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Treasury Chambers, Parliament Street, SW1P 3AG
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28 June 1988

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

Dear Paul,

NHS REVIEW

... I now enclose the second of the two Treasury papers for Thursday's meeting - a note by the Chief Secretary on financing hospitals.

I am copying this letter and the enclosure to Sir Roy Griffiths, Geoffrey Podger and Jenny Harper (DHSS), and Richard Wilson (Cabinet Office)

Yours,
Moira.

MOIRA WALLACE
Private Secretary

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NHS REVIEW: FINANCING HOSPITALS

Note by the Chief Secretary, Treasury

At our meeting on 24 May, I offered to prepare a note about how the system of allocating resources to health authorities could be improved to reward hospitals which attracted more patients by greater efficiency. This I attach.

2. The scheme involves "top-slicing" some of the total budget for hospital expenditure and distributing it to districts according to their success in improving their efficiency. A further allocation might be made on the basis of activity in those areas where waiting times are longest, if attractions were seen in replacing the present waiting list initiative with a more systematic arrangement.

3. These allocations would be built into baselines for future years. There would continue to be scope for regions to adjust the baselines on account of population changes and in order to target improved services. Similarly, districts would be free to allocate funds to hospitals according to local management priorities, which might involve building up some services or spending money to remove obstacles to improving efficiency in particular areas.

4. On the specific points raised in the paper, my views are as follows:

a. While it may make sense, initially at least, to build on the present performance indicator system, it is by no means ideal for this purpose and we must set work in hand to devise

a clear and open method for introducing the right incentives while commanding reasonable confidence among health authorities.

b. I have no strong views on whether the allocations should be made by regions or by the DHSS, and would welcome the views of colleagues on this.

c. When we have reached conclusions on the Secretary of State's paper on self-governing hospitals, we can consider how to adapt this system for them. But this should not present overriding difficulties.

5. I think a scheme of this nature has a number of attractions. Further work is needed on how it would work in practice, but it should be possible to secure three desirable objectives:

- providing real incentives for health authorities to improve their efficiency

- directing resources towards those areas where efficiency was being given priority; and

- thereby allowing money to flow to those who improved their capacity to treat patients.

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FINANCING HOSPITALS

Note by the Treasury

This paper examines the scope for rewarding the best performing parts of the NHS through a "top-sliced" element of the health budget. It is intended to tackle quickly the problems that exist now. It does not necessitate structural change in the NHS and involves only relatively modest change at first. But it could be adapted readily to an evolving NHS structure.

The problem

2. The present resource allocation system is based on need. Money is distributed to regions on the basis of the relative priorities revealed by the RAWP formula, and then from regions to districts. The criteria applied by regions in allocating funds to districts vary, and by no means all follow RAWP-style methods. But in general the system takes no account of efficiency or performance.

3. In theory, the main incentive to improve efficiency is that it enables a hospital to provide a greater volume of services within a fixed budget. But in practice this turns out to be only partially true, because treating extra patients of itself generates increased costs. In general, if throughput is improved so that more patients can be treated within existing capacity at existing staffing levels, unit costs do not fall commensurately, so that the improved treatment rates cannot be achieved without increased funding. So the incentives to improve efficiency are not as great as they could be.

Top-slicing

4. In outline, the system would be quite simple. Most current expenditure would be allocated as now: distributions to regions in the previous December; allocations by regions to districts completed by late February. The amount allocated in this way might be based on the total of health authority budgets the previous year, leaving the balance to be allocated on the basis of performance. Typically, after allowing for increased costs, including pay awards to doctors and nurses, this has left room for real growth of around 2%, or £250m.

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5. This would be in February, so that hospitals would go into the year in full knowledge of their budgets. The total available for distribution would have been determined in the previous public expenditure survey. If, for the sake of argument, it was 2% of the total, the extra performance-based allocations might vary between 0 and 5% of initial allocations. The distribution within the total sum available for these allocations could be settled only when the overall performance of all health authorities had been assessed.

6. The interaction between the system and that for allocating resources generally would be complex, but it should be possible to ensure that rewards were carried forward into baselines for future years, and were not lost at the end of the year. Initial allocations to regions would be based on the previous year's total allocation (including performance awards). If there were to be further movement to RAWP targets, allowance would have to be made: either (and this would be controversial in RAWP-losing regions) by adjusting these allocations up or down; or by using some of the growth money for RAWP adjustment rather than rewarding performance. Regions would be asked, in their allocations to districts, to take full account of previous performance awards, alongside the other criteria they apply. So a district's allocation should reflect the carrying forward of previous awards, possibly with some adjustment for other factors.

7. A number of questions need however to be addressed:

- to whom would the performance-based allocations be made: hospitals or districts?

- how would their performance be measured?

- would the objective be to reward activity or efficiency?

- would performance be measured against some external standard, or would the criterion be improvement in measured performance?

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District or hospital?

8. Allocations direct to hospitals, or even to departments within hospitals, would provide the most direct incentives to improve efficiency. Money would be diverted to the best performing parts of the health service in a very direct way. But it could be difficult for DHSS to interpret sensibly information coming forward from individual hospitals. Moreover, such information is not yet available in the required detail.

9. Giving the money to districts would enable them to allocate it both in accordance with local priorities and so as further to improve efficiency, in the knowledge that this could be expected to result in further financial rewards. Districts should be asked to link allocations to hospitals to performance and efficiency targets. This would be a first step towards a management system in which funding is tied more closely than now to performance and to meeting activity and efficiency targets.

10. Whether allocations to districts should be made by regions or by the department is a matter for judgement. Regions would have considerable scope to undermine the effect of the performance-based allocations by offsets in their disbursements to districts. On the one hand, it could be argued that separating the two processes by the department making the performance-based allocations would minimise the scope for this. On the other, it could be argued that the commitment of the regions to the new system would be best secured by giving them responsibility for allocating the money. Ministers are invited to consider the balance of argument between giving the function to regions or the department.

How to measure performance?

11. Officials will need to do more work urgently on ways of measuring performance. An obvious starting point would be the Korner information system, introduced from 1 April 1987. But the performance indicators produced by this system are primarily intended to be aids to local management rather than objective measures of performance, and it might be necessary to find a way of supplementing them.

Activity or efficiency?

12. This depends on the area being considered. Where waiting times are excessive, increasing activity levels - and maintaining the increase - is the only way to get them down. But increased activity is not a good measure of performance in other areas - for example, psychiatry.

13. This suggests a two-pronged approach. In order to introduce the right incentives and to deal with the problems identified in paragraph 2 above, the general criterion for distributing the top-sliced money should be efficiency. But the concept could be imported into the present efforts to tackle excessive waiting times for routine procedures. A separate top-sliced allocation, replacing the present waiting list initiative, could be distributed to those who had done most to increase activity in certain defined areas, thus reducing waiting times, in order to encourage them to go further, if necessary taking patients from waiting lists in other nearby districts.

Absolute performance or improvement in performance?

14. Any attempt to devise a "standard" performance measure would be very complicated. The formula would have to take account of the size and distribution of hospitals within the district, the range of specialties covered, the characteristics of the local population. It might also have to cover factors like how many sites hospitals are spread over, and their layouts, which affect efficiency but are beyond the control of the local management. No matter how sophisticated the formula, many would continue to argue that they were subject to special factors which were not given their due weight.

15. Such problems would be avoided by measuring performance over the most recent 12 months and comparing it with the previous period. It would be much more difficult to argue that there were special factors which inhibited improvement in performance, as opposed to the absolute level of that performance. Rewards based on improved performance would also offer more immediate incentives to management. Those who started well down the league might need to spend several years improving their efficiency before qualifying for extra money if the criterion were absolute level of

performance. Management might get discouraged in such circumstances, whereas they could start to benefit immediately if it was fmprovement in performance that was being rewarded.

16. One difficulty with rewarding improvement in performance is that it might be the least efficient authorities with most scope for improvement (eg because they had been slow to introduce competitive tendering) who would benefit most. But once the system had been running for a few years, the best authorities should have found ways of improving their efficiency as well over time. So long as the system ensured that the allocations were built into baselines for subsequent years, the best districts should be able to reap suitable rewards.

Implications for self-governing hospitals

17. The system would need to be adapted for self-governing hospitals, independent of districts. It is difficult to say what form this would take, without clear decisions on the nature and structure of such hospitals. Among the questions to be considered are:

- whether their allocations should distinguish "baseload" functions (service to the local community, just like any other district general hospital, referrals by GPs etc) from any functions as "centres of excellence", eg the referral by consultants in other hospitals of particularly difficult cases

- whether the financing of their "baseload" services should be able to share in the growth money given out to the rest of the system in performance-based allocations

- if so, whether they too should be subject to the same regime of performance measurement

- whether the "centre of excellence" functions could be financed differently, eg by direct payments from the budgets of other hospitals whose consultants referred their patients on.