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PRIME MINISTER 28 June 1990

NHS REFORMS

The Department of Health has now peeled away some layers of opacity and given us a much clearer picture of the future workings of the internal market. The section 'Financial Management in Health Authorities' is particularly revealing. We can now assess the risks in far more detail.

All in all, our view remains unchanged. On the one hand, Kenneth Clarke's paper gives us additional comfort that the internal market can be introduced next April in most areas without too many hiccups. All embracing information systems are not a prerequisite. So the proposal to introduce pilot schemes in two regions only is far too negative and unnecessary. This would be a recipe for little change.

On the other hand, we continue to believe there are considerable dangers of severe disruption in London.

What are the main risks?

The greatest danger is the potential lengthening of waiting times for in-patient surgery and the possible closure of active hospital wards. If this happened, the problems would be blamed on the reforms, and the Government's competency would be challenged.

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There would be three main causes:

1. GPs may decide to change their existing referral patterns.

2. District Health Authorities (DHA) could fall short of money.

3. Hospitals could fall short of money.

1. **GP referrals**

Most people - including the Audit Commission - agree with Kenneth Clarke's view that GP referral patterns will remain largely unchanged next year. And in paragraph IV 7 (d) of Kenneth Clarke's paper, there is evidence emerging that good progress is being made on the ground to establish the present and future movement of patients. This is being achieved by working closely with GPs.

2. **DHA Funding**

A much greater risk is the inability to reflect these GP referral patterns fully in the new funding pattern.

The section 'Financial Management in Health Authorities' helps us to look at this more closely. The calculations are based on the 'Bristol and Weston' district health authority, an area with a resident population of over 350,000, served by a teaching hospital, another acute hospital, a mentally ill and mentally handicapped unit and community health services.

This year, the total cost of running the services is £114 million, funded via the Regional Health Authority.

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Next year's allocation by the South Western Region will be £124 million (assuming no inflation for the purposes of the example). The difference between the two amounts reflect three adjustments:

- **First, capital charges**: £22 million will be added to the district allocation to represent capital charges. This amount will be shared between the hospitals and community services, as part of the contractual agreements for services rendered. The hospitals will then need to pay capital charges back to the Region to reflect the annual capital cost of the RHA's total investment in hospital buildings and equipment.

  In the first year, the money will wash through the system with hardly any impact on anyone.

  On the surface, this adjustment looks like a bureacractic nonsense. Nevertheless in the longer run, we will be introducing a strong financial discipline on capital investment. In the past hospitals have treated capital allocations as a 'free good'. In the future, over-capitalised hospitals will be penalised financially. This mechanism will therefore encourage hospitals to think twice before purchasing new equipment. They will have to ask the question 'will this help us to improve the quality of service to patients and our cost effectiveness?'

  In summary, capital charging will have little impact on funding in the first year.

- **Second, transfer from other DHAs**: £13 million will be transferred from other districts.

Next April, a district will receive funding to enable it to service the health care needs of its local resident population, wherever they are treated. For example, if a Bristol patient is treated in Somerset, the Bristol DHA will have to pay. This £13 million addition to Bristol's funding allocation reflects the present 'indicative' cost of all such referrals.

About three-quarters of this allocation will be spent on block contracts with two districts (page 7 of the paper). This leaves £3.9 million to be spent on referrals to 85 districts. This money will be set aside to meet the costs of the referrals when they arise during the year, and will not form part of a pre-agreed block contract.

So the greatest risk at the DHA level is that the cost of these extra-contractual referrals could exceed £3.9 million. Yet even if this amount is underestimated by 10%, the extra cost of £400,000 would only be 0.3% of the district budget.

In this type of district, Kenneth Clarke is right to feel comfortable with the risk.

- **Third, tranfers to other districts**: If we apply the principle of resident based funding, districts will no longer be responsible for the cost of treating patients from outside the area. So Bristol and Weston DHA will lose £26 million to other districts.

This brings us on to the third risk.

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3. **Hospital Funding**

If the three acute hospitals in the Bristol district want to run at precisely the same cost level, they will need to arrange contracts with other districts to attract £26 million of new funds to bridge the gap.

In the case of the teaching hospital ('Unit 1' on page 8), block contracts will be arranged with three other districts to bridge two-thirds of this funding gap. But the balance of £7 million will have to be bridged during the year with as many as 116 districts. If the income from non-contractual referrals from other districts is 10% less, there would be a £0.7 million shortfall, (1% of the hospital's income). The money could only be raised through income generating schemes (eg expanding a private patient wing) or staff redundancies (possibly leading to bed closures).

On the basis of these numbers, the risk of a major financial failure in a similar hospital is low. This risk would be reduced further by introducing a Regional Bridging Fund to cover, say, up to a 10% shortfall in vulnerable (ie uncontracted) income (para 7.8 page 10). This idea needs to be developed further.

The London Problem

The financial jig-saw is far more complicated to put together in London. Most London teaching hospitals will only be able to generate a third to a half of their revenue from the local DHA. This compares to around three-quarters in the case of the Bristol hospitals.

Furthermore, in Bristol the teaching hospital will be able to cover 90% of its costs through contracts with its own

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DHA and only three others. While in Guys and Kings, 90% of their costs will be covered by the local DHA and as many as nine others. In the case of St Bartholomews, only 81% will be covered by 10 districts.
In short, London will be one big problem next year:

- Risk of failure is compounded many times.

- Financial problems are already acute in some areas (eg St Thomas's).

- There is a risk that the shire counties around London will not put back some of their windfall into London.

- Medical professions make the most noise in London.

- According to a private telephone conversation with Chris West, general manager of Portsmouth DHA (you were impressed with him at Chequers a few years ago), the London regions are ill-prepared.

The Way Forward

1. A more realistic asessment of the state of readiness of each of the fourteen regional health authorities needs to be prepared. This should help to steer Kenneth Clarke away from implementing the internal market in London (and possibly one or two other regions if necessary).

Another seminar is unlikely to take us much further. A few non-executive members of the NHS policy board could be asked to give their assessment in a few weeks time (Graham Day of Rover, Robert Scholey of British Steel and Roy Griffiths), with the specific remit of reviewing the state of readiness of each region, with a particular focus on the Thames regions.

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2. In parallel with this exercise, Department of Health officials should be asked to develop the Regional Bridging Fund' idea further.

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