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PRIME MINISTER

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NHS REVIEW

This package of eight papers is a mixed bag. Two themes still emerge from behind the print; a lack of conviction behind the reforms and a failure to drive the reforms forward. The papers tackle the reforms by way of central management control rather than by releasing latent enterprise from the system.

The paper on 'Funding Issues' seems to anticipate a very long transition period between today's NHS and a future unshackled system where hospitals and GPs will each compete for patients. The paper on 'Capital' is far too bureaucratic. And there is a danger that the paper on 'Managing The Family Practitioner Services' could constrain competition and discourage GPs from managing their own budgets for elective surgery.

These crucial points, and others, will need to be addressed in the meeting.

PAPER 1

Policy unit comments

MEDICAL AUDIT

The profession will need to take a key role in the 'medical audit' procedures. But there is a danger that the professions could run rings around Department officials and senior administrators in the Region, Districts and Hospitals.

Paragraph 10 suggests that a district general manager should be free to invoke an independent professional audit. But it should be made clear in the paper that the results of the audit should be made available to the DGM and preferably made public.

A few months ago, a very senior obstetrician in North East Thames told me about a recent 'training audit' that he had conducted on behalf of the Royal College. In theory, consultants who are below the standards set by the Royal College should lose their training status. During the audit, he found that one obstetrician had fallen 'well below' the minimum standards. His students were unsupervised and untrained. Yet the auditor's very critical report was not acted upon.

The General Medical Council would be a very effective tool for setting auditing standards, receiving copies of audit reports and enforcing disciplinary procedures.

Paragraph 19 suggests that GP medical audit is more complex because care is delivered in more places - 10,000 surgeries plus patients' homes. Treatment is less well defined and medical records are less detailed. But some of these issues can be addressed. For example, an audit of a GP practice could include a patient circularisation test whereby a sample of patients are sent a letter, in confidence, requesting information on the actual level of service provided. This test could be central to a GP medical audit.

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Questions

1. Why not ask the General Medical Council to police the auditing process?

2. Why not include a 'patient circularisation' as a key test in the audit of a GP practice? (the quality and level of service could be guaged).

PAPER 2 Policy Unit comments

FUNDING ISSUES - 're-emergence of top-slicing'

This paper is very disappointing and confusing. There is a distinct danger that two new reforms will take centre-stage; top-slicing and sub-regional RAWP.

In paragraph 2, the paper proposes a so called short-term funding scheme to allocate £50 million of top-sliced money each year. A complex set of rules will emerge on how to allocate this marginal budget, presumably depending on a mix of the 450 performance indicators. There is only one 'non-political' solution to resource allocation, namely that money should follow the patient. Every minute of management time spent on top-slicing is a minute lost in the drive towards self-governing hospitals and GP budgets. This proposal should proceed no further.

In Paragraph 10, the paper suggests that there would be considerable political and managerial difficulties in abandoning the present arrangements. This statement is a recipe for the status quo. In paragraph 14, the paper makes a very worrying point "Regions can and should discontinue the use of sub-Regional RAWP target, but they will have to manage the transition in a different way" ie with sub-Regional RAWP. It is not clear at all how the transition will be managed. Also, if we wait for sub-Regional RAWP to equalise allocations to district, we may have to wait until the next century or beyond. And the two key reforms of self-governing hospitals and GP budgets will never emerge.

I believe it is crucial to move very quickly towards a national age-weighted capitation fee adjusted for areas of deprivation. We need to be sensitive to the obvious political risks over the change specially for areas that are currently over-resourced. If we fall short of this objective, cross-border flow will be minimal, hospitals

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will not opt out and GPs will continue as before. In practice central management accounting, as proposed in Paragraph 19 will become the norm.

Questions

1. How will top-sliced funds be allocated in practice?

2. How long is 'short-term' (para 2)?

3. Why is it not a practical proposition to bring districts currently below target, closer to target (Para 14)?

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PAPER 3 – POLICY UNIT COMMENTS

RECONSTITUTING HEALTH AUTHORITIES

It is crucial that the proposed new executive committee of the Board (Para 17) is responsible for all day to day operations of the health service. The NHS Management Board should no longer operate as a 'consulting' group often one step removed from the decision-making process. Kenneth Clarke should be asked to spell out the division of duties between the Board and non-Board functions.

One member of the Board - not a civil servant - should have executive responsibility for achieving specific targets for numbers of self-governing hospitals and new GP budget holders. I believe that this appointment is key to the reforms.

Questions

1. **What is the precise breakdown of responsibility between the new NHS Management Board and non-Board staff?**

2. **Why not appoint an executive member of the Board to drive the reforms?**

PAPER 4

Policy unit f

MANAGING THE FAMILY PRACTITIONER SERVICES

"Without competition at the primary care level, competition elsewhere will be hard to achieve."

Patrick Minford
(taken from a recent article)

Kenneth Clarke's paper proposes that an annual ceiling should be placed on GP numbers each year. But in his paper 'Professional and Employment Practices', Kenneth Clarke examines ways to eliminate restrictive practices in the profession. Surely, this proposal to cap GP numbers is introducing yet another restrictive practice.

One major objective of the NHS Review is to broaden consumer choice. And to encourage GPs to be responsive to the needs of their patients. If patient service is poor in an area, our aim should be to attract more vigorous enterprising GPs to compete for patients. This trend will be thwarted if GP numbers are limited.

This proposal dates back to the Binder Hamlyn report.

'Binder Hamlyn' Revisited

In 1983, the DHSS commissioned a report on GPs from the accounting firm 'Binder Hamlyn'. A rather turgid document 'Forecasting and Control of Expenditure on the Family Practitioner Services' recommends that powers should be taken to control GP numbers. DoH officials have now persuaded Kenneth Clarke to incorporate this recommendation.

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On financial grounds this proposal seems very reasonable. FPS expenditure is not cash limited. But some elements of expenditure - namely capitation fees - are capped by virtue of population size. There are 4 main categories of GP income:

(1) At present capitation fees form on average 47% of a doctors' income. The Primary Care White Paper seeks to increase the capitation element but only to around 50% of income.

This element of expenditure will not vary with GP numbers.

(2) The Basic Practice Allowance of £7,800 provides a degree of financial control since it is only payable to GPs with 1,000 or more patients. But this allowance plays into the hands of the BMA. During a fringe meeting at the Brighton Conference, Dr Michael Wilson made it quite clear that smaller list sizes is one of their primary objectives. Yet there is no evidence that practices below the average national list size of around 1,800 provide a better service for patients.

(3) Item-of-service fees, such as vaccinations, cervical cytology tests or night visits do not depend on the number of GPs, only on patient demand.

(4) The final element in GPs' income is payment to cover expenses actually incurred. These include payments normally in full for rent or rates. GPs can also claim back 70% of the salary of certain auxilliary staff, up to a maximum of 2 whole-time equivalent staff per GP. About 25% of GPs total income is now met by payments of this kind. The payment will be made whether or not the GP has any patients. New GPs can therefore cover most of their expenses with a very small practice. This expenditure item seems to be the main reason behind the desire to control GP numbers.

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If GP remuneration is replaced by pure age-weighted capitation fees - adjusted for areas of social deprivation - the need for controlling GP numbers will then evaporate. And costs will be capped as follows:

Total Cost = Average Capitation Fee x Population.

Yet in an earlier paper by officials, they commented:

> "A major expansion of the capitation element in pay would not, however, appear justified at least on present evidence. It is necessary to reflect other factors in pay and to make better provision for these costs which do not vary in proportion to list size."

This is a bureaucratic argument designed to fix a GP's salary level within a well defined narrow range. Surely, a GP should be given flexibility in appointing staff. Why should we prescribe an ideal staffing structure? If GPs provide a poor service because of a failure to maintain adequate premises or satisfactory staff support, he will lose patients and income.

I believe that this hides the real issue. DoH officials are concerned not to force the hand of the BMA beyond a capitation level of 50%. Yet surely, the BMA would also object to a limit on GP numbers.

Questions

1. **Why not introduce a pure capitation fee over a 3 year period? (after all, elective surgery budgets will be based on pure capitation).**

2. **Why not let market forces dictate GP numbers?**

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Prescription Costs

Prescribing rates are still very erratic.

It is crucial that GPs change their prescribing habits. In a recent survey of 3,800 people by RIPA, under the chairmanship of Roy Griffiths, 22% of all patients agreed that their GP "always seems to reach for the prescription pad as I come through the door". In many of these cases, a plecebo may be just as effective and far cheaper.

A cash limit on drugs expenditure should be placed on FPCs. This should not be a burden on each of the 90 FPCs. It may be too early to place a cash limit on each GP. There would be a potential for many of the 30,000 GPs (and their patients) to protest. But each FPC would then have a natural incentive to improve the prescribing habits of its GPs.

Question

Why not place a drugs cash limit on each FPC?

Incentive for GP Budgets

Paragraph 15 is illusory. It suggests that there will be two main incentives for large GP practices to take on budgets for elective surgery:

- it will enable GPs to back their choices with money;

- it opens up the possibility of generating funds for their practice through virement.

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But why should a GP take on the increased responsibility and risk, purely for the carrot of a new computer. A number of DoH officials have also privately expressed their own scepticism to me on this issue.

There is a significant danger that GPs will not opt for elective surgery budgets. Since only 10% of practices would be permitted to manage their budgets - if limited to 6 partner practices or more - there is a risk that very few GPs may decide to opt out. This reform could emerge as a damp squib.

At a minimum, GPs should be allowed to retain a percentage of the surplus at the end of the year, up to a maximum. Medical Audit would be the controlling mechanism to prevent under-treatment. Also, patients would leave second rate GPs if the quality of service falls.

Also, paragraph 15(iii) suggests that we should only introduce GP budgets, not drug budgets. There is no reason why GP budgets should not include drug budgets provided an incentive is available to the GP.

Questions

1. **Why not allow personal financial incentives to GPs?**

2. **Why not incorporate drugs in GP budgets?**

3. **Why not reduce the ceiling of partners from 6 to 4, for the purposes of enabling GPs to manage their own budget? (This would increase the potential market for opting out from a very low 7% to almost 30% of practices).**

PAPER 5

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CAPITAL

This paper is vague, bureaucratic and falls well short of a sensible capital system.

In an earlier paper I noted that the subject of capital is intertwined with the move towards self-governing hospitals. Self-governing hospitals without a truly developed capital structure will wither on the vine.

The paper clearly envisages a long time horizon in Paragraph 5. Kenneth Clarke plans to introduce a notional management accounting system to 'enable the NHS to go through a process of familiarisation'. In the light of that experience, the health service would 'move towards a fully effective system of real charges as soon as reasonably practicable'. This is absolute nonsense. In the current system, we will never reach this utopian state of familiarisation. This way of thinking seems to avoid the real issue:-

> Surely, the philosophy behind self-governing hospitals is to give local management real responsibility over service to patient; staff and capital assets. Managers will have a natural incentive to find - and motivate - good quality financial staff. They will need to be paid a performance bonus to attract good quality professionals.
>
> We are not simply trying to improve the existing system.

The Treasury are clearly trying to avoid real capital charges, ownership of assets and access to private capital.

We need to establish minimum criteria for any proposals on capital. I believe that we should seek the following as an absolute minimum:-

1. Self-Governing Hospitals should own their fixed assets. They should be free to dispose of assets up to a higher limit than a paltry 5% (say 30%).

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

3. Private hospitals; self-governing hospitals and DHA-run hospitals should operate on a level playing field.

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

5. Real (not notional) capital charges should be improved, to reflect a return on investment in the hospital by the Government.

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

Each of the above points should be considered by the Ministerial Group before officials spend any more time on this crucial issue.

Questions

1. **Why not address the 'minimum criteria' listed above (Point 3 is particularly important)?**

2. **Why delay the introduction of a real capital charging system?**

PAPER 6

A BETTER SERVICE TO PATIENTS

This paper is key. Many of the reforms will not bear fruit for a few years. We must ensure that patient service is improved in the short-term.

In the consumer survey mentioned earlier in the note, nearly half of those who have been to outpatient departments agree that 'no-one seems to care that patients have busy lives!' About half agreed that appointment systems were designed to help hospital staff, not patients. A third or more complained that no-one ever tells you only you are waiting (79% of the sample complained of this latter point in Bolton).

In the last few days, I have spoken to a number of District General Managers, GPs and consultants about this issue. One very efficient well respected DGM finds it very difficult to encourage some consultant's to manage the appointments system more efficiently. One excuse given is that some patients arrive late or not at all - consultants then overbook (like an airline) to ensure a flow of patients. This is not the reason.

Often, consultants, registrars and houseman will operate three clinics side-by-side. If a registrar has a problem he will then interrupt the consultant's clinic for advice. This slows down the appointments process. Sometimes, consultants are late and fail to telephone the clinic to inform the appointments clerk.

Consultants contracts should include clauses on the management of out-patient clinics. Performance payments should be linked to managing out-patient clinics efficiently. Bromley's objective is to limit all waiting times to 20-25 minutes.

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Question

Management of out-patient appointments is crucial. Why not link this responsibility to performance payments in the consultants contract.

PAPER 7

THE PUBLIC AND PRIVATE SECTORS

Paragraph 7 suggests that we have made good progress in recent years on tendering of non-clinical support services. But are we too complacent?

A recent CBI report "The competitive advantage" notes that only 28% of non-medical support expenditure in hospitals and community care are available for competitive tendering. Services not so far covered include:

- Administration (over £1 billion).
- Portering
- Security
- Medical Research
- Building Maintenance
- Garden Maintenance.
- Estate Management

Question

Are there plans to extend competitive tendering to the above areas of expenditure?

PAPER 8

PROFESSIONAL AND EMPLOYMENT PRACTICES

This paper proposes an inquiry into the best use of professional resources in the NHS, with the aim of breaking down the rigidities caused by professional boundaries ie restrictive practices. I see very little value in such an inquiry. Paragraph 12 proposes to set up a small team of 3 or 4 lay people of suitable standing. Paragraph 15 then goes on to suggest that the team would spend two or three months on defining 'the issues on which they wished to focus their attention'. This is far too vague. I believe that the best way of breaking down restrictive practices will be to break down the monolithic structure of the NHS. This is precisely what we are trying to achieve with self-governing hospitals and GP budgets.

An inquiry should be avoided.

Questions

1. Why not avoid an inquiry?

2. What are the barriers set by the Royal Colleges in controlling the flow of students into the teaching hospitals and the progression of medics through the system?

Ian Whitehead

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