3(a-e)

PRIME MINISTER

SEMINAR ON NHS REFORMS

You are hosting a small seminar tomorrow on the NHS reforms. Mr Clarke and members of the NHS Management Executive will give the presentation. The seminar is also being attended by the Chancellor, Chief Secretary, Lord Rayner, Sir Robin Ibbs, Sir David Wolfson and Policy Unit members.

The presentation will take the following form:

(i) Introductory remarks by Kenneth Clarke.

(ii) The overall strategy (Duncan Nichol).

(iii) The contracting system (Peter Griffiths).

(iv) The financial arrangements (Sheila Masters).

(v) The IT support system (Michael ~~Fisher~~ Farley). Farley

(vi) Concluding remarks (Kenneth Clarke).

The whole presentation will take about 20 to 30 minutes, leaving an hour for the discussion. At flag A is a brief from Policy Unit.

BACKGROUND

The fundamental change in the NHS reforms is the contracting system.

- District Health Authorities (DHAs) will in future receive budgets, based on resident population, to act as purchasers of various health services on behalf of those residents, e.g. acute services, emergency services etc, from hospitals in their area.

- The suppliers of these health services to the DHA might be the hospitals in their own District; hospitals

b

in other districts; or the new NHS Trust "opted out" hospitals.

- GP practices would become budget holders with budgets based on their practice lists and purchasing services from local hospitals etc.

For 1991/92 Mr Clarke's specific proposals are as follows:

a. About 400 GP practices to become fund holders.

b. Some 40 to 60 NHS Trust self-governing hospitals to be set up.

c. The major reform, the introduction of a contracting system, to be introduced nationwide.

MAIN ISSUES

The discussion will focus on the contracting system. The NHS Trust's proposal is broadly accepted as practical on the scale proposed next year. The GP Fund Holders are also less controversial.

The central difficulty on the contracting system is whether it can be managed on the scale proposed, and with the precision required; and the damaging political and financial consequences likely to follow if errors are made.

Accordingly the discussion might usefully consider the following factors:

(i) Experience: So far four regions have been undertaking an experiment in so-called block contracts, e.g. a contract between a purchasing DHA and supplying hospitals for a block of service such as all acute services or emergency services. The corollary is that the other (ten) regions have not yet begun to work with

the block contract proposals. How effective has the experiment been? How quickly and successfully can the lessons be spread across other regions?

(ii) Information: Vital to the block contracts is sound information on the flows of patients within each DHA, to hospitals in their own district and elsewhere. This may be straightforward in more rural areas where the great bulk of patients will be dealt with by hospitals and ancillary services within their own district. But it breaks down once one considers more urbanised areas. Some work done earlier suggests that one London authority (Bloomsbury) might be contracting inflows of patients from as many as 40 other District Health Authorities (DHAs). What chance is there of identifying all the relevant patient flows? How stable are they from year to year? What about then arranging for financial transactions mirroring the projected patient flows to appropriate districts?

(iii) Information Technology: According to Sir David Wolfson, and others with expertise in the health service, the IT systems in place are not sufficiently sophisticated to identify the information and cost flows required and deliver the details necessary to run a complex contracting system. Mr Clarke will argue that block contracts do not require this. The accuracy and stability of information found in IT needs to be discussed.

(iv) Cooperation with the Medical Colleges: There is no prospect of securing cooperation of the BMA but at least some of the Royal Colleges might be brought on side for the application of the reforms in some pilot areas only. It seems desirable to avoid entering a risky massive reform without securing the cooperation of some practitioners.

(v) Political Repercussions: The biggest danger lies in failures in the block contracting system. District Health Authorities will initially be faced with a budget, based on resident population, well below last year's budget. They may take precipitate action either immediately in May or June of 1991 or perhaps a few months later, to cut services by closing wards etc when faced with inadequate budgets. This will take place if either the flows of patients and money have been inadequately identified in block contracts: or if the reforms are insufficiently understood.

(vi) Financial implications: Mr Clarke's bids are more modest than might have been expected. This may be designed to avoid an argument that the public expenditure consequences of the NHS reforms cannot be afforded. Even so, the 1991/92 costs of the reforms (base line + bid) is £500-£600 million. He may also be counting on the fact that, once reforms are embarked upon, there will be intense political pressure to find the resources to match them. The Treasury continue to fear they will come under pressure for more resources once the reforms get under way next year.

(vii) London: It is acknowledged even by the Department of Health that the problems are particularly acute for the London area. This reflects both the over-provision of major teaching hospitals; the widely dispersed flows of patients and hence money into and out of London; and the general difficulty in the public sector in London of finding acceptable staff for administrative and financial posts.

MAIN OPTIONS

At the last discussion, the Chief Secretary put forward an alternative approach on block contracts. This would transform Mr Clarke's so-called block contracts into shadow contracts for the

year ahead. The basis of his proposals is as follows.

First each District Health Authority would receive a budget for 1991/92 on the same basis as in previous years, i.e. not on resident population, but on the basis of the costs of providing services from the hospitals and other facilities within its area. Second, it would receive a 'shadow' budget on the basis of the new resident population-based system. Third, it would be responsible during 1991/92 for seeing how the gap between its old style and new style budget arose, by identifying the necessary patient and financial flows. On this basis the way would be open for the block contracting approach to be introduced from April 1992 onwards.

A possible way forward might therefore be to confine Mr. Clarke's block contracting system to some or all the regions which have already had experience of operating the contracts. This would give longer for them to spread that expertise through training etc to the other regions. In the meantime, over the first year, those other regions could operate the shadow contract proposals put forward by the Chief Secretary.

Such an approach should reduce the political risks, and the financial costs for the year ahead. It might also form the basis for securing the cooperation of the Royal Colleges.

CONCLUSION

So far, as you know, there has been no indication that Mr Clarke is willing to slow down the proposed pace of reforms. The above package would allow him to go ahead as he plans in four regions and make a start on the block contracting system elsewhere. It could be presented as the Government (hopefully) cooperating with the Royal Colleges in order to secure an agreed way forward. But it remains unclear whether Mr Clarke will move.

BHP

BARRY H. POTTER

13 June 1990

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NHS REVIEW COSTS

Direct costs in baseline, in anticipation of 1 April 1991 implementation:

	£ million		
	1991-92	1992-93	1993-94
	391	388	400

Total of 1990 survey bids related to NHS Review measures:

126	140	139

plus as yet unquantified bid for capital expenditure by NHS trusts, possibly up to

100	100	100

and technical bid (PSDR-neutral, but increases planning total) for interest payments by NHS trusts:

100	200	300

Indirect costs arise because of the need for a resource cushion against the new risks inherent in implementing the reforms. The risks are two-fold:

- that contracts will deprive some providers of income they would otherwise expect to receive, leaving them with deficits which have to be financed by the Exchequer or by cuts in services

- that some purchasers will over-commit themselves under their contracts and breach their cash limits.

The tighter the overall financial position, the greater these risks. If therefore the reforms go ahead as planned, the NHS will need more money to spend on services than it otherwise would. Difficult to quantify, but every 1% extra on hospital services costs £150m.

Total Declared Bids on this Programme (£ billion)

1991-92	1992-93	1993-94
+1.8	+2.3	+3.4