PRIME MINISTER

HEALTH SERVICE REFORMS

David Wolfson telephoned me today about the NHS reforms. There is a strong movement afoot from the medical profession to persuade the Government to implement its reforms on a progressive basis e.g. by applying them in only two regions for a couple of years - see attached cutting. David strongly supports this and wants to come in and talk to you about his concerns.

He argues:

(i) it is proposed to make the majority of the changes in a Big Bang - Norman: only a few hospitals will apply

(ii) it is an enormous change taking the NHS from the quill pen to the computer age in one go

(iii) no major organisation would attempt such a large change so quickly. They would try it out in a number of branches first

(iv) the prerequisite for success is the installation of IT and accountancy systems. These are running behind schedule

(v) the Government is heading for another community charge i.e. a major upheaval with lots of snags emerging requiring hurried remedial action, only even closer to the Election. One risk is that a hospital gets its costings wrong and finds that, part way through the year, it is making a loss and running out of money.

David believes, perhaps naively, that a consensus could be achieved with the medical profession on a region by region introduction. A more cynical view is that having failed to stop the Bill, the profession is simply trying to slow down

implementation.

Before seeing him, I think you need some briefing on a number of the propositions he makes:

- Is it true there the system is being introduced with a big bang? No
- Is a phased introduction feasible? - It is depends on application, the Treasury determines the rate
- Is there a danger of chaos?
- Are the management systems behind schedule?

My understanding is that a big bang is proposed and is to some extent inevitable. Districts will no longer be funded as providers of services but as purchasers of services on behalf of their residents . A district with a big teaching hospital relative to the size of the population, e.g. Cambridge, will receive a much smaller core budget. For example, Addenbrooke's will receive only £50 million rather than £90 million at present. The balance will go to the surrounding districts with people but no hospitals. The expectation is that Addenbrooke's earns the necessary £40 million by treating patients from say Newmarket. But if the information on the flows of patients between districts and the costs of the treatment they receive are inaccurate it is possible that Addenbrooke's could find itself not earning enough to staff the facilities it has retained. Eventually as trading becomes better established this will sort itself out but their could be problems early on. The difficulty is that in this example, one cannot move just Cambridge onto the new basis; one must also adjust the funding of the surrounding districts who are net exporters of patients so that they have the money to pay Cambridge.

It would not be possible to take one of the Thames regions as a starter as the cross boundary flows are enormous. It might, however, be possible to find a more self contained region e.g. Wessex. But there are also disadvantages to a safety first approach. While Wessex might be able to press ahead, enthusiasts

in West Midlands would be held back.

I doubt if there is much value in seeing David until some further work has been done for you on what DOH are planning, how far they are up to schedule, and what the risks of things going wrong. I suggest that you ask Ian Whitehead to investigate some of David's propositions with the Department and then to prepare a report for you. You could then see David with a better appreciation of the facts.

Agree?

AT

Yes. If we had only two pilot schemes there would be some merit delaying to see what they were worth.

Andrew Turnbull

30 March 1990

c: Wolfson (MJ)