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PRIME MINISTER

National Health Service

Meeting of Ministers 24 May 1988

Paper by Secretary of State for Social Services

20 May 1988

DECISIONS

The Secretary of State's paper develops his proposals for separating the buying and provision of health services by establishing:

- independent hospitals or groups of hospitals; and

- local health agencies, which would buy services for patients from these hospitals.

2. The Group has been attracted to the idea of independent hospitals. But at its last meeting it decided it wanted more information about how the buying arrangements would work on the ground before it could endorse those in principle. The Secretary of State was therefore asked to write this paper.

3. The central issue for this meeting is whether the Group agrees that the buying arrangements proposed by the Secretary of State are right in principle and represent a substantial improvement in present arrangements. In considering this, you will want the Group in particular to explore their practical effect. If the Group decides that the proposals are right in principle, it will want to consider them in more detail, as suggested by the Secretary of State in his covering minute. But you will want to be reasonably sure that the proposals are broadly on the right lines before further detailed work is done on them. If you have any doubts about their clarity or practicability in management terms, one

possibility would be to invite Sir Roy Griffiths to prepare a paper, drawing on his management experience, about how he would make the proposal for independent hospitals and statutory buyers work in practice.

ISSUES

Who are the buyers?

4. This is a critical question. It is not discussed in much detail in the paper. This says simply that the buying agencies will be 'the successors to the present health authorities and family practitioner committees' (paragraph 5) and might have a typical population of around 500,000 (paragraph 7).

5. You will want to probe the following points:

- Will the buying agencies simply be the present district health authorities (DHAs) under a new name? Will they entrench the present NHS bureaucracy? Or can the Secretary of State give an assurance that they will be much smaller bodies? and that they will be non-political?

- Why does the Secretary of State think the right population is likely to be about 500,000? This presumably indicates around 100 buying agencies, as against 190 DHAs, but no doubt there would be some regional variation. What is right for an inner city would not necessarily be right for a rural area.

- What will happen to the Regional Health Authorities (RHAs)? The paper refers (Annex 2, paragraph 3) to the value of an effective regional tier, although it also says that at a much later stage (Annex 2, paragraph 4) the role of the regional tier can be reviewed. So it looks as if the RHAs will be kept, at least at first. Is that necessary?

- What will happen to the Family Practitioner Committees (FPCs)? The reference in paragraph 5 to the local buying agencies being successors to the FPCs suggests that FPCs will be abolished. Is that correct? Does Mr Moore see any difficulty about the public presentation of this, in view of his White Paper last November which referred to "an enhanced role" for FPCs?

The role of the GP

6. This is unclear, and you will want to probe it. If, as proposed, the agency buys services by placing contracts with providers, it would seem that the GP could refer only to the providers chosen by the agency. This would be said to reduce his freedom of referral, and thus be a reduction in the service which the patient could get from the NHS.

7. Paragraph 16 however appears to propose that in the last resort the GP would retain the right to make referrals of his own additional to those for which the agency had contracted. Is the Secretary of State suggesting that the GP can override the buying agency? How will the override work? How will it be financed? The paper apparently suggests a cash limited 'back pocket' from which the agency would fund independent GP referrals. Would that arrangement lead to argument between the agency and the GP? Who would decide the cash limit and what would happen when it was reached? Would bids on the agency's reserve take a long time to deal with, so that GPs might be reluctant to make an independent referral?

8. The paper also refers to GPs as 'providers' (Annex 1, end of paragraph 2) as well as buyers, in the sense of making their own referrals. It is not necessarily impossible for them to assume both roles but you may want to probe the point. You may also want to ask how the GP would be paid. There is no need to settle the detail now, but you will want to be reasonably sure that the relationship between the GP and the buying agency will be workable in practice.

<u>Competition between agencies</u>

9. The paper does not apparently envisage competition between the agencies, at least at first. It refers to them as having populations for which they are responsible (paragraph 6), and refers to competition only as a possibility 'in due course' (Annex 2). <u>This concept of buying agencies which do not compete between themselves and have resident populations strengthens the impression that they are Health Authorities under another name</u>. <u>You may want to explore whether this is the only model</u>. For example, could there be competition between buyers right from the start with FPCs or groups of GPs setting up as buyers? Such competition would, apart from its general advantages, reduce the conflict with the GP's right of referral, since GPs, even if they were not buyers themselves, would be able, if they did not like the providers chosen by their buyer, to transfer to one of its competitors. And if GPs themselves were buyers, the structure could be radically simpler, without the need for an agency at all; but most GPs would not be equipped to take on this task at present.

<u>Effect on resources</u>

10. In his paper for the last meeting Mr Moore said 'that the upward pressure on public expenditure on the NHS would be, if anything, increased by these changes'. He does not return to this point in his new paper, although he does suggest (paragraph 8) how the buying agencies would be funded. Again, you will not want to settle the detail now, but <u>you will want to be reasonably sure that the resource implications of the change will be manageable</u>. In fact, it is not clear why the pressure on resources need be greater under the new structure. For example, the agencies could be funded by a capitation fee, which should impose an effective ceiling on their expenditure. And, as the paper says, the changes could be combined with the introduction of cash-limiting on GPs.

<u>Transition to the new structure</u>

11. If the principle of the new structure is acceptable, <u>you will want to be satisfied that it can be introduced in a way that avoids dislocation and unnecessary controversy</u>. There are some points to probe here:

i. As to buyers, Annex 2 suggests a gradual adaptation of the existing structure. But at some point the 190 DHAs and the FPCs would need to be re-formed into perhaps 100 buyers. At that point a substantial reorganisation seems inevitable, with all the short-term inefficiencies which any reorganisation inevitably involves. It would be important to be able to demonstrate that the upheaval was justified by the benefits which it produced.

ii. As to providers, how are the hospitals to decide whether to become self-governing? What would happen if at first only some chose to become self-governing? Would those remaining with the DHAs be favoured in the placing of contracts? Would a 'Big Bang' therefore be necessary? You may also want to probe the paper's argument (Annex 1) that hospitals may have to organise into groups rather than become self-governing individually. If the aim is to free management enterprise, independence would have to be real and businesslike.

Next Steps

12. The Cabinet Office outline timetable, which the group endorsed, suggested as the next step a meeting in the week of 6 June to discuss greater private sector involvement in:

- the provision of health care;

- the financing of health care, for example by tax reliefs or contribution rebate.

You may want this meeting to go ahead as planned, especially to discuss financial incentives to the private sector. But Mr Moore's covering note now also suggests a number of papers on the details of his new structure. The most important of these further papers, or a summary of them, might also come before the next meeting, but further work on secondary detail is only worthwhile if you are satisfied that the main structure is broadly on the right lines. If not, you may prefer to ask for a more concrete description of

how the new approach would work in the light of the discussion, perhaps with a paper by Sir Roy Griffiths on the practical management aspects.

RJW.

R T J WILSON
Cabinet Office
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