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PRIME MINISTER

NHS REVIEW

I enclose a note providing observations upon a number of the major features of the NHS Review.

These are views from a Welsh standpoint. In Wales the function of a Regional Health Authority is largely performed by my Department. My NHS Directorate, headed by a Director recruited from the private medical sector, is achieving some considerable economies and improvements in efficiency.

I give in the attached memorandum my observations on self-governing hospitals, GP budgets, improvements in the quality of managerial and financial staff and the use of more private capital.

I am sending copies of this minute and enclosure to Nigel Lawson, Kenneth Clarke, Malcolm Rifkind, Tom King, John Major, David Mellor, to Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No.10 Policy Unit, and to Mr Wilson in the Cabinet Office.

Keith Joseph

31 November 1988

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Approved by the Secretary of State
and signed in his absence

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MEMORANDUM BY THE SECRETARY OF STATE FOR WALES

Self Governing Hospitals

In his paper HC46 on self-governing hospitals, Kenneth Clarke proposed that the opportunity to become self-governing should be open to all major acute hospitals in England. He defined these as hospitals with in excess of 250 beds and showed (in the appendix to HC46) that no less than 141 of the 260 such hospitals are located within 5 miles of another such, thus providing good preconditions for competition between them, at least for elective surgery.

In Wales there are 17 major acute hospitals with more than 250 beds. Of these only 3 are within 5 miles of each other. As it happens, these 3 are in Cardiff and, although in separate management units, they work in co-operation in providing the clinical base for Wales' only teaching hospital. The other major acute hospitals are widely dispersed. Gwynedd and Pembrokeshire each have only one; Powys none at all, relying on acute provision in neighbouring districts in Wales and in England. In large parts of Wales, therefore, there would be little or no effective competition between hospitals for elective surgery. The private hospital sector in Wales is tiny, with just 215 beds. The two main private units are based on the north Wales coast and in Cardiff, leaving our valleys and rural areas entirely reliant on the DHA-run acute hospitals.

I am already pursuing key objectives we have identified in the review: the devolution of management responsibility to hospital level (the introduction of unit general management has been completed successfully); the strengthening of hospital management; and the close involvement of clinicians in management, budgeting and accounting for their use of resources. Our resource management project is in the vanguard of the national drive to create effective clinical budgets and to price treatments - the essential pre-condition to move to a more open market in health care. We have been leaders in contracting our services to the private sector where that provides the most cost-effective option, for instance in developing more accessible renal dialysis of a high standard.

These achievements provide good foundations for pursuing our objectives in the review. In carrying these forward, however, I must be able to carry out my statutory responsibilities for the NHS by ensuring that an adequate range and quality of care is provided to all regardless of means.

The first and most obvious issue for me would be to ensure that a self-governing hospital continued to provide an adequate range of services for the people in its district, and that it did not abuse its monopoly or near-monopoly position as a provider of acute hospital services.

One of the key tests of whether or not self-governing has any meaning would be the ability of hospitals to employ whatever staff they judge necessary (with the exception of junior doctors, but including consultants) and to settle the pay and conditions of those staff. At the same time, I would have to ensure that the exercise of this freedom did not compromise the ability of other areas in Wales to recruit and retain staff. We are already struggling in parts of Wales (particularly in the valleys and the rural areas) to fill key medical and other posts. I could not allow this situation to deteriorate further. I confess that I see no answer which would square this circle, short of ensuring that the NHS could pay the going rate to get the staff it needs.

I should also have to ensure that the education and training of staff, and particularly doctors, was not adversely affected. That would mean that a full range of quality services must continue to be provided in each area, not least in the 3 hospitals in Cardiff which provide the clinical base for our only College of Medicine and the bulk of our regional services.

All this would be tricky enough if I were confident about the standards of management and financial control in the major hospitals. I am afraid that quite the contrary is the case, and I should expect to have to carry out a sustained programme of action to improve this state of affairs before I could allow any existing hospital in Wales to become self-governing. As things stand, there would be the strong likelihood of dominant medical personalities seeking to increase their individual independence from management at a time when most of them are just beginning to develop understanding about what it means to take responsibility for budgets and to account for their performance. I would expect this to be particularly true in the isolated acute hospitals in our rural and valleys areas.

If we were to proceed immediately towards a programme of encouraging hospitals to become self-governing in Wales, I would see no alternative (whatever the statutory basis for the establishment of self-governing hospitals as legal entities in their own right) but for me to be able not only to determine whether or not a hospital may become self-governing, but also:-

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i. to define the minimum services it will need to provide;

ii. to approve proposals for significant capital investment and to consent to the disposal of assets. (I agree with Kenneth Clarke that these hospitals - and the NHS more generally - should have more open access to private sector capital, but the bulk of funding would continue to come from central Government); and

iii. to be able to withdraw the right to self-government if a hospital failed to fulfil these requirements, or in any other sense acted in a manner which abused its position of monopoly or near-monopoly supplier.

Given these circumstances and the current management weaknesses I have described, these requirements would necessarily involve strengthening my Department to lead and assist the programme and to monitor closely any hospitals which were to become self-governing, to ensure that they were performing adequately and not abusing their freedoms. It would be a grave mistake in my view to dissipate in this way our concerted drive to secure improvements and create a more effective and efficient hospital service in the longer-term.

GP Budgets

I see GPs in Wales developing a much more direct role in the shaping of hospital services, and I believe strongly in what we are doing throughout the UK to provide incentives to GPs to carry out more work and so to prevent unnecessary referrals to hospital.

We are establishing a pilot project to involve GPs directly in the development of hospital services. Before the NHS review, proposals were developed for an experiment in the Powys District Health Authority area (which, as noted above, does not have a major acute hospital), to test, on the basis of notional GP budgets for hospital services, the effect on patterns of resource distribution of linking GPs into the planning and budgeting arrangements for hospital referrals. Subject to the results of a pre-feasibility study, to secure the co-operation of GPs and establish the notional budgets, I expect the project to begin next Spring.

I have to say, however, that the quality of our GPs and practices in Wales is often poor, especially in some of the South Wales Valleys. Kenneth Clarke has proposed that practices with list sizes in excess of 11,000 might initially be eligible for independent budgets. In Wales I estimate that only some 30 practices (out of a total of 589) would be eligible on this

basis, and only a minority of these would be capable of handling competently GP budgets in the foreseeable future.

Moreover, I still have major worries about the proposals for independent budgets for GPs. The proposals we have discussed would, it has been suggested, provide GPs with a significant incentive to refer to hospitals less indiscriminately and to undertake more work themselves. This would be achieved, it is said, by allowing them to retain a proportion of any underspending on their budgets provided that this is reinvested in their practices. But what would that in fact mean? One obvious course for the GP would be to buy bigger and better practice premises. In due course he would be able to dispose of a valuable capital asset. And how are we to control what is and is not regarded as a legitimate investment of the underspend? Would cars for practice use be included? In a sense, these things would be tolerable (even if presentationally extremely difficult for us) were it not for the fact that they might well be achieved at the expense of patients who did not receive referral to hospital when they needed it or who were denied drugs and other treatments they need directly from the GP.

In addition, the FPCs in Wales are managerially weak and their memberships are unimpressive. They would not, in my view, be able to handle effectively the support for GPs generally which our proposals would require. Indeed, our decision as part of the review to remove professional members from the FPCs would make our position even worse in this respect, since most of our more effective chairmen and members are contractors. For this reason - and to secure the more effective long-term development of the role of GPs in the planning and delivery of health services in the round - I would wish to merge the DHAs and the FPCs in Wales and to secure more vigorous enforcement of the revised contract for GPs by DHAs operating with a far stronger managerial ethos and competence.

Ingredients for success

The key thrusts of our objectives for the NHS require that members, managers and practitioners should operate with more flair, imagination and drive. They will need the right management skills to be able to do this and the right management context.

I see little point in our embarking on a purportedly radical programme of action if we do not ensure that the NHS has skilled people to tackle the job. I have seen more than enough in Wales of poor standards of financial management which would simply not be tolerated in any commercial organisation with a similar level of cash flow. The best paid Welsh DHA Treasurer earns some

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£34,000, plus an annual enhancement of up to 4% in performance-related pay (PRP). This is for handling a revenue budget in excess of £150 million. By way of comparison the Financial Director of a private sector company with only a £100m turnover would expect to earn over £50,000 plus related benefits.

I feel strongly that we have gone down the wrong road in seeking simply to adjust pre-existing pay arrangements. As a result we have achieved only a modest leavening of outsiders. I believe that we need a much more radical approach, under which we would pay-off humanely those who are simply not up to operating with the entrepreneurial flair and energy which is needed, and recruit top class managers, particularly financial managers, from the private sector who could bring a dynamic approach to the management of property, to the generation of income, and to the operation of a substantially more open market in health care, where health authorities and hospitals will be competing directly with the private sector. We would ensure that this flexibility was not abused by exercising control over appointments at regional level.

In my minute to you of 13 October I leant my support to Kenneth Clarke's proposals for opening up the use of private capital and suggested an initiative, to be launched as part of the outcome of the review, to use the private sector to reduce waiting times to our targets. I set out in an annex to this memorandum a list of the key areas where I feel we should be tapping private sector funding. The key will be to relax the self-defeating Treasury rules which force comparisons on the basis of the relative cost of the Government borrowing money as opposed to the private sector. This will always point to Government funding for all but the shortest life projects. But this is a meaningless conclusion when we all know that the extent of public capital investment will be strictly limited. The need is for investment in health care services now - in renovated and new buildings, in information technology and systems, in medical equipment and so on - and there is every reason to believe that the private sector is able and willing to make this investment.

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ANNEX

POTENTIAL AREAS FOR USE OF PRIVATE SECTOR FINANCE IN THE NHS

1. Hospitals

Two new district general hospitals are planned in South Wales over the next few years. The timetable for their construction would be greatly accelerated if the private sector were invited to design, build and, possibly, run them. The DHAs involved would either lease the buildings on completion or, if they were run by the private sector, contract with them for the services to be provided.

2. Management Information and Information Technology

The Welsh Office has an Information and Information Technology strategy to equip the NHS to be managed effectively and efficiently through improved clinical budgeting, manpower planning, patient administration, integrated telecommunications and coherently managed community health services. The total investment needed is in excess of £40 million. At current possible levels of direct Government investment the systems will not be available throughout Wales for about 10 years. The private sector could design, install and maintain them on contract within one or two years, subject to DHAs being able to fund leasing and contractual arrangements from revenue expenditure. The rapidly developing field of information systems points to leasing as likely to be the most cost-effective use of public resources.

3. Medical Equipment

It makes little sense for the same reasons for the NHS to invest heavily in high-risk short-life technologies - and the pace of technological change is increasing all the time. Again, leasing from the private sector is likely to offer the most cost-effective solution.

4. Energy Savings

There are significant savings to be made which would be available for use on patient care, if private finance could be used to accelerate the capital investment necessary to finance energy savings. Also contract energy management schemes using private sector funding should be developed.

5. Specific Services

Four subsidiary renal dialysis units are already contracted out to the private sector in Wales. In addition, heart surgery for people in North Wales is purchased from AMI's hospital in Manchester. Other areas where the private sector might most cost-effectively carry out treatments include hip and knee replacement operations. cataracts, hernias, varicose veins, and

ANNEX

gynaecological operations. More radically, it might be possible to set up with private finance (and possibly run by the private sector) a "factory" style central treatment centre or centres in Wales to ensure rapid turn-round of cases, with direct referral by GPs to ensure that local consultants do not decline to refer for fear of the implications for their private practice.