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From the Private Secretary

15 September 1988

SUBJECT CC MASTER

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister held the eleventh meeting of the group discussing the review of the National Health Service on 14 September. **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 Secretary of State for Scotland, the Chief Secretary to the Treasury, the Minister of State, Department of Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. Whitehead (Policy Unit).

The meeting had before it a paper by the Secretary of State for Health, "Funding Elective Surgery" (HC 38). In discussion the following were the main points raised:

a. The paper took as its starting point the method of funding hospital treatment generally which had already been broadly agreed. It was concerned only with the funding of elective surgery. This represented a comparatively small part of hospital treatment, although it was a politically important part if only because it accounted for the bulk of waiting lists. It was important that work on other aspects of the Review, where there was a lot of common ground, should move ahead quickly.

b. The question raised by the paper was how the new funding arrangements should operate at the local level, and how GPs could best be fitted into them. It was of great importance since GPs were the patients' main point of contact with the NHS and since the absence of cash limits on them posed major difficulties for expenditure control. In its work before the recess, the group had already identified one way of giving GPs a proper place in the new structure. This was by merging the FPCs and DHAs and making the combined body responsible for buying elective surgery as well as other

hospital treatment for its population. Local politicians would be excluded from the boards of the new bodies and GPs given a substantial representation on them. The participation of GPs would ensure that the new bodies were properly responsive to GPs' and patients' needs, and dealt fairly with independent hospitals. The merged bodies would be cash limited and there could also be a cash limit on elective surgery alone within the general cash limit. This approach was clearly workable and should be considered further. HC 38 did not propose its rejection and indeed it could be viewed as a variant of Method 1; but the description of Method 1 in the paper left out some essential features of this approach, such as the FPC/DHA merger and the cash limiting of the combined body.

c. HC 38 put forward a second method for experiment - GP buying of elective surgery - because it would make the system more responsive to the needs of GPs and patients. But the group had already expressed severe reservations about whether this would be workable in practice. There must be considerable doubt whether GPs generally would be competent to manage a budget, and the problem of monitoring would be formidable. Above all, individual GPs' practices would be too small to provide a reasonable spread of risk. One way of dealing with these problems would however be to provide that GPs could choose to "opt out" of DHA/FPC buying of elective surgery. The "opting out" process could be controlled so as to ensure that the buying role was undertaken only by those practices competent to perform it. In particular it should be restricted to practices containing a minimum number of GPs, perhaps six. Large practices would have the spread of risk which was essential.

d. If experiments on opting out by large groups of GPs were to be considered further, it was important to establish more exactly how they would work in practice. What type of contract would GPs place with the hospitals? How would the price be fixed? Would GP freedom of referral or patient choice be constrained, and would it matter if they were? What would happen if the money ran out in the year? What should be the distribution of risk between the GP and the hospital? These and similar questions should be properly thought out before the Government committed itself.

e. GPs' budgets must not be open to abuse by unscrupulous GPs increasing their incomes by spending less on their patients than they should. It would be politically very damaging if the system was seen as likely to work that way. This aspect needed to be further considered. Such a result should be avoided by the introduction of an

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effective system of medical audit, which was indeed an essential feature of the new arrangements as a whole. Even so, some sort of incentive for GPs would be needed. It might be right in certain circumstances to provide for part of surplus income to be retained and invested in the practice.

f. There was a powerful case for cash limiting GPs. The group favoured this in principle. The question was how it could best be achieved. On one view the best approach was through merging FPCs and DHAs. On another view it was argued that cash limiting was a separate question from that of the organisation of buying, and it required closer control of the total number of GPs, of their allocation to practice, of their prescribing habits and of their referral patterns. Each of these would require a major cultural change and would be fiercely resisted. Cash limiting might need to be introduced on a phased basis, starting with elective surgery.

g. HC 38 also suggested as a subject for experiment a third option, that of the FPC buying elective surgery. It was a way of achieving a reasonable spread of risk, but would require a substantial increase in FPC staffing and could produce a conflict with the individual GP's freedom of referral. If, however, opting out of the larger GP practices was to be considered, opting out by FPCs was another possibility.

h. The treatment of consultants would need further work. At its previous meeting the Group had come to the view that the necessary changes could be made by better management of consultants within the broad essentials of their existing contracts. But more detail was needed on exactly how present management practices would be varied so as to achieve these changes. It was especially important to ensure that the system of merit awards could be reformed and that there was a proper relationship between pay and time worked. It was arguably not realistic to think that contracts could be terminated at less than six months' notice.

i. Under the new arrangements, the DHA's buying role would be important. Many DHAs would not be competent to perform it with their present management. The Government needed to consider what management standards were desirable and how they could be attained. This aspect too required further work. The setting of standards would probably be a matter for the NHS Management Board and the present weaknesses showed yet again the importance of effective audit arrangements.

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The Prime Minister, summing up the discussion, said that there was considerable common ground. In particular, the group agreed that RAWP should be abolished, and replaced by a simpler capitation-based approach, weighted as appropriate; that hospitals should be given much greater independence and where they had the competence made fully self-governing (the teaching hospitals could provide a useful precedent for such an arrangement); that they should be funded on a contractual basis and according to their success in attracting business; that the accountability of consultants should be strengthened by medical audit and by money following the patient; that hospitals should be given incentives to better performance and should be more responsive to the needs of GPs and their patients; and that effective audit arrangements were crucial.

There were however many matters of great practical importance still to be worked out. The group had discussed the position of consultants and agreed that the broad essentials of the present contracts would remain but a precise statement was needed of the substantial management changes that would be needed to achieve the Government's objectives. Satisfactory audit arrangements had still to be worked out: papers were needed both on medical audit and on an audit commission for the NHS. Another area which the group would need to consider was what the practical arrangements would be for a hospital which wished to become fully independent. It was important to ensure that there was fair play for independent hospitals when it came to funding: there could be a conflict of interests for a DHA which both bought services from hospitals and ran some of them itself. Further work was also needed on the suggestion which had been made at the meeting that the Government needed to decide how to set and enforce - perhaps through the NHS Management Board - the higher standards of management competence that would be required of the DHAs. Treatment of capital under the new arrangements still had to be resolved: joint work on this was in hand by the Department of Health and the Treasury. The group also still wished to consider the case for withdrawing some inessential treatment altogether from the NHS, at least unless it was charged for. The Secretary of State for Health should bring papers before the next meeting of the group listing all the outstanding points and his proposals for resolving them. These and all the papers to be circulated for the next meeting should first be discussed in the official group under Cabinet Office Chairmanship.

Turning to HC 38, the group had agreed that further work was needed to specify in detail how viable options for the buying of elective surgery would operate. One important option which needed to be pursued was that FPCs and DHAs should be merged, and that the buying of elective surgery, like that of hospital treatment generally, should be undertaken by this merged body which should become cash-limited. The group believed that cash limits on GPs' expenditure were right in principle.

The group had ruled out the option of giving budgets for elective surgery to every GP, but saw attractions in allowing GPs to opt out of whatever funding arrangements were decided, provided that opting out was limited to large practices, probably those with at least six GPs. It was for consideration whether budgets for those who opted out might extend beyond elective surgery, so that GPs could vire between different types of treatment. Such an arrangement would be consistent with the dispersal of responsibility to as low a level as was reasonably practicable, which was one of the main themes of the review. GPs who opted out would attract more patients if they were successful. The idea would be to have an experiment to test the possibility, but it was important first to answer the practical questions as to how it would operate which had been raised in the discussion. The Department of Health and the Treasury should consider this with a view to agreeing practical arrangements and the Secretary of State for Health should bring a paper on the subject before the Group's next meeting.

Finally, it was important to make progress with the White Paper, which was in danger of slipping behind the timetable earlier set. The Secretary of State for Health should bring a draft outline of the White Paper before the next meeting of the Group. What was emerging was a White Paper with 'green edges'. But it was important that any experiments should not give an impression of muddle or of the Government not knowing its own mind.

I am sending copies of this letter to the Private Secretaries of the Ministers attending the meeting, and to the others present.

PAUL GRAY

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Department of Health.