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NHS REVIEW

Public expectations for an improved health service are high. Yet there is a real danger that the Review will be inadequate. The reason is that there are two very different interests in the Review at present:

(a) NHS Management Board and DH officials who wish to improve the existing NHS system by piecemeal measures, such as better performance indicators, and

(b) Others who feel that the minimum changes necessary in the review to change existing practices are a change in structure (self-governing hospitals, GP budgets) of the NHS itself - which allows the latent enterprise of consultants, GPs and nurses to be chanelled to better use.

At present, there is no real commitment to (b). The danger is that we simply reshuffle the existing furniture of the NHS without making progress. It is unclear whether there is real commitment behind the main theme which should underpin the NHS Review, namely, freeing up enterprise from the constraints of the system.

The Labour Party has sensed this uncertainty. When Robin Cook announced the publication of his 'Green Paper' last week, he stated "The time has come for Labour to exploit the heavy weather the Review has run into and go on the offensive." We need to regain the initiative.

SECRET

Kenneth Clarke has distributed 7 papers for consideration at tomorrow's meeting. The papers have improved. But they are still tentative and short on detail.

It is crucial that the Review be refocussed on the central issues. Kenneth Clarke must list his 5 key elements he is proposing to change in the order of importance which he deems necessary.

Key Issues

The main problem with the NHS is its bureaucratic nature. It is driven by producer interests rather than the interests of patients. For example, major advances such as 'endoscopy' which radically reduces the costs of abdominal surgery are virtually unavailable. The system has not caught up with this development.

The automatic reaction of such a system to cost constraints is to cut services to patients rather than to provide services more cost effectively. Allowing hospitals and doctors more independence would encourage innovation. Treasury fears that this would drive up costs are unfounded - one health expert believes that the health service is 30% overfunded.

The move to self governing hospitals and opting out by GPs are the fundamental agents of change. They are the twin pillars on which the health service could be transformed in the future. They will unleash individual enterprise to provide better and more cost effective treatment. The NHS will remain largely unchanged if this strategy is not achieved. Demands for more resources would then be insatiable.

There is a risk that the fruits of the Review could be restricted to fiscal incentives and internal reorganisation.

The Government would then be criticised for failing to tackle one of the central problems of the NHS: waiting lists.

Kenneth Clarke's 'Outline White Paper' fails to address waiting lists specifically. But self-governing hospitals and opted out GPs would strike at the heart of the waiting list problem by introducing consumer choice into the system. Patient service would become the main priority. Cross border flows of patients would increase dramatically; hospitals would manage their resources more efficiently and restrictive practices would break down.

The two key papers on self-governing hospitals and opting out by GPs should incorporate mechanisms to eliminate barriers and to drive the process of change.

PAPER HC 39

Self-Governing Hospitals

1. Driving Force

The move towards self-governing hospitals is central to the Review. Other reforms will be ineffective without it:

- The continued linkage of hospitals to their DHAs would frustrate cross-border patient flow.

- Opted-out GPs would not compete effectively with DHAs when buying services from DHA - run hospitals.

- 'Real' responsibility and accountability for managing resources would not be devolved from DHAs down to hospital managers and clinicians.

Paragraph 4 of the paper suggests that three stages need to be reached before self-governing status should be attainable:

- Resource Management Initiative.

- Greater flexibility over manpower and capital.

- A "contractual" style of management.

This tentative strategy could fail. In practice, a hospital will not have a contractual style management until it achieves self-governing status. Neither will it gain greater flexibility over its resources until it is freed from direct control. Imposition of new management initiatives may have some effect. But will attitudes really change before independence?

I sensed the future potential for self governing hospitals during a recent visit to Plymouth. The local district general manager wants to arrange an employee buyout of the entire health authority. This may seem a dramatic step, well beyond our notion of self-governance. But he believes that patient care would improve markedly, within existing resources. Surely self-governing hospitals could achieve similar attitudinal changes.

The minimum criteria for self-government should be simplified - Do the hospital management and clinicians want it? If so, regional task forces should drive the process at an early stage. The NHS Management Board should oversee the process. And the Board should be mandated to achieve a minimum target within a present timeframe (say two-thirds of all hospitals within 5 years).

Question to ask:

Will the NHS Management Board be charged with a specific mandate?

What incentives would be given to encourage the trend? Better management incentive schemes?

What are the plans for a pilot scheme? Where? What is the target for achieving self-governing status? And over what timeframe (say, two thirds of all hospitals over 5 years)?

2. Capital

Paragraphs 13-15 addressed briefly the 'capital ownership' issue. Capital is then considered in more detail in a separate paper - previewed in Appendix 1.

Paragraph 14 states "It would be possible to vest ownership of all assets in the management boards. This would achieve the fullest delegation of responsibility, but it would limit the scope for gradually changing the distribution of assets to reflect wider service needs."

But who determines the 'service needs'?

- Central management who are several steps removed from the day-to-day operations of the health service? or

- Hospital management?

Idris Pearce, NHS Management Board, has proposed a charitable trust to own and manage the estate. The aim would be for the trust and its Property Executive Boards to become largely self-financing. But would this strategy succeed? The Property Services Agency (PSA) has not been successful.

Ownership should be devolved to the hospitals once they become self-governing. Charging for cost of capital will be the most important discipline for managing assets. Hospitals would be forced to examine the cost-effectiveness

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of all land, buildings and equipment.

PAPER HC 40

GP Practice Budgets

Kenneth Clarke's paper paints a much clearer picture of the opting out process. And there are a number of helpful comments:

Paragraph 3

- Sir Roy Griffiths has endorsed the concept of wider GP budgets to include accident and emergency work if they so wish.

- Also, he suggests that smaller practices could group together to opt-out.

But there are three main issues not addressed fully:

First, GPs will need a well defined incentive system to encourage opting out. One natural incentive would be to attract more patients by minimising waiting lists. But perhaps GPs should be entitled to retain a percentage of any annual surplus, provided they achieve acceptable standards of quality. Audit and peer review could be the monitoring agents.

Second, the nature of the contract for elective surgery is still not clear. Paragraph 9 states "I do not envisage GPs having waiting lists for non-urgent referrals". In practice, there will be times when patient flow exceeds the contractual flow. A GP waiting list will emerge.

Third, the contract for out-patient referrals is unclear. There is no reason why a contractual limit should not be placed on the number of referrals (paragraph 7). A limit on

referrals would place a useful discipline on GPs. And it would encourage more GPs to carry out minor surgery.

Question to ask:

What incentives will be given to GPs? How will it work?

How will the contracts work in practice?

Other Papers

1. Detailed comments on 'Management of Capital Assets and Investments' and 'Merging FPCs and DHAs' are included in Appendix 1 and 2 respectively.

2. The proposals for 'NHS Audit' appear to be reasonable provided the Audit Commission has the capacity to take on the increased responsibility.

3. Kenneth Clarke's proposal for a much less detailed White Paper is reasonable. But the main thrust of the Paper needs clarification. Waiting lists are not addressed.

Summary

1. There is a need to refocus the Review. Kenneth Clarke's papers are tentative and still short on detail.

2. Three main points need be agreed at the meeting.

   (a) The move to self-governing hospitals and opting-out for GPs should be endorsed as central to the Review.

   (b) The NHS Management Board should be mandated to drive the process of change and to remove barriers.

(c) Specific targets should be set (say two-thirds of all hospitals should become self-governing within 5 years).

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Appendix 1

Management of Capital Assets and Investment

The subject of capital is intertwined with the move towards self-governing hospitals. Self-governing hospitals without a truly devolved capital structure will wither.

The paper on 'Capital' is a highly sensitive issue, evidenced by the inability of the Treasury and DH to resolve their differences. The only tangible agreement has been to increase delegated limits for capital expenditure from £5 million to £10 million for Regions and £10 million to £15 million for the DH. Larger projects will be vetted by the Treasury. This devolutionary trend is most welcome as a first step. But it will have little impact on local decision making at hospital level.

Any proposals on capital should satisfy the following minimum criteria:

1. Private hospitals, self-governing hospitals and DHA - run hospitals should operate on a level playing field (or at least as level as possible).

2. Hospital managers should have a real incentive to maximise the efficient use of buildings and equipment. Hospitals should own their own fixed assets; maintain asset registers; keep full financial accounts and pay capital charges in cash. Legal limits could be placed on the hospitals preventing the board of directors from selling more than an agreed level of assets.

3. Hospitals should be free to spend a portion of their net earnings on performance payments to staff and to purchase new equipment.

4. Within limits, hospitals should be free to borrow private capital.

5. The responsibility for building new hospitals should be clearly defined.

There are three major issues raised in the paper.

First, the DH presents a very strong case (Paragraph 9 of the Appendix) for capital charges on an actual cash basis. The Treasury would prefer a notional charging system. The Treasury believes that notional charging could still influence the contract prices charged by hospitals for cross border flows of patients. In my experience, notional accounting is ineffective. The discipline of an actual charging system should be supported.

Second, the proposed mechanism for capital charging is too bureaucratic. Hospitals would be required to pay for capital on a quasi-leasing basis. The cost (or initial valuation) would be repaid on a straightline basis over the estimated useful life of each asset eg 5 years for equipment. In addition, interest would be charged on the outstanding total.

The hospitals would then receive additional revenue allocations to cover the payments. These payments would be based upon a centralised formula which may be lower than the total cost. The aim of this mechanism would be to force hospitals to sell-off some assets if they are over-capitalised.

These artificial mechanisms would be anathema to the private sector. Would a level playing field be maintained? Consideration should be given to forming companies limited by shares or guarantee. Hospitals could be required to pay

preference dividends to the Regions. Contract pricing would then need to incorporate depreciation costs and a profit element.

Third, The paper proposes a limited injection of private capital money. This suggestion is very welcome at a time when the condition of the hospital stock is deteriorating. Many cost effective projects are delayed because of a short-term lack of funds.

For example, Bromley desperately needs a replacement hospital at a cost of around £15-20 million after land sales (£70 million gross). Since most of the land cannot be sold until completion of the new hospital, a £50 million 2 year loan would be required during the interim. Once the new hospital is built, annual costs would fall by £3 million. An injection of private short-term loans would help such cost-effective rebuilding programmes.

Questions to ask:

What is the status of the discussion on capital between the Treasury and DH?

Why not consider the possibility of self-governing hospitals being constituted as companies limited by shares or guarantee? Each hospital would own its land, buildings and equipment.

Appendix 2

Merging FPCs and DHAs

Amalgamation

A decision on whether to merge FPCs and DHAs should be influenced by one main principle - would the amalgamation encourage the trend towards self governing hospitals and opting out for GPs. If not, the merger should be delayed.

On balance, I believe that the two should be merged at some point. If a majority of hospitals seek self-governing status, the DHA role will be transformed to procurement only. And if GPs opt out, the DHAs procurement role would diminish. The 191 DHAs and the 90 FPCs could then be merged into 90 new manageable groupings.

But the amalgamation could be delayed for a 5 year period. In the short-term, management efforts should be directed towards the main goals.

Kenneth Clarke proposes to strengthen the management of FPCs, as an alternative to merger (paragraph 3). Is this really necessary? Do we need an extra tier of management in the future? After all, opting-out will encourage the trend towards larger, more efficiently managed practices. The need for a more professionally managed FPC will therefore diminish.

Cash limiting

Drugs and dentistry would be difficult to cash-limit in the short-run. But improved preventive care in dentistry and increases in water fluoridisation are combining to reduce

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demand for dentistry. And levers could be applied to reduce the drugs bill (paragraph 28). Kenneth Clarke should be asked what results have been achieved so far.

One solution would be to cash limit other FPs expenditure, including items of service payments. This could be achieved by an entire switch to capitation - based remuneration only (Paragraph 24). And it would eliminate the need to control the numbers of GPs.

Questions to ask:

Why not consider the merger of FPCs and DHAs after the main drive towards self-governing hospitals is complete? Why strengthen FPCs?

Why the need for regulating GP numbers (a capitation based remuneration would obviate this)?

Has the drugs bill been reduced by applying the list of levers (paragraph 28)?