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NHS REVIEW

The Way Forward

Kenneth Clarke's second paper "FUNDING ELECTIVE SURGERY" summarises the main areas of agreement so far, namely the move towards independent hospitals; the role of consultants; increased use of performance based management and the need for better information.

The paper then considers three options for funding elective surgery:

1. Budgets held by DHAs for their resident population (HC 35).

2. Budgets held by GP Practices (HC 37).

3. Budgets held by FPCs on behalf of GPs.

The paper is rather general and weak on the precise mechanics of how each option would work. It is extremely sketchy and needs elaboration. Separation of procurement and provision of health services is crucial if we are to have tangible reforms. This does not happen under option 1 because DHAs would remain allied to their hospitals and they would remain as monopoly suppliers. Option 2 has great merit but may be impractical in the short run. Option 3 achieves very little on its own.

It is crucial that a another option be considered.

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Basic criteria for an improved NHS

Any proposed changes to the structure of the NHS should satisfy certain basic criteria:

- The procurement and provision of health services should be separated.

- Money should truly follow the patient.

- GPs should be motivated to compete for patients on the best terms possible.

- Consultants should be motivated to compete for GPs' referrals.

- These can only happen if the role of each participant (DHA, RHA, FPC, GP) is well defined and demarcated.

Problems with the existing options

Option 1

It is probable that this option would produce a better managed monolith but one still insensitive to the changing needs of patients. Centrally improved budget limits would continue to be the only driving force behind the NHS, rather than the more effective dynamism of an enterprise culture. Surely, management budgeting should follow, not constrain, the pursuit of market opportunities. Financial exposure limits can still be set in advance, as any business which makes a forward plan knows. Greater incentives can be introduced into the existing health service without major disruption.

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In this option, money would not always follow the patient and DHAs would necessarily act both as buyer and provider. DHAs will be unwilling to shop around for contracts because of the risk of diluting the provision of services in its own hospitals.

The move towards self-governing hospitals would be frustrated by the parochial interests of DHAs. Previous papers have referred to the need for regions to manage the process of change to self-governing status but it is now clear that this was only lip service. This statement is too vague. In practice, DHAs must in their own interest frustrate this ambition. It would be easier for Pravda to break the control of the Kremlin's censorship, than for hospitals to break free from some DHAs if the latter continues to hold all the trumps.

Questions to ask:

- What motivation will any DHA have to break its own monopoly?

- What will be the real driving force behind the move to independent hospitals? Precisely how will it work?

- How can GP freedom of referral be reconciled to available resources other than by centralised budgeting?

- Top-slicing is proposed as an interim measure in Paragraph 5 of HC 35. How long is this interim measure expected to last? What is the potential political risk of top-slicing? Could Central Government be accused of withdrawing resources from poorly performing hospitals?

Option 2

GP budgets would satisfy the 'basic criteria' list. But there are a number of practical problems with this option.

There are a little over 9,000 GP practices in England for the 24,460 GPs (Appendix). It is doubtful whether the 2,920 sole practitioners would have the management resources to opt out. Also, they would not benefit from pooling of risk for an average resident list size of just over 2,000. Perhaps over time new firms may emerge to take over the administrative burden on behalf of GPs.

Questions to ask :

- Should minimum criteria be set for GPs (eg size of practice), to enable them to operate their own budgets?
- Would there be a place for good GPs who are unable both to manage their own budgets and to shop for lower cost contracts?
- How would GPs ration their contracts?

Option 3

As a stand-alone model, this option has very little to commend it. There are better ways to segregate buyers of services from their hospitals (providers) without expanding the role of FPCs. The option could lead to another level of bureaucracy in the system.

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Question to ask:

Would the enhanced role for FPCs produce a new level of bureaucracy unable to cope without the management concentration in many DHAs?

Another option: DHAs as budget holders (buyers) - but GPs could opt out

There is another solution, which would build upon some existing strengths of the NHS in the short-term, but incorporate the benefits of GP budgets. This reform will build on gradual change as well as incorporating greater enterprise within the health service.

1. DHAs would act as buyers for all hospital and community health services for their resident population.

2. Regions would be responsible for setting and monitoring budgets for the hospitals during a transitional period. The RHAs would receive a specific mandate to prepare hospitals for self-governing status within a set time-frame, say 3 years, where they are so willing.

3. Where GPs are willing and administratively able, permit them to opt-out of the DHA on behalf of their patients. GP practices would receive an age-weighted capitation fee for their list of patients. Additional payments could be made for patients with an existing chronic complaint. Opting out could initially be restricted to elective surgery and out-patient clinics, but ultimately could be extended to include all hospital care.

If opting out was restricted to a list size of at least 8,000 and a minimum of 4 GPs in the practice (probably equating to a health centre) opting out should be feasible. Approximately 2,500 practices (28% of the total) could opt

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out under this model. (See Appendix for distribution of GPs and size of patient lists).

4. FPCs would be merged with DHAs as previously proposed.

5. <u>There is a very strong argument for separating the buying and providing functions for all hospital and community services, not merely elective surgery</u>. The age-weighted capitation fee could cover all hospital costs. GPs would be required to arrange annual contracts with a nearby hospital to provide accident and emergency services. But patients would still be given an automatic right to receive attention at any hospital in the country. If an accident occurs in another town, the nearest hospital would be required to respond immediately. Costs incurred would be billed to the home hospital. In practice, a large percentage of the cross-border flow would net out.

<u>Why has this option not been proposed?</u>

1. Kenneth Clarke may have a subconscious belief in expanding the role of FPCs. As Minister of Health in 1985, he was responsible for the separation of FPCs from DHAs. But he would probably accept this new option as a compromise, as hinted in Paragraph 15 of his Note.

2. Roy Griffiths has initiated some of the most radical changes in the structure and dynamics of NHS management since its creation. These changes are bearing fruit with improved performance and cost savings. He may be inclined to reject new initiatives if there is a risk that it could deflect from building upon the existing structure. His scepticism over the new proposal by Kenneth Clarke was evident during last week's meeting.

3. Treasury officials have argued that GPs should only be given budgets for out-patient clinics (not elective surgery) since referrals are within their control but the decision to

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operate is taken independently by consultants. But this argument is illusory. If a consultant automatically operated on every patient referred by the GP, the GP would soon exhaust his contractual agreement. And the consultant would rapidly gain a poor reputation. In the following year, the GP would be behoven to arrange a contract with another consultant.

Recommendations

1. There is a need for properly worked out proposals. Kenneth Clarke's paper is too skimpy on the detailed mechanics.

2. It is crucial that a different option be considered with the following characteristics:

   (a) DHAs to have responsibility for buying all hospital and community health services.

   (b) Responsibility for setting hospital budgets and monitoring performance to be transferred to the Regions.

   (c) Regions mandated to prepare hospitals for self-governing status within a set time frame.

   (d) GP practices given right to opt out of the Districts if they are willing and able.

Are these compatible

Kenneth Clarke might be asked to consider developing this approach, as well as expanding existing ones.

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APPENDIX

DISTRIBUTION OF GPs BY LIST SIZE (England, 1986)

List Size	No of GPs	%
Up to 1000	426	1.8
1000 - 1499	2053	8.4
1500 - 1749	3373	13.8
1750 - 1999	5781	23.6
2000 - 2249	5464	22.3
2250 - 2499	3870	15.8
2500 - 2749	1847	7.6
2750 - 2999	864	3.5
3000 - 3499	631	2.6
Over 3500	151	0.6
Total	24460	

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DISTRIBUTION OF GPs AND PRACTICES BY PARTNERSHIP SIZE

(England 1986)

No. of Partners	No. of GPs	No. of Practices	%	Average List Size* per GP
1	2926	2926	33	2104
2	3824	1912	21	1894
3	4976	1659	18	1996
4	4390	1098	12	2042
5	3805	761	9	2075
6 and over	4539	648**	7	2101
Total	24460	9004		

* taken from England and Wales data combined

** average of 7 partners for this category.