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HC57

REVIEW OF THE NATIONAL HEALTH SERVICE

DECISIONS SO FAR

Note by the Cabinet Office

1. The Group may find it helpful to have a summary of the policy decisions which it has taken so far. What follows is based closely on the minutes of the Group's discussions and on papers which it has endorsed. It is not intended to anticipate the drafting of the White Paper.

GENERAL APPROACH

2. The Government is firmly committed to ensuring that a high standard of medical care is always available to all, regardless of income. It is also determined to modernise and improve the NHS where it is weak (analysis in HC32).

3. The Government therefore proposes to introduce a programme of reforms designed to produce a better NHS and greater choice for patients. The main features are as follows:

i. new funding arrangements are to replace RAWP;

ii. hospitals are to be given greater responsibility for running their own affairs, with early progress towards full self-governing status for those major acute hospitals which are ready for it;

iii. consultants are to take more responsibility under their existing contracts for the management and delivery of hospital services;

iv. a system of medical audit is to be in place in every District and self-governing hospital within two years;

v. District Health Authorities (DHAs) are to be reconstituted and will concentrate increasingly on buying health care for their resident population;

vi. Family Practitioner Committees (FPCs) are to be strengthened and given a more effective role in securing cost-effectiveness in general medical practice (but the option of merging them with DHAs is to be retained as a 'green' element in the White Paper);

vii. large GP practices are to be given the option of holding their own budgets for defined categories of expenditure;

viii. Regional Health Authorities (RHAs) are to be reconstituted and slimmed down, with responsibility for overseeing implementation of these reforms;

ix. the external audit of RHAs, DHAs and FPCs is to be transferred to the Audit Commission;

x. the NHS Management Board is to continue as a focus of strategic and policy issues, with day-to-day operational issues being handled by an executive committee and the Health Services Supervisory Board being abolished;

xi. there is to be a greater role and encouragement for the private sector;

xii. there is to be a package of measures to improve the service given to patients.

NEW FUNDING ARRANGEMENTS

4. RAWP will be abolished and replaced by a simpler capitation-based approach, weighted as appropriate. After a suitable transitional period, Districts will receive funding related mainly to population, but with an allowance for extra costs, such as the number of elderly people. The complicated adjustment under the present system for funding cross-boundary flows will be phased out so that these flows will be funded directly and at the time. This arrangement, while simpler, will preserve financial control since the funding received by Districts will be cash-limited.

5. Hospitals will be funded increasingly on a contractual basis and according to their success in attracting business. The main types of contract will include:

i. core funding. These contracts will cover essential local services which cannot be provided elsewhere such as accident and emergency treatment. Payments to hospitals will flow steadily through the year, regardless of variations in throughput within the year, but DHAs will lay down tight performance specifications;

ii. contract funding. These contracts will cover services which can be obtained further afield if need be, and at a chosen time, such as elective surgery. DHAs, and GP practices with their own budgets, will place contracts with hospitals for a set level of provision at an agreed unit price. Payment will flow according to the patients treated.

[NOTE: there will be further discussion of Funding on 23 November.]

MANAGEMENT OF HOSPITALS

6. All major acute hospitals, of which there are 260, will have greater responsibility for running their own affairs. There is to be greater devolution of managerial responsibility, stronger hospital management and funding based on performance, with the money following the patient for elective surgery. The aim for all

these hospitals is to have them working as independently as possible within overall District control unless and until they become self-governing.

Self-governing status.

7. The option of applying for self-governing status will be available to, and will be offered to, all 260 major acute hospitals. It will be possible for an application to be initiated by a variety of interests including the Government, the Regional or District Health Authority, the hospital's own management or staff, and local community interests. The procedure for applying will not be elaborate and will avoid any consultation process which might give a veto to those who are opposed to the policy. The decision will be a matter for the Secretary of State who will need to be satisfied as to the hospital's financial, professional and management competence: only those hospitals which are capable of exercising full, devolved responsibility will be ready for self-government.

Powers of self-governing hospitals.

8. Hospitals which achieve self-governing status will be able to do for themselves all the things which would previously have been done for them by their District Health Authority (DHA), including:

i. hiring and firing staff;

ii. entering into direct contracts for the provision of services with Districts, Regions, large GP practices with their own budgets, private individuals and insurance companies;

iii. buying in services and supplies, and sub-contracting as they wish the services which they provide; and

iv. receiving capital grants from Regions.

In addition, self-governing hospitals will have some powers which DHAs do not have, including:

v. settling the pay and conditions of their staff;

vi. employing consultants and holding their contracts;

vii. employing whatever staff they judge necessary, without manpower controls; and

[viii. raising capital.]

[NOTE: i. HC 56 on The Management of Capital will be on the table at the next meeting on 23 November.

ii. A joint paper on Pay Issues is in preparation for a later meeting.]

Constitution of Self-governing Hospitals.

9. Where a hospital is to become self-governing, the Secretary of State will appoint a "shadow" chairman to prepare the way. The Regional Health Authority will be responsible for managing the transition. The boards of self-governing hospitals will be small: six non-executive members, one of them the chairman, chosen [by the Secretary of State] for their ability to keep a critical watch on how things are going, plus five executive members, including the chief executive and the finance director, chosen by the non-executive members. The aim will be to create non-political bodies which can get on with the job of managing the hospitals efficiently within a clear financial framework and proper arrangements for medical audit, free from bureaucratic or other needless interference. The hospitals will own their own assets [and will be able to dispose of them without outside approval].

Timetable

10. The Government will wish to make early progress with the introduction of self-governing hospitals (five or six by 1991 would be slow). There is to be a centrally driven programme to ensure a steady stream of candidates for self-governing status. The intention is to make as much progress as possible within existing legal powers and to introduce legislation in the 1989-90 Session of Parliament to develop and refine those powers as necessary.

CONSULTANTS AND OTHER PROFESSIONALS

11. Consultants are to be required to take more responsibility for the management and delivery of hospital services and for the quality and cost-effectiveness of what they do. This will require substantial changes which will be secured partly through better management of consultants' existing contracts and partly through medical audit. The new funding arrangements with money following the patient will be an important incentive to hospitals to manage consultants better.

[NOTE: i. The Secretary of State for Health is considering further the detailed application of the Group's decisions on managing Consultants' Contracts and reforming distinction awards.

ii. HC49 (paragraphs 38 and 39) on Funding set out a proposal, not yet considered, for establishing a target of an additional 120 consultant posts on a permanent basis over two years in acute specialties.

iii. A paper on Professional and Employment Practices is to be considered at the meeting on 23 November.]

MEDICAL AUDIT

12. A system of medical audit will be put in place, within the next two years, in every District and self-governing hospital, based on self-audit and peer review. Every consultant will be expected to take part. District managers will be responsible for ensuring that the system is in place and that the work of each consultant's team is reviewed at regular, frequent intervals. The

system will be medically led but the general results will be available to managers. Managers will also be able to initiate an independent professional audit, and there will be provision for the possibility of a joint enquiry combining medical and management skills in cases where both types of issue are involved. Information about the medical record of individual hospitals or units will be published.

13. As to medical audit of general medical practice, a term will be inserted into GPs' contracts requiring them to participate in medical audit once a satisfactory system has been developed.

[14. The Government will take action to ensure that the private sector has adequate medical standards.]

DISTRICT HEALTH AUTHORITIES

15. As decision-taking is devolved to hospitals, the role of DHAs will increasingly be to purchase health care for their resident population, as well as to run the remaining services for which they remain responsible, including hospitals for the priority care groups. Districts will continue to be accountable to RHAs and Ministers for the quality and cost-effectiveness of the services which they purchase for their residents.

16. DHAs will be reconstituted to make them more effective as executive bodies, without political representation. Their membership, at present 16 to 19, will be reduced to six non-executives including the chairman and five non-executives. Local authorities would no longer be able to appoint members. DHAs would continue to meet in public, with private sessions where necessary.

FAMILY PRACTITIONER COMMITTEES

17. FPCs will be strengthened and will be given a much bigger and more important role than hitherto. They will continue to be responsible for holding contracts with GPs, including those whose practices have their own budgets, but will have clearer responsibilities and stronger powers to manage those contracts, monitor performance and call to account those practices which are inefficient. There will be improved arrangements to supply FPCs and GPs with information about prescribing costs and referral costs to enable FPCs to have effective control. The non-executive membership of FPCs will be strengthened, [and the professional representation will be reduced to a clear minority]. The non-professional members will be of sufficient calibre and independence to stand up to professional interests when necessary and to take a tough line with inefficient GP practices. The possibility of merging FPCs and DHAs is an option for the future which has not been ruled out.

[NOTE: there is to be further discussion of HC51 on Managing the Family Practitioner Service on 23 November.]

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BUDGETS FOR LARGE GP PRACTICES

18. Large GP practices, with typically six or more doctors and list sizes of at least 11,000 patients, will be able to opt to hold their own budgets. These will cover:

i. outpatient services including associated diagnostic and treatment costs;

ii. a defined group of acute elective inpatient and day-case treatments;

iii. diagnostic tests undertaken by hospitals at the direct requests of GPs;

iv. improvements to practice premises and the costs of employing practice team staff;

[v. expenditure on drugs;]

[vi. experiments on the inclusion of expenditure on accidents and emergencies.]

There will be arrangements which will allow GP practices with budgets to carry forward overspends, but will also encourage underspends.

[NOTE: The possibility of giving large GP practices the option of having a drug budget too is discussed in paragraph 15 of HC51 which is to be taken on 23 November.]

REGIONAL HEALTH AUTHORITIES

19. RHAs will be reconstituted to comprise ~~six~~ non-executive members, including a non-executive chairman, and five executive members. The chairman and members will continue to be apointed by the Secretary of State. The functions of RHAs, other than their "head office" functions, will be scrutinised to produce blocks of work which can be streamlined, delegated to districts or contracted out, with a view to producing a net reduction in their staffing and costs. The slimmed down RHAs will be the main vehicle for ensuring that Ministerial policy is being carried out on the ground, and for managing the changes in the White Paper.

20. RHAs will continue to appoint the members of DHAs, although the chairmen will be appointed by the Secretary of State. [The Secretary of State will set guidelines for RHAs about the exercise of their power to appoint members of DHAs.]

EXTERNAL AUDIT

21. The Government wishes there to be a body responsible for the audit of the NHS which is independent of the Department of Health and the NHS, and whose reports will be published. The external audit of health authorities and FPCs will therefore be transferred to the Audit Commission. There will be no change in the role of the National Audit Office.

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NHS MANAGEMENT BOARD

22. The NHS Management Board will be streamlined. It will in future be responsible for the family practitioner services. It will deal with strategic and policy issues, as well as the more critical operational matters. Its size will be reduced and it will be reconstituted to bring in a higher proportion of non-executive directors from outside. Much of the day-to-day work will be handled by an executive committee of the Board chaired by the chief executive. The Health Services Supervisory Board will be abolished.

GREATER ROLE FOR THE PRIVATE SECTOR

23. The private sector is an integral part of the nation's health care. A strong private sector is good for the NHS, and vice versa, as a source of both competition and co-operation. The Government welcomes the joint ventures which have begun to take place. It will encourage the growth of the private sector by:

[i. more joint ventures;]

ii. fostering local initiatives to extend competitive tendering to clinical as well as to non-clinical work;

iii. asking all NHS hosptials to review the scope for selling spare capacity to the private sector;

iv. encouraging more pay beds in NHS hospitals, particularly the introduction of new private wings (eg in accommodation which becomes surplus following rationalisation).

[NOTE: HC54 on The Public and Private Sectors will be on the table at the meeting on 23 November.]

A BETTER SERVICE TO PATIENTS

24. The Government's proposals for increased performance will mean that patients will benefit from a more responsive NHS and a thriving mixed economy in health provision. But there will also be more specific benefits.

[NOTE: HC53, making proposals about a Better Service to Patients, will be on the table on 23 November.]

CABINET OFFICE
17 November 1988.

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FUNDING THE HOSPITAL SERVICE

Note by the Chief Secretary to the Treasury and the Secretary of State for Health

This paper considers the mechanisms by which:

a. the Department of Health allocates funds to regional health authorities

b. regions allocate funds to district health authorities, and

c. districts fund hospitals, including both self-governing hospitals and those managed by the districts.

Introduction

2. As a Group we are agreed that RAWP, the present system for allocating funds to regions, should be ended and replaced by a simpler system along the lines of the model set out in paper HC35. Regions would be funded by the Department on the basis of "weighted capitation" (total population adjusted for age structure and morbidity). Regions would fund districts broadly on the same basis, and districts would introduce performance-related incentives into the funding of hospitals.

3. We are also agreed that health authorities should continue to be responsible for providing those "core" services which have to be available locally: casualty, urgent medical treatment, paediatric services, maternity and ante-natal care, some types of long stay care, and so on. They would have to be funded to enable them to do this. They would also have to enter into contracts to secure other types of service, mainly elective surgery, on behalf of their local populations.

4. This new system will introduce new incentives to improve efficiency. Health authorities will secure health care from the hospitals they consider best able to provide it, while hospitals will be able to compete for business from health authorities other than their local one. Under the present system, by contrast, money is allocated according to where the hospitals are. The RAWP process has been seeking over several years to equalise the spread of hospitals across the country, with considerable upheaval and protest in consequence.

5. When fully operational, this system will make redundant the present role of regions in allocating funds to districts and the adjustments on account of cross-boundary flows. But both will have to be retained during the transitional period. So it is important to keep in mind the distinction between regions and districts in moving to the new system. The problems are quite different at the two levels. We look first at the regions.

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The regional transition

6. Until such time as we can do away with the role of regions in allocating resources, the aim should be to fund regions year-by-year, replacing RAWP with a simpler system. Allocations would be based on regional populations, weighted according to age structure and demographic mix, with some adjustment for, eg, London weighting pay costs. The overall health of the region's population would also figure, although the precise method would have to be considered further. Mortality rates are used as a proxy in RAWP, but this is not wholly satisfactory, since today's mortality tends to represent yesterday's, rather than today's, ill-health.

7. It will be essential to remove the present arrangements for dealing with cross-boundary flows by complicated and obscure modifications to population weightings. Instead there would be explicit cash adjustments based on the most recent data for numbers and up-to-date costings of different types of treatment. Moreover, these adjustments would, unlike the present system, be made to allocations, ie the money paid to the regions, and not to the artificial targets. In this way, cross-boundary adjustments would become much fairer and much more transparent.

8. Getting to the new distribution of resources will be a problem. The existing pattern of allocations is unlikely to match it very well. Just how great will be the mismatch can best be judged from the existing RAWP targets, which are the best indication we have of the shift in resources that would be implied by an immediate switch to a weighted capitation system. This is

discussed further in Annex A, which shows that while most regions are now fairly close to target, quite sizeable transitions are still implied for three - NE Thames, NW Thames and East Anglia.

9. There are three broad options for managing the transition:

a. move to a weighted capitation system as soon as possible, with some transitional buying out if need be

b. an immediate move to weighted capitation for the 11 regions within 3% of RAWP targets, phasing in the system for the other three

c. bring all regions to a weighted capitation distribution, perhaps over a period of, say, three years, with those above target losing resources to those now below target.

10. The "levelling up" implied by the first of these options would be very expensive indeed: full levelling-up would cost over £750m a year, while anything less would mean that significant disparities would remain. Nor do we think it would be acceptable to treat a minority of regions differently from the rest, as the second option would imply: this will create confusion, and would if anything prolong rather than remove the problems created by RAWP targets.

11. So in our view the best course would be a phased adjustment. This could be achieved over 3 years from 1989, although some residual transitional protection might be needed for NE Thames.

Those regions who lost money would not however be obliged to respond with unplanned hospital closures: their hospitals will, under the new system of "contractual" funding, be able to compete to attract patients from outside the region.

12. To sum up, therefore, we recommend moving to the new weighted capitation system, with no "targets" different from the cash allocations. This would be over a period of 3 years with cash adjustments for cross-boundary flows. After the transitional period, allocations would be set year-by-year based on the new, simplified formula.

The transition for districts

13. At present districts are funded by regions, but on varying bases. Some use formulae akin to RAWP, but most fund their districts according to the pattern of hospitals. Under the new system, we would propose, as with regions, to move to weighted capitation allocations and to make cross-boundary flow adjustments explicit and transparent.

14. But there are significant complications to the district-level transition:

- the change will have to run alingside the move to a contractual basis of funding. It will take time to develop a system for districts to enter into contracts with hospitals which make sense in terms of financial management without unacceptably limiting the ability of GPs to refer their patients to where they can be treated quickest or most cost-effectively;

- variations in provision between districts are much larger than between regions, and it would be placing an unrealistic weight on cross-boundary adjustments to expect them to pick up all differences between population and provision;

- any shift in resources away from inner city areas with historically high hospital use to suburban and rural areas would have to take account of differences in primary care standards, and be managed carefully over time; and

- the capital charging system proposed in HC56 will have differing impact on districts, according to the state of the capital stock they inherit, and will have to be phased in carefully.

15. For these reasons, the transition to weighted capitation at district level is likely to take longer than that at regional level.

16. A start cannot be made without improved information at district level about population, movement of patients and costs of different types of treatment. Once that is available, and it should come naturally from the improved information systems we are proposing more generally, cross-boundary flows could be dealt with by a rather similar process as for regions.

- Explicit cash adjustments would be made to allocations in anticipation of cross-boundary flows based on the previous year's experience. Until we have legislation allowing inter-district charging, allocations to districts would be net of such adjustments.

- Districts would then physically pay the adjustments to each other, once the necessary legislation was in place, the amounts determined by a formula set at regional level.

- Finally, regions would stand back entirely from the process of cross-boundary adjustment between districts. The adjustments would simply follow as a result of contracts agreed between districts.

17. To sum up, the transition at district level will take longer than at regional level. But the general principles - the objective of weighted capitation funding and transparent cross-boundary charging - are the same. Once "contracted" funding is in place, cross boundary adjustments and - ultimately - the regional role in funding can be phased out.

Performance funding of hospitals

18. The final stage in the resource allocation process is the passage of money from districts to hospitals. Once the new system is fully operational, there will be automatic performance incentives, since districts will be seeking the most cost-

effective deals from hospitals. But during the transitional period, a system of top-sliced performance funding, along the lines set out in HC27, is necessary. This will help to deal with the common complaint that hospitals which increase their efficiency cannot make commensurate improvements in the numbers of patients they treat without some additional funding to cover the variable cost element of treating those extra patients. The scheme would also include incentives for some hospitals to concentrate on waiting list cases and to draw in patients from elsewhere so as to have the maximum impact on waiting lists. The amount of money to be set aside for the scheme within the agreed total provision for health expenditure should be the subject of annual discussion between us in the public expenditure survey.

Self-governing hospitals

19. There is no reason why the process of transition to the new funding arrangements should delay the programme of self-government in hospitals. It is of the essence of self-governing hospitals that they will be funded by contracts with districts. We need to ensure that districts are ready to negotiate these contracts, possibly before they are set to move into "contract funding" more generally. To that extent, the introduction of self-governing hospitals will help to accelerate the pace of change at district level. The hospitals will need contracts to supply both "core" and "contract" services on behalf of local districts. Further work is needed on the form that these contracts will take, and on the costings that will underpin them.

20. One effect of hospitals switching to self-governing status may be to denude some districts of most of their functions. They will need to amalgamate with other neighbouring districts. If districts had already merged with the - in terms of area, larger - FPCs, this subsequent disruption might be avoidable.

GP practice budgets

21. While the principle of GP practice budgets is attractive, the Treasury have reservations about their practicability. This is to be addressed separately. Assuming for the moment, however, that these problems are resolved, GP practice budgets would be an alternative mechanism for funding part of the acute hospital sector. The money for them will therefore need to come out of the hospital and community health services budget, not the FPS.

22. Whether the allocation should be made by districts or by regions depends on whether a decision is taken to merge districts and FPCs. If we go ahead with merger, it would be logical and sensible to give the merged bodies responsibilities for setting budgets for those practices who opt to hold them. If however districts and FPCs remain separate, there might be difficulty if districts are allocating money to GPs who are then not responsible to FPCs for their stewardship of it. It would be better in these circumstances to give the responsibility to regions, to whom both districts and FPCs would be reporting.

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Capital

23. The capital programme is at present allocated to regions on the basis of weighted capitation, projected 5 years ahead. We see no need to change this principle, although the formula will in future need to be the same as that for current expenditure.

24. Self-governing hospitals would have to bid against regional budgets if they wished to undertake new capital investment. They would be required to produce business plans and investment appraisals which would demonstrate the soundness of the proposed investment against the normal criteria applied to NHS capital projects.

Timetable and summary

25. The proposals in this paper may be summarised in the form of the following schematic timetable.

April 1989 - Transitional allocations, based on existing RAWP formula, but with more transparent cross-boundary adjustments.

- Begin work on improved information about population etc at district level.

April 1990 - First year of new weighted capitation formula as basis for allocations to regions.

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- Experimental schemes for contractual funding of hospitals

- New top-sliced performance funding scheme.

April 1991 - Introduction of explicit cash payments for cross-boundary flows between districts.

April 1992 - Extend contract funding to all districts

- Cross-boundary adjustments negotiated between districts; adjustments between regions unnecessary.

- transition to weighted capitation at regional level complete

April 1994 - Introduction of contract funding completed; cross-boundary adjustments at district level and performance funding phased out.

April 1995 - Substantial progress towards weighted capitation at district level.

ANNEX A

REGIONAL ALLOCATIONS AS COMPARED WITH WEIGHTED CAPITATION

The best proxy for weighted capitation that is available at present is RAWP targets. These give distributions between regions, according to population, adjusted for age mix, morbidity and cross-boundary flows. The following table shows the actual allocations in 1989-90 (with estimates in brackets of what the figures would be without adjustment for cross-boundary flows), and the distances of the allocations from target in 1988-89 and 1979-80. Most regions are within two or three percentage points of target now, except for East Anglia (4% below) and NW and NE Thames (4½% and 7% respectively above target). While the changes in individual regions vary quite considerably over the period - compare, for example the progress of NE and SE Thames respectively towards target - largely as a result of the targets themselves shifting with population changes, the general picture is of very considerable movement towards target, and hence a more equal spread of resources across the country.

	Allocation 1988-89 (and estimated allocation without cross-boundary flow adjustment) £m	Percentage distance of allocation from target 1988-89	Percentage distance of allocation from target 1979-80
Northern	735 (731)	- 1.56%	- 7.47%
Yorkshire	830 (834)	- 1.39%	- 3.68%
Trent	1010 (1034)	- 2.70%	- 7.25%
East Anglia	438 (426)	- 3.99%	- 5.10%
NW Thames	808 (837)	+ 4.46%	+12.98%
NE Thames	1007 (987)	+ 7.29%	+11.46%
SE Thames	898 (905)	+ 1.69%	+10.03%
SW Thames	746 (754)	+ 0.97%	+ 5.90%
Wessex	615 (625)	- 1.79%	- 3.70%
Oxford	482 (494)	- 2.58%	+ 0.58%
South Western	732 (721)	- 1.39%	- 4.01%
West Midlands	1186 (1174)	- 1.32%	- 5.81%
Mersey	586 (583)	+ 1.48%	- 1.00%
North Western	1005 (972)	- 1.35%	- 8.76%
Average distance from target	-	2.43%	6.27%