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MRM

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cc/JU

10 DOWNING STREET

LONDON SW1A 2AA

15 May 1990

From the Private Secretary

Dear Andy,

HEALTH SERVICE REFORMS

The Prime Minister held a meeting yesterday with your Secretary of State, the Chancellor and the Chief Secretary, on the implementation of the Health Service Reforms. Professor Brian Griffiths (Policy Unit) also attended the discussion.

Your Secretary of State said that his aim had always been to achieve a soft landing in implementing the Health Service review. He was conscious of the political risks of any short-comings in implementation and the damage that ward closures or longer waiting lists would do to the prospects of successful reform. At the heart of the reforms was the development of the contracting system. For both the GP practices, which became fund holders, and the NHS trust hospitals which opted out of control of the Health Authorities, the contracts would be real. But District Health Authorities (DHAs) in general, in the first year, would carry on much as before. They would have to agree block contracts, specifying service levels and payments, principally with the hospitals in their own areas, but also with other hospitals or health facilities outside their area, where there were cross boundary flows. Many DHAs had already undertaken preparatory work in order to be ready to put contracts in place in time for implementation on 1 April 1991. But in October or November 1990, he would take informed decisions about the precise arrangements for implementation next April.

The Chief Secretary said he was concerned at the proposed switch in the funding of DHAs. As from 1 April 1991, the basis of funding DHAs would move from the existing system, based on the costs of running the local health service facilities, to an arrangement based on a per capita amount for the resident population. There would be bound to be gainers and losers amongst DHAs under this approach: while in theory any gaps should be closed by the block contracts, there must be concern that this would happen with less than perfect efficiency. Health authorities often had inadequate records or lacked the necessary IT to produce the detailed information on patients and financial flows necessary to draw up the block contracts. If the information and hence the contracts were inadequate, too many funds could end up in some areas while in others funds would be insufficient - leading to ward closures etc. Accordingly he saw merit in continuing to allocate funds to health authorities on the basis of existing budgets (and costs of service delivery), while using next year to identify the patient and financial flows within and between health authorities on a shadow basis, so as to pave the way for successful introduction of the reforms thereafter.

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The Chancellor said that he shared the Chief Secretary's anxieties. In principle the Health Secretary's proposals should work. But in practice there could be unacceptable political and financial risks because of dramatic swings in the flows of funds to health authorities. Many DHAs would get less money: to make a political case against the reforms they would cut services. Like the Chief Secretary, he saw attractions in introducing the reforms more gently and moving to the shadow contracting system.

The following were the main points made in discussion.

i) GPs already had the right to refer patients wherever they wished. In practice most tended to refer them to the local hospitals. It would take some time before their practice changed. In the short term other savings could arise from the introduction of GP fund holders, for example, on drugs expenditure. Indeed there was some indication of a slow down in the growth of the drugs budget: it had been expected to increase by about 6 per cent in real terms this year; the out-turn was likely to be real growth of around 0.5 per cent.

ii) It was important to ensure that the opted out NHS hospitals were able to secure a fair budget. Some experts had expressed concern that such hospitals might do well to the cost of less efficient hospitals that stayed within the financial control of the health authorities. But that was how the market-based reforms would work - putting pressure on the inefficient to improve services and reduce their costs. The self-governing hospitals would have to negotiate with their local health authorities to settle their funding: the authority would have an interest in securing the best services (and it is in general the efficient hospitals that are going to opt out), and would not wish to squeeze their funding below adequate levels.

iii) Reforms of this magnitude and importance were bound to involve some risks. Massive efforts were being made to get the reforms in place in time. There would be political risks in restraining the enthusiasm of those committed to the reforms by pursuing shadow contracts only. This would be widely seen as a paper exercise. It would give time for opposition to the reforms to build up based on groundless fears about short-comings under the new approach.

(iv) In general the aim would be to get the block contracts agreed and in place by 1 April. No health authority should be in the position of suddenly finding itself with inadequate funds.

v) Particular problems could be expected to arise in London, however, and more widely in districts containing teaching hospitals. In Bloomsbury the budget would fall from £160m (the cost of the service provided) to around £50m (based on resident population). It might be very difficult to identify and arrange all the necessary transfers from other DHAs to reflect the net inflow of patients to Bloomsbury. More generally, there was over-provision of health

authorities in London relative to resident population. In time one of the major teaching hospitals might have to be closed. Particular attention needed to be paid to how the reforms were best brought into effect in London.

vi) The degree of freedom for health authorities to exercise their new powers to purchase services from outside the area in the first year would need to be examined carefully. It might be appropriate to give some percentage guarantee of funding : this would mean that, while health authorities would be funded on the new per capita basis, each would be guaranteed that, after block contracts had been arranged, the total funding to the authority would be set at 100 +\- x percentage of the preceding year's budget. Further work was necessary on what 'x' figure would be appropriate.

vii) It was recognised that the Public Expenditure pressures on the Chief Secretary were particularly difficult this year. But there were also pressures from the Health Service on the Health Secretary. The Chief Secretary and the Health Secretary would need to reach an accommodation that took full account of both the pressures in the Health Service and the overriding need to get public spending under firm control.

Summing up the discussion, the Prime Minister said that the key issue was how to implement the NHS reforms so that the political and financial risks were minimised. A number of variants on the phasing, taking account of the particular difficulties in London, should be examined. The aim would be to see whether the basic approach proposed by the Health Secretary and the shadow contract system advocated by the Chief Secretary could be brought closer together so as to minimise disruption in the pattern of funding. To this end, the Health Secretary should provide a presentation, with Duncan Nichol in support, setting out the proposals for implementing the reforms. This would provide an opportunity for further discussion on how the proposals might be modified to provide the best possible phasing in of the reforms. Attendance at the presentation should include those at the meeting. The timing of the presentation should be discussed further to take into account further meetings of the NHS Management Board and the Public Expenditure Survey process.

I am copying this letter to John Gieve (Chancellor's Office) and Carys Evans (Chief Secretary's Office).

Yours,

Barry

BARRY H. POTTER

Andy McKeon, Esq.,
Department of Health.