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From the Private Secretary

6 October 1988

SUBJECT CC MASTER

Dear Geoffrey,

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister held the twelfth meeting of the group discussing the review of the NHS on 4 October. The meeting considered papers HC39 to HC44 previously circulated by the Department of Health.

I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with the CMO arrangements.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Health, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. Whitehead (Policy Unit).

In discussion of paper HC39, on self-governing hospitals, the following were the main points made -

a. The Government would need, when it produced its proposals, to say in detail how the transition to independence would be made and how it would work. There must be convincing answers to all the questions that were bound to be asked about the practical effect of the proposals. It would not be sufficient to rely on statements of general principle or the outcome of experiments. More work was needed before the Government was in the position to answer such questions.

b. One important set of questions which required further work concerned the transition to the new arrangements. Who should take the initiative in proposing that a particular hospital should become self-governing? What constituted a hospital for this purpose? Would new institutions have to be set up in each hospital? HC39 suggested answers to these questions. In particular it suggested that proposals for moving to a new status would normally be made by the hospital management team, although sometimes they could come from the DHA. But this required further thought.

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Even if some DHAs might be far-sighted enough to propose self-government for their hospitals, most would regard it as against their interest to do so. Management teams as at present constituted did not have the competence either to decide when self-government was desirable or to run the hospital after it was achieved. One possibility to be considered further was that the Regional Health Authorities could identify and prepare the hospitals for self-government. Another was that the Government itself should decide which hospitals were candidates and drive through the change.

c. Other aspects also needed further thought. HC39 proposed that major assets should be vested in the ownership of the Secretary of State, that continuing central controls would be necessary over training and other manpower matters and that consultants' contracts might not be held by independent hospitals. There was a risk that these proposals would unduly detract from the freedom of the hospitals to manage their own affairs, and they should be reconsidered. More work also needed to be done on the implications of the new arrangements for public expenditure. This should look at pay and the income of hospitals as well as at treatment of capital, on which consultation was already taking place.

d. A move to self-governing hospitals could be seen as a reversal of trends in the NHS over recent years, and there was a danger that the self-governing hospitals would bid up demand for manpower and other resources. Self-government would, however, provide hospitals with the ability to run their own affairs. This would be attractive to the ablest consultants. It would improve motivation and raise efficiency. The group had therefore at an early date identified self-governing hospitals as an essential part of the necessary reforms. But this did not mean that self-government would necessarily be appropriate for all or even a majority of hospitals. It was most likely to be suitable for teaching hospitals and others in big cities. For hospitals in remoter areas, where there was little effective competition, it was less likely to be suitable. Further thought should be given to the question of what number of hospitals the Government would wish to see move towards self-government.

e. If a move to self-governing hospitals could be achieved without statutory provision it would have some advantages. This possibility needed to be further explored.

The following were the main points made in discussion of HC40, on GP practice budgets -

a. The principle of opting-out by some GPs was an attractive element in the reform package. Many GPs were likely to welcome the opportunity for greater freedom to run their own affairs, and the result should again be better motivation and higher efficiency. As with the

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proposal for independent hospitals, opting out by GPs would also help to blur the distinction between the public and private sectors; such an outcome was one of the most important benefits to be gained from the package of reforms.

b. Again, however, more work was needed to ensure that the Government had an answer to all the questions that would be asked about how the opting-out would work in practice. In particular, the scope of the expenditure to be covered in the opted-out GPs' budgets needed to be further considered. It was agreed that outpatient referrals should be covered. There was also a strong case for covering expenditure on drugs. This would bring much better control on major items of expenditure, and allow opted-out GPs more scope for viring so as to stay within their budgets.

c. The group also needed to be absolutely clear about what would happen if opted-out GPs overspent or underspent. On overspending, if there was a major and unforeseeable event like an epidemic, provision would of course have to be made for the necessary treatment, probably from a contingency to be held by the FPC. Otherwise, it was up to the GPs to budget prudently. If they failed to do so, they would be subject to audit, and their opted-out status could be terminated. If they underspent, there was a good case for allowing them to use the surplus to develop the practice. This could reduce subsequent referrals to hospitals. But there was some risk of abuse of complete freedom to plough back the surplus. Further consideration should be given to whether there was a need to define the uses to which a surplus could properly be put within the practice, without bureaucracy.

In discussion of HC41, on merging FPCs and DHAs, the following were the main points raised -

a. It would be a mistake to merge FPCs and DHAs. The Government's main objective in its relationship with GPs was to get their spending under better control and in particular to reduce hospital referral rates and expenditure on drugs. The way to do this was to strengthen the FPCs and their ability to monitor and control doctors' practices. The strategic aim was to move towards management of GP contracts by the FPCs. Merging them with DHAs would be inconsistent with this. It would also tend to make GPs more subservient to hospitals, contrary to one of the main themes of the review.

b. On the other hand, it was argued that the Government's objective of getting better control over GP spending could best be achieved by merging FPCs with DHAs and cash limiting the combined body. The cash limiting would be practical because of the opportunities created by the merger to vire between hospital and GPs'

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expenditure. This change was not ruled out by any assurances which had been given to the profession. The fact that it was a reversal of the previous decision to separate the FPCs from the DHAs need not prove embarrassing, since it could be presented as one of the large number of changes emerging from the current review.

c. HC41 proposed that the contractor professions should be removed from membership of the FPCs. This change was designed to make them more independent and therefore better able to take on the task of managing the contracts. But it ran contrary to the Government's general aim of involving the professions more directly in management. If the calibre of professional members was a problem, the solution was to find better members.

d. Another approach to the problem of getting better control over GPs' spending was possible. This was that FPCs themselves should be given responsibility for general budgets covering all the expenditure of their contractors, except those who had opted out. Since the FPCs covered a large number of GPs there would be a good spread of risk, although they would still need to operate a contingency reserve. Individual GPs would as at present receive their funding from the FPCs, and this could be used to increase the control FPCs exercised over their expenditure. They would not be subject to a cash limit, but if their spending threatened to exceed the level which the FPC regarded as reasonable and consistent with their own budget, they would be subject to audit, both efficiency audit and medical audit. Such an arrangement would be a development of the present policy, which was already producing results, of giving FPCs greater influence over GPs' expenditure. It was an attractive option, and needed to be considered further.

The Prime Minister, summing up the discussion, said that the review must have a convincing outcome. It must be seen to lead to substantial changes. Tinkering with the present system after such a long process of consideration would undermine the Government's credibility. The Government must also show that it had made up its mind on the main points at issue. It would be damaging if it was seen as waiting for the results of experiments. Finally, it must be able to explain in detail, step by step, how the changes it was proposing would be made, and how they would operate. More work was needed to enable the Government to answer all the questions that would inevitably be asked about the practical effects of their proposals.

The Group had reaffirmed that the introduction of independent, self-governing hospitals would be an important change to come out of the review, although it recognised that there might be many hospitals for which this status would not be appropriate and which would not proceed further than the present process of devolution. The Department of Health should now undertake further detailed work to show exactly how the change would operate and should put forward detailed

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proposals for achieving it. This work would need in particular to consider who would take the initiative in proposing a move to self-governing status for individual hospitals and how the transition would then be achieved. It should cover the suggestion made in discussion that the Government itself should identify the candidates for this status. It should also include proposals, whatever the route to self-government, on how many hospitals might be suitable for it. The Group was unconvinced of the need for the Secretary of State to own the hospitals' assets, or for the continued operation of some of the other central controls recommended in HC39. These aspects should be further considered. There should also be a fuller statement of the implications of the new arrangements for public expenditure. Finally, the further work should explain how far it would be possible to make hospitals self-governing without statutory provision.

The Group had agreed that provision for opting out by GPs in large practices was an important part of the package of reforms. But more work was needed on the scope of the expenditure to be covered in the opted-out GPs' budgets. In particular, the Group believed that there was a strong case for including expenditure on drugs, as well as out-patient referrals. More work should also be done on the practical consequences of overspending or underspending by the opted-out GPs. It should make proposals on the re-investment of a surplus in the practice, including the possibility of allowing GPs to build up reserves.

As to the future of the FPCs, the Group believed that there was a strong case against removing the contractor profession from membership, as had been proposed. More generally, they were attracted by the proposal to give the FPCs responsibility for general budgets covering all their contractors' expenditure, with individual GPs becoming subject to audit by the FPC if their spending threatened to become excessive. This proposal should be worked up in detail.

The Group had briefly discussed the constitution of the DHAs and RHAs. It had reaffirmed the view that local politicians should be excluded from them, while noting that such a step could be controversial with the Government's own supporters. A paper should be prepared on the exact form the reconstitution of these authorities should take.

The Group had agreed the proposal in HC42 that the Audit Commission should be responsible for the external audit of the health authorities and FPCs. More work was however needed on medical audit, the effective development of which was central to the whole package of reforms. A paper should be brought forward setting out exactly how medical audit would work, and how it should be introduced.

The Group believed that it was important for the new policy to blur the boundary between the public and private sectors. Many of the reforms already discussed would help to do this. But the Department of Health should prepare a paper

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considering whether there were other possible ways of doing so, or of strengthening the private sector.

Finally, the Group had asked for a paper on how to improve the working of cross-boundary flows.

All these papers, and any others on points which needed to be resolved before the White Paper could be drafted, should be prepared for the next meeting of the Group, to be held at 10.30 am on Monday 17 October.

I am sending a copy of this letter to the Private Secretaries of the Ministers at the meeting, and to the others present.

Yours,
Paul

PAUL GRAY

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