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PRIME MINISTER

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NHS REVIEW

The current papers from Kenneth Clarke are very much better than anything we have had to date. They are detailed, tackle the issues you raised and set out a plausible scenario for the move towards self-governing hospitals and budgets for general practices.

These two reforms are central to the review. They build upon the theme of the conference debate - the need for a more efficient service responsive to consumer demand. This central message was well received by delegates.

But a number of questions still remain. The proposed pace of change is still timid. And barriers to self-governing status should be minimized as far as possible. Some of the proposed controls are still too bureaucratic.

Other papers proposed in last week's meeting have not been presented for consideration on Monday for two main reasons, both reasonable. First, officials have focussed their energy on preparing two detailed papers on the central issues. Second, Monday's decisions will influence the drafting of the follow-up papers. But it is crucial that momentum is maintained. Progress on the 'capital' paper is extremely slow. DH and Treasury officials are unlikely to resolve their differences quickly. Kenneth Clarke and John Major should be urged to present a paper at the next meeting (incorporating their differences of opinion, if necessary).

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PACE OF CHANGE

The papers reflect a greater commitment to the concept of self-governing hospitals and GP budgets. But the suggested pace of change is very slow. Paragraph 4 of the paper on self-governing hospitals proposes "at least some major acute hospitals to be self-governing within the NHS." Paragraph 35 suggests "at least 5 or 6 hospitals become self-governing with effect from April 1991". Later on the paper suggests 30 to 40 hospitals should be self-governing by 1994. But if we set higher short-term targets we will raise expectations of what is possible. Then the driving force behind reform will be more positive.

One argument for moving at a snail's pace will be that NHS hospitals do not have the necessary quality of management.

This is absolutely true in most cases at present. But it is a misleading argument, often raised by those who would prefer to maintain the status quo - namely, DH and Treasury officials.

There are many counter-arguments to this claim:

1. Responsibility will be devolved down to the hospitals. Governing boards will therefore have to take a first major step. That is to appoint competent managers. These may or may not be employed on the existing staff. Peer group pressure will encourage this process. Hospitals will compete for high calibre staff in their eagerness to attract patients to their hospitals.

2. Private sector firms will emerge - they are doing so already - to direct and train managers. Peat Marwick Mitchell, sensing the change in climate, has recently set-up one such consultancy unit. Firms will also advise, and sometimes provide, computer services.

3. Attitudes will change very quickly. For example, Winchester hospital is instituting a computer-based "patient care plan". Each ward will house 2 or 3 computer screens. Drugs, pathology tests, and X-ray tests will be ordered by the consultant on the computer terminal. Management information will then emerge as a by-product of the system, not as a necessary evil. Many of the consultants are responding very favourably to the changes.

4. We had a similar debate on schools opting-out of local government control. Local education authorities, unions and the education establishment resisted the changes fiercely. Yet now there is much greater enthusiasm. Why? Because heads and senior teachers value their new freedom and because they see firms emerging to advise schools on management techniques.

5. The NHS has focussed on building up management strength at the district level. There will be a need to winkle out the management expertise at DHA level. Expertise needs to be devolved alongside responsibility.

The government is loosening its control over education and housing. Kenneth Clarke's paper needs to reflect a faster pace of change in health. The move towards GP budgets and self-governing hospitals should be driven by an action - orientated team in the Department of Health (possibly with very small regional teams).

SELF-GOVERNING HOSPITALS

Detailed points as follows.

Paragraph 7 The paper proposes that the Region will allocate 'capital grants' down to the hospitals. But surely, capital will not be a free good in the new world. In practice, hospitals would compete for fresh capital to maximise their return on investment. I assume that this is merely incorrect word usage.

Question: Should the phrase 'capital grants' be changed to 'capital investments'?

Paragraph 11 The paper suggests that staff pay rates will increase in self-governing hospitals once they are free from the Whitley system.

This is realistic. But private hospitals pay nurses at the same basic rate as NHS hospitals. Nurses are attracted by flexible working hours, stronger management and performance pay. Basic pay is unlikely to change. Total pay may be higher, but it will be linked to stronger financial performance.

Question: What is the papers rationale behind higher basic pay levels?

Paragraph 19/20 The arguments supporting the statutory body are flawed. The paper rejects the limited company model on the basis that special legislation is required. But a statutory body would require legislation also.

If we expect self-governing hospitals to operate on a level playing field with the private sector (or at least as level as possible), why not use the limited company concept? Would a statutory body (or trust) be motivated by profit? A company limited by guarantee would compete for business, generate earnings, pay taxes, pay performance bonuses to staff, reinvest retained earnings in new equipment and dispose of assets where necessary. A level playing field then becomes a reality.

Paragraph 22 There is a danger that the two non-executive members, drawn from the local community, will have no business expertise. And there is an even greater risk that they could be left-wing agitators on the local council. They will not have voting control. But they may decide to publicise difficult decisions taken by the Board. There is a real possibility that one or two members could keep a stranglehold on the Board. I believe that the local community should be represented on the CHC only, not on the hospital board.

Question: Why not restrict non-executive directors to those with professional and business experience? Business skills will be essential to the process of change.

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Paragraph 27 I believe that we should place no restrictions on the minimum size of self-governing hospitals. Small businesses are central to the booming economy in Britain. There is no reason why small specialist hospitals should not seek independence. Financial expertise could be provided by outside firms on contract.

BUDGETS FOR GENERAL PRACTICE

The Treasury will criticise the paper on three main counts.

First, they will argue that GPs will not be efficient at managing their budgets. And that costs will increase because of the need to appoint a practice manager. This is illusory. A number of larger GP practices have already appointed practice managers. A 4 partner practice in Beaconsfield to which I have talked has found such an appointment invaluable. The salary, which is paid out of the GPs' capitation fees "more than justifies her salary" according to one of the partners.

Second, they will argue, quite correctly, that GPs will need to be offered an incentive to manage their own budget. The incentive to attract more patients may not be enough. The paper suggests an incentive to manage drug bills more effectively. Why not apply similar incentives for managing the elective surgery budget? The Treasury will then argue, quite incorrectly, that incentive payments will force up the capitation fee because of pressure on costs. But incentives will only be available where GPs operate within their budget. Medical audit will be the counter balance to under referring.

Third, they will argue that FPCs should be cash limited for their drug expenditure. I agree with this. But this in itself is not a criticism of the GP budget concept. Cash limiting would actually enhance the budgeting concept. GPs would be more accountable for their prescribing practices. As in elective surgery budgets, the FPC (or GP) would need to hold a reserve fund.

In summary, the Treasury criticisms should not be allowed to stand in the way of this reform.

Detailed comments on the paper as follows:

Paragraph 3: Roy Griffiths suggested, quite reasonably, that accident and emergency budgets could be included in the GP budget. 75 out of the 260 major acute hospitals are located within 2 miles of each other.

Question: Why not include accident and emergency costs in the GP budget?

Paragraph 7: Revenue allocation for elective surgery and out patient costs will be allocated to the Regions, then to the Districts and then to the GPs. Surely we should be cutting down the responsibility of DHAs.

Question: Once the capitation fees have been fixed for a GP who has opted out, why not bypass the district?

Paragraph 16: There is no reason why a contractual limit should not be placed on the number of referrals. A limit on referrals would place a useful discipline on GPs. And it would encourage GPs to carry out more minor surgery.

Paragraph 22: The GP will need to take certain responsibilities over waiting lists. A GP could institute a system requiring the consultant to contact the GP if a patient's waiting time exceeded a pre-agreed maximum. The GP will then use his reserve budget to pay for treatment in another hospital. Otherwise, he may find his patient list falling because of poor service.

Paragraph 26. The mechanism for 'carry forward' is unclear. This needs clarification. Also, one possible incentive to minimising overspending would be to charge interest on carry-forwards.

SUMMARY

The two papers are the best we have seen so far. But a number of issues need to be addressed, notably the slow pace of change. It is crucial that the two reforms be driven ahead side by side, as quickly as possible.

Six key points need be agreed at the meeting.

1. Higher targets need to be fixed for numbers of self-governing hospitals.

2. A small, action orientated team of professionals should be set up to drive the process.

3. The two non-executive board members, drawn from the local community, should have a business background.

4. The proposed system of revenue payments to GPs should be simplified.

5. Actual budgets (not notional) should be set for drug expenditure.

6. Kenneth Clarke should be asked to present all remaining papers to the next meeting.

Ian Whitehead

IAN WHITEHEAD