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PRIME MINISTER

LETTER FROM THE CHANCELLOR OF THE EXCHEQUER
[Letter dated 18 November 1988]

1. The Chancellor of the Exchequer has written to the Secretary of State for Health, commenting on three of his papers. The main point which you may wish to discuss is the reservation which the Chancellor expresses about budgets for large GP practices.

Budgets for Large GP practices

2. The Chancellor argues that the proposed ability of GPs to use public money to refer their patients privately, even where those patients would otherwise have paid for themselves, could mean a substantial substitution of public for private financing with a resulting increase in public expenditure. He sees this as a serious flaw in the proposals for GP practice budgets. He rules out the option of prohibiting GPs from using their practice budgets to refer patients privately, on the grounds that it would go against established Government policy; and he argues that the alternative is to find some way of reducing GP practice budgets to reflect the number of their patients who use the private sector. He asks how Mr Clarke thinks the problem can be tackled. (The paper on Funding Hospital Services (HC58, paragraph 21), just circulated, also expresses Treasury reservations about 'the practicability of a full-blown scheme for GP practice budgets': presumably a reference to the same point.)

3. You may wish to ask Mr Clarke how he reacts to the point the Chancellor has raised. Depending on the discussion, you may wish to draw on the following points:

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i. is the risk a real one? The Chancellor's argument appears to discount the discipline which budgets will place on GPs to use their money effectively. In practice, budgets ought to give GPs an incentive to want patients to use their own money to buy health care from the private sector, not to collude with them to substitute public for private financing. Patients who want to pay for themselves privately will take some of the pressure off GP budgets, and GPs will have an interest in encouraging private patients, not in taking them on to the NHS as the Chancellor suggests. Moreover from the point of view of the patient, there is an important difference between an NHS patient who hopes that the doctor will send him to the private sector but cannot be sure of it, and a private patient who can require the doctor to do so; there will still be an incentive to patients to retain their health insurance.

ii. wrong to reduce budgets. Patients who want to be treated privately will nonetheless have contributed to the cost of the NHS as taxpayers, just as much as NHS patients. It would be wrong to reduce the NHS allocation to the GPs for treating private patients, as the Chancellor suggests, just because those patients choose to pay for themselves.

iii. see how it goes. If the Chancellor's point is seen as a serious concern, one possibility might presumably be to ask large GP practices to tell their FPC how many private patients they had on their books at the time when they undertook their budget, and then to monitor the number annually. If the number of private patients fell sharply, the FPC could then explore the reason and then - and only then - if it appeared that the GP was deliberately encouraging private patients to come onto the NHS, the budget could be reduced as the Chancellor suggests.

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Other papers

4. The Chancellor's other points on Mr Clarke's papers are much less fundamental and, subject to dicussion, you may be inclined to agree with him on them.

i. A Better Service to Patients. The Chancellor is disappointed by the absence of firm proposals. He also questions the emphasis on broad issues of health policy, and doubts the wisdom of including anything in the White Paper on health indicators.

ii. The Public and Private Sector. The Chancellor regrets the assurances which Mr Moore gave last November which rule out competitive trading for clinical support services such as pathology. But in the circumstances he reluctantly agrees with what Mr Clarke proposes.

iii. Professional and employment practices. The Chancellor is opposed to the proposal for an independent inquiry into the role of professions and boundaries between them. He thinks the inquiry could well get into territory covered by the Review (eg on consultants) and give the impression of muddle.

RTJW.

R T J WILSON
Cabinet Office
21 November 1988

CONFIDENTIAL

SECRET

9

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HC 58

FUNDING THE HOSPITAL SERVICE

Note by the Secretary of State for Health and the Chief Secretary to the Treasury

This paper considers the mechanisms by which:

a. the Department of Health allocates funds to regional health authorities

b. regions allocate funds to district health authorities, and

c. districts fund hospitals, including both self-governing hospitals and those managed by the districts.

Introduction

2. As a Group we are agreed that RAWP, the present system for allocating funds to regions, should be transformed into a simpler system along the lines of the model set out in paper HC35. Under the new system, regions would be funded by the Department on the basis of "weighted capitation" (total population adjusted for age structure and morbidity). There would be no published "targets". Regions would fund districts broadly on the same basis, and hospital funding would be based much more than now on performance and success in attracting additional patients. Cross-boundary flows (of patients across health authority borders) would be handled by way of cash payments from the district in which the patient resided to that where he or she was treated.

3. We are also agreed that health authorities should continue to be responsible for securing those "core" services which have to be available locally: casualty, urgent medical treatment, paediatric services, maternity and ante-natal care, some types of long stay care, and so on. Hospitals must be funded in order to make these

available on demand, as now. They would also compete for contracts to supply other types of service, mainly elective surgery, to districts, who would be acting on behalf of their local populations.

4. This new system will introduce new incentives to improve efficiency. Health authorities will secure health care from the hospitals they consider best able to provide it, while hospitals will be able to compete for business from both their own district and other health authorities. Under the present system, by contrast, money is allocated largely according to where the hospitals are, irrespective of their efficiency. The RAWP process has been seeking over more than a decade to equalise the spread of hospitals between regions, with considerable upheaval and protest in consequence.

5. The problems posed by moving to such a system are quite different at the regional and district levels. We look first at the regions.

The regional transition

6. We have agreed that allocations to regions would be based on population, weighted according to age structure, with some adjustment for, eg, London weighting pay costs. There already exist generally accepted methods for age adjustments, based on the average cost to the NHS of people in different age groups. The overall health of the region's population (as expressed by morbidity) would also figure in the weightings. Further work is in hand to finalise the details of the best and most acceptable measure of morbidity weighting.

7. We need to decide how best to move to a new system of allocations. It will be essential to remove the present arrangements under which cross-boundary flows are reflected only in complicated, obscure and belated modifications to population weightings. Using the most recent data for numbers and up-to-date costings of different types of treatment, all regions would be required during 1989-90 to agree how much cross-boundary flows are

costing. The sums so identified could be physically paid between regions. Ultimately, as the transition at district level proceeds, the need for such regional cross-boundary adjustments would fall away. This would mean that the main financial allocations to regions would in future be for the services used by their resident populations.

8. There are three broad options for managing the transition:

a. move to a weighted capitation system as soon as possible, without any regions losing. This would mean injecting additional funds to bring every region up to the level of the highest

b. bring all regions to a weighted capitation distribution, over a period of, say, three years with those currently funded above the average (in effect the Thames regions) losing resources to those below it

c. move over three years to weighted capitation funding, but at a higher level for the Thames regions than for the rest. The justification for this differential would be the particular problems faced in the capital.

The practical consequences of each option are set out in the Annex. Both the second and third options are illustrated on a self-financing basis. For comparison, the effects of the present RAWP system are also shown .

9. The full "levelling up" implied by the first option, without imposing cuts or freezes elsewhere, would cost at least £800m a year. This is out of the question and we do not consider it further.

10. The approach underlying option (b) is that which the Group has indicated it prefers in principle. As the Annex shows, however, in this form it would involve significant shifts away from present levels of funding. The losing regions would, in the

new system, be able to compete to attract patients from elsewhere. But they might not in the short term be able to attract enough to make up for a loss of funds on this scale. This would be particularly true in London.

11. Option (c) would give an explicitly higher level of funding to the Thames regions. This would be in recognition of a number of factors: the higher costs of the South East generally (not just pay costs); the less comprehensive primary care services in London; and the historically higher rate at which residents of inner city areas in London make use of hospitals, even after allowing for measurable factors like age and morbidity. This last factor has a number of causes, including the simple behavioural fact that people living near to large hospitals will tend to make more use of them.

12. We recommend this third option. We think the proposed 3 per cent differential between the Thames regions and the rest is defensible for the reasons given. On the nil cost basis illustrated, the Thames regions would still lose resources to the rest, but their position would be noticeably better than under RAWP. And most other regions would still gain as compared with the present distribution.

The transition for districts

13. At present districts are funded by regions, but on varying bases. Some use formulae akin to RAWP, but most fund their districts according to where hospitals happen to be located. Under the new system, we would propose, as with regions, to move to weighted capitation allocations, with direct payment between districts for cross-boundary flows.

14. But there are significant complications to the district-level transition:

- the change will have to run alongside the move to contractual funding for hospital services. It will take time to develop a system for districts to enter into

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contracts with hospitals which make sense in terms of financial management without unacceptably limiting the ability to refer patients to where they can be treated quickest or most cost-effectively;

- differences between current levels of funding and those implied by a weighted capitation system are much larger than at regional level. An immediate switch would involve substantial shifts in resources.

- any shift in funds away from inner city areas with historically high hospital use to suburban and rural areas would have to take account of differences in primary care standards, and be managed carefully over time; and

- the capital charging system proposed in HC56 (not yet discussed by the Group) will have differing impact on districts, according to the state of the capital stock they inherit, and will have to be phased in carefully.

15. For these reasons, the transition to weighted capitation at district level is likely to take longer than that at regional level.

16. A start depends on improved information at hospital and district level about population, movement of patients and costs of different types of treatment. Once that is available, and it should come naturally from the improved information systems we are proposing more generally, cross-boundary flows could be explicitly costed and paid for.

- First, districts would identify and cost the services which were being provided for the residents of other districts, which would then be paid for. District allocations would thus be based on the cost of services that were being provided for their residents, rather than the cost of the hospitals they contained.

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- Self-governing hospitals would be paid direct by districts. Otherwise districts would initially pay one another, the necessary legislation having been enacted. As more hospitals become self-governing and more directly-managed hospitals become capable of handling contracts, so payments to districts would give way to payments direct to hospitals. Districts would be free to look to hospitals elsewhere and hospitals to compete for the business of other districts.

17. To sum up, the transition at district level will take longer than at regional level. The general principles - the objective of weighted capitation funding and transparent cross-boundary charging - are however the same as for regions. Once "contractual" funding is in place, the regional role in making cross boundary adjustments can be phased out. The internal market will predominate.

Performance funding of hospitals

18. Once the new system is fully operational, there will be automatic performance incentives, since districts will be seeking the most cost-effective deals from hospitals. But during the transitional period, a system of top-sliced performance funding, along the lines set out in HC27 and HC49, is necessary. This addresses the common complaint that hospitals which increase their efficiency cannot make commensurate improvements in the numbers of patients they treat without some additional funding to cover the variable cost element of treating those extra patients. The scheme would also include incentives for some hospitals to concentrate on waiting list cases and to draw in patients from elsewhere so as to have the maximum impact on waiting lists; and provision for establishing additional consultant posts along the lines set out in HC49. The amount of money to be set aside for the scheme within the agreed total provision for health expenditure should be the subject of annual discussion between us in the public expenditure survey.

Self-governing hospitals

19. Self-governing hospitals will accelerate the pace of change at district level. It is of their essence that they will be funded by contracts with districts. We need to ensure that districts are ready to negotiate these contracts before they are set to move into "contract funding" more generally. Self-governing hospitals will need contracts to supply both "core" and "contract" services on behalf of local districts. Further work by the Department of Health is in hand on the form that these contracts will take, and on the costings that will underpin them.

20. One effect of hospitals switching to self-governing status may be to denude some districts of substantial functions. This may encourage amalgamations with neighbouring districts, a process which might be consistent with merger with the - in terms of area, often larger - FPCs.

GP practice budgets

21. The Treasury have reservations about the practicability of a full-blown scheme for GP practice budgets. This is to be addressed separately. Assuming for the moment, however, that these problems are resolved, GP practice budgets would substitute for part of districts' spending on acute hospital services. The money for paying hospitals would therefore need to come out of the hospital and community health services budget, not the FPS.

22. The proposal is an extension of those for funding districts as "buyers" of services. It would make sense therefore to give regions the responsibility for allocating funds to practices, since it is they who would also be responsible for funding districts. This would be consistent with lines of accountability irrespective of whether FPCs and DHAs are merged.

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Capital

23. Capital allocations would be based on capitation weighted by age and morbidity. Land sales would continue to be retained for developments within regions. Other capital issues are being addressed separately.

Timetable and summary

24. The proposals in this paper may be summarised in the following schematic timetable.

April 1989 -
- Regions required to agree cost of cross-boundary flows.
- Districts begin work on improved information about population, movements of patients, and costs of different forms of treatment.
- First candidates for self-governing hospitals identified.

April 1990 -
- First year of transition to new weighted capitation formula as basis for allocations to regions.
- Explicit cash payments introduced for cross-boundary flows between regions.
- Development of schemes for contractual funding of hospitals.
- New top-sliced performance funding scheme.

April 1991 -
- Introduction of explicit cash payments for cross-boundary flows between districts; cross-boundary adjustments to regional allocations no longer needed.
- First wave of self-governing hospitals set up, funded by contracts with purchasing districts.

April 1992 -
- Extend contract funding to more hospitals.
- Transition to weighted capitation at regional level complete.

April 1994 -
- Introduction of contract funding of hospitals completed; cross-boundary adjustments at district level and performance funding phased out.

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ANNEX

	(1) Existing Alloc Excl the effect of cross-boundary flows	(2) Gain(+) or loss(-) under Option(A)	(3) Gain(+) or loss(-) under Option(B)	(4) Gain(+) or loss(-) under Option(C)	(5) Gain(+) or loss(-) of moving to RAWP targets
	£m	£m	£m	£m	£m
Northern	731	+ 64	+10	+ 3	+12
Yorkshire	834	+ 79	+17	+10	+11
Trent	1034	+103	+26	+17	+28
East Anglia	426	+ 47	+15	+11	+18
N W Thames	850	+ 13	-45	-29	-34
N E Thames	1002	0	-68	-49	-68
S E Thames	915	+ 67	+ 1	+19	-15
S W Thames	716	+ 50	- 2	+13	- 7
Wessex	625	+ 77	+29	+23	+11
Oxford	494	+ 34	- 2	- 6	+13
S Western	721	+ 82	+28	+21	+10
W Midlands	1174	+ 80	- 6	-16	+15
Mersey	583	+ 32	-10	-15	- 9
N Western	972	+ 77	+ 6	- 2	+14
Total RHAs	11076	+807	0	0	0

All figures relate to 1988-89 initial allocations (excluding Review Body additions). There are two points to note about the figures in Column 4. They are the cumulative effect of changes in three years and they would in any event alter dramatically as a result of inter year changes.