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PRIME MINISTER

21 DECEMBER 1988

WHITE PAPER: FIRST DRAFT

Overall, this is a good first draft of the White Paper. The theme of improving patient service by devolving responsibility down the line is clearly presented. And GP practice budgets and self-governing hospitals rightly take centre stage in the paper. Chapter 12 gives an excellent summary of the main reforms and benefits.

But there are a number of significant problem areas that will need to be tackled:

- Some chapters are too wordy, require more punch and will need to display greater conviction behind the reforms.

- The rationale behind the changes needs to be more clearly stated (Chapter 2).

- It is essential that more work is done on GP budgets (Chapter 3).

- The distinction between self-governing hospitals (Chapter 4) and DHA-managed hospitals (Chapter 5) should be brought out more clearly.

- The proposed procedure for the medical audit of GP practices is too vague (Chapter 8).

- The draft white paper - and many review papers before it - lack real conviction behind the central role and authority of the NHS Management Board (Chapter 9).

Also, a final decision is required on the proposed tax relief for health insurance payments by the elderly (Chapter 10).

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Chapter 2: Delivering a better service

There needs to be a clearer delineation between the sections on 'the business of caring' (Para 2.5) and 'customer care' (Para 2.13). The similarity of the titles fuels this confusion. Also, the waiting list problem is mentioned after the main reforms have been listed. We need to explain the necessity for the changes before they are discussed in Para 2.8 onwards.

Chapter 3: GP Practice Budgets

The Treasury has reached an impasse with the Department of Health. First, they do not believe in the overall concept of GP budgets. In particular, they remain unconvinced that the benefits outweigh the risk of higher costs. Second, they do not accept that the scheme is workable. I agree with the second point but not the first.

It is essential that the Treasury is not permitted to water down the introduction of GP budgets for a number of reasons:

1. Most of the proposed changes are several steps removed from the patient. They will take time to bite. On the other hand, GP budgets will give patients a greater say.

2. GP budgets will help break the monopoly of districts operating as buyers. Cosy arrangements between districts and hospitals would be challenged.

3. If GP budgets become more limited in scope, their impact will be marginal.

4. The risk of a major increase in expenditure is slight. If all large practices - with over 11,000 patients -

opted out, the total budget for these GPs would be no more than £400 million.

The benefit of GP budgets should outweigh the risks. But the Treasury is right to question the workability of the scheme as proposed by DoH. I have two major concerns:

First, bureaucracy could start burgeoning like a banyan tree. Para 3.12 states:

> 'The Government believes that the fairest and least cumbersome approach is for GP practices within the scheme to negotiate their budgets with the relevant DHA, which will in turn need to consult the practices FPC'.

These tripartite discussions will be a recipe for confusion. Allocation to GP practices should be based upon the same formula as the allocation to the district.

Second, the day-to-day operation of the GP budgets is still unclear - in particular the role of virement in Para 3.9. In my previous note, I suggested that we should treat the GP budget like a 'client account' in a firm of solicitors. The bank balance would be segregated from other GP practice money.

In this way, the operation of the budget is well defined and the benefits are clear. Expenditure could be incurred by the GP practice as follows:

(1) A fee to cover the management and other costs of participating in the scheme (as in Para 3.20).

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(2) Payment for elective surgery from DHA-run hospitals, self-governing hospitals or the private sector.

(3) Payments for minor surgery carried out in the GP practice.

(4) A performance bonus would be paid to each GP (examined in more detail below).

(5) Savings would be retained as a reserve for future years - up to a maximum.

(6) Any surplus would be returned to the Region to be used to offset any shortfalls in other practices or to improve other services.

Many have criticised the concept of a bonus on the basis that GPs will be encouraged to underprovide. Ken Clarke prefers to camouflage the bonus by enabling GPs to plough back 50% of any surplus into improving their practices and offering more and better services to their patients (Para 3.18). Most people will see through this guise as a back-handed payment to the GP.

The political arguments would be countered by making it clear that performance payments will also depend on the result of medical audit and financial audit. More importantly, performance payments will only be paid if GPs pay a surplus back to the Region. This money will be used to improve services elsewhere.

Chapter 4: Self-Governing Hospitals

Para 4.5 — Hospital Trusts

Not in their capacity as councillors

Could local authorities councillors be members of the governing board of a Hospital Trust?

Para 4.14 — Employment of staff

This paragraph states:

'But Hospital Trusts will be free, by agreement with their staff, either to continue to follow national pay agreements or to adopt partly or wholly different arrangements.'

The phrase 'by agreement with their staff' should be taken out. In practice, management would negotiate with staff but we should not state this implicitly.

Para 4.17 — Borrowing capital

As agreed in the last meeting, this paragraph will need to state that Hospital Trusts will have to bid for a proportion of the annual financing limit.

Para 4.20 — Achieving self-government

The first paragraph rightly states that hospitals should have to meet only a few essential conditions to achieve

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self-governing status. So far so good. But the paragraph then goes on to list too many essential conditions.

Chapter 5: Managing the Hospital Service

Para 5.3 Introduction

It should be made clear that DHA-managed hospitals will not have the same flexibility as self-governing hospitals. The statement 'but the Government believes that the same principles should be applied in all hospitals' is unclear and inaccurate.

Para 5.17-18 Cross-border flow will not increase without a strong information technology base.

But I am still sceptical as to whether a nationwide Resource Management Initiative is the best way forward. Local Management should be the driving force behind the introduction of information systems, not central management. The role of the centre is to set minimum criteria and to allocate resources and then to monitor results.

Kenneth Clarke should be asked to report on the results of the RMI so far.

Chapter 6: The Work of Hospital Consultants

Para 6.17 Will consultants still be able to appeal to the Secretary of State? The phrase 'should normally lead to concluding an appeal within nine months of the dismissal' is vague.

Chapter 7: Funding Hospital Services

Figure 7:1 — Graph of Regions distances from RAWP revenue targets.

This looks like a Department of Transport plan for future roadbuilding! It is incomprehensible. The graph should be simplified or perhaps excluded completely.

Para 7.13 — Allocation to DHAs

Kenneth Clarke will need to clarify the meaning of the statement 'such changes must be carefully managed over a period of time'. Will this be RAWP 2?

Para 7.28 — Funding specialist services

The paper proposes 'central funds will cover the fixed costs of the units providing these services with the variable costs covered by contract funding from buyers'.

This will be extremely difficult to operate in practice. What is the exact dividing line between fixed costs and variable costs? Will there be a temptation to abuse the system?

Surely, districts should be responsible for buying specialist services, including fixed and variable costs of managing the services. Why should this system be any different to other health services?

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Chapter 8: Managing the Family Practitioner Services

Para 8.4 Medical Audit

The proposals for medical audit should be tightened up. I have two main concerns.

First, less detailed medical records is no excuse for weaker audit procedures. A central audit procedure - not mentioned in the paper - should be to send a circular by post to patients on the GPs list, eliciting the patients' own views on the quality of service provided by the GP (in confidence).

Second, the effectiveness of the proposed self-audit is unclear. What does self-audit mean? As part of a GPs contract, they should be willing to spend a few days a year on audit in other practices.

Para 8.7 Capitation Fees

This paragraph states that average remuneration of GPs accounted for by capitation fees will be increased 'from 46% to 60%, as soon as possible'.

This is very tentative. Could it be changed to '46% to at least 75%'?

Para 8.18 Composition of FPCs

If we have to keep FPCs separated from DHAs the proposed number of members on an FPC (12) should not exceed that proposed for a DHA (11). Could we limit FPC membership to 10 or 11 members?

Chapter 9: Better Decision-Making

Para 9.6 Composition of health authorities

What does the phrase ' the executive members, who will be co-opted by the non-executive members' actually mean? Co-opted members are usually additional to the core board.

Para 9.9 Central Management of the NHS

One comment is particularly worrying in this paragraph 'The government proposes however to streamline management arrangements with the Department by giving the Board a clear role in major strategic issues'. This statement is extremely unclear.

Surely, the NHS Management Board should be given a clear mandate to manage the health service, not merely to 'deal with day-to-day operational matters' as suggested in this section. The Board should report direct to the Secretary of State, not via a Policy Board, as suggested. I have no doubt that such a Policy Board would be controlled by officials. This would be a recipe for

failure. The NHS Management Board would not gain any real authority and strong business leaders will continue to be unattracted to work in such a confused environment.

Chapter 10: Working with the Private Sector

This chapter will need a lot more attention. It is tentative and poorly written.

Para 10.8 Competitive Tendering

This paragraph stresses the wider scope for competitive tendering, beyond non-clinical support services. But it is far too vague. Specific examples should be given, such as pathology testing and drug management. Also, it should highlight the enormous scope for additional non-clinical support services, as the CBI report shows (Appendix).

Tax relief on health insurance premium in respect of for the elderly

This issue must be finally resolved in the meeting. The arguments for and against tax relief have been well aired. Tax relief would give an immediate stimulus to the private sector. But the actual benefits are difficult to estimate.

On balance, I believe we should incorporate this fiscal stimulus, provided it is also available for families willing to contribute towards the cost of insurance premiums for their elderly parents. This will help diffuse the political problem that we are only giving tax relief to the rich elderly.

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Chapter 11: Health services in Scotland, Wales and Northern Ireland.

These papers have just been received. Comments will follow later.

Ian Whitehead

IAN WHITEHEAD

Extract from - Report of the CBI - The Competitive Advantage. Appendix.

Extending competition

51 The CBI Task Force agrees with the Treasury's conclusions[18] that:

- the prime objective of competitive tendering should be value for money;
- *all* activities should be examined to assess the scope for competition;
- managers should account for decisions to stay in-house;
- value for money does not always mean the lowest tenders.

52 Though there is now a much greater appreciation of commercial realities in the public sector, the Task Force does not believe this has developed sufficient momentum to carry forward the extension of competition on the scale required. Legislation has so far been the most effective method of extending competition and, while it would be preferable to proceed by co-operation rather than coercion, regrettably this must still be the main way forward. But the approach taken will need to vary between different areas of Government, and the co-operation of individual managers will be an important factor in ensuring success.

The National Health Service

53 At present no central initiative is planned to extend competitive tendering to other activities in the NHS. The three ancillary services at present subject to competition make up only 28% of non-medical support expenditure in hospitals and community care. (Table 9). Services not so far covered include: portering, security, medical records, building maintenance and grounds and garden maintenance. In addition, it is not clear what proportion of capital expenditure, which includes the professional support services of architecture, quantity

[18] 'Using Private Enterprise in Government', HM Treasury, 1986

Table 9
Total spending on hospital and community care services in England, 1986/87

		£ million
Patient care services		6,485
of which:		
Medical, nursing, and dental staff services	4,640	
Supplies, equipment, and services	871	
Medical and para-medical support services	974	
General services		2,902
of which:		
Administration	622	
Medical records	115	
Training and education	58	
Catering	361	
Domestic/cleaning	377	
Laundry	151	
Portering	63	
Linen services	121	
Transport	43	
Estate management:		
engineering maintenance	282	
energy and utility services	264	
building maintenance	153	
ground and gardens	22	
general estate expenses	164	
Miscellaneous	86	
Additional administration costs		435
Capital expenditure		937
Total spending		10,759

Source: Health Authority Annual Accounts, National Summary 1986-7

surveying and law, is open to competition. Consistent application of the principle of competition demands that professional services also be subject to the discipline of specification and outside competition.

54 If competition were extended to all general non-medical services and cost reductions of a similar proportion to those on ancillary services are achieved, the savings would be worth over £350 million. The non-front-line medical services, such as pathology, cervical and cytology screening centres, pharmacies, radiology and radiography departments have also been put forward as candidates for competition. Including these areas could make possible a further £300 million of savings. There is also potential for competition in some clinical services.

55 In view of this great potential, the Task Force recommends that, each year, the NHS central administration should select a range of services which could be opened to competition. These could be piloted in, say, 10 different Health Authorities, which *volunteer* to open the particular services to competitive tendering or contracting out. With successful pilot schemes in existence, compulsory tendering of all authorities would be the logical next step. This step by step approach would utilise the co-operation of local management and alert managers to potential problems and pitfalls. Closer monitoring of competitive tendering will be needed and the Task Force therefore believes that the plan to cease collection of the costs of contracts and the savings on them is a mistake.

Central Government

56 Outside the NHS, the main problem facing central directives is the differing nature of departments' operations. The major 'common-denominator' services of catering, cleaning, security and maintenance have already been designated for compulsory tendering. The Task Force notes the slow progress in tendering for security services and the lack of data on which to assess the proportion of maintenance expenditure which is subject to competition.

57 The Task Force therefore recommends that the principal responsibility for choosing the specific areas to which competition is to be extended should rest with individual departments. Nevertheless, an increasing proportion of running costs should be subject to competition each year and these targets should be set by the Treasury with the aim of covering the majority of all departmental expenditure as soon as is practically possible.

58 Individual departments should develop a 'competitive position', laying out the progress of competitive tendering within their own budget. This should be published as a chapter in the department's Annual Expenditure Report, which will replace Volume II of the Public Expenditure White Paper in January 1989. The 'competitive position' should include:

- the extent of expenditure under different functions which is subject to competitive tendering, plus a target for the next three years;
- an assessment of the savings from competitive tendering, together with an estimate of the costs of the tendering exercise, highlighting any gaps in the market where private sector tenders were not forthcoming;
- properly audited budget out-turns for successful in-house providers compared with their budgeted bids;
- an analysis of the quality of service, drawing on customer survey work and the department's monitoring procedures. The criteria applied should be the same for both in-house provision and private contractors.