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PRIME MINISTER

REVIEW OF THE NATIONAL HEALTH SERVICE
[Papers by the Secretary of State for Health:
HC39 Self-governing hospitals
HC40 GP practice budgets
HC41 Merging FPCs and DHAs
HC42 NHS Audit
HC 43 Outstanding issues
HC44 Outline White Paper]

DECISIONS

1. You may find it helpful to divide the discussion into three parts.

2. First, decisions are needed in two areas which have occupied the group a great deal in recent meetings:

i. independent hospitals. Mr Clarke's paper (HC39) makes proposals for carrying forward this concept;

and ii. opting out by GPs in large practices. Paper HC40 suggests a way of implementing this idea in practice.

In each case you will wish to establish whether the proposals are workable in practice, and whether they will achieve what is wanted. The Chancellor may be sceptical about opting out by GP practices.

3. Second, there is Mr Clarke's paper on merging Family Practitioner Committees and District Health Authorities (HC41). There are two separate but related issues:

iii. whether FPCs and DHAs should be merged. The Chancellor is likely to argue that they should. Mr Clarke disagrees. He proposes instead that FPCs should be retained and

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strengthened, with their composition being changed to reduce the influence of the professions and the Regional Health Authorities (RHAs) acting as 'agents of change';

iv. if FPCs and DHAs are to be merged, whether the combined body should be cash limited. The Chancellor will argue that it should; Mr Clarke will be strongly opposed. He would prefer instead to try to concentrate on controlling the numbers of GPs and drug bills, and to try to move to capitation-based fees for GPs.

4. The answer on these issues may depend to some extent on how many hospitals and large GP practices you think will opt out of DHAs and FPCs and become independent, with their own (cash-limited) budgets, and how quickly. If 'opting out' happens on a large scale, cash-limiting the remainder might be something which could be introduced as a natural corollary in due course. You may wish to explore with Mr Clarke how big a change he expects opting out by hospitals and GPs to be: does he anticipate it being just at the margin, or a major, radical reform of the NHS?

5. Third, after touching briefly on the paper on NHS audit (HC 42), you may wish to concentrate on how the work of the Review should be carried forward. There are two main aspects.

v. outstanding issues. Mr Clarke's paper (HC43) summarises some important points which the Group still needs to look at. It is not exhaustive;

vi. outline of the White Paper. Mr Clarke's outline (HC44) provides an opportunity to consider what the main messages emerging from the White Paper should be and what sort of style and tone it should have.

In concluding this part of the discussion you may wish to ask Mr Clarke to prepare further papers on the main outstanding issues for discussion in a meeting towards the end of this month. You

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may also wish to consider making the next meeting a fairly lengthy one, to give the group a chance to make progress and clear the way for drafting the White Paper.

ISSUES

Independent Hospitals (HC39)

6. Improving the present system. Mr Clarke's paper begins by placing emphasis on developing hospitals within the present system. He proposes that all hospitals should be given greater managerial responsibility with funding which 'follows' (which presumably means 'rewards') performance to agreed standards. He places particular emphasis on the Resource Management Initiative, greater flexibility over manpower and capital, and a 'contractual style of management'. There is however an important difference between greater managerial devolution within a system of strong central control, and giving hospitals genuine independence and responsibility for running their own affairs. You may wish to ask him how important he considers the aim of independence for hospitals to be, and over what timescale, compared with streamlining the present system. Is independence a long way down the road for most hospitals, or is it a major policy objective which the Government wishes to drive through?

7. Self-governing hospitals. The paper proposes legislative changes which would enable hospitals to become separate legal entities, holding their own contracts and employing their own staff. Their funding would depend on what contracts they had won from DHAs, GPs and the private sector, and they would be accountable for the quantity and quality of their service under those contracts. On the management of their assets they would be acountable to Regional Health Authorities. The decision on whether a hospital should be able to opt out would be a matter for the Secretary of State. You may wish to explore:

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i. how independent self-governing hospitals would be. The paper indicates a number of qualifications which taken together might add up to a considerable constraint. Thus, Regional Health Authorities would retain oversight of professional training and future needs for skilled manpower (paragraph 18 of Annex); the Department of Health would establish a national pay bargaining system (paragraph 17 of Annex); the Secretary of State would retain ownership of all major assets so as to "secure flexibility in their longer-term distribution" (paragraph 14 of Annex); and it is not clear whether self-governing hospitals would hold consultants' contracts (paragraph 16 of Annex).

ii. whether independence would be a sufficiently attractive proposition for a management team. It is esssential that independence should be an attractive challenge to the right sort of managers. There is no reference in the paper to the opportunity which the Chief Secretary's proposal for 'top-slicing' money for waiting-lists would give, for instance. There is no reference to the possibility of greater freedom on capital investment (perhaps because of disagreement with the Treasury). And there is no discussion of the possibility of some sort of performance-related incentives for managers, consultants and staff.

iii. statutory status. The paper proposes that self-governing hospitals should be a new form of statutory body. You may want to explore the implications of this. For instance, it is not clear whether a self-governing hospital would have to keep its own financial accounts. Presumably it would. If so, and if it ran at a loss, a private sector body might wish to bid to take it over. Would its statutory status inhibit this?

GP Practice Budgets (HC40)

8. Mr Clarke's paper proposes that GPs in large practices (effectively six or more doctors) should be able to opt to have a budget of their own to finance out-patient referrals and a defined

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range of elective treatment, together with that proportion of FPS spending which is cash-limited (principally improvements to premises, and the cost of practice team staff). You may wish to explore:

i. the scope of the proposed budget. The paper proposes that budgets should not cover the cost of drugs even though this is a substantial area of public expenditure which GPs control directly (the average drug budget per GP practice is £170,000): is this right? And Sir Roy Griffiths has suggested that budgets should cover such areas of hospital expenditure as accident and emergency: how would this work?

ii. the budgetary discipline. One major aim would be to give GPs an incentive to be more cost-conscious. But on outpatient referrals (which GPs can control) there would be "annual fee" contracts giving unconstrained access for all patients referred to the hospital whereas for elective treatment (which is actually controlled by the consultant rather than the GP) the GP would be charged on the basis of the work done. You may wish to discuss how far it would be practicable to give GPs financial responsibility for the things which they can actually control (eg drugs, outpatient referrals);

iii. how the system would work in practice. Previous papers have envisaged giving GPs a choice between independent hospitals, DHA hospitals and private hospitals, when referring their patients to a consultant. The implication of this latest paper is that they would contract to refer all their patients to one hospital initially, and make the choice between different hospitals only when a need for subsequent treatment arose. You may wish to explore whether this is realistic. Consultants may for instance be reluctant to accept a diagnosis made by another consultant in another hospital;

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iv. information technology. Earlier on in the Review there was agreement that GPs should be given regular information about hospital places around the country, so that they could see whether they could shorten their patients' waiting times. You may wish to check where this has got to.

Merging FPCs and DHAs (HC41)

9. This paper continues the debate which was begun at the last meeting on whether FPCs and DHAs should be merged and, if so, whether they should be cash-limited. The Chancellor and Chief Secretary are likely to argue for this, on the grounds that it is likely to be the quickest route to constraining a sizeable area of public expenditure which at present is uncontrolled. Mr Clarke's main arguments against a merger are that:

i. it would be the fourth administrative upheaval in a decade;

ii. a merger could be portrayed as the Government not knowing its own mind, given that it was responsible for separating off FPCs in 1985;

iii. a merger would blur the distinction between buyers and providers, and would subject primary care to the interests of the hospital service.

10. These arguments, particularly about an administrative upheaval, have to be taken seriously. At the same time, the group has agreed in principle at the last meeting that the case for moving towards cash-limiting of all GP expenditure is strong. Mr Clarke argues in his paper however that there should be no move to cash-limiting "unless and until we have sufficient, sensible controls in place within the FPS themselves". He proposes:

i. setting a ceiling on the number of practitioners;

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ii. considering further what practical steps can be taken to extend capitation-based remuneration for GPs;

iii. considering further what practical steps can be taken to control expenditure on prescribed medicine.

You will wish to consider whether Mr Clarke's arguments against a merger between DHAs and FPCs should prevail, and if so whether his proposals for controls on the FPS are strong enough. A certain amount may depend on whether opting out by GP practices is going to lead to GPs volunteering to have cash-limited budgets on a large scale. To the extent that they do, the problem of cash-limiting the FPS should diminish. But unless there is a realistic prospect of this happening, the Chancellor is likely to press his case for a merger and cash-limiting.

NHS Audit (HC 42)

10. This paper is the outcome of a lot of discussion between the Department of Health and the Treasury. Its main recommendation is that, subject to Mr Ridley's agreement, the Audit Commission should take over the external audit of health authorities and FPCs. You may wish to ask whether the Treasury are satisfied that the Audit Commission could take on this task without over-extending themselves or diminishing their effect on local authorities (Mr Howard Davies has already said he is satisfied on this point). Subject to this, you may not wish to spend long on this item.

Outstanding Issues (HC 43)

11. Mr Clarke's paper describes the current state of play on further work commissioned by the group on 8 July and subsequent meetings.

i. Consultants' contracts. At its last meeting the group asked for more detail on exactly how present management practices would be varied so as to achieve these changes. You suggested that it was unrealistic to try to terminate

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contracts at less than six months' notice. There is also the question of appointing a number of consultants on short-term contracts to help deal with waiting lists. You may wish to consider whether you want a progress report for the next meeting.

ii. Charging for inessential treatment (eg aesthetic cosmetic surgery). Mr Clarke proposes not to pursue this issue. You will wish to consider whether you are content to drop it.

iii. Restrictive practices. It is not clear from paragraph 7 what Mr Clarke is proposing. You may wish to ask him what action he has in mind.

iv. Competitive tendering. Mr Clarke proposes 'fostering and evaluating' local initiatives on competitive tendering, in particular for pathology and radiology. You may wish to ask that the White Paper commitment should be clear.

v. Medical Audit. Mr Clarke's description of this key area in paragraph 13 is rather brief. You may wish to ask for a paper.

On the other items mentioned - the package to improv e the treatment of patients, the role of the NHS Management Board, Information Technology and the RMI - you may wish simply to note that work is in hand.

12. There are other important areas, not covered in the paper, which the group may also wish to consider. In particular:

NB The DoH paper HC45 is not agreed by the Treasury

i. the treatment of capital, where the Treasury and the Department are locked in disagreement;

ii. the role of Regional Health Authorities where Mr Clarke accepts that they should be "slimmed down" but his papers envisage their having a continuing role in a number of areas (eg preparing hospitals for independence, overseeing future

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needs for skilled manpower and tgraining, becoming agents for change for Family Practitioner Committees and continuing to hold consultants' contracts);

iii. reconstituting District Health Authorities to make them less political;

and iv. community care. There is an important link between the NHS Review and decision on the Griffiths Report on Community Care. This will need to be resolved before the White Paper is finalised.

but the first priority is to be clear about the NHS priorities - then see how community care might fit in. PRCG

Outline White Paper (HC 44)

13. At this stage there are perhaps two main issues which you may wish to concentrate on:

i. the style and content of the White Paper. Mr Clarke sets out a choice between a fairly detailed exposition of Government thinking and a briefer document setting out themes and conclusions. He favours the latter, on balance;

ii. what the main themes should be. Mr Clarke proposes to focus on the Government's concern first and foremost with the health care needs of patients. Another possible theme is the need for greater efficiency in the use of the massive resources devoted to the NHS - which again is very much in the interests of patients.

Next Meeting

14. No further meetings of the group have yet been fixed. Given the amount of further work which needs to be done, you may wish to invite Mr Clarke to put forward furthe papers in the light of the discussion for a meeting towards the end of this month. You may also wish to consider making it a half-day meeting, as in July, to try and make a lot more progress.

RTJW.

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Cabinet Office 3 October 1988