SECRET - CMO UNTIL 31-12-89

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SUBJECT ON MASTER

FILED ON NATIONAL HEALTH Expenditure + Efficiency A 16

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

16 December 1988

Dear Andy

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister this morning held the seventeenth meeting of the group reviewing the National Health Service. The group considered papers HC 64, 65, 66 and 63.

I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with 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 Chief Secretary to the Treasury, Sir Roy Griffiths, Sir Robin Butler, Mr Wilson and Mr Monger (Cabinet Office) and Mr Whitehead (No.10 Policy Unit).

Pay conditions of NHS staff

The group began by considering the joint paper by the Secretary of State for Health and the Chief Secretary to the Treasury. 'Pay and conditions of NHS staff', HC 64.

In discussion the main points made were as follows:

a. Individual health authorities at present had only relatively limited freedom to vary pay and conditions without central approval. This meant that they were unable to exercise one of the most important functions of management. It was highly desirable that the arrangements for determining pay in the NHS should become much more flexible and decentralised. Quite apart from the review, some progress had already been made in this direction and considerably more was planned, along the lines set out in the paper. It should be an especially high priority of policy to ensure that the national Whitley arrangements could not stand in the way of the necessary flexibility at local levels.

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b. One important part of the policy of flexibility was the introduction of more regional pay. Proposals had been put to the Nurses Review Body for a sum of £5m. to be set aside in 1989/90 for a pilot exercise in supplementing national rates of basic pay where this was appropriate on recruitment and retention grounds. The sum involved was modest but if this approach was successful it would imply acceptance by the Review Body of the principle of regional pay and could pave the way for much greater use of it.

c. It was not realistic to suppose that Review Body staff in self-governing hospitals could be paid below the rates resulting from Review Body awards, and the proposals in HC 64 assumed that the Review Bodies would continue. Nevertheless, it was desirable to give these hospitals, for all staff, the freedom recommended by the paper to decide their arrangements for pay determination. They might want to pay at rates higher than those recommended by the Review Bodies, for example to get agreement to the introduction of improved working practices. The pay costs of self-governing hospitals would in practice be reduced by cutting numbers rather than pay rates but the scope for cutting numbers and improving efficiency was likely to be substantial.

d. It was also highly desirable to ensure that Ministers would no longer be answerable for detailed decisions on pay. The drafting of the White Paper must take account of this. Some progress in this direction had already been made, in particular by telling the new Chief Executive that he would be responsible, outside Parliament, for presentation of NHS decisions in this area. But a more formal shift of responsibility from Ministers to management would require legislation, and might meet with some resistance in Parliament where there would be opposition to any reduction in accountability.

e. The standard of financial management in the NHS was generally low, and the Government's reforms could not be carried through successfully unless it was raised. Success in achieving the reforms would also need more managers who could stand up to professionals. Improvement in NHS management would indeed be a major task for the Government. But many top managers were good. The weakness was more at lower levels and the other changes proposed by the government should force a more commercial approach throughout the organisation. Recruitment of better managers would cost money but it would be money well spent.

The Prime Minister, summing up this part of the discussion, said that the group endorsed the proposals of HC 64. They thought it important to achieve much greater flexibility in pay arrangements in the NHS and they supported the moves already underway to achieve it.

Financial arrangements for self-governing hospitals

The group then discussed the paper by the Secretary of State for Health and the Chief Secretary to the Treasury, 'Financial arrangements for self-governing hospitals', HC 65.

The following were the main points made in discussion:

a. The proposals in the paper were agreed by the Secretary of State and the Chief Secretary, except on the important question of whether there should be an annual limit on total borrowing by self-governing hospitals.

b. It was argued against having such a limit that the Government's objective was that the hospitals should behave commercially, and should attract good local businessmen to sit on their boards. These objectives would not be achieved if the boards did not enjoy the fundamental freedom to decide for themselves how much they should borrow. Universities and polytechnics already had much greater freedom in this respect. The proposal that there should be a separate External Financing Limit for each such hospital, fixed in the PES round, seemed especially bureaucratic.

c. On the other hand, it was argued that borrowing by the self-governing hospitals, which would be within the public sector, would be public expenditure. It would be effectively backed by the Government's credit since, whether or not there were a formal guarantee, the Government could never let such a hospital go bankrupt. Failure to fix an annual limit on borrowing by self-governing hospitals would therefore mean an unacceptable weakening of public expenditure control. The proposal was only that a limit should be fixed in PES on borrowing by those hospitals as a whole. It was primarily for the Secretary of State for Health to decide how this limit should be translated into controls for individual hospitals, for instance by hospitals bidding for their share of the borrowing allowed in a Region in a particular year.

d. As the paper noted, further work was required on some secondary aspects of the proposals. Some clarification was needed of the reference in paragraph 15 to monitoring arrangements to protect the position of the Accounting Officer. Another point, not mentioned in the paper, which needed further thought was the treatment of professional indemnity insurance by self-governing hospitals.

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there must be an annual limit on self-governing hospitals' borrowing since it was public expenditure and effectively underwritten by the Government. The limit would apply to all self-governing hospitals taken together. It was for the Secretary of State to decide how this limit should be translated into controls for each hospital individually, but some flexibility would be desirable. Finally, the group noted that further work was needed on some secondary aspects of the proposals, as set out in the paper. This should cover the position on professional indemnity insurance.

Access to private capital

The group then discussed the note by the Secretary of State for Health and the Chief Secretary to the Treasury, 'Access to private capital', HC 66.

The Prime Minister, summing up this part of the discussion, said that the group had noted that work was still underway and no decisions were required now. They endorsed the conclusions in paragraph 14 of the paper. They were attracted by the scheme for Bromley described in paragraph 9(c), and it should be pursued in the further work now underway.

Managing the FPS

Finally, the group considered the note by the Secretary of State for Health, 'Managing the FPS: outstanding issues', HC 63.

The Secretary of State for Health, introducing the paper, said that at an earlier meeting the group had provisionally decided that that part of the White Paper dealing with the future of the FPCs and in particular the case for merger with the DHAs should be green in character. He thought that this would get the worst of all worlds. The consultation that would then have to take place would produce nothing new, since opinions would not have changed since the last such consultation a few years ago. But it would distract the attention of all those concerned and hold up the implementation of the review. He was therefore sure that it was much better to take and announce in the White Paper a definite decision one way or the other. As to what this decision should be, he still believed very strongly that merger of the FPCs and DHAs would be a mistake. It would mean another administrative reorganisation, especially since there were many more DHAs than FPCs. All those concerned would in practice concentrate their attention on it for some time to come instead of getting on with their jobs and implementing the other reforms. He understood that merger had been proposed mainly as a way of getting control over FPS expenditure and he had therefore put forward in HC 63 a scheme for achieving this without merger. He recommended this as the way forward. There would be a major conflict with the professions whatever was done, but this should be in relation to a change which was effective and sensible.

In discussion it was argued that the scheme for controlling FPS expenditure put forward in HC 63 would not be effective. It contained no sanction against overspending, it did not provide enough scope for viring, and it was too bureaucratic. If the White Paper were to announce a definite decision, it should be in favour of a merger between the FPCs and DHAs.

On another matter, it was argued that further thought had demonstrated that there were major difficulties with the proposals for GP practice budgets. The decision to include them in the Government's proposals should be reconsidered.

The Prime Minister, summing up this part of the discussion, said that the judgment of the Secretary of State for Health on the future of the FPCs had to be accepted. But the whole group agreed that proper control over FPS expenditure was necessary. The Secretary of State's proposals in HC 63 for indicative budgets for drugs represented a big step forward, but the discussion had shown that other members had doubts about their practical effectiveness. In particular, the most appropriate means for achieving some viring between FPS expenditure and DHA expenditure should be considered further. As to GP practice budgets, the group had already decided in principle that they should be included in the White Paper. But if there were particular problems with the present proposals these should be addressed. The Secretary of State should now hold urgent discussions with Treasury Ministers to try to meet the concerns which had been expressed in the discussion. She would be prepared to chair a further meeting in the following week if necessary.

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

Yours ever

Andy

pp Paul Gray

Andy McKeon, Esq.,
Department of Health.

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SECRET - CMO

1. Mr Wilson
2. Mr Gray

G W MONGER 16/12/88

Draft letter for Mr Gray to send to the Principal Private Secretary, Department of Health

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cc BK p

FINANCIAL ARRANGEMENTS FOR SELF-GOVERNING HOSPITALS

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

Introduction

1. Self-governing hospitals will offer better value for money, higher efficiency, increased choice for patients and closer links with their local community, providing a spur for the improvement of standards in the rest of the hospital service. To achieve these objectives they will need the maximum freedom and flexibility in managing their financial affairs consistent with maintaining public expenditure control and accounting propriety. This paper considers what financial arrangements will be required.

2. We consider that the best available model for the financial framework for these bodies is that of the public corporation. Thus self-governing hospitals would have:

(i) ownership of their assets and the freedom to use them as they think best subject only to certain reserve powers of the Secretary of State;

(ii) freedom to retain surpluses and to build up reserves;

(iii) freedom to manage any temporary deficits;

(iv) freedom to borrow to finance their working capital and capital investment.

The Secretary of State and the Chief Secretary agree that the hospitals' access to private sector capital should not be subject to over-rigid public expenditure constraints. The Chief Secretary considers that, like other public corporations, self-governing hospitals should be subject to an annual financing limit.

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Freedoms of self-governing hospitals

i) Ownership and use of assets

3. The assets of self-governing hospitals would be vested in their boards, in keeping with the overall objective of giving them the maximum possible freedom to run their own affairs. They should also have the freedom to make use of their assets to provide the pattern of service they think best. This should include the freedom to dispose of assets subject only to a reserve power for the Secretary of State to intervene if the disposal was against the public interest.

4. To impose the necessary commercial discipline, the hospitals should not be given these assets as a free good. We propose that - like Trading Funds - the hospitals should be given an interest bearing originating debt, equal to the value of their initial assets at vesting. This would have the same financial management advantages as the capital charging system to be introduced into the rest of the hospital system from 1991 onwards. Self-governing hospitals would be set financial targets designed to cover the cost of capital employed.

ii) Retention of Surpluses and Reserves

5. To give self-governing hospitals end-year flexibility on their operating surpluses, they should be allowed to retain these surpluses. They should also have the freedom to build up reserves to improve their services and help finance capital investment. This will give them an additional incentive to maximise their efficiency and keep their costs down. (The legislation will need to specify the form in which these reserves can be held.)

iii) Deficits

6. We cannot be certain that self-governing hospitals will invariably be able to balance their budgets every year. A hospital may end a particular year with a deficit despite being in a sound underlying financial position. A requirement that hospitals could not run end-year deficits would be an artificial and unnecessary

constraint on their activities. However, a self-governing hospital should not be entitled to run a continued deficit: this would undermine its viability and build up potential liabilities for the Exchequer. This would be avoided by setting a requirement that they should break even taking one year with another.

iv) Working Capital and Capital Investment

7. Self-governing hospitals' income and expenditure cash flows are unlikely to match each other at all times throughout the year. They will therefore need access to working capital through loans/ overdraft facilities. (They will need a loan at their foundation to give them the necessary working funds until the income from their contracts starts to flow.) More significantly, they will also need access to funds for capital investment so that they can maintain and expand their facilities to meet demand and provide the required standard of service. They are unlikely to be able to finance their capital investment solely from sales of assets and/ or the reserves they have built up. They should therefore be able to meet their capital requirements through loans, which they would have to service from their income in the same way as hospitals in the rest of the NHS will be charged for capital.

8. There is a degree of disagreement between us when it comes to the arrangements for controlling the scale of the borrowing of self-governing hospitals. As public corporations, all the hospitals' borrowing from whatever source and their other external finance would be public expenditure. Moreover, the liability for any borrowing by the hospitals would lie ultimately with the Government. The Chief Secretary considers that to maintain public expenditure control there will therefore need to be annual limits to the amount the hospitals can borrow. The overall limit for the self-governing hospital sector would be set in the Public Expenditure Survey with each individual hospital then receiving an annual financing limit.

9. The Secretary of State considers that this remains too restrictive. He considers that self-governing hospitals' access to private sector capital should not be subject to public expenditure constraints. Discipline would be exercised by audit;

by the need to cover costs at price levels which attract business and therefore income (which in the case of contracts with district health authorities would come from within the cash-limited allocations for health authorities' revenue); and by the existence of certain reserve powers requiring, for example, hospitals to obtain the approval of the Department if they wished to borrow above given levels. The Secretary of State believes that self-governing hospitals will prove at least as capable as Universities and Polytechnics at managing their investment programmes and these higher education bodies have considerably greater freedom. The Chief Secretary notes, however, that these are private sector bodies.

10. The Chief Secretary considers that the arrangements for self-governing hospitals proposed by the Secretary of State would leave their impact on public expenditure entirely open-ended. The absence of any financing limit on private borrowing would seriously undermine control of public expenditure and set a very unwelcome precedent for other public sector bodies, which are not absolved from annual expenditure control, still less allowed to borrow as they see fit.

11. Self-governing hospitals could be allowed to borrow from the private sector and/or the Government. Loans from commercial banks would be more expensive - even if covered by Government guarantees - and in practice the Chief Secretary believes that the hospitals would almost certainly want to use the Government for their capital borrowing. (This would also be more transparent to Parliament.)

12. Loans from voted funds, rather than the National Loans Fund, would be the appropriate source of borrowing from the Government. This would reflect the Department of Health's responsibility for the NHS and for self-governing hospitals in particular. It would be for the Departmental Accounting Officer to satisfy himself that the loan would be serviced, and repaid, in full. Otherwise, if borrowing was from the NLF, the Treasury would share this responsibility, which would unacceptably muddle accountability to Parliament for the hospitals.

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13. There would need to be arrangements to ensure that funds borrowed from the Government could not be put on deposit at higher rates of interest since the Accounting Officer would be open to criticism if loans were used for this purpose.

Maintaining financial standards in self-governing hospitals

14. Self-governing hospitals should have the maximum freedom consistent with normal Accounting Officer principles. As they remain public bodies, the Secretary of State will need some controls over their exercise of their powers. He will, of course, be able to dismiss the board of a hospital and remove its self-governing status. However, these are draconian sanctions for use in extremis if it is clear that a hospital is no longer fit to run its own affairs. It will also be necessary for him to have the power to intervene if abuses of self-governing status are occurring. Since self-governing hospitals will not be subject to the general direction of the Secretary of State in the manner of the rest of the NHS, he will need some limited specific powers, for example, regarding the sale and purchase of assets and size and use of reserves. These powers would only be for use where there was a serious risk that a hospital was abusing its freedoms or getting itself into difficulties.

15. Further controls may need to be provided to prevent any hospital with a local monopoly of health care provision unfairly exploiting its position by, for example, charging high prices for its services. The system of capitation funding for health authorities will provide some protection. An authority will have a fixed sum to purchase services for its population which will constrain what it can pay the self-governing hospital. Its contracts with a self-governing hospital may not by themselves provide all the funding the latter requires. The hospital may need to compete for business from outside its home district and this will affect the prices it can charge. However, it will be necessary to consider whether this needs to be reinforced by specific powers.

Other issues to be settled

(i) Tax

16. The tax treatment of the surpluses made by self-governing hospitals needs to be considered. (As the law currently stands, the view of the Inland Revenue is that health authorities are probably liable to tax on their profits from treating private patients and other income generation activities.) The VAT treatment of contracts let by health authorities to these hospitals is another issue to be considered.

(ii) Accounting for Capital

17. Self-governing hospitals would be required to maintain their own accounts. These should include provision for depreciation. The interest self-governing hospitals should pay on their inherited assets, the method of valuation and accounting for depreciation will need to be considered further in tandem with the details of the capital charging scheme: the different arrangements should not result in self-governing hospitals being placed at a competitive advantage or disadvantage to the rest of the hospital sector.

(iii) Accountability

18. The operations of self-governing hospitals will be subject to audit by the Audit Commission like the rest of the NHS. As our intention is that these hospitals should be as autonomous as possible, they will not be under the same direct control of the Department as the rest of the NHS. The Department's Accounting Officer will not be accountable for each individual hospital but he will have an overall stewardship responsibility for their use of public funds. (As now, he will remain accountable for payments, including loans, made from his votes to the hospitals and, in his capacity of Accounting Officer for the HCHS, for payments to health authorities.) To protect the position of the Accounting Officer it will therefore be necessary to ensure that there are adequate monitoring arrangements.

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19. The NAO will remain responsible for auditing the consolidated accounts of the NHS and for scrutinising the Departmental Vote under which loans are made to the self-governing hospitals. They will have right of access to papers relating to the accounts and audit of self-governing hospitals and will also be able to include self-governing hospitals in their value for money studies of the NHS. In each self-governing hospital there will therefore need to be a single person with overall financial and accounting responsibility.

Conclusion

20. The Group needs to decide whether self-governing hospitals should be subject to annual limits on all their finance or whether these should not apply to their access to private sector capital. With the exception of this issue, we are in agreement that the financial regime outlined above should be created by the legislation establishing self-governing hospitals.

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HC63

NHS Review

MANAGING THE FPS: OUTSTANDING ISSUES

Note by the Secretary of State for Health

1. This paper addresses three issues which are outstanding from the Group's discussion of my last paper on managing the FPS (HC51):

* the timetable for changes in budgeting and organisation.

* options for controlling GP numbers.

* incentives to join the GP practice budget scheme.

I BUDGETING AND ORGANISATION

Budgets for prescribing costs

2. We are agreed in principle that we should move towards a system of setting reasonable budgets to cover the costs of prescribing by GPs.

3. We must first be clear about how such a system would work. I suggest that the most practicable scheme to develop and implement would be one along the following lines:

i. a single, national drug budget would be negotiated for each country as part of the annual public expenditure round. It would be set at a level which was designed to achieve the effect described at (iii) below. Forecasting the drug bill is notoriously difficult, and to the extent that the forecasts underlying the budget provision fell short of out-turn, in-year increases would be necessary. Under the present arrangements these are voted through in Supplementary Estimates. It would be necessary to continue this arrangement to ensure that practitioners,

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and patients, did not pay the penalty for forecasting errors or, rarely, increased incidence of disease because of an epidemic.

ii. the Department would allocate budgets to Regions. Each budget would constitute that Region's share of the money available nationally for FPS drug spending. If we go down this route we shall need to do more work before the White Paper is published on two important, practical issues:

- the calculation of each Region's share. In principle, some form of simple, weighted capitation would be the best approach, as for the funding of hospital services. At present the (unweighted) average, per-capita cost of drugs prescribed by GPs varies from just over £30 in the Oxford Region to £39 in the North Western Region. We shall need to develop an approach to coping with these variations without an adverse impact on patients.

- each Region's information needs for budgetary control purposes. The time lags which are inherent in the present information system would make budgetary control difficult. We might need to invest in establishing an adequate information system.

iii. Regions would then allocate budgets to FPCs (or in due course, if this is the route we decide on, to merged FPCs/DHAs). Each budget would be negotiated with regard to the FPC's "expected" level of drug spending, based on weighted capitation and average unit costs, and their actual current spending (with whatever allowance was agreed generally for increases in costs). The FPC would be accountable to the RHA for ensuring that the prescribing costs of their GPs were held within the budget. As a further incentive to bring down prescribing costs, it would be open to an FPC to agree with its Region a target level of savings, with a proportion of any such savings being returned to the FPC to finance primary care initiatives in their area.

iv. FPCs would in turn allocate indicative budgets to GP practices outside the practice budget scheme. These budgets would be negotiated in broadly the same way as FPCs' own budgets. There would be scope for adjustment to match particular circumstances which might affect a practice's prescribing costs. (In the first year of the

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scheme's operation, "current" spending for the purpose of negotiating budgets might be taken to be spending at 1988-89 levels. This would avoid giving GPs an incentive to push up their prescribing costs in the meantime.) We would need to impose a change to the GP contract to spell out a requirement to conform to their FPC's policies on effective and economical prescribing. To make indicative budgets "bite" at practice level, FPCs would also need

- to buy in independent, medical support, in practice mainly from the Department's Regional Medical Service, and

- to be empowered by Regulations to impose financial penalties where GPs persisted on over-prescribing.

More detailed proposals in each case are set out in HC 51.

4. An approach along these lines would have the following, important characteristics:

i. it would keep the drug budget separate from other FPS or hospital spending. This separation would reflect the fact that there is a particular, and widely recognised, justification for driving down prescribing costs. It would also ensure that excessive prescribing was tackled in its own right and not deflected into unjustified pressures on other services.

ii. the use of indicative budgets for GPs would recognise the difficulty - which we have acknowledged in the context of practice budgets - that real budgets would be difficult and expensive to manage at the level of the small or average-sized practice. Giving them to FPCs allows more scope for absorbing unexpected pressures whilst controlling overall expenditure.

iii. negotiating indicative budgets for FPCs in the way I propose would allow the overall rate of growth in drug spending to be steadily ratcheted downwards by focusing on the highest spending practices.

5. We can expect vociferous opposition from the profession. It would be wise to try to defuse some of this opposition by being willing to consult on the detailed application of the scheme, for example the basis on which budgets might be adjusted for individual practices. A willingness to consult might also help to deal with accusations that the Government was reneging on the implied commitment in the Primary Care

White Paper to rely for the time being on "voluntary means" to more effective and economical prescribing.

6. Subject to the outcome of such consultations, I suggest we aim if we can to bring the new scheme into operation from April 1991. It would necessarily be a little rough-and-ready to begin with, and we shall need to invest in the management as well as information capacity to make it work. A 1991 target date should allow adequate time not only for consultation but also for any necessary renegotiation of the Pharmaceutical Price Regulation Scheme. It should also allow time for FPCs to gain at least some working experience of the new "PACT" information system, which will be available to all FPCs by 1990-91. With improved timeliness, "PACT" information could then be used for monitoring expenditure against budgets.

The future of FPCs

7. A majority of the Group is in favour of merging FPCs and DHAs in England and Wales, and it was suggested at our last meeting that the case for doing so should be set out as an option in the White Paper.

8. I have given this further thought since our last meeting. My firm view is that, whatever conclusion we reach on its merits, this must not be a "green" issue. Politically, the Government must be seen to know its mind. We have already consulted once on the subject, and the responses to consultation are entirely predictable. It would not be difficult for our opponents to caricature a consultative proposal as indecision about whether to reverse a decision (or even about which decision to reverse). We can expect no public interest in yet another debate about administrative and boundary changes, merely another protracted argument with the profession. Managerially, consultation would simply generate wasteful effort and uncertainty.

9. I do not rule out the possibility that merger may become desirable in due course. But I believe the White Paper should say, at most, that it is far too soon to reopen the issue. I shall not repeat here the arguments I have advanced before for keeping FPCs separate in England, but two further points are relevant in the context of my proposals for drug budgets:

i. merger is not necessary to achieving the objectives set out in paragraphs 2-6 of this paper. Merger and budgets are quite separate issues. In so far as the purpose of merger is to create the scope to vire between drug budgets and HCHS spending, the same flexibility could be achieved in practice through my proposal to give

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the cash for drug spending to Regions. In any event, as I have argued in paragraph 4(i), there are strong arguments for keeping drug spending separate, at least in the first instance.

ii. developing and implementing drug budgets will be a substantial additional challenge to FPS management. By distracting attention, merger would get seriously in the way of these and other steps which are needed if GP contracts are to be effectively managed along the lines which were set out in the Primary Care White Paper and which will be reinforced by the outcome of the present review. I do not believe that administrative and boundary changes are our real priorities.

10. In short, I urge colleagues to agree that we can and should achieve our objectives whilst leaving FPCs separate. We shall still need primary legislation to secure the accountability of FPCs to RHAs, but that is a much more limited - though still essential - change. I believe we should also strengthen FPS management along the lines proposed in HC51, in brief by

i. taking powers to reduce the size of FPCs and make lay members a clear majority over professional members, and

ii. recruiting higher quality chief executives.

II GP NUMBERS

Options

11. At the Group's last meeting I was asked to circulate a further note on options for controlling GP numbers, including in particular the possibility of doing so through increasing the capitation element in GPs' remuneration.

12. I have identified two options for the Group to consider. The first is that of imposing direct, statutory controls along the lines proposed in HC51. The second is to use the remuneration system, partly but not exclusively by increasing the capitation element. The two options are not necessarily mutually exclusive. The following paragraphs spell out how the second option might work.

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Using the remuneration system

13. The average GP received an income of £55,000 in 1987/88. This covered remuneration and all expenses, and was the total cost of delivering general medical services, excluding drugs, to 2000 patients. In round terms it was made up as follows:

- remuneration through fees and allowances £27,000
- expenses met through fees and allowances £12,000
- expenses directly reimbursed £16,000

14. The £39,000 which is paid through fees and allowances is made up as follows:

	£	%
Basic Practice Allowance (paid in full for 1000 or more patients and prorated for fewer numbers)	8,000	21
Capitation fees	18,000	46
Allowances (eg seniority payments, group practice allowance, training allowances)	6,000	15
Fees (eg childhood immunisation, cervical cytology)	7,000	18
	39,000	100

15. There are two levers here which we could pull to exert downward pressure on the growth in GP numbers:

i. increasing the proportion accounted for by capitation fees. Colleagues are familiar with the arguments here. The Government is already committed to this policy, although not specifically as a means of reducing the rate of growth in GP numbers. The position as stated in the Primary Care White Paper is:

> "It is the Government's intention to make the NHS contract with family doctors more sensitive to the range of services provided. This will be achieved over time by adjusting the balance between the doctor's income from capitation fees and the income

from allowances. A basic core of health provision is expected for the payment of capitation fees which in turn will be complemented by incentive payments designed to encourage the provision of services targeted at specific health care objectives (for example, high levels of vaccination, immunisation and cervical cytology). At present capitation fees form an average 47 per cent of the doctor's income. The Government intends to raise this to at least 50 per cent in the first instance. As public awareness increases and services improve, the Government intends to move further in this direction in order to encourage doctors to practise in ways that meet patients' needs."

ii. increasing the number of patients needed for a GP to qualify for the basic practice allowance (BPA) (which is in effect a form of capitation, paid to meet running costs). Under present arrangements a full BPA of £8,560 is paid into the practice for each GP if the average number of patients exceeds 1000. So if by dividing the number of patients by the number of GPs in the practice plus one the result is still 1000 or more, the practice has a strong incentive to recruit another GP. Increasing the qualifying number would tend to discourage practices from expanding and from replacing retiring partners. This in turn would reduce the growth rate, although at the expense of reducing the incentive to increase practice sizes.

16. Changes along both these lines are currently being discussed with the profession as part of the negotiations flowing from the Primary Care White Paper. Specifically, we have proposed that

i. capitation fees should be increased, as a proportion of fees and allowances, to over 50%.

ii. qualification for the full BPA should be changed from 1000 to 1500 patients.

The potential impact of these changes on the rate of growth in GP numbers has not been modelled, but we might reasonably expect a reduction from 1.9% to, say, 1.0% a year over a number of years. Assuming that such a reduction were achieved steadily over a period of 5 years, the revenue saving by year 5 would amount to about £45 million, with further cumulative savings of £15 million a year thereafter.

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17. By pursuing this approach we could change the structure of remuneration to something along the following lines:

	Current	Future (approx)
Basic Practices Allowance	21%	25%
Capitation fees	46%	60%
Allowances	15%	(
Fees	18%	(15%
	100%	100%

This would still allow scope for targeted incentive payments, for example for childhood immunisation or cervical cancer screening. But there is little doubt that the profession would oppose changes on this scale, so that we would almost certainly have to impose them.

18. Other developments which will tend to depress growth in the numbers of GPs are: compulsory retirement of GPs on reaching the age of 70; the retirement over the next few years of the post-war bulge in GPs (having attained 40 years' NHS service); and the departure of GPs unwilling to give the extra commitment which will be necessary under the new contract to maintain current levels of income.

Impact of the Review Body

19. Colleagues have raised the question whether the impact of such changes could be negated by the Review Body's recommendations. The Review Body's job is to recommend changes in GPs' income due to inflation and workload. Each year it recommends an intended average net income and average expenses, both to be reimbursed through fees and allowances. If capitation fees are to form a greater proportion of income, that would be a Government decision. It would then be for the Review Body to set fees and allowances so that capitation represented on average the required percentage of income from fees and allowances.

20. The Review Body would need some help over the transition, and officials are meeting the Review Body secretariat to discuss ways and means in respect of the changes currently being discussed with the profession. But I do not think that the Review Body's activities need frustrate the Government's aims. If the average GP's workload and expenses increase, the Review Body will recommend an appropriate increase in the intended average income including indirectly reimbursed expenses. But to meet the workload and expenses costs of the

Primary Care White Paper, £48 million (from the new charging arrangements) is already to be made available from April 1990. Our discussions with the Review Body secretariat are designed to ensure that the Review Body does not exceed that amount in its recommendations. We can and should try to maintain this line, although there remains a risk that the Review Body will make consequential recommendations with a total cost exceeding this sum.

Conclusion

21. Tackling the growth in GP numbers through the remuneration system would be feasible. It would also be consistent with the approach we are taking generally to reforming the NHS through changing incentives and increasing competition. But it would be uncertain in its effects, and changing the qualification for the BPA would tend to depress the size of practices. Taking direct manpower controls would be a surer approach, and easier to fine-tune. But it would be bureaucratic and would need primary legislation. The Group will wish to discuss these relative advantages and take a view on them.

22. Under either approach we would need to secure an adequate number of practice vacancies for good, young doctors wishing to enter general practice. (At present there is a more than adequate supply of such candidates everywhere.) I shall need to give further thought to this, too. The best approach, as I suggested in HC 51, might be

i. in due course, to reduce from 70 to 65 the retirement age for GPs which we are introducing through the Health and Medicines Bill.

ii. to ensure that, when filling single-handed practice vacancies, FPCs give priority to younger doctors who are keen to work as members of primary health care teams.

I am looking separately at ways in which FPCs could have more influence over the filling of vacancies in partnerships.

III GP PRACTICE BUDGETS: INCENTIVES

23. I was asked to consider further what could be done to strengthen incentives for GP practices to opt into the practice budget scheme.

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Incentives currently envisaged

24. As we have so far developed the scheme, the main incentive to participate is the opportunity it gives GPs to improve the services they offer. For example, it enables them

i. to use hospitals which might discourage referrals if the money did not go with the patient.

ii. to generate funds to improve their practice by viring within the scope of the budget, for example by employing more staff or improving practice premises.

25. We have not so far introduced any element of direct, financial incentives to GPs personally. But there will be an important, indirect incentive of this kind to the extent that participating practices attract more patients and therefore increased remuneration through capitation fees. Any increase in the capitation element of the remuneration structure would, of course, increase this incentive effect.

Possible additional incentives

26. The possibility of introducing a personal, financial incentive of a continuing kind needs careful consideration. In earlier papers I have taken the view that direct, personal gain should not be permitted. My concern has been that we could be accused of diverting into GPs' pockets money which was intended - and had been voted - to provide services to patients. We would need to be sure that we had good answers to such a charge.

27. I proposed in HC 47 that, in addition to viring within the scope of the budget itself, practices within the scheme should be able to

i. carry forward any underspend, up to a limit of, say, 20% of their budgets, so that they could save up for, say, premises improvements.

ii. spend any surplus on aspects of the practice which fell outside the budget, but only subject to the agreement of the FPC.

One approach to incentives would be to offer practices within the scheme an optional, performance-related variant. Under this approach, practices which met specified performance standards would be free to retain without restriction up to, say, 5% of their budget in any one year, on condition that an

equivalent sum was clawed back by the Region. (On the basis of the assumptions in HC47, 5% would amount to around £3,000 or so for each GP.) We would need to develop and present this carefully as a way of buying high standards, not as a way of cutting costs at the expense of patients, and we would need to select the performance standards carefully with this in mind.

28. The Group will wish to consider whether we should float something along these lines in the White Paper. If so, I shall need to work up the detail, including some possible performance standards, in the meantime.

December 1988

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HC66

ACCESS TO PRIVATE CAPITAL

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

Our paper HC56 said that we would report back to the Group when we completed our further work on this question.

2. We have examined a range of projects which individual health authorities would like to undertake. In so doing, we have applied two general principles: that value for money must be secured on behalf of the taxpayer; and that, where the capital costs of a project ultimately devolve onto the taxpayer, there is a presumption that it should not be additional to the agreed public expenditure programme.

3. For the most part, the application of these principles to particular cases is clear, and we have found no reason why they should impede the projects from going ahead. The following are among the examples we have considered, and which we see every reason to encourage:

a. a joint venture between the NHS and the private sector, who share the construction of hospital facilities, with costs apportioned according to the use they plan to make of them. There would be opportunities for trading between the two sectors, with the private sector selling capacity to the NHS and the NHS selling diagnostic services, etc to the private sector. The NHS would receive rent from the private health care provider in respect of the land;

b. leasing NHS land, buildings or other facilities to private sector health care providers. The private sector would run facilities on an NHS hospital site. The lease might be on conventional repayment terms, or might enable the NHS as landlord to share some of the profits generated by the lessee;

c. as b., but with the lessee providing a non-health facility. This might be a hotel, shops, or a sports centre. It could sell its services to the hospital, to patients and to visitors. Again, the lease could either be conventional or involve an element of profit-sharing. This would be an alternative to the sale of the freehold, if the health authority considered that it offered a better deal;

d. leasing part of a hospital site to a housing association which would provide low-cost accommodation for NHS staff. The NHS might subsidise the lease, and possibly share in the profits. The housing association could either build afresh or refurbish existing accommodation.

4. In all these cases, there are no complications resulting from the private finance principles. The health authority needs to assess the commercial risks it faces from the venture (eg if its partner went out of business) and to ensure that it has the right management capacity and skills to deal with this as appropriate.

Contracting out

5. Contracting out is an issue, however, which raises slightly more difficult questions. In principle, if a service is contracted out to the private sector, the need for capital in the NHS is reduced. But since the contractor's fees will involve an element for the cost of financing its capital expenditure, the health authority's current costs rise. In principle, therefore, health authority capital allocations should be reduced, and current allocations increased. Where services have been contracted out so far, however - mainly, catering, cleaning and laundry services - the capital element in the contractor's fee has been so small as not to warrant any adjustment. But, at the other end of the spectrum, there are

cases where adjustments between capital and current allocations are clearly appropriate - for example, in the hypothetical case of a health authority which decided to contract out all its hospital services.

6. There is a grey area in the middle. It has already been explored for contract energy management schemes, under which a contractor takes over the energy management of a hospital, including perhaps the installation of a new boiler incorporating modern technology, with the aim of substantially reducing energy costs. Guidelines for taking account of the contractor's capital expenditure have been agreed across government. Rather similar issues will be raised by the need to upgrade or replace NHS incineration plant to comply with new statutory controls on emissions. Again, this is an area where the expertise resides in the private sector, and where significant capital expenditure by the contractor may be involved. Another case is that of a health authority which is seeking to contract out the care of some geriatric patients, rather than to replace itself an outdated and crumbling hospital.

7. Our two Departments are in touch bilaterally on these issues. We propose that officials should continue their work to clarify the ground rules in such cases.

Cost-saving projects

8. we have however identified one more difficult case. This is the financing of cost-saving projects of the sort now proposed for Bromley District Health Authority. In this case, outdated town centre facilities would be moved to a greenfield site just outside the town with the capital costs largely financed from the proceeds of selling the present sites. There would be recurrent savings from rationalisation. There is however a timing problem in that the land sales receipts are not available until after the new hospital has been constructed and the patients moved into it.

9. We are agreed about the desirability of such projects going ahead. In principle, there are three ways in which they could be financed:

a. by making room in the region's capital programme to finance the expenditure, taking credit for the associated receipts in later years;

b. by expenditure from a separate "fund" which is held back for allocation centrally rather than by regions, to which the eventual receipts are also scored. Such a "capital loans fund", which could be expected to be self-financing after about three years, was proposed by Department of Health in this year's public expenditure survey;

c. to enter into an arrangement with a contractor under which he builds the new hospital in return for vacant possession of the land so released. In effect he provides bridging finance between the construction costs and the land sales receipts. But such finance would carry a higher rate of interest than if the project were financed conventionally, as in options a. or b.

10. The Secretary of State considers that the Region's capital programme is fully committed for several years ahead, and health authorities have no objective basis for comparing cost-saving projects with those that meet service objectives. So service development inevitably tends to take priority in regional capital programmes. In the Secretary of State's view, the practical choice facing health authorities in this situation is between mounting the cost-saving project now using private finance or mounting it considerably later using public finance. In these circumstances, the Secretary of State believes that the extra costs would be outweighed by the benefit of bringing the project forward.

11. On the other hand, the Chief Secretary would argue that projects promising such a good return should be accommodated within the level of capital expenditure agreed for the NHS, even if regions do not give them high priority. This could be ensured by an arrangement on the lines of option b. Option c. would also mean giving greater freedom to health authorities than to local authorities, where we have recently been tightening up.

12. The responsibility of the Accounting Officer to secure best use of resources also needs to be considered. This issue is being addressed at present in the Bromley case, and will need also to be considered in any other such projects which are put forward.

13. We will be considering these options carefully in the Bromley case, with a view to agreeing how to proceed, with if possible an announcement around the time of the White Paper.

Conclusions

14. In conclusion, we invite colleagues:

a. to note that private finance considerations are fully compatible with a wide range of co-operative ventures which health authorities wish to enter with the private sector;

b. to agree that our two Departments should do further work on the detailed application of the general principles to the different types of contracting out which are possible;

c. to note that we shall be considering further the options for cost-saving schemes in the light of the specific Bromley case, with a view to reaching a conclusion next month.

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HC62

NHS Review

DRAFT WHITE PAPER

Note by the Secretary of State for Health

1. I attach for the Group's consideration on 16 December:

* a suggested outline of the White Paper.

* a first draft of the two introductory chapters.

* a first draft of the chapter on self-governing hospitals.

2. Work on the other draft chapters is proceeding as quickly as possible.

December 1988

SECRET

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WHITE PAPER: SUGGESTED OUTLINE

Chapter 1: Foreword

Chapter 2: Delivering a better service

Chapter 3: GP practice budgets

Chapter 4: Self-governing hospitals

Chapter 5: Managing resources

Chapter 6: The role of doctors

Chapter 7: Funding hospital services

Chapter 8: A better organisation

Chapter 9: Working with the private sector

Chapter 10: Health services in Scotland, Wales and Northern Ireland

Chapter 11: A programme of change

Note Subject to the outcome of the Group's discussion of HC63, it may be desirable to add a chapter on managing the FPS.

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Draft White Paper

CHAPTER 1: FOREWORD

1.1 This White Paper explains how the Government plans to reform, strengthen and revitalize the National Health Service to make it fit for the 1990s and beyond.

1.2 Underlying everything we propose is a simple aim - a service that puts patients first. To achieve that, we must build on all that is best in the NHS, while standing by the principles on which it was founded. Our Health Service must continue to be available to all, regardless of income, free at the point of delivery, and financed out of general taxation. The society it serves today, however, is very different from that of the 1940s when it was created. Nowadays, we all quite rightly expect better service, higher quality, more choice. It is to those ends that this White Paper is directed.

1.3 To deliver the highest standards of care that we all want the NHS must be run more efficiently. In this respect, it is just like other businesses. Like them, it will benefit from stronger and more flexible management. The spur of competition will sharpen its performance. The quality of its service will be improved if it listens to what its customers want. Greater efficiency is the key to a better, more caring service for patients.

services?

1.4 Change on the scale we propose is never easy. Nor will it happen overnight, for we must be certain that the new, modern NHS has strong and secure foundations. It will require huge effort and commitment from management and staff. I am confident that those who serve the NHS will make that commitment on behalf of those who use it.

Draft White Paper

CHAPTER 2: DELIVERING A BETTER SERVICE

Introduction

2.1 The NHS has an enviable record of success. Since it was established in 1948 it has played a major part in improving the nation's health. Immunisation and vaccination have virtually wiped out previously common diseases such as diphtheria and poliomyelitis. Perinatal mortality has fallen by three-quarters since 1948, and maternal mortality is down to 5% of its 1948 level. Medical advances have meant that people not only live longer but can enjoy a better quality of life. Transplant surgery, for example, is now commonplace, and it has become possible to carry out hip replacements for people in their seventies and eighties. The introduction of antibiotics has revolutionised the treatment of many diseases.

2.2 The NHS itself has grown out of all recognition. Its total gross expenditure has increased from £433 million in 1949 to nearly £24 billion in 1988/89, a fourfold increase in real terms. The number of hospital and community doctors and dentists has grown from [11,000] in 1949 to [43,000] in 1986, and the number of nurses and midwives from [130,000] to [403,000]. These staff now care for [3½ million] more in-patient cases than their counterparts in 1949. [The square-bracketed figures are for England and Wales only. UK figures are in preparation.]

2.3. Progress has been even faster in recent years. The service is treating 1½ million more in-patients, 4 million more out-patients and over half a million more day cases than it was a mere ten years ago. Improved productivity and a substantial increase in the money provided by Government have made this huge stride forward possible. The NHS now employs 15,000 more doctors

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and dentists and 70,000 more nurses than it did in 1978.

2.4 But although medical advance has been spectacular since 1948, the organisation that provides that care has not developed at the same rate. That is why the Government announced early in 1988 that it was undertaking a thorough review of the NHS. This announcement has in turn stimulated a wide-ranging debate. Many people share the Government's view that now is the time to bring the Health Service up to date.

The business of caring

2.5 Experience shows that direct, central government intervention and control is not the most effective way of delivering the services that customers want. By the same token, it is not the best way to deliver services for patients. It is essential that those whose job it is to meet the changing needs and wishes of those patients have the authority, flexibility and incentive to innovate and adapt.

2.6 Whilst remaining unique, the NHS must be run more like other businesses. The best businesses are geared to putting their customers first. They also know that their customers will get a proper service only if the unseen parts of the organisation are working well - if resources are properly managed; if talented people are found and given their head; if everyone working for the organisation is encouraged to give of their best, and rewarded for doing so.

2.7 Making the NHS more business-like will not make it less caring. It will mean that it can deliver better care and more care to more people than every before.

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Competition and choice

2.8 Doctors, nurses, managers and others who work in the NHS are committed to improving services for patients, and know how to do so. But they are often held back by the rigid way in which the service is presently organised and financed. The Government intends to free up the system by introducing more competition and more choice.

2.9 The most fundamental reforms proposed in this White Paper are directed to this end. In particular:

* large GP practices will be able to opt to have their own budgets for buying a range of services direct from hospitals. This will enable GPs and their patients to back their own choices with money, and the size of each practice's budget will depend on how many patients its GPs attract. GPs will be encouraged to compete for patients by offering better services. Hospitals will be encouraged to compete for the custom of GPs.

* hospitals will be given much more responsibility for running their own affairs. Major hospitals will be able to apply for self-governing status within the NHS. This means that they will be free, for example, to set the rates of pay of their own staff [and, within limits, to raise capital in the private market]. They will be free to sell their services to other parts of the NHS, to the private sector and to patients. Because they will have an incentive to attract patients, they will want to make sure that the service they offer is what their patients are looking for.

* funding arrangements will be changed so that each health authority's duty will be to buy the best service it can

from its own hospitals, from other authorities' hospitals, from self-governing hospitals or from the private sector. Conversely, hospitals will be free to sell their services to different health authorities. In this way money will in future go more directly to where the work is done best. At present a hospital or service which becomes more efficient and could treat more patients may be prevented from doing so by its budgetary limits. At the same time, one which is failing to deliver is still paid its share of NHS resources, calculated by means of a complicated formula. Any exercise of choice by patients and their GPs is thereby made ineffective. The Government's proposals will change this.

2.10 These and related reforms are set out fully in chapters [3,4 and 7]. They represent a shift of power and responsibility to people whose job it is, at local level, to advise patients, to provide services to them, or to fund services for them. By placing the patient centre-stage, they will improve the standard of service he or she receives.

Giving management the freedom to manage

2.11 In recent years the Government has given a high priority to strengthening the management of the NHS, most importantly through the introduction of general management following a report by Sir Roy Griffiths in 1983. The reforms outlined in paragraph [2.8] will build on this progress and take it further. It will become all the more important that objectives for improving services, and responsibilities for achieving those objectives, are clear; and that money is not spent ineffectively or inefficiently when it could be used to buy more or better services in other ways. Achieving objectives through the efficient use of resources is the job of management. Local managers in particular must be both freer and better equipped to do that job.

2.12 Chapters [5,6,8 and 9] propose a range of important changes to strengthen local management. They will build on the introduction of general management, and on the proposals for the better management of the family practitioner services (FPS) set out in "Promoting Better Health" (Cm 249). Among the most important aims behind these changes are:

* ensuring that hospital consultants - whose decisions effectively commit substantial sums of money - are involved in the management of hospitals; are directly responsible and accountable for their own use of resources; and are encouraged to use those resources more effectively.

* ensuring that GPs too take greater responsibility for their use of resources.

* introducing new arrangements for the effective monitoring of medical care by doctors themselves.

* providing the audit support which management needs, through a stronger and more independent source of financial and value-for-money audit.

* improving the information available to local managers, enabling them in turn to make their budgeting and monitoring more accurate, sensitive and timely.

* contracting out more functions which do not have to be undertaken by health authority staff and which could be provided cost effectively by the private sector.

* turning both District and Regional Health Authorities into tighter, more effective management bodies.

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* restructuring the national management of the service to provide for a corporate management team which is freer to manage the service within policy objectives and financial targets set for it by Government.

Customer care

2.13 All these reforms will in time improve the quality of the service that the NHS is able to offer those who use it. The quality of the medical and nursing care itself is widely recognised as excellent, but there are other changes which will make a real difference to the day-to-day services which patients receive.

2.14 Many people are still having to wait too long for treatment, and still have little if any choice over the time and place at which treatment is given. The Government has already done much to tackle this problem. Over the past two years, for example, an additional £55 million has been spent on reducing waiting lists and waiting times, allowing over 200,000 patients to be treated. A half of all waiting list patients are now admitted from the list in five weeks or less. But the problem remains.

2.15 The service provided by a hospital is still too often impersonal, inflexible and even stressful. Patients should be treated much more like valued customers. The practical improvements that may often be needed include:

* appointments systems which give people individual appointment times which they can rely on. Waits of two or three hours in out-patient clinics are unacceptable.

* quiet and pleasant waiting and other public areas, with proper facilities for parents with children, for counselling worried patients or relatives, and so on.

* clear information leaflets about the facilities available and what patients need to know when they come into hospital.

* once someone is in the hospital, clear and sensitive explanations of what is happening: on practical matters, such as where to go and who to see; and on clinical matters, such as the nature of an illness and its proposed treatment.

* clearer, easier and more sensitive procedures for making suggestions and, if necessary, complaints.

* rapid notification of the results of diagnostic tests.

* a wider range of optional extras and amenities for patients who are prepared to pay for them - a choice of meals, single rooms, personal telephones, TVs and so on.

2.16 The Government has prepared detailed proposals for making the NHS much better able to offer shorter waiting times for treatment and an improved quality of service. The chapters which follow set out these proposals in full.

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Draft White Paper

CHAPTER 4: SELF-GOVERNING HOSPITALS

Introduction

4.1 There are currently over 320 major acute hospitals in the UK - "major" defined as having more than 250 beds. This chapter sets out the Government's proposals for enabling as many of these hospitals as are willing and able to do so to run their own affairs.

4.2 Major acute hospitals are substantial businesses. Even the smallest of the management units which currently run these hospitals may have revenue budgets in excess of £10 million a year. The largest may have budgets in excess of £30 million. Yet none of these hospitals can employ its own staff or enter into contracts in its own right. Nearly all of them are run by health authorities which have other responsibilities as well - psychiatric and other single-specialty hospitals, community health services, and so on. In England alone 66 District Health Authorities (DHAs) are responsible for two or more major acute hospitals.

4.3 It is already a central plank of Government policy to push down decision making to local, operational level. Some of the larger acute hospitals now have substantial responsibilities delegated to them for running their own affairs. The Government intends to take this process a significant stage further by providing for a new, self-governing status within the NHS.

4.4 The Government believes that greater independence for hospitals will encourage a stronger sense of local ownership and pride, building on the enormous fund of goodwill that exists in

local communities. It will stimulate the commitment and harness the skills of those who are directly responsible for providing services. Supported by a funding system in which successful hospitals can flourish, it will encourage local initiative and - particularly in urban areas - greater competition. All this in turn will ensure a better deal for the public, improving the choice and quality of the services offered and the efficiency with which those services are delivered.

Hospital Trusts

4.5 The powers and responsibilities of each self-governing hospital will need to be formally vested in a board of management. The Government will bring forward legislation enabling the Secretary of State to establish such boards, to be known as Hospital Trusts. The Government proposes that Hospital Trusts should be constituted as follows:

* each should have ten members, five executive and five non-executive, and in addition a non-executive chairman.

* the chairman should be appointed by the Secretary of State.

* of the non-executive members at least two should be drawn from the local community, for example from hospital Leagues of Friends and similar organisations. These two "community" members should be appointed by the Regional Health Authority (RHA). The remaining three non-executive members should be appointed by the Secretary of State on the advice of the chairman. All the non-executive members should be chosen for the contribution they can make to effective management of the hospital. None should be an employee of a health authority or hospital, of a trade union with members who work in the NHS, or of a major contractor or other

hospital supplier. For teaching hospitals, the non-executive members will need to include a representative of the relevant medical school.

* the general manager, as chief executive, should be appointed by the non-executive members.

* the remaining four executive directors should include a medical director, the senior nurse manager and a finance director.

4.6 Hospital Trusts will assume all the powers and responsibilities previously exercised by the hospital's health authority. Specifically, they will be empowered by statute to employ staff; to enter into contracts both to provide services themselves and to buy in services and supplies from others; and to generate income within the scope set by the Health and Medicines Act 1988.

Funding and accountability

4.7 A self-governing hospital will need to generate income by selling its services. The main buyers will be health authorities. Other buyers will include GP practices with their own budgets, private patients or their insurance companies, and perhaps other self-governing hospitals. This form of funding will be an opportunity for growth and a stimulus to better performance.

4.8 It will be an opportunity for growth because the money will flow to where the patients are going. If a hospital attracts more patients it will get more income. A successful hospital will then be able to invest in providing still more and better services.

4.9 The funding arrangements will be a stimulus to better performance for two reasons. First, they will inject an element of competition. There will not always be an alternative provider of, say, local accident and emergency services. But for some services - and in some areas for many services - the hospital will be at risk of losing business if it does not meet the needs of its customers. Secondly, the hospital's contracts will need to spell out clearly what is required of it, in terms of both price and quality, by those who entrust patients to its care.

4.10 Each Hospital Trust's line of accountability will be through these contracts. The consequences of a failure to meet the terms of a contract - potential loss of future business, for example, or renegotiation of the contract - will be for the buyer to settle. The arrangements set out in chapter [7] will ensure that patients who are in need of urgent treatment are not turned away from a hospital simply because their treatment is not, or may not be, covered by a contract with that hospital.

Freedom and responsibility

4.11 The Government proposes to give Hospital Trusts a range of powers and freedoms which are not, and will not be, available to health authorities generally. The Government believes that greater freedom for self-governing hospitals will create more scope for competition, diversity and innovation within the NHS. Greater freedom for their leadership will stimulate greater enterprise and commitment, which will in turn improve services for patients. Self-governing hospitals will be a novel part of a system of hospital care alongside health authority-managed and private sector hospitals, and will increase the range of choice available to patients and their GPs.

Employment of staff

4.12 The Government intends that Hospital Trusts should be free to employ whatever staff they consider necessary, irrespective of any manpower controls which may apply to health authorities. The only exception should be junior doctors' posts, which will continue to need the approval of the relevant Royal College for training purposes. The Government sees it as particularly important that Trusts should employ their own consultants. Where consultants work also for other NHS hospitals or in the private sector, a Trust will need to employ them on a part time basis consistent with their commitment to the Trust's hospital.

4.13 The Government also intends that Hospital Trusts should be free to settle the pay and conditions of their staff, including doctors, nurses and others covered by national pay review bodies. [Expand and/or modify in the light of the Group's decisions on pay flexibility.]

Capital assets

4.14 [This section will need to be expanded and modified in the light of the Group's decisions on "Capital".] The Government intends that the assets of a self-governing hospital should be vested in the Hospital Trust, as follows:

* the Trust will be free to use the hospital's assets to provide health care, in accordance with stated purposes laid down by the Secretary of State when self-governing status is granted.

* the Trust's management of its assets will be subject to independent audit in accordance with the proposals in chapter [5].

[* sub-paragraph on disposal of assets.]

[* sub-paragraph on charges/"interest" payments on the Trust's initial "debt".]

* the hospital's assets will revert to the ownership of the Secretary of State if for any reason the Trust is wound up.

Capital investment

[4.15 Paragraph[s] to be drafted following the Group's decisions on "Capital".]

Achieving self-government

4.16 The Government will lay down a simple, flexible process for establishing a Hospital Trust. A hospital has no definable constituency equivalent to, for example, the parents of children attending a school. It will therefore be open to a variety of interests either to initiate the process or to respond to any initiative taken by the Secretary of State. These interests could include the DHA, the hospital management team, a group of staff, or people from the local community who are active in the hospital's support.

4.17 Similarly, the Government is not proposing a rigid definition of what a "hospital" should be for the purposes of self-government. For example, it will often be sensible for two neighbouring hospitals to combine, or for a hospital to retain its existing obligations to run a range of community-based services.

4.18 The Government intends that hospitals should have to meet only a few essential conditions to achieve self-governing status.

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It has two main criteria in mind. First, management must have the skills and capacity to run the business, including strong and effective leadership, sufficient financial expertise and adequate information systems. Secondly, senior professional staff, especially consultants, must be involved in the management of the hospital, and there should be a comprehensive system of medical audit along the lines proposed in chapter [6]. The Secretary of State will also need to satisfy himself that self-governing status is not being sought simply as an alternative to an unpalatable, but necessary, closure.

4.19 The Government will look to RHAs to play an active part in guiding and supporting hospitals which can be expected to meet these criteria and are interested in achieving self-government. In each case the Secretary of State will need to satisfy himself at an early stage that there is a good prospect of being able to approve the creation of a new Hospital Trust. With the advice of the RHA, he will also need to identify a "shadow" chairman who can act for the hospital in preparing the ground.

4.20 The RHA will be responsible for establishing the precise range of services and facilities for which the proposed Trust will be responsible; for ensuring that the proposal to seek self-governing status is given adequate publicity locally; and for preparing and submitting a formal application to the Secretary of State. No-one will have the right to veto such an application.

Implementation

4.21 The Government believes that self-governing hospitals have a major role to play in improving services to patients. It will therefore encourage as many major acute hospitals as possible to seek self-governing status as Hospital Trusts. The Government's aim is to establish a substantial number of Trusts with effect from April 1991, in the wake of the necessary legislation. The

experience gained will then inform the process of establishing more Trusts in later years.

4.22 In the meantime the Government will take the initiative, with the help of RHAs, in identifying suitable candidates for self-government and encouraging them to seek and prepare for self-governing status. The Secretary of State will be publishing shortly a more detailed document which will form a basis for discussion with interested parties. The aim will be to ensure that the hospitals concerned make productive use of the next two years by building up their capacity to run their own affairs effectively and by securing the maximum devolution of management responsibility from their DHAs. Self-government will then be - as it should be - a natural step forward from devolved management within the present structure.

4.23 The establishment of self-governing hospitals will mean a substantial change in the responsibilities of the DHAs which were previously responsible for their management. The Government does not believe that this implies a wholesale reorganisation of the NHS. But as more and more proposals come forward for establishing Hospital Trusts, RHAs will consider the viability of existing DHAs and, if appropriate, propose mergers of neighbouring Districts. The implications for the role of DHAs are set out more fully in chapters [7] and [8].