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From the Private Secretary

9 November 1988

Dear Andy,

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister yesterday held the fourteenth meeting of the group reviewing the National Health Service. The meeting considered papers HC50, 49, 52 and 51, circulated by the Secretary of State for Health.

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 Health, the Secretary of State for Scotland, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. Whitehead (No. 10 Policy Unit).

Medical audit

In discussion of the paper on medical audit (HC50) the following were the main points made:

a. The paper proposed that peer review findings in hospitals would normally be confidential to the consultants involved, unless they agreed otherwise. It was argued that this proposal reflected the very specialised nature of medical audit. Efficiency, and value for money, which were of special interest to management, would be the concern of the Audit Commission and the new advisory service suggested in HC53. It also had to be recognised that medical audit was still only at the development stage. It was essential to obtain the co-operation of the professions in its systematic application, and they would not give this co-operation if they thought that management would participate, and use it for its own purposes. On the other hand, it was argued that the alternative was not for management to participate directly in purely medical audit but for it to have access to the general results of audits. Unless this happened, it was unlikely that the audit process would be effective.

Professionals left to themselves would not be sufficiently rigorous in correcting any defects which it revealed.

b. There was also a question whether the results of medical audit should be published. It was argued that already, much information was published to show how well hospitals did against specified performance indicators. This was in practice sufficient to allow a judgement to be made about their efficiency. To go further and require the publication of the outcome of medical audit would jeopardise the co-operation of the profession in its introduction. On the other hand, it was argued that the fullest possible information for patients was essential to the working of the new system. There could of course be no question of publishing the outcome of audit in individual cases. But publication of information about the medical record of individual hospitals or units would help patients to form a better judgement about their relative merits, and would be only an extension of what happened already.

c. As the paper recognised, there was a considerable overlap between medical audit and management audit. It would be wrong if the establishment of a system of medical audit were to strengthen the hand of the profession in trying to exclude management from studies which covered both medical and management issues. The suggestion in the paper that medical audit could cover the use of resources demonstrated the management interest in medical audit. One way of dealing with the overlap would be to establish a mixed procedure, combining medical audit and audit by the Audit Commission, where both medical and management issues were involved.

d. The proposals for medical audit of GPs seemed less developed than those for hospitals. The application of medical audit to GPs required special care, since the technique was still being developed and since GPs could plausibly claim that it would involve them in extra costs. It would be wrong therefore to try to go too fast. But there was little doubt that some GPs had slipped into slack ways which a proper system of medical audit could correct. One way of strengthening the system once it had been developed would be to put a term into GPs' contracts requiring them to participate in medical audit.

e. The proposals in the paper for the private sector did not go far enough in ensuring that it had adequate medical standards. Unless potential patients were confident that it had such standards, its growth would be very slow. The possibility of more direct Government action to enforce standards, in the way that it did for independent schools, had

to be considered.

f. The group had already discussed the treatment of consultants. Its general view had been that existing contracts should be better managed. But it had not yet discussed in detail how this better management should be achieved. This needed to be pursued.

The Prime Minister, summing up this part of the discussion, said that the group accepted the recommendations in HC50, subject to a number of important points. First, the general results of medical audit must be available to management: this was essential. Second, information about the medical records of individual hospitals or units must be published. Third, there must be provision for the possibility of a joint enquiry combining medical and management audit in cases where both types of issue were involved. Fourth, a term should be inserted into GPs' contracts requiring them to participate in medical audit once a satisfactory system had been developed. Fifth, the possibility of Government action to ensure that the private sector had adequate medical standards should be further considered. Finally, the group attached importance to there being clear plans on how the better management of consultants' contracts was to be achieved: outstanding issues would need to be resolved.

Funding

The main points made in discussion of the paper on funding issues (HC49) were:

a. The paper appeared to be inconsistent with the conclusions so far reached by the group on funding, on the lines set out in HC35. It had already been agreed that RAWP should be abolished, and replaced by a capitation-based system weighted for factors such as demography and morbidity. A capitation-based system would be simpler to operate and understand, and would be more acceptable to many than RAWP. Most fundamentally, it was necessary for the introduction of self-governing hospitals and GPs practice budgets, two of the most important elements in the package agreed by the group. It must of course be recognised that it was not practical to move at once to a capitation basis and that there would need to be a transitional phase in which there would need to be limits on the extent of the movement in each year (just as there were transitional arrangements for 'gainers' and 'losers' under the Community charge). But a capitation basis must be clearly set as the objective.

b. By contrast, the paper appeared to propose intensification of RAWP at the regional level, by payment of a special sum in 1990-91 to those regions which were significantly below their RAWP

targets. At the district level, the proposal was apparently that RAWP-type redistribution would continue for some time. The paper gave the impression that a capitation-based approach was not practicable (for instance, in paragraphs 10 and 14) and that the status quo would broadly be maintained.

c. More emphasis should be put on performance funding, as a way of making the system more responsive to the needs of the patient and raising efficiency. There could even be a case, if a substantial measure of performance funding were to be introduced, for allowing RAWP to continue until its effects were worked out. The remaining redistribution to be achieved according to RAWP criteria was relatively limited. It might be possible to establish a capitation-based system which produced results very close in practice to those which would follow from RAWP. If such a system were to be introduced, one valuable improvement over the present system, which could be introduced relatively easily, would be to relate allocations to prospective rather than historical population.

d. On the other hand, it was argued that the paper did propose the abolition of RAWP at the regional level, and also ending the use of sub-regional RAWP targets for allocation at the district level. But a pure capitation-based method of funding for the NHS was not practical politics. People did not use NHS services on a per-head basis. Any reversal of the redistribution achieved by RAWP over the last ten years would arouse a storm to protest.

e. Any further work on the subject should take into account the absence of effective management and management techniques in the NHS. Because hospitals did not have proper balance sheets or revenue accounts there was not at present sufficient information to take proper decisions on the allocation of resources. And the quality of financial management was generally very low. Unless these defects were corrected, the other changes being discussed would be of no effect.

The Prime Minister, summing up this part of the discussion, said that the group were concerned that the recommendations in HC49 were unclear and appeared to be inconsistent with the conclusions it had earlier reached. In particular, it appeared to reject a capitation-based method of funding and to continue with RAWP-type redistribution. It was also for consideration whether more emphasis could be put on performance funding in establishing the new arrangements. The Chief Secretary, Treasury, and the Secretary of State for Health should now reconsider funding in the light of the discussion and sort out a paper on the subject for the next meeting of the group.

Reconstituting health authorities

The group then discussed the paper on reconstituting health authorities (HC52). The following were the main points made:

a. The proposals in the paper, although necessary for the efficient functioning of the authorities within the reformed NHS, would be perhaps the most controversial part of the Government's package. The proposal to exclude local authority representatives from the boards of the district health authorities (DHAs) would be especially controversial, even with the Government's own supporters.

b. Regional Health Authorities (RHAs) were now required by statute to consult a variety of bodies before appointing members of DHAs, including local authorities and trade unions. Legislation would of course be necessary in any event, and it would be possible to remove this requirement to consult. There was indeed a strong argument for doing so, on the ground that it would complete the depoliticisation of the DHAs. On the other hand, the proposal to exclude local authorities from membership was likely to prove so controversial that it must be very doubtful whether Parliament would accept also removing from them the right of consultation.

c. The proposal was that the RHAs would continue to appoint members of the DHAs other than the Chairman. It certainly seemed impractical for this power of appointment to be transferred to the Secretary of State when some 1,000 DHA members were involved. But in principle it would be possible for the RHAs to appoint unsuitable members of DHAs. The fact that the RHAs were themselves appointed by the Secretary of State should provide a safeguard against this, but there was much to be said for establishing guidelines for the exercise of the RHA power of appointment.

d. The paper proposed that the National Health Service Management Board should be under Ministerial not independent Chairmanship. This was largely on the ground that it was not realistic to suppose that the NHS could be divorced from politics, or that Ministers would not be held responsible for its actions. On the other hand, Ministerial Chairmanship might appear to be inconsistent with the Government's emphasis on the importance of introducing better management into the Service. It would in practice lead to interference with management for political reasons.

The Prime Minister, summing up this part of the

meeting, said that the group broadly endorsed the conclusions in HC52. They believed however that further thought should be given to the case for setting guidelines for RHAs for the exercise of their power to appoint members of DHAs. They had some doubts about the continuation of Ministerial Chairmanship of the NHS Management Board, but had not decided to reject it.

Family Practitioner Services

In a first discussion of the paper on managing the Family Practitioner Services (HC51) the following were the main points made.

a. It was argued that the Family Practitioner Committees (FPCs) should be merged with the DHAs, as they were in Scotland and Northern Ireland. This would avoid the creation of another bureaucracy as FPCs were strengthened to manage GPs' contracts; would make for closer integration between the family practitioner services and the hospitals; and would allow for cash limiting these services. On the other hand it was argued that the merged bodies would be dominated by the hospitals side and so would be less effective than separate FPCs in the crucial task of achieving better management of GPs' contracts; that cash limiting required effective control of the main items of expenditure for which GPs were responsible, and could not be produced simply by organisational change; and that the merged bodies would be subject to conflicts of interest, since they would be responsible both for GPs and for hospitals which did not become self-governing.

b. The route described by the paper for controlling GP numbers was not the right one. The tendency for these numbers to increase was a result of the present system of remuneration under which the capitation fee accounted for less than half a GP's income. The right solution was to increase this proportion, so that GPs' incomes were more closely related to the number of patients on their lists. This would put effective downward pressure on GP numbers. On the other hand, such an approach, attractive though it might be in principle, would mean a radical change in policy, as most recently expressed in the Primary Care White Paper.

c. The proposal for setting GP practice budgets did not appear to take account of the fact that some GPs would have patients on their lists who were covered by private insurance and would not therefore involve as much expenditure as those covered by the NHS.

The Prime Minister, summing up this part of the discussion, said that the group believed that the possibility of merging FPCs and DHAs should be mentioned as

an option in the White Paper: it would be a 'green' element in the Government's proposals. They had agreed that more thought needed to be given to the present structure of GPs' remuneration and the possibility of changing it so as to encourage a reduction in numbers. The Secretary of State for Health should set this in hand. Otherwise, discussion of this paper would have to be resumed at the next meeting of the group, in about a fortnight's time. That meeting would also discuss the other papers listed in the Department of Health letter of 3 November, and the new paper on funding which the group had commissioned at this meeting from the Chief Secretary, Treasury, and the Secretary of State for Health.

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

Yours,
Paul

Paul Gray

Andy McKeon, Esq.,
Department of Health.