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P 03282

PRIME MINISTER

NHS REVIEW: FUNDING

[HC 58]

DECISIONS

1. This is the paper by the Chief Secretary and the Secretary of State for Health which you asked for at the last meeting. We understand that it has been drafted by the Treasury and is the outcome of considerable discussion and agreement between them. The group found the earlier paper on the subject by the Secretary of State unclear, and were concerned that it seemed inconsistent with the approach in HC35, which adopted a weighted capitation basis for the funding of health authorities.

2. The new joint paper seems much better. It is clear, and sets the firm objective of abolishing RAWP and moving to a weighted capitation basis of funding. It proposes a better and simpler system of financing cross-boundary flows. It sets out a step-by-step timetable for implementation up to 1994.

3. In discussion, you may wish to concentrate especially on the distributional effects of the formula for capitation funding which the paper proposes. The three options in paragraph 8 and in the table at the end of the paper are important. They point to a further shift in resources away from the North Thames regions despite the ending of RAWP. The formula recommended in the paper (option C) would temper this shift a little by giving the Thames regions an explicitly higher level of funding than the rest of the country. But North West Thames would still lose another £29 million compared with £34 million under RAWP, and North East Thames would lose £49 million compared with £68 million under RAWP. You will wish to decide whether this is the best than can be done or whether to ask for more work on options which would reduce or avoid the losses to the North Thames regions.

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b

4. You may also wish to check that you are content with the timetable in paragraph 4. There are two particular points which might be worth raising:

i. self-governing hospitals. The first candidates for self-governing hospitals are to be identified by April 1989 and the "first wave" are to be set up by April 1991. It is not clear from this how many such hospitals are envisaged, nor what progress is intended in the period between now and April 1991;

ii. allocations to Districts. The timetable proposes that capitation-based funding of Regions should be completed by April 1992, but says nothing about capitation funding of Districts. The text of the paper merely says that the transition at District level will take longer than at Regional level (paragraph 17).

5. Finally, on capital allocations the paper is brief: see paragraph 23. You may wish to deal with capital under the separate item on capital in the agenda.

BACKGROUND

6. There have already been considerable shifts in resources between Regions under the RAWP system: see Annex A to this brief (supplied by the Treasury). Most regions are now within two or three percentage points of their RAWP 'target' except for East Anglia which is 4 per cent below and North West and North East Thames which are still 4.5% and 7% respectively above target.

ISSUES

7. The new paper is an improvement on HC49. It puts forward a clear description of a system which would:

a. begin the transition away from RAWP for the regions from 1990;

b. make Regional allocations on a weighted capitation basis, as the group wanted;

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c. introduce explicit cash payments for boundary flows from 1991, in place of the present artificial RAWP arrangements for taking account of them;

d. develop contractual funding of hospitals from 1990.

There would also be a temporary scheme of top-sliced performance funding from 1990 until the new system is fully in place.

8. In discussion you may wish to endorse the principle in particular of the abolition of RAWP, the better arrangements for cross-boundary flows, and the introduction of contractual funding for hospitals. You may then wish to concentrate discussion on the distributional implications of the new system.

9. There are three questions in particular on distribution which you may wish to probe:

a. Is the extent of the redistribution which the new system entails acceptable, in particular the continued losses suffered by the North Thames regions? The Table shows that North-West Thames would still lose £29m as compared with £34m from continued RAWP; and North East Thames would still lose £49m compared with £68m under RAWP. There are other results which also could be controversial: for instance, Oxford would be £6m worse off than at present, rather than £13m better off as it would be under RAWP; and West Midlands would be £16m worse off compared with £15m better off under RAWP.

No

b. What redistribution would the new system effect between districts? The paper does not set this out. But it makes it clear that the range between districts, in terms of RAWP targets, is much greater than the range between regions (paragraph 14). If therefore the new system involves continued redistribution between districts like that between regions, it would seem likely to create some large losses and gains in comparison with present funding levels.

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c. How would the introduction of the new system be presented and defended publicly? The paper is not clear about this. Its preferred option would involve a move over three years to weighted capitation funding, but at a higher level for the Thames regions than for the rest (paragraph 12 mentions a 3% differential). Presumably the Government would have to say now what the basis of the capitation would be, and what the preference for the Thames regions would be, in order to justify the allocation in the first year, and the departure from RAWP. You will wish to consider how an explicit preference for the Thames regions could be presented politically. Could the RAWP bias against these regions be removed in a less controversial way?

Other Options

10. If after discussion you are concerned about these distributional issues you could consider asking for more work to be done on options which build on the proposals in the paper but have a different distributional effect. Some possible ideas are suggested below.

An increase in resources

11. Levelling all other regions up to the level of the best (North East Thames) would, as the paper says, cost some £800m. It would not change the relative redistribution away from the Thames regions, but it would avoid their suffering further losses. You will probably want to rule out any solution involving substantial increases in NHS funding. It might however be worth exploring whether a small increase could in some way be used to find a solution: for instance, by 'capping' the gains and losses of Regions each year, so that the shift away from the North Thames regions could at least be limited.

Freezing current allocations

12. Another possibility might be to start by freezing Regions' shares of the NHS total at the 1989-90 level. There would then be no further gainers or losers except to the extent that simple adjustments to reflect, say, changes in the size of population were needed. This approach would stop the redistribution away from the Thames

regions implied by the paper. It might be defended on the practical ground that the RAWP changes had caused controversy and upheaval, and the Government believed that some stability was now desirable. But it could be criticised on the ground that the level of allocations reached in 1989-90 had no particular validity, and was based neither on RAWP-type distributional considerations nor on weighted capitation.

Special arrangements for Thames Regions

13. Another possibility which might be worth exploring would be to have some sort of special arrangement for the four Thames region. It is noticeable that Option C in the paper, which the Chief Secretary and the Secretary of State are recommending, would paradoxically be of more benefit to the South-East Thames and South-West Thames Regions than to the Northern Thames regions which it is particularly designed to help. You may wish to ask whether there is any way in which a defensible arrangement could be devised which would take these four Thames regions together and even up the differences between them.

Changing the weighting

14. Finally, there is the possibility of adopting a different weighting for capitation payments from the one assumed - but not set out in detail - in the paper. The system in the paper appears to be weighted to take account of:

i. size of population;

ii. age structure;

iii. the health of the population, or morbidity, which is assumed to be linked to the more easily measurable indicator of mortality;

iv. higher costs in London.

15. It seems clear from table B attached to this brief, obtained from the Department of Health, that these weightings can make quite a lot of difference. For instance, a weighting for morbidity appears to involve a shift of £34m away from North West Thames and £13m away from North East Thames, compared with capitation weighted solely for age.

16. You may wish to ask how far the new system has changed the weighting under RAWP; and whether further changes in the weighting could be made which would further help the Thames regions. There are two points which you could use to support such a question:

a. paragraph 6 of the paper suggests that further work is anyway being done on the weightings;

b. paragraph 11 lists a number of factors which could be used to justify explicitly higher funding for the Thames regions. If they could be used in that way, why not use them to make less obtrusive changes in the weightings?

17. Depending on the course of the discussion on these points, you may ask for more work to be done on the effects of changing the weightings. This could for example show the effect of each weighting by itself, and of variations in it. This would help the group to see whether an acceptable pattern could be produced by changing the weightings.

Performance funding

18. Paragraph 18 of the paper contains proposals for a temporary system of top-sliced performance funding. The group was earlier attracted by such a system, although no final decision was made to adopt it. You could on this proposal ask:

a. If it is still necessary. One reason for putting it forward before was, as paragraph 18 says, that at present hospitals are not paid extra if they attract more patients though greater efficiency. But that defect would be corrected by

explicit cash payments for cross-boundary flows, which, according to paragraph 25, would be introduced from 1991, only a year after the performance funding scheme.

b. If it would lead to extra expenditure. Paragraph 18 says that the amount to be spent on the scheme should be the subject of annual discussion in PES. But the money must come from somewhere. Will it reduce the basic provision for hospitals generally, or will it in practice have to be financed from a higher NHS allocation?

c. What the purpose of the scheme would be. Paragraph 18 says that it could be used to reduce waiting times or to provide extra money for consultant posts. Should the group have a clearer idea how the money would be spent before it takes a decision in principle?

The timetable

19. According to the timetable in paragraph 25, the new system would not be fully in place until 1994, around the middle or second half of the next Parliament. You will wish to consider whether you are content. In particular, you may wish to explore how many self-governing hospitals are planned, and what early progress is possible within existing legislation. Also, there appears to be no clear date for transferring the funding of District Health Authorities to a capitation basis.

RTJW.

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Cabinet Office
21 November 1988

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ANNEX A

REGIONAL ALLOCATIONS AS COMPARED WITH WEIGHTED CAPITATION

The best proxy for weighted capitation that is available at present is RAWP targets. These give distributions between regions, according to population, adjusted for age mix, morbidity and cross-boundary flows. The following table shows the actual allocations in 1989-90 (with estimates in brackets of what the figures would be without adjustment for cross-boundary flows), and the distances of the allocations from target in 1988-89 and 1979-80. Most regions are within two or three percentage points of target now, except for East Anglia (4% below) and NW and NE Thames (4½% and 7% respectively above target). While the changes in individual regions vary quite considerably over the period - compare, for example the progress of NE and SE Thames respectively towards target - largely as a result of the targets themselves shifting with population changes, the general picture is of very considerable movement towards target, and hence a more equal spread of resources across the country.

	Allocation 1988-89 (and estimated allocation without cross-boundary flow adjustment) £m	Percentage distance of allocation from target 1988-89	Percentage distance of allocation from target 1979-80
Northern	735 (731)	- 1.56%	- 7.47%
Yorkshire	830 (834)	- 1.39%	- 3.68%
Trent	1010 (1034)	- 2.70%	- 7.25%
East Anglia	438 (426)	- 3.99%	- 5.10%
NW Thames	808 (837)	+ 4.46%	+12.98%
NE Thames	1007 (987)	+ 7.29%	+11.46%
SE Thames	898 (905)	+ 1.69%	+10.03%
SW Thames	746 (754)	+ 0.97%	+ 5.90%
Wessex	615 (625)	- 1.79%	- 3.70%
Oxford	482 (494)	- 2.58%	+ 0.58%
South Western	732 (721)	- 1.39%	- 4.01%
West Midlands	1186 (1174)	- 1.32%	- 5.81%
Mersey	586 (583)	+ 1.48%	- 1.00%
North Western	1005 (972)	- 1.35%	- 8.76%
Average distance from target	-	2.43%	6.27%

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TABLE B i

Region	(1) Existing allocation excluding the effect of cross-boundary flows	(2) Simple capitation	(3) Capitation with age	(4) Capitation with age and morbidity
	£ million	£ million	£ million	£ million
NORTHERN	731	716	686	741
YORKSHIRE	834	841	819	851
TRENT	1,034	1,086	1,042	1,060
EAST ANGLIAN	426	471	471	441
NORTH WEST THAMES	850	819	839	805
NORTH EAST THAMES	1,002	881	947	934
SOUTH EAST THAMES	915	851	942	916
SOUTH WEST THAMES	716	697	761	714
WESSEX	625	682	697	654
OXFORD	494	584	523	492
SOUTH WESTERN	721	747	788	749
WEST MIDLANDS	1,174	1,213	1,133	1,168
MERSEY	583	561	535	573
NORTH WESTERN	972	929	901	978
TOTAL RHAs	11,076	11,076	11,076	11,076

Explanatory Notes

1. Capitation: population of the Region.

2. Age weighting reflects our knowledge of the relative use of health services by different age groups.

3. The morbidity measure reflects geographical variations in hospital use.

4. Columns (1), (3) and (4) include adjustments to take account of higher pay costs in London and the South East.

5. Figures relate to initial allocations for 1988/89 before Review Body additions.

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