on three main aspects:

i. common ground. It is helpful that Mr Clarke sees a substantial area of common ground. It is however important to be clear about what it covers. At present there still seem to be some important points to be clarified, as well as a lot more work to be done on the details;

ii. budgets for elective surgery. The question is still which of the three options outlined by Mr Clarke would be the most practical administratively while giving consultants, hospitals and GPs the right incentives;

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iii. experiments. The last paragraph of Mr Clarke's paper seems to point in effect to a White Paper with 'green fringes', in which the ideas which he is putting forward would only be outlined tentatively. He even suggests experiments with all three options. But it would still be important to be sure that they were potentially workable, given the need for legislation.

3. The Review is at risk of slipping behind the timetable agreed in July, which envisaged a White Paper in the second half of November. For the next meeting on 4 October you may want to ask Mr Clarke to prepare:

i. an outline of the White Paper which he has in mind. This could serve two purposes: first, to confirm the main features of the package which the Government will be putting forward, and second, to give the Group a chance to discuss the White Paper's style and structure, before work goes too far;

and ii. a detailed description of how an experiment with GP/FPC budgets would work in practice, assuming that he wishes to pursue the idea. This sort of working model seems essential if the group is to be able to decide whether to include it in the White Paper, however tentatively.

BACKGROUND

4. At the last meeting Mr Clarke proposed that GPs should be responsible for purchasing elective acute services on behalf of their patients and should be given budgets for that purpose. Your conclusion was that, although patient choice was important, the group was not convinced that it would be right to give budgets to GPs because of the monitoring and other problems that would be involved. You asked Mr Clarke to consider the options further in the light of the discussion and provide a paper for the next meeting.

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ISSUES

THE COMMON GROUND

5. Mr Clarke's proposals only concern the funding of 5-10% of hospital care. He says that the rest of the package "continues to offer a strong and attractive agenda for immediate action nationally" (paragraph 22). You may wish to check that the following principles are agreed.

(1) i. RAWP should be abolished, and replaced by a simpler, capitation-based approach. Funding would be determined mainly by population but with an allowance for extra costs such as the number of elderly people.

How does this work with a capitation approach?

ii. Hospitals should be given much greater independence in running their own affairs with corresponding responsibility for the results. In particular, their funding should be based on the work they perform. Those hospitals which are competent to become fully independent should be able to do so; and there should be competition between hospitals, in particular to shorten waiting lists. All this requires much better cost information in hospitals.

iii. The responsibility and accountability of consultants should be strengthened. Hospitals should be encouraged to manage their consultants properly. The more that money follows the patients, the more incentive hospitals will have to get the best out of their consultants. But this must be accompanied by effective medical audit arrangements to make sure that hospitals and consultants do not carry out unnecessary tests and operations in order to inflate their revenues.

iv. The hospital service needs to be responsive to the needs of GPs and their patients. GPs should have better information about the services which different hospitals can provide. But they should also be given incentives to be cost-conscious.

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v. Overall, the acid test for any new system is whether it provides incentives to better performance by hospitals, health authorities, GPs and consultants, without a costly administrative upheaval.

6. Assuming that all this is common ground, there are three general issues about the way in which the new arrangements would work which you may wish to clarify before turning to Mr Clarke's proposals for elective surgery.

7. First, there is the role of DHAs. The approach which was emerging before the Recess was for DHAs to become non-political bodies which would give hospitals much greater freedom to manage their own affairs, and would concentrate instead on buying hospital services. They would do this through core-funding for hospital services which had to be provided locally (eg accident and emergency) and contract-funding for other services (eg elective surgery). At the last meeting Mr Clarke questioned whether it was realistic to expect DHAs to distance themselves from hospital management in this way; but his paper now appears to accept the earlier proposals for all services other than elective surgery. You may wish to explore this, with particular reference to

i. the funding of independent hospitals. If DHAs are responsible both for managing their own hospitals and for funding all hospitals, what guarantee would there be of fair play for independent hospitals?

ii. the funding of teaching hospitals and specialist units. This has so far been left open, except for the suggestion that referrals from one hospital to another should be funded by the referring hospital.

8. Second, there is the position of FPCs. The group agreed on 8 July that there was a strong case for merging FPCs with DHAs. It also saw some attraction in cash-limiting the operations of the

merged bodies. Mr Moore agreed to examine the possibility. You may wish to explore whether Mr Clarke agrees with it. His idea of giving FPCs budgets for elective surgery would only seem to make sense if FPCs are not merged.

9. Third, there is the role of Regional Health Authorities (RHAs). The group agreed on 8 July that there was a strong case for slimming down the operations of RHAs and that they might in time become regional offices of the DHSS. You may wish to explore what role Mr Clarke has in mind for them as 'agents for change'.

BUDGETS FOR ELECTIVE SURGERY

10. Against this background, Mr Clarke's paper focuses on the relatively narrow question of who should actually handle the funding for elective surgery: the GP, the DHA or the FPC.

11. Giving the GP a budget has attractions in principle. In particular it would bring the choice of treatment nearer the patients and make the system more responsive to their wishes, increase competition and reduce the role of the NHS bureaucracy. But the group identified serious disadvantages to this approach at the last meeting. You will wish to ask Mr Clarke and other members of the Group what further thoughts they have had on the administrative and political practicability of GP budgets. In particular:

i. would it be possible to monitor all GP practices? The paper says that there would be around 9,000 practice budgets in England but that much of the burden would in practice be carried by FPCs (paragraph 14 i);

ii. what would happen if GPs ran out of money in the middle of a year? Would they lobby for higher expenditure? One answer might be for the GP to place contracts with hospitals under which they undertook, for a fixed price, to meet his patients' needs for a fixed period. It would then be for the

hospitals not the GPs to ensure that expenditure was contained within the contract price and the GP himself would not run out of money. But this would tie the GP to the hospitals and reduce patient choice;

iii. would GP practices be large enough to bear the risk of a lot of patients being ill at the same time? About half the practices in England consist of 3 or more GPs, and for such practices there should be a reasonable spread of risk. But what about the rest? Would it be more workable for them if GP budgets covered all their costs (eg drugs and prescriptions), not just elective surgery? But would they have the skills to manage such budgets?

iv. what incentive would there be to cut costs? Most of the cost of the treatment would be decided by the consultant not the GP. The Treasury may argue that if GPs are to be given budgets, they should cover those matters which GPs themselves decide eg outpatient referrals;

v. if GPs could place contracts with private hospitals, what incentive would there be to take out insurance to cover the cost of private treatment? The answer may be that a patient with private insurance could choose to have private treatment whereas a patient on the NHS could only hope for it. But if the GP wanted to attract patients, might he not be tempted to prescribe what his patients wanted, however expensive?

FPC BUDGETS

12. Mr Clarke suggests as an alternative that budgets could be held by FPCs on behalf of GPs. This is to meet the objection that GPs might not have the administrative competence and would have practices too small to provide an average profile of risk. But here again there are questions about practicability:

i. FPCs at the moment would not have the staff or the management to carry out this role. A new layer of bureaucracy, with a sizeable increase in staff, would presumably be needed to enable them to cope with the role;

ii. there would be a risk that FPCs would be a new pressure group for more money for the NHS;

iii. there could be a conflict between the individual GP's freedom of referral and the role of the FPC.

OPTING OUT BY GPs

13. Mr Clarke's paper hints at one further possible option, which would be to allow GP practices to take over responsibility for their budgets as and when they felt willing and able to do so (paragraph 18). He restricts this idea to opting out from FPCs, but it is not clear why it should not also apply to opting out of DHAs. The new system could start with DHAs buying elective surgery as well as all other treatment (as at present proposed). But GPs working in large practices would be able to apply to the Secretary of State to run their own budgets themselves if they wished. The practicability of this option would have to be explored properly. But on the face of it, it might have some advantages:

i. GP budgets would come in gradually and in response to local conditions;

ii. only those GPs who wanted budgets would be given them. In order to qualify, they would have to demonstrate that their practices were large enough to bear the risks, and that they had the necessary management competence;

iii. their budgets would not necessarily be restricted to elective surgery, but could also cover outpatient referrals and other costs such as drugs and prescriptions;

iv. the practicability of monitoring arrangements would be one of the factors to be taken into account when deciding how many practices to approve;

v. GPs would find it less easy to complain about the size of their budgets if they had voluntarily opted into the new arrangements in full knowledge of what they would be getting and the basis on which it would be allocated in future years;

vi. if they exceeded their budgets or mismanaged them, they would risk losing them.

But, as with the other options, this idea would need to be worked up properly, before decisions could be taken.

NEXT STEPS

14. If Mr Clarke wants to pursue one or more of the options in his paper, you may wish to invite him to prepare a paper for the next meeting which sets out in some detail how his experiment would work. This might cover such questions as:

i. what legislation would be necessary;

ii. what the timetable for the experiment and decisions would be;

iii. whether participation would be voluntary;

iv. how the experiment would be monitored and by whom;

v. what would happen if a budget holder overspent? underspent? ran out of money mid-year?

vi. what teatment exactly would be covered;

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vii. what form contracts with hospitals would take and how the bills would be handled.

15. In addition you may wish to invite Mr Clarke to prepare an outline of the White Paper for the next meeting, as suggested above (paragraph 3).

RJW.

R T J WILSON
12 September 1988

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