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SECRET

BARRY POTTER 2 May 1990

HEALTH REFORMS

I spoke to David Wolfson today to discuss the status of the health debate. I presented the case for pressing Kenneth Clarke to slow down the pace of change in the most vulnerable area ie London, as set out in the attached note to the Policy Unit. David Wolfson agreed with me that London is by far and away the riskiest area, although he would prefer to limit the reforms only to those districts around the country where there is a self-governing hospital.

After Kenneth Clarke's next note, I strongly suggest we continue to press him for specific options to slow down the momentum in London.

The attached note, given to me privately be a senior department of health official, confirms this view. The Prime Minister may be interested to see it.

IW

IAN WHITEHEAD

SECRET

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POLICY UNIT MEMBERS 1 May 1990

HEALTH REFORMS

During a recent bilateral with Kenneth Clarke, the Prime Minister expressed her concern about the pace of implementation of the NHS Reforms, in view of the political and managerial risks and the pressures from the medical profession.

There are three main legs to the NHS reform, to be introduced next April:

(1) an internal market (or contracting system) between purchasers of health care (health authorities) on the one hand and hospitals on the other;

(2) 40-50 self-governing hospitals;

(3) 300-400 GP budget holders.

Kenneth Clarke was asked to consider the possibility of phasing in the contracting system in 4 or 5 Regions with the possibility of retaining (2) and (3). He wants to press ahead on the existing timetable. I would appreciate your views on the next step.

PROBLEMS

(1) The Department of Health feel it is not possible managerially to introduce self-governing hospitals and GP budget holders into a non-contracting environment for the reasons decribed in my previous note to the Prime Minister.

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(2) While I believe the changes can be managed steadily in most parts of the country, there are very severe dangers for London.

- the London teaching hospitals receive up to two-thirds of their patients from outside their contract area. It is highly likely that outer London health authorities will start diverting more patients away from central London to local hospitals (along with the cash resources). In the longer term, this change is positive, but it could lead to more bed closures in central London.

- Perhaps most importantly, the PES round will be tight this year. Last year's PES round was viewed as generous but has still not alleviated the financial problems of central London.

- the quality of financial management in London is often lower than other areas. Pay levels are not viewed as competitive.

- If there are more severe financial problems in London, bed closures will be blamed on the reforms.

My view is that we should continue to press for implementation of the reforms, mentioned above, outside London. Yet I am encouraged by the attached private note from a senior department official, which supports the case for delaying the introduction of an internal market in London for a year or so.

PP D. A. Lewis

IAN WHITEHEAD

For Ian Whitehead

1 Inevitably there will be teething problems as the internal market settles down. It needs little imagination to see the possibility of criticism if contracts are wrong (ie they do not reflect patients' and GPs' wishes) or inadequate (they do not cover significant referrals particularly extra-district ones). The complexity of London, four contiguous regions, massive cross boundary flow and often a lower level of staff competance at middle management levels particularly in the financial and planning departments, makes it likely that if there is a mess it will be in London. One would wish for an honest appraisal of the likelihood of trouble. This might not come from senior management who are encouraged to solve problems, not report on them.

2 Does the state of development of information systems, the competance and experience of middle management, and the security of patients from inadvertent muddle permit the successful introduction of an internal market on the timetable envisaged. It there is a serious possibility of a breakdown - and what would be the consequentials of slipping the introduction in London by, say, a year?

3 The immediate problem is that the country would be operating on two different systems. This would not matter in most places, but at the margin of the zones there would be a need to operate both (although one would certainly be dominant). In most countries, however, multiple funding/provider systems exist, and hospitals assemble their operating budgets from a variety of sources. From the provider point of view it probably matters little whether the money arrives in a block allocation, as a result of contractual money "travelling with the patient" or by a combination of the two. The problem is primarily one for the funding agency. Money allocated under a block allocation system would need to be abated by the amount which was passing through a contractual channel. If one assumed that the Royal Free Hospital in Camden was going into a full internal market a year after Barnet (which supplies the Royal Free with a significant number of patients) how could this be handled, not least because they are in different RHAs? Could the answer be for Barnet to continue to set the contracts its residents needed, including contracts with the Free, and for the North East Thames RHA to provide a block allocation reflecting patient flows from "non-internal market" districts?

Hospital Trusts

4 While NHS Review proposals to some extent are interlinked, they are not wholly inter-dependant. For example the nature of governance is not crucially dependant upon the pattern of funding. Until 1974 teaching hospitals had a large measure of self-governance under their Boards of Governors. There was no internal market and they drew a block allocation from the Department of Health. Conceivably this could have come via the RHAs, given sufficient protection from RHA intervention. It could be argued that the very time when one should not be changing the financial pattern in a radical way is the time at which one is changing the top management of a Trust - although the lower levels of the organisational structure may need to reflect internal financial management, for example clinical units as cost centres.

GP [illegible]unds

5 Similarly NHS hospitals already draw moneys from a variety of sources, including private health care. The existence of GP Fund holders, who will be responsible for only a few percent of the hospitals' revenue, could be accommodated whether or not the internal market was in full operation. Inevitably the block allocation (based on resident population and patient flow) would be marginally lower if residents were being looked after by GP Fund holders.

6 Essentially what is needed is a rapid judgement about whether many of the gloomy things said about the incapacity of middle management to cope with the change are true or merely shroud-waving. If the latter we should press ahead - although there are many people who would welcome confusion and problems. If there is a substantial risk of difficulty, there is a case for rapid examination of whether hospitals within, say, the north and south circular roads, might introduce a full internal market a year later and whether interface systems could be developed. Other projects should go ahead on time.