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PRIME MINISTER

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FUNDING THE HOSPITAL SERVICE

The presentation of the paper has improved and it is far more readable. But the slow pace of change is still very worrying. We may need to delay the timetable for the completion of the White Paper if many of the outstanding issues are not resolved soon. A delay would be better than a half-baked review.

Funding is a complex area. But it is crucial that the transition does not obstruct the move towards self-governing hospitals and GP budgets at an early stage. Unfortunately, this is a distinct possibility. In an earlier draft of the paper by the Treasury, self-governing hospitals were not even incorporated in the timetable in Para 24. And in the same draft, the Treasury tentatively suggested that 'substantial progress should be possible within about 5 years'. Clearly, the Treasury cannot be relied upon to help drive the main reforms forward.

The Regional Transition

Paras 6-12. Kenneth Clarke will need to spell out the assumptions underlying the age-weighted capitation payments outlined in the Annex. And he should explain the main changes between the previous RAWP targets and the new proposal. Is this formula simpler? Or is it RAWP-2?

The relative impact of age and morbidity on the simple capitation formula is not clear. What are the relative weightings? For example, I have heard that the morbidity

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adjustment increases the allocation to Northern Region by £55 million, decreases the allocation to North East Thames by £13 million and decreases the allocation to North West Thames by £34 million. How is morbidity determined?

We will need to be quite clear what the estimated shortfalls will be (after cross-border patient flows) for political and managerial reasons. The Annex takes no account of current cross-border flows of patients. Also the deficits could be offset further by allocating lower growth money to some of the Regions over the next 3 to 4 years.

Questions: - What assumptions are used in calculating the allocations in the Annex?

- How does this differ from RAWP?

- How is morbidity determined?

- What weightings are applied to a simple capitation formula for age and morbidity? How does it affect each Region?

- What is the impact of estimated cross-border flows of patients, based on existing data?

- Could the deficits be offset further by allocating lower growth money over a 3 to 4 year period?

C

The Transition for Districts

The Timetable in Para 24 assumes that the transition at regional level will be completed by April 1992. The transition to district capitation will take longer. But there is no reference to completion of the transition. An earlier draft of this paper suggested a target of April 1995. This has now been removed.

We must move to a firm foundation for district funding within a short time frame. Otherwise, self-governing hospitals will never emerge. Many hospital managers will wait until the funding pattern settles down before seeking self-governing status. Our objective should be to achieve an absolute minimum of 40-50 self-governing hospitals by 1992/3. Funding patterns should not be permitted to slow down this process, even if it means slightly higher costs in the interim to manage the transition.

Questions: - Will uncertainties in funding delay the move to self-governing hospitals?

- How will the transition to capitation funding be managed?

- Over what time-frame?

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Top-slicing

Para 18. The proposal for 'interim' top-sliced performance funding for hospitals makes no sense:

- In principle, it would operate for a very short 4 year period.

- Allocation formulae will be highly complex, no doubt based on a mix of the 450 performance indicators.

- The total payment will be marginal (£50 million was mentioned in the previous paper).

- A new bureaucratic administration system would be spawned to manage the payments.

- Most importantly, there is a real danger that top-slicing could be used as a surrogate for other reforms such as self-governing hospitals.

The Treasury has repeatedly proposed top-slicing. This is not surprising. From its perspective as a financial controller, the Treasury prefers the 'less risky' option of top-slicing (a centrally managed marginal increase in funding). And Treasury officials remain sceptical that self-governing hospitals and GP budgets will be major reforms. The DoH is also attracted to top-slicing. The role of the centre would be enhanced.

The real incentive for improved hospital efficiency will emerge from two main sources:

- the changing management philosophy (including consultants) of the 'new world' in the NHS, and in particular,

- the desire to achieve self-governing status.

Management time at each level of the NHS - Management Board, RHA, DHA, hospitals - should be devoted to the key NHS reforms not on short-term fine-tuning.

Top-slicing should proceed no further.

Question: - Why introduce such an unnecessary time wasting, short-term mechanism of top-slicing?

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Capital

'Capital' is an extremely sensitive subject in Whitehall. But after weeks of discussion between the Treasury and DoH we have received very little output - one page on a bureaucratic system of capital charges, 14 lines on the need for more work on private sector capital and now 3½ lines on capital funding.

NB This refers to a earlier paper, not this one. P.

Para 23. I assume that age-weighted capital allocations relate to Regions only. What about districts and self-governing hospitals? Would they have to bid against regional budgets if they wished to undertake new capital investment? There is a clear need for Kenneth Clarke to provide a step-by-step summary of his proposed 'capital' system.

The following points - which I firmly believe are highly defective - will probably emerge in the meeting:

1. DHA-run hospitals and self-governing hospitals will have little access to private capital.

2. The capital charging system will be more like a quasi-leasing system. In essence, each new building or each piece of equipment will be financed by a loan from the Regions. For example, a new CAT scanner would probably be repaid by the hospitals over 5 years - including principal and interest. The same will apply to hospital buildings over a longer period - probably 20 years. The private sector does not operate in this way. They rely on a mix of equity, bank loans and leased equipment. From the point of view of the investor, he hopes to increase his return over a longer period while accepting lower returns than current

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interest rates in the short-term. On the other hand, a company likes issuing equity to minimise its cost of capital in the short-run. Only a small minority of companies operate on 100% gearing ie all debt.

3. Self-governing hospitals will probably have little room to manoeuvre in their disposal of assets.

4. Capital charges will probably be matched one-for-one by increased allocations to the hospitals. In effect, money would be circulating internally in the health service.

5. The DoH is unclear as to how retained earnings will be utilised.

6. The DoH/Treasury proposal includes a 'notional' charging system. In my experience, notional charging is largely ignored by management. Only actual cash payments place a real discipline on management.

7. Self-governing hospitals would be required to justify the benefits of every single capital purchase.

In summary, these points will result in a highly bureaucratic, artificial, complex capital structure. Self-governing hospitals will have little control over their resources.

I strongly believe that an alternative option should be considered on the following lines:

1. Regions and potential self-governing hospitals would agree an initial valuation of land, buildings, equipment and working capital. This total would

represent the Net Investment of Regions in self-governing hospitals.

2. Each year, a hospital would deduct depreciation charges from its net profit (or loss), similar to any other company.

3 The hospital would be required to pay a preference dividend on the Net Investment (eg 8% a year). If in one year, the hospital fails to make a payment because of an operating loss, the preference dividend would be delayed until the next year (cumulative dividend).

4. Repayments of capital could be delayed for, say, a 5 year period. But this is not necessary. Equity capital is rarely paid back to investors unless a company is sold.

5. Net earnings could be partially distributed to staff or retained for further use in future years. Soviet health reforms would be way ahead if we fail to incorporate this characteristic.

6. Regions would then allocate capital on the basis of the best overall return (not by analysing internal hospital management reports). Net investment would then be increased.

7. Hospitals could borrow funds from the private sector, within limits, and lease equipment.

8. The capital structure would then be much closer to the private sector, but at the same time assuring 100% public ownership.

Questions:

- How would 'capital funding' work in practice (allocation of capital to districts, capital charging, access to private capital)?

- Why not move directly to a system of actual cash charges for capital? (weakness of existing financial accountants is not a valid reason).

- Does Kenneth Clarke really believe that his proposal will mirror capital structures in the private sector?

- Why not introduce the alternative option proposed above?

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