PO-CH/NL/0102

PART D

Part. D.

SECRET

(Circulate under cover and notify REGISTRY of movement)

Begins: 28/4/88
Ends: 16/5/88.

Chancellor's (Lawson) Papers:

THE NATIONAL HEALTH SERVICE REVIEW

Disposal Directions: 25 Years

Dmclusa

9/8/95.

PO -CH /NL/0102
PART D

25.4.3

SECRET

FROM: R B SAUNDERS

DATE: 28 April 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir Peter Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Satchwell
Mr Tyrie
Mr Call

NHS REVIEW: MEETING ON 27 APRIL

1. The main paper for the next meeting will be Mr Moore's note entitled "Charting the way ahead".

Summary

2. The paper shows a welcome willingness on the part of DHSS to think radically and constructively, in which we have been encouraging them. It sets out a new NHS structure with the potential to improve significantly on the existing organisation, by building in the right financial incentives and a more responsive service. But there are major problems to be sorted out:

- how to set up the new "buyer" organisations, who are central to the proposal, virtually from scratch and without adding to bureaucracy

- to whom the "self-governing" hospitals would be accountable, and how capital expenditure would be planned

- how to avoid costs running out of control.

These are not overriding objections to the proposal. But more work needs to be done on how they can be overcome and whether the potential benefits would in fact materialise. The objective of the meeting should be to identify these problems and get that further work commissioned.

Discussion

3. The paper proposes a radical reorganisation of the existing NHS structure. Hospitals would cease to be funded directly. Instead, they would earn their income by contracting with new public sector agencies - referred to in the paper as "buyers" - responsible for securing health services on behalf of their resident population. The "buyers" would be free to procure services from private as well as public sector hospitals. District (and possibly regional) health authorities would be wound up. So would family practitioner committees, since GPs would contract instead with the new "buyers".

4. In principle, such a reorganisation would hold out the prospect of major improvements if it can be made to work:

a. There would be an internal market, with the potential for greater efficiency than the present system.

b. The providers of health care would have an incentive to provide the best service to the customer, since their contracts might not otherwise be renewed.

c. The providers would have an incentive to maximise their income, for example by seeking private patients more actively.

d. The "buyers" would have an incentive to avoid costly hospital admissions, for example for minor surgery.

e. It would provide an opportunity for the views and interests of consumers to be better articulated than now. (See paragraph 5d.)

A further potential advantage is that, as Mr Moore's paper notes, this structure could provide a non-local authority solution to the problems of community care identified in the Griffiths Report. Mr Moore's buyer/provider split is conceptually very similar to the "enabler"/"provider" split envisaged by Griffiths (who saw local authorities in the "enabling" role).

The "buyers"

5. If the approach is to work, these are of central importance. Mr Moore's paper does not tell us very much about them. They would have several functions:

a. GPs would contract with them to provide primary care locally.

b. They would ensure the availability of other non-hospital services, such as community health, family planning clinics and minor surgery, which they might even provide themselves in some cases.

c. They would contract with "providers" (hospitals etc) for the provision of particular services or classes of service. These contracts would need to specify standards of service and performance criteria. They are discussed further in paragraphs 21 and 21 below.

d. Possibly a "consumer watchdog" function, ranging from taking up claims of negligence to pressing complaints about inefficient appointments systems. This is not mentioned in Mr Moore's paper, but is a logical extension of the other functions, and is important if the new arrangement is to bring about improvements which are visible to the customer. The relationship with the Health Ombudsman and the future of Community Health Councils would have to be considered.

e. Possibly a co-ordinating responsibility for community care.

6. These add up to a formidable job description, implying substantial new organisations. There is not very much to build on at present, although the proposals in last autumn's primary care White Paper may turn FPCs into prototype "buyers" of GP etc services. Of the second function, some (eg community health and cottage hospitals) is done by district health authorities. In part, the last function is now the responsibility of local authority social service departments. But the other functions would be new.

7. There is an obvious danger of extra bureaucracy. Health authorities and FPCs would tend to be swallowed whole rather than abolished. There will be new skills needed - doctors to audit hospital clinicians, lawyers to draw up and enforce contracts and maybe more accountants.

8. What geographical areas should they cover? There may be something to be said for following the present FPC structure rather than that of district health authorities, since there would be fewer new bodies - there are 90 FPCs as against 191 districts.

9. To whom would they be accountable? They would presumably be run by boards appointed by DHSS. But what would be the relationship of the boards to the Department?

10. How would they be financed? Presumably on the basis of population covered, but with adjustments to cover age structure and other factors. This would draw the Government into tricky areas like the relationship between social deprivation and health needs. The structure would have to be more finely tuned than RAWP. What is to stop it becoming another RSG?

11. We need some detailed proposals from DHSS on all these points.

The providers

12. There are problems here too, although not of so fundamental a nature. In management terms, responsibility would be devolved from district to unit level. (There are on average about 3 units per district, some comprising one hospital only, others more than one.) This should be feasible: district headquarters staff are relatively few, and day-to-day management is carried out at unit level. Units are already the prime movers on estate rationalisation, income generation and cost improvements. They are less strong on the financial systems needed to underpin the sort of system now proposed. Most would need to beef up their finance departments. They would also need new people to negotiate contracts, in the same way as the "buyers" would.

13. If the FPC structure were followed, 600 NHS units would be seeking business from 90 "buyers". This may offer scope for competition, although there might be a tendency for particular units to specialise in particular disciplines.

14. A major question would be accountability. If the hospitals remain in the public sector, they would presumably have boards of management, appointed by DHSS. What would be the relationship between the board and the department? What controls would be applied? It would probably be insufficient to argue that accountability was adequately exercised through the purchase of services by the "buyers". The hospitals would have considerable financial autonomy, but would nonetheless have an implicit Government guarantee. Some form of supervision would be needed. DHSS do not seem to have seriously addressed these issues yet.

15. How would capital expenditure be determined? At present there is a £1bn a year hospital capital programme effectively run by regional health authorities, although the day-to-day management of projects is delegated to districts. Depending on their size, projects are approved by the region, by the department or by the Treasury. The system works pretty well, with cost over-runs a relatively infrequent occurrence and no wasteful duplication of facilities in general. Mr Moore's paper notes capital as an issue (paragraph 8(i)) but offers no ideas. Is there a case for retaining regions (but not districts) with the reduced role of planning and co-ordinating facilities and capital expenditure? If not, who is to initiate capital projects, and what approval procedures are to apply?

16. Alternatively, there may be scope for privatising hospitals in whole or in part. This would bring about a system not unlike that in Canada (where hospitals are privately owned by charities but usually non-profit-making), managed by locally-appointed boards of trustees and financed through taxation. There is a range of possibilities, which might coexist with each other and with publicly-owned hospitals: charities, provident associations, public companies, and management buy-outs. Private sector

providers would have a much more arms-length relationship with Government, although it would still be difficult to stand back from problems which arose at a hospital which was largely financed publicly. You will also wish to consider the political acceptability of large scale privatisation of hospitals in the near future. Even if it is not considered possible now, it might be retained as an option for the longer term.

Cost control

17. We would agree with Mr Moore's assessment in paragraph 16 of his paper that this system would loosen control over costs. While the likely effect on expenditure levels is unclear, it could be significant. We should be relinquishing direct control over hospital costs, relying instead on indirect control through the "buyers". As experience in the USA and elsewhere has shown, we cannot necessarily rely on competition to provide an alternative mechanism for keeping down costs. It is also evident from overseas experience that the more attenuated the links between the ultimate sources of finance and supply, the greater the problems of cost control.

at all!

18. There is however one bright spot. Since the "buyers" would be responsible for securing both primary and secondary care, this presents us with a golden opportunity to bring the family practitioner services within cash limits. It is an anomaly that the FPS should be regarded as "demand-led". The main reason is that the DHSS are reluctant to exercise control over the number of GPs, although there are also some difficulties in controlling expenditure on drugs (about half of FPS expenditure). You should therefore make clear that you do not accept Mr Moore's presumption (paragraph 23 of Annex B) that the FPS should continue to be outside cash limits.

19. The main pressures for increased expenditure would be the following:

a. Pay. It is said that the NHS is able to hold down pay rates by means of centralised bargaining. This is certainly true for consultants, whose NHS salaries bear no comparison with what they can earn privately. But this year's award to

nurses is not a sign of great success in controlling pay costs centrally. Nurses are paid the same rates in the private sector as in the NHS, although this might not continue in a new system. The DHSS have done well over the last few years in negotiations with non-clinical groups: the ancillaries have tended to fall behind local government manuals, and junior administrative staff behind the civil service, where there were formerly pay links.

Delegation of pay to local management always runs the risk of an upsurge as they use their new freedoms. Mr Moore's proposals would no doubt result in new pay pressures. We would probably do better to retain central control over pay (even if more flexibility is allowed to local managers within limits) - although we would do even better if we could get rid of the Review Bodies. We could only retain such central control if the majority of NHS hospitals were to remain in the public sector, so that the NHS continued to be a price maker rather than a price taker.

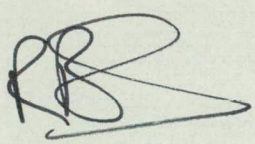
b. Demography. The effect of an increasing and ageing population is that NHS expenditure needs to rise by about 1% a year in real terms, in the absence of other factors like efficiency improvements. This is usually the subject of a PES bid by DHSS, which last year we only conceded in part, not because we disputed the underlying calculations but because we regarded the bid as overlapping with others. A switch to per capita funding (whether or not in the form of an explicit age-related capitation fee) would make it more difficult to mount this argument. The demography bid would thus be in effect conceded before the Survey began, and the Treasury would have to work much harder to contain other bids. Overall, the outcome would be likely to be less favourable to the Treasury.

c. Service improvements. Mr Moore argues that this system will be more transparent than the present one, and that the payment of fees for the provision of specific services will generate greater pressures for improvements or the plugging

of perceived gaps, particularly as new treatments become available. There are considerable pressures of this sort already, but they could be amplified by the local special pleading to which the new system would give rise.

20. More work needs to be done on expenditure control, and we will ensure that this is kept to the forefront in the further development of this model. The form of the contract between buyers and providers will be very important. Annex B to Mr Moore's paper discusses this further. Generally, this annex is very weak. It approaches the issue from the point of view of the producer, not the consumer. The buyers could use the contract to enforce efficiency improvements - penalty clauses for failure to meet standards, requirements for productivity improvements over the term of the contract, and so on. But there is no reference to this. Nor does it deal with the term of the contracts - it is important that they should run for no more than, say, three years. And there are alarming suggestions of "cost-plus", for example the talk in paragraph 2 of paying the marginal cost of treating each patient.

21. On the form of the contract, the annex identifies in paragraph 2 three possibilities of contract. From our point of view, much the best is the fixed annual fee (which the paper for some reason calls "capitation"), which would introduce the maximum certainty into the budgetting of "buyer" organisations. Much the worst would be the fee for service arrangement which the DHSS (again very oddly) call "average cost". This would be open-ended, with the risk of "buyers" running out of money three-quarters of the way through the year and generating the maximum clamour for more public expenditure. Some fee-for-service element may be desirable - for example to encourage GPs to undertake health promotion activities - but in general the expenditure control considerations point towards fixed fee contracts.



R B SAUNDERS

CONFIDENTIAL

10 DOWNING STREET

LONDON SW1A 2AA

CH/EXCHEQUER
REC. 03 MAY 1988
ACTION CST
COPIES TO

GRAY → PODGER NHS REVIEW 29/4

From the Private Secretary

29 April 1988

BF 6/5

[CST to produce his own note]

Dear Geoffrey,

NHS REVIEW

I attach some notes of the points raised in discussion at the NHS seminar at Chequers on Sunday 24 April. I am also enclosing some contributions to the Review I have received from doctors who were present at the 27 March seminar - Professor Lee, Mr. Robin Touquet, Professor Chantler and Mr. Dutt.

I am sending copies of this letter to Alex Allen (HM Treasury), Jill Rutter (Chief Secretary's Office), Jenny Harper (Tony Newton's Office, DHSS), Sir Roy Griffiths (Department of Health and Social Security), Richard Wilson (Cabinet Office), and John O'Sullivan (Policy Unit, No. 10).

Yours,
Paul

PAUL GRAY

Geoffrey Podger, Esq.,
Department of Health and Social Security

CONFIDENTIAL

MEETING WITH NHS AND PRIVATE SECTOR ADMINISTRATORS: CHEQUERS: 24 APRIL

Sir Donald Wilson opened the discussion. He saw two main strands to the exercise. First long-term issues, involving financing and structure, which would take time to have effect and might require pilot schemes and legislation. But second there was a range of action it would be possible to take in the short-term, within a period of months, which could be implemented by management action. The main aspects were:

- The essential starting point was the provision of more cost information. It would be possible to have a system up and running by the summer of next year. This would open up a range of opportunities, eg developments towards an internal market, with districts bidding to provide services; the possibility of privatising some activities such as radiology where the private sector could do them better and more efficiently; and patients being made aware of the costs of their treatment. It would also make possible the principle of money following the patient (at present reimbursement could take two years).

- Raising customer/patient awareness of the quantity and quality of services. GPs were the key to this.

- Tackling the entrenched areas of professional and trade union privilege. This needed vigorous action from the centre to tackle a wide range of unacceptable working practices, many of which were so far untouched. Junior doctors were likely to welcome this process.

- A clearer distinction between the funding of health care and its delivery in the NHS.

Mr. M. Smith raised a number of general points about the independent sector. He stressed that the sector was not anti-NHS, and recognised there were benefits from

specialisation between the public and private sectors. The independent sector was not looking for special treatment, but would resist what it saw as competition from a subsidised public sector. The private sector did now make a substantial contribution to the overall level of health provision, and research showed that the public welcomed this trend.

He went on to identify two barriers to improving efficiency in the NHS:

- The lack of cost information. This was something the private sector already had to have; the NHS must follow.

- The present rigid demarcation in the controls over revenue and capital funding.

Mr. Smith also saw considerable scope for further expanding the role of the independent sector. The key requirement was that it should be offered an adequate return. Within this framework, the private sector was very good at performing elective surgery; it currently had a market share of 25 per cent in some specialities and this could be increased. There was also a role for the private sector in primary care services; changes in the contract arrangements for GPs, as well as consultants, and the drugs bill could increase patient choice and reduce costs. Some private sector operators were now able to offer turnkey contracts to build hospitals. And the sector could also play an important role in ensuring the willingness of the general public to take prevention seriously.

Mr Doughty said that progress had been made since the introduction of the Griffiths reforms. Although it inevitably took time, management grip was accelerating. Amongst the priorities he saw were:

- The need for accounting changes to ensure the availability of clean and timely data;

- The regions were the best vehicle for radical change, and they might take on more functions from the centre. There would be advantage in the RHAs including private sector representatives; and that principle might later be extended to the DHAs.

- Performance review was progressing, but he agreed with previous speakers there was scope for more privatisation, e.g. in pharmacy.

- Consultants' contracts must be looked at. But it was also important to offer help to consultants; many of them were children in the arts of management.

Mr Byrne wondered why the NHS did not have adequate cost information: the most likely explanation was that earlier management structures had not produced a need for it. They had got by each year by asking for their present level of expenditure plus inflation plus a little bit more.

He was keen to see the independent sector integrated with the NHS in the sense of two sectors actively competing for contracts for publicly funded health care. This could bring in a lot more private capital, for instance for the building of hospitals. He also saw scope for the independent sector to compete for primary care services, particularly in the inner cities; and to expand from its existing 50 per cent market share in the long stay care market.

Mr Tiley stressed two points:

- It was essential to change the nature of RHAs from predominately political and administrative to predominately hard-nosed business. The RHAs should bid for resources in return for a given output of health care; and they should then sub-contract the provision of this health care to districts.

- Problems over NHS costs arose not just from operations and treatments that were carried out but from the major difficulties when patients did not turn up as scheduled. This imposed a heavy cost burden, about which the public needed to be made aware.

Mr. West thought one reason for the paucity of information of NHS costs was because of past under-investment in management resources. He was also concerned about the possibility of any further major structural management changes in the NHS; this could easily lead to a further period of management paralysis.

He said that a major problem over consultants contracts was that these were held by the NHS regions. This meant it was all too easy for the BMA to obstruct progress. Although the majority of consultants honoured the spirit of their contracts major problems arose from those who actively sought to exploit the system. The solution was for contracts to be held at district level, and for appointments to be made by the managers with the medical profession acting only as observers. Management must also be able to demand that consultants answer questions about the implementation of individual contracts and work programmes.

A related point was the importance of focussing on the quality of consultants work. Under present arrangements it took many years to sort out cases of individual incompetence. This had to be resolved by the introduction of local management sanctions, based on a system having fixed term contracts, annual performance bonuses rather than merit awards, annual work programmes, and reconstituting appointments bodies so that they were not dominated by the medical professions. It was also important to end the system of special payments for domicilary visits.

Commenting on these points, Mr. Tiley suggested that:

- The RHAs might be reconstituted to comprise the DHA chairman.

- Some consultants might have contracts involving a 100 per cent commitment to the NHS, but this would require adequate remuneration.

Commenting on the second point, the Prime Minister said she thought it better to allow consultants to work both in the NHS and the independent sectors, but the key requirement was to specify precisely their responsibilities to the NHS.

Mr. Carter raised the following points:

- He agreed with earlier speakers about the importance of changes in consultants' contracts.

- The Griffiths reforms were working well in some places. But some authorities had not sought to implement them seriously, and had just bolted on minor changes to their existing systems. As previous speakers had said, some DHAs spent too much time playing politics.

- It was important to have the private sector more in competition with the NHS , and to avoid the private sector simply creaming off the easy and profitable elements of treatment.

- Initiatives in which sums of money were targetted on particular problems, such as waiting lists, had been very effective. The NHS was clogged up in some areas; DHAs should be encouraged to turn to the private sector for health care which it could provide efficiently.

Mr I. N. Smith described arrangements in Somerset where the DHA had resisted pressures to spend all their revenue

provision in servicing old facilities, and had set aside a reserve which allowed them to finance investment in new facilities including the one-off costs of re-equipment.

Although he saw advantages in the development of the internal market, it was important to remember that only 25 per cent of total NHS treatment was elective; the other 75 per cent was acute and emergency work where it was essential for the NHS to respond quickly. He also questioned whether in areas of dispersed population it would be as easy to operate an internal market as it was in large population centres. If the internal market was to operate effectively it would be necessary to increase labour flexibility, e.g. by relaxing manpower control and other ceilings.

Mr. Nichol welcomed the scope for health authorities to use the private sector to provide additional services. In the Mersey area, the total acute budget came to £250 million, not all of which was well managed. They believed that £10 million could be placed in contracts for hi-tech operations by the private sector, and another £20 million could be held back from allocated budgets, with the DHAs being invited by the RHA to bid competitively with proposals for contracting work out to the private sector. Patients did not mind whether something was done by the private sector or the public sector. He also saw scope for an increased role for the private sector in residential care for long-term and mentally ill patients.

Mr. Nichol also thought there was scope for a substantial increase in the number of minor operations carried out directly by GPs. At present most GPs instinctively referred far too many cases, e.g. minor head wounds, to the hospital sector.

He agreed with other speakers on the need to develop cost information. He saw the particular requirement as the identification of treatment costs for different conditions.

Mrs. Quinn said that the private sector was keen to cooperate with the NHS, rather than compete. She was currently involved in a joint venture with the NHS in the area of psychiatric work and the mentally ill. It was right for the private sector to continue to focus on those tasks they were good at; this could include the development of new approaches, such as the initial planning of the total resources for health care in new towns.

Having worked in both the NHS and the private sectors, she had asked herself why it was that doctors and other staff behaved differently (and better) in the private sector. An important factor was that private sector clinical staff felt they had a say at all stages in what happened to patients, and this added to productivity. It was crucial that staff at all levels should be given more training so that they were more productive and could make an active contribution to management.

Mrs. Quinn also saw the need for education of patients. She agreed with previous speakers about the cost problems when NHS patients did not turn up to appointments, and wondered whether some system of fines could be introduced. More generally it was important to tell the patients what they should expect from the health care services and what this cost.

Mr. Stokoe felt it was important to have active competition between the NHS and the private sector. Management reforms in the NHS still had a long way to go. In his area he had been conscious of business being lost to the private sector and had set out actively to compete with BUPA by developing a private wing in Hemel Hempstead Hospital. This had been very successful, and plans for a further wing were under consideration. It meant that the private sector were setting standards for the public sector. This process would be helped if general managers in the NHS had more freedom, e.g. over the raising of private finance. (The Prime

Minister pointed out that this would only be feasible if it could be made clear that no form of public guarantee was available for the borrowing.)

Mr. Weaver thought it was necessary to consider structural changes, and he saw considerable attractions in health management units. By contrast he thought a number of difficulties with the idea of a contract between a DHA and the users of its services had been understated; would this help reduce costs or improve the status or patients? how far was it reasonable to expect patients to travel? Would it be possible adequately to define waiting times? He thought that such a "contract" would be cosmetic.

Mr. Burgess explained that the Shanning Group was involved in a wide range of independent provisions. He thought that the NHS presented a paradox: it was simultaneously one of the best and one of the most inefficient health services in the world. Maybe by attempting to be all things to all people it was trying to do too much. He also thought that patients did not realise key aspects of the nature of NHS arrangements; for example, did they appreciate that GPs were members of a subsidised health club and not directly employed by the NHS?

He was distressed by the resistance within the UK to proposals by his company to sell turnkey hospital contracts. RHAs were not interested in fixed price total contracts, and their resistance was strengthened by a range of Treasury and DHSS controls. The result was the UK had persisted with NHS planning of new hospitals which was amateurish and high cost. He was also concerned about the lack of willingness by the authorities to deal with abuses and wastage in the NHS.

Sir Donald Wilson pointed to the benefits of delegated budgets. These worked extremely well as long as clinical staff were able to keep some of the financial savings they made. That was the key to improved motivation.

The Prime Minister asked for ideas on how to improve the

utilisation of nurses' time. Mr. I. Smith said that in Somerset he was undertaking a study of the required standards for types of nurses' work; this was involving work study, which was as essential to breaking down professional restrictive practices. Mrs. Quinn said that nurses' perception of their role was largely determined by their initial training. It was necessary to change those perceptions, and for all concerned to recognise that many of the services patients needed did not require nurses; standards of care could be improved at lower cost by using new types of staff for non-clinical services.

Mr. West argued that one of the difficulties over training was that the bodies concerned with accreditation, notably the English National Board for Nursing, were outside the main management chain. A related feature was that the faculties of the Royal Colleges set unreasonably high standards. These were not problems faced to the same degree by private hospitals. Mr. Byrne commented that the private hospitals found it difficult to obtain training courses from the ENB because of political opposition; Mrs. Quinn reported that she was now after a long period beginning to break through this problem. But she did not believe it right for independent hospitals to get involved in the basic training requirements for registered nurses. Mr. Burgess said that nurses recruited by his organisation from the NHS frequently had no perception of costs and standards of services; there was a requirement for increased training in these aspects for all levels of staff.

Sir Roy Griffiths commented on the difficulties of dealing with the professional unions in the health service. It was important to remember that for the first 35 years of its existence the whole of the running and management of the NHS was in the hands of the professions. They were very tough bodies who had been determined to create artificial shortages for example through their training standards; the ENB's Project 2000 was a classic example of this. (Mr. I. Smith agreed and said that this was in practice an academic

education programme not a training programme.) Sir Roy also pointed to the reduction in managers' freedom of manoeuvre flowing from the decision to hand over responsibility for pay to the Review Bodies. After the large increases now agreed following the 1988 reports it was essential for management to tackle restrictive practices with the unions forcefully.

Mr. Tiley returned to the treatment of revenue and capital expenditure in the NHS. He hoped that these could in future be treated differently along normal business lines. It was essential to introduce commercial accounting for capital expenditure. The Prime Minister commented that one of the difficulties with present capital allocations to health authorities was that managers automatically assumed they had a right to spend up to those limits rather than searching for cost-effective expenditure projects.

(PAUL GRAY)
25 April 1988
KAYAAC

THE TIMES

Spending White Paper likely to be replaced

By Our Economics Editor

The annual White Paper on Public Expenditure, which has been an important event in the government calendar for nearly 20 years, is likely to be discontinued.

The Treasury has decided to accept the recommendation from the Treasury and Civil Service Select Committee that it should be replaced by an expanded Autumn Statement and a series of departmental annual reports. The new system is likely to come fully into operation from 1989-90.

The proposed change, detailed in a memorandum now with the committee, will give departments the chance to present a fuller account of their activities, and give select committees better information on which to base their monitoring. The Treasury is expected to lose some editorial control.

The new reports are likely to be published a little later in the year than the White Paper, which comes out in January, but before the new financial year begins. One option would be to produce them over a period of a week at the beginning of March shortly before the Budget. The ill-attended Commons debate on the White Paper, which now takes place around the end of February, is expected to go.

In the current financial year there is likely to be a transitional procedure. The Chancellor's Autumn Statement will be slightly expanded to include the information not already contained in Volume One of the Public Expenditure White Paper. This mainly concerns spending levels in real terms and changes from the previous plans.

Then, in January, the Treasury will produce a series of reports on spending by departments, which will contain most of the material formerly available in Volume Two of the White Paper and will be the forerunners of the planned departmental documents. The Treasury is expected to keep control over the spending numbers in the departmental documents and will advise on their form and coverage.

Ministers do not favour combining departmental annual reports with the Parliamentary Estimates as the Public Accounts Committee and the Comptroller and Auditor General, who advises the Committee, have suggested.

In the Treasury's view the time to discuss expenditure decisions is after they are announced in the Autumn Statement.

Lunchtime draft p.r. → cks must permit... you blabbed. pmp (financial reporting to plan).

THE INDEPENDENT

NHS review could back away from radical changes

By Nicholas Timmins
Health Services Correspondent

THE Government's NHS review appears to be backing away from some of the most radical ideas put to it, such as a switch to American-style "health maintenance organisations". The aim would be more to build on changes already taking place in the health service, but push them along faster.

A review of consultants' contracts looks increasingly likely. They could become renewable every five years and more clearly defined. The controversial merit award system, which can virtually double a consultant's salary, is likely to be revamped.

Regional health authorities are likely to be slimmed down, with more of their responsibilities moved down to district level.

Ministers hope that experiments at six sites round the country in providing detailed information on the cost of treatment will prove adaptable in the rest of the NHS. That would allow a more full-blown internal market to develop. Health authorities would become increasingly purchasers of service from other districts and the private sector, and less simply providers through their own hospitals. Hospitals that contracted to do extra work would receive the money to pay for it from the authority that sent the patient.

East Anglia has already volunteered to be a test-bed for an internal market, although ministers may favour a less rural region with better communications if a formal experiment is decided upon.

Consideration is still being given to trying to ensure that money for treatment would travel with the patient, with a guarantee of treatment in the NHS or privately within, say, six months. But the Treasury worries about how the cost of that could be controlled.

Ways of getting more private money into health care are still being examined in detail. But moves in that direction may be less marked than some on the Conservative right hoped; objections have been raised to tax relief on private health insurance, or to switching NHS funding to national insurance and allowing people to contract out of all or part of NHS cover.

As yet, no option has formally been ruled out. But rather than go for a "big-bang" change, the review looks increasingly likely to settle for evolutionary changes which would allow more far-reaching change to come later.

Better costings of NHS treatment would also provide more information for medical audit and peer review — getting doctors to examine the quality of care and resources used against the benefit for the patient. A change of contract could help to encourage that. Ministers, however, are anxious that a purge on consultants who abuse the system should not sacrifice the goodwill of the bulk of their colleagues, who do more NHS work than they are paid for.

The review seems as yet undecided whether to try simply to change the contract for new consultants — a move that would take 20 years to work right through — or to change it for all consultants, possibly by a buyout of existing contracts.

Changes to the merit award system would go with that. Worth between £6,260 and £33,720, the awards are given to about 37 per cent of consultants for academic excellence and dedicated work in the NHS. But the doctors' pay review body said last month that some are given after the age of 60, or even after retirement, to boost pensions. They cannot be removed even if the consultant's performance declines.

Ministers are set to seize on the review body's suggestions that the awards should have an age limit and be made renewable for fixed terms.

mjd 3/129m

SECRET

MPW NHS REVIEW 3/5

FROM: MISS M P WALLACE

DATE: 3 May 1988

MR SAUNDERS

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Satchwell
Mr Tyrie
Mr Call

NHS REVIEW: MEETING ON 27 APRIL

The Chancellor was most grateful for your minute of 28 April, which he found a very ~~usual~~ efml analysis. He has commented that, on the central issue of hospitals, he is much more attracted to the reform ... advocated in this week's Economist (attached), than to the model in paragraph 7 of the DHSS paper.

MPW.

MOIRA WALLACE

The Economist

ECONOMIST ARTICLE "SET THE HOSPITALS FREE"

Set the hospitals free

CARING for people's health is the biggest single business in every rich country—and everywhere it is in trouble. In most countries the worry is that spending is out of control. In Britain, where the government both finances and supplies the bulk of health care through the National Health Service, the grumblers say the spending is too mean.

Margaret Thatcher's third-term government has therefore begun a review of the NHS—reluctantly, because any changes in its much-loved mess would probably take effect just before the next general election. So the government will need to build carefully on the service's two perceived strengths. People see it as fair, because getting treatment does not depend on being rich. And the NHS's tight control of costs (including pay) makes it relatively cheap to run.

These advantages should be kept. But the NHS also has many weaknesses. Patients get little information and less choice about who treats them or how. They are kept hanging about, and too many of the staff who eventually treat them are arrogant or indifferent. They get plenty of costly treatment, not much advice on how to stay healthy. The structure of the NHS is rigid and over-centralised. Hospital managers in Newcastle and Guildford have to pay physiotherapists and lab assistants the same rates, even though in Newcastle they could get them for less. Health visitors in places as different as Barrow and Bournemouth are supposed to follow priorities laid down in Whitehall. Above all, incentives for more efficient treatment are either lacking or perverse. Some teaching hospitals find that it pays them to keep patients away.

If cash alone could cure

So far the British debate has concentrated on cash and methods of financing, with the left clamouring for more public and the right for more private money. Both are wrong. No good will come of throwing more of either sort of money into Britain's health service until governments have decided how to throw more efficiency-breeding competition into it. Since hospitals account for over 60% of the cost of the NHS, it is there that change and competition should begin.

Britain's hospitals are financed and run by district health authorities; staffed by consultants (senior doctors) who account to managers neither for their clinical decisions nor for their pay; and often filled with patients who could be looked after better and more cheaply elsewhere. A consultant's patients are referred by general practitioners who may have played rugger with him at medical school, but know nothing of how good at his job he now is. A first-class hospital pulls in patients from other districts without getting extra cash to pay for them. A consultant who works hard to cut a waiting list for plastic hips may have to stop when his budget runs out.

Such nonsenses would best be cured by separating the running of hospitals from their financing. Health authorities should become purchasing and financing agents on behalf of patients and the general practitioners who refer them. Hospitals would be set free to compete with each other for patient referrals. Those that treat more applicants would get more cash from the taxpayer. Costs would be subject to maximum rates for clinical treatments, like American diagnosis-related groups, and the hospitals that underbid these would benefit by getting more patients. To maintain quality and improve choice, all hospitals would have to publish information (currently hushed up) on rates of death or surgical mistakes. Their paymasters in the health authorities would monitor the cost and quality of treatment in each.

No central rules are needed on what form of independence would suit each hospital. Some might be privatised; others could be bought and run by their own staff; still others could become trusts or charities. They would fix their own pay-rates and raise their own capital outside the Treasury's iron public-sector borrowing rules, bringing into the health service some much-needed investment. They would put out to competitive tender both non-clinical services, like cleaning, and clinical support services, like pathology testing. If they did not attract enough patients, their management and staff would have to change—or they might close.

Doubters will seize on this last point to argue against floating off Britain's hospitals. Yet hospitals are closed every week, usually on the whim of strategic planners. Much better to use a market test—albeit an imperfect one—to decide. The doubters will also say that managers are not strong enough or bright enough to run independent hospitals. If so, hospitals that wanted to thrive would soon recruit managers who were. These tougher new managers would force hospital doctors to accept many of the things they currently resist in the name of clinical freedom: short-term contracts, performance-related pay, peer review and medical audit.

Such a reform would increase the responsibilities of general practitioners. To keep them up to scratch, their contracts should also be short-term—and made with the health authorities that finance hospital care, instead of (as at present) with independent family-practitioner committees. Like the hospitals, GPs would compete to attract patients, who in turn would be freer to switch. Health authorities would monitor

GPs, keeping a wary eye on the zeal with which they prescribe drugs and refer patients to hospital, and making sure that they offer good preventive medicine. Some limit might be needed on the freedom of GPs to refer patients to whichever hospital they liked: if so, the health authority could give them lists of "preferred providers" who met cost and quality standards.

Getting the NHS's structure right would make it easier to decide on sensible financing. The case for relying largely on revenue from general taxes remains strong. That kind of finance is fair, predictable, cheap to collect and avoids the shortcomings of coverage and selectivity that weaken so many insurance systems. Earmarked taxes, from which people could partly opt out, are a bad idea. Once earmarking was allowed, other taxpayers would plead to opt out for education, or social security, or defence. Opting out could lead to health care that was blatantly two-tier: more wizard gadgetry for the rich, even longer queues for the rest. The same goes for tax relief for private health insurance.

If taxation remains the main source of health finance, governments cannot escape responsibility for deciding how much should be spent. More competition will improve the choice and quality of health care—so people will want more of it. That is why extra public spending will eventually be inescapable, bringing the amount that Britain spends on health (about 6% of its GDP) perhaps one percentage point closer to the average for the rest of Europe (9%). But hospitals should also be encouraged to raise extra money themselves—eg, by allowing patients to buy non-clinical extras like privacy or better meals; or by lotteries or shops in hospitals.

The scope for experiment is huge, and the timing is just about perfect. The NHS will be 40 on July 5th. Its mid-life crisis has come, right on cue, but it need not be followed by a steady decline. For a few years in the early 1990s the extra pressure that an aging population is putting on the health service will ease, so doctors and administrators will have a breathing space in which to change their ways. Mrs Thatcher should give them their chance, by setting the hospitals free.

America's friendly invaders

A country with a trade deficit should thank its lucky stars that foreigners want to invest there

AFTER decades of buying up the rest of the world, America faces an invasion of foreign investors clutching fistfuls of devalued dollars. Each week another piece of its economy is sold abroad. The process fuels and is fuelled by a new and, to many Americans, sinister burst of takeover business on Wall Street. The predator of the moment is Britain's Beazer, which is fighting for control of Koppers, a big American supplier of building materials. Shearson Lehman, the investment banking scion of American Express, traitorously advised and co-financed the redcoat. The citizens of Pittsburgh, Koppers' home town, were so incensed by this that hundreds of them ritually destroyed their American Express cards.

Canada's Mr Robert Campeau has acquired Federated Department Stores, and thus Bloomingdale's. (On average, by the way, every Canadian now owns a square foot of Manhattan.) Britain's Marks and Spencer has bought that most American of American menswear chains, Brooks Brothers. Japan's Bridgestone has swallowed Firestone Tire and Rubber. For each of these headline-making deals there have been hundreds of others amounting to more of the same thing—foreigners buying not just America's paper assets, but its factories, laboratories, office buildings and brand names as well. By making it necessary for the dollar to fall so far, President Reagan's economic policy has, in effect, put the American economy up for sale. The selection is tempting, the prices unrepeatable; but the sales staff exude little charm.

Like less heavily indebted countries to the south—Brazil, Mexico and Argentina—America should welcome an inflow of foreign investment as a way of consuming beyond its means while averting, all being well, the crunching recession it would otherwise endure. But, like those southern debtors, it does not know a good deal when it sees one. The Pittsburgh card-party has a particular resonance. How apt for Americans to destroy the little green card with which they have done so nicely around the world for so long.

The gathering wave of economic xenophobia looks oddly timed. The chances that America will enact no new trade law this year—much the best outcome for believers in liberal trade—have improved from slim to fair. Congress has just sent the president a bill that he has promised to veto (see page 39). If he keeps his promise, Congress will, with luck, lack the inclination or the votes to overrule him. But suppose a trade bill—the present one, or a version altered to satisfy Mr Reagan—becomes law after all. It will be far less trade-restricting than earlier versions. Mr Richard Gephardt's procrustean "solutions" to the trade problem failed to win him the Democratic Party's presidential nomination. After years of trying to pass a really damaging trade law, it seems that the protectionists in Congress will settle for inflicting minor injuries.

The new economic nationalism

Why are tempers rising over trade in capital when, in the related matter of trade in goods, the pendulum has swung away from Mr Gephardt's extremism? One plausible reason is that, for trade in goods, the pro-market lobby is beginning to shout down the protectionist one. America is in the middle of an export boom, so the last thing its industries want right now is a trade war from which they would have so much to lose. Many American companies producing for their home market need imported raw materials and components to prosper. Last year's sanctions against Japanese chip-makers backfired instructively on the American computer manufacturers they were supposed to help. The growth of world trade and the spread of the multinational company (a trend designed and

CH/ I have circulated Guardian piece on this to the Cast-list for Monday's mtg. ST are digesting the full IHSM report and will be including comments on it in a summary of outside suggestions for the review which they will let us have shortly now

IHSM Report

SUMMARY AND CONCLUSIONS

Chapter 1: Identifying the need for review

1 The NHS in its present form will not be able to meet the rising demands and expectations for health services in the future (1.1). In spite of the need for change, however, much of the criticism of the NHS is unjustified and does not recognise the contribution it has made to the health care of the nation over the last forty years (1.4).

Chapter 2: Current strengths and weaknesses of the NHS

2 The debate about the future of the NHS is hampered by disagreement over its current strengths and weaknesses. As experienced by practising managers the problems of the NHS fall into several groupings (2.1-2).

3 **Financial issues** There is a legacy of underinvestment in the NHS. These cut across such diverse areas as buildings, equipment, management technology and clinical research (2.3).

4 The use of cash limits has meant that health authorities have had to constrain levels of output and the system of funding the NHS creates a climate of uncertainty. The NHS does not have recourse to the same range of solutions as the private sector when confronted with these problems (2.4-7).

5 **Service issues** Some of the most pressing current inadequacies in the provision of services by the NHS include lack of adequate amenities and privacy for patients; concern over waiting lists and waiting times; too little systematic attention given to the quality of services; too little knowledge about the outcomes of health care; relatively slow development of new services and application of new technology; inadequate services for the priority care groups; and a limited impact of health promotion policies (2.7).

6 **Staff and organisational issues** Pay levels in the NHS are too low and there are insufficient rewards. This has resulted in low morale and has made it increasingly difficult to recruit and retain staff (2.8).

7 The NHS still does not possess the information systems necessary to support a more rigorous approach approach to assessing its efficiency and effectiveness (2.9).

8 The problems of the NHS should not be allowed, however, to conceal major strengths which should be preserved in the future. These include the fact that it is comparatively comprehensive, equitable and accessible, irrespective of ability to pay. It is remarkably cost-containing in national economic terms and it still provides relatively good standards of care by international comparison. It has

a personalised family doctor system and lastly, it entails a comparatively low management and administrative cost (2.10).

Chapter 3: Establishing the criteria

9 The current debate about health services lacks a framework of criteria against which options can be judged and the inevitable trade-offs between options made explicit. These criteria fall into three broad groupings (3.1).

10 The **founding principles** are those associated with the foundation of the NHS in 1948. These are comprehensiveness, equity, and services free at the point of delivery. It would be foolish to jettison these objectives in any attempt to move towards fundamental change in the existing system of funding and delivery of health care (3.2)

11 The **emergent values** have arisen naturally out of the development of the service, a higher managerial profile and the emergence of new political values. These include effectiveness, efficiency, quality, choice and consumerism (3.3).

12 The **pragmatic principles** are concerned with the realities of implementing change in the system. They include the impact of change on society at large in terms of economic viability, political feasibility and social acceptability. They also relate to the impact of change within the health service itself. This raises criteria such as smoothness of transition, professional acceptability, and managerial technology and capacity (3.4).

13 Much recent debate has also focussed on the level of resources and level of health care provided. This raises the question of adequacy or whether services and resources are sufficient both in terms of international spending and individual provision of care (3.5-8).

14 These different sets of criteria are used to test out various delivery and funding options. Alternative systems should only be adopted if they: address real current problems; achieve the most effective balance tested against the criteria; and do not produce a new range of problems which may have greater disadvantages than the current system (3.9-10).

15 This explicit presentation of criteria and assumptions is vital to the debate, if it is not to be superficial (3.11).

Chapter 4: The sources of funding health services

16 Previous work commissioned by the IHSM, the RCN and the BMA, proposed that the growth in NHS funding be linked to the growth in the gross domestic product. Should the growth of health care funding not keep pace with GDP, then the gap between spending on health and public expectation will

quickly widen (4.1-3).

17 The Working Party has no objection in principle to additional funding coming from private sector expenditure provided the criteria are met. It is, however, unrealistic to expect voluntary private health spending by itself to compensate the shortfall in overall spending created by political restraint (4.4).

18 Although this country might spend too little on health care, it is doubtful that an increase in the level of resources would alone solve the perceived problems of the NHS (4.5).

19 The **major options for health care funding** are considered in terms of the criteria. These are general taxation; public health insurance/hypothecated taxation; private health insurance; and direct user charges (4.6).

20 **General taxation** The current system of funding health services is largely based on general taxation with some user charges and a relatively small private sector. It is considered still to adhere closely to the original founding principles despite certain shortcomings. However, it is also thought to offer too little choice and inadequately satisfies consumer need. The Working Party strongly supports the retention of the option of general taxation as the major source of funding (4.8-13).

21 **Public insurance/hypothecated taxation** This would still be dominantly publicly funded with services free at the point of delivery and therefore would perform in a similar fashion to general taxation. It is however argued that the advantages of public insurance or hypothecated taxation are that they more easily allow the public to identify with the cost of health care. It might also be cushioned, but not immune, from general public expenditure policy. Much would depend on the system of collection. It is possible that some forms of collection public insurance would result in a regressive distribution and would therefore affect equity. The conclusion is that not enough is known about the precise effects of a shift away from general taxation. The potential problems associated with public insurance should not preclude it from being considered as an option. The Working Party believes that hypothecated taxation as the major source of funding for health services is a sustainable option and should be taken forward for further discussion (4.14-23).

22 **Private health insurance** As the major source of funding, private health insurance would threaten the founding principles of the NHS, in particular equity, equality of access and comprehensiveness. It is possible that it would offer a higher quality of service and more choice but it is unlikely that these benefits would be bestowed on the whole population. Private health insurance as the major source of funding is ruled out on these grounds (4.15-26).

23 **Direct user charges** This system would probably ultimately

imply private health insurance for those who could afford it, with the associated problem of premiums based on health status. Those who could not pay would probably get some sort of state support. Even if those groups had only to make small payments themselves, the evidence indicates that this would deter them from making use of health services. Therefore direct user charges are ruled out as a major source of health service funding (4.27-28).

24 **The public/private mix** The debate is about which major source of public funding should be made available for health care and how that source should relate to the various private sources of health funding. Private expenditure takes two major forms: topping up (whereby people pay for additional services whether through the NHS or the private sector) and opting out (whereby people leave the major health care system and receive some form of rebate (4.29-30).

25 The Working Party has no objection to topping up provision in the NHS, but only for non-clinical services. The purchase of additional clinical services is likely to increase, however, and the NHS should be able to offer private facilities to compete for this growing market; the NHS should not deny itself the benefit of the additional potential income from this expanding market. If it were to ignore this source of income, then this would accelerate the development of a two tier health care system and institutionalise it in separate sectors (4.31-34).

26 There was little support, however, for opting out schemes which would offer rebates to leave the system. The majority of the Working Pary took the view that opting out schemes were not practical and could deprive the main system of resources. A minority view thought that these problems were not insurmountable and might be worth the additional consumer choice (4.35-37).

27 **Supplementary sources of income** These include private health insurance, where there is some room for expansion as a supplementary source of income. Direct user charges do not perform well against the criteria, however; the evidence indicates they affect the take up of services by the poor and by children in general. The Working Party is opposed to further extension of this form of funding. Income generation is supported and should be pursued energetically provided it is cost-effective in the use of management resources. But national lotteries are thought to be a nuisance and a distraction from the central funding issues. They might also jeopardise local fund raising schemes (4.38-44).

28 The Working Party therefore concludes that (i) general taxation and (ii) public insurance/hypothecated taxation should be discussed further. It also concludes that whatever the major source of public funding, it will go hand in hand with supplementary sources of income which should include private insurance, topping-up schemes and income generation (4.46-47).

Chapter 5: Options for delivery

29 The available evidence on delivery options is too insubstantial to make hard choices. Decisions over delivery options will therefore be somewhat tentative if they are not too involve a leap in the dark (5.2).

30 The **options for delivery** are considered against the criteria. These options are the NHS at present; retrospective reimbursement at full cost; prospective payment by item of service; provider markets; health maintenance organisations (HMOs); and reimbursing primary care providers (5.3).

31 **The current NHS** suffers from inbuilt inefficiency because there is no direct link between funding and workload. Consequently health districts might be discouraged from increasing their output and could therefore be operating at an inefficient level of capacity. In the primary sector there are perverse incentives for GPs to offload their costs onto the hospital sector. It is difficult to verify whether inefficiency exists in practice by looking at international comparisons. However, wide variations in resource use within the UK are prima facie evidence that inefficiency exists. This indicates that the current delivery system does not encourage the optimum use of resources (5.4-11).

32 **Retrospective reimbursement at full cost** has an inbuilt bias towards inflation and its general lack of cost-containment rule it out as an option on the grounds of cost-effectiveness alone (5.12-14).

33 **Prospective payment by item of service** has certain advantages in that providers receive a fixed amount for a specific item of workload. It therefore constrains costs and when introduced in the United States resulted in reduced length of stay. It is, however, by no means certain these improvements would be repeated if prospective payment were introduced into the NHS. The lack of evidence means that it is difficult to assess prospective payment as an alternative to the current system (5.15-19).

34 **Provider markets** The separation of the purchasing of health care from its provision creates the possibility of a market for providing services among health authorities and also among organisations outside the NHS. The implications are that health authorities might be able to increase their workloads because they would be able to sell their services to other authorities or they might have to reduce their facilities because they can purchase services elsewhere cheaper than they can provide them themselves. The term provider market is used because it implies the involvement of all the providers of care, whether from the NHS, voluntary agencies, the non-profit private sector or the for-profit private sector (5.20-22).

35 A more radical version of the provider market would be for this separation to take place organisationally. The health authority would only purchase care for its population, it would not provide it. The acute hospital sector could become a separate organisation or hospitals could become independent institutions. Regulations might be necessary to protect policy principles or to retain some control over the pattern of provision (5.23).

36 In the light of the recent report on community care by Sir Roy Griffiths, one further option might be for the purchasing agency to take over the complete spectrum of care to include acute services, primary care and the priority groups. This might be thought to cover too great a range of services but the organisation would be purchasing care only. It has been argued that the organisational complexity and variety across the spectrum of care is, in itself, a reason for bringing the responsibility for its purchasing into one distinct agency (5.24).

37 The advantage of both versions of provider markets would be that competition and possible efficiency gains would be combined with the intrinsic equity of a central allocation system (5.25).

38 Despite the advantages of a provider market, smoothness of transition needs to be carefully considered as there is a danger that the running down of provider facilities could have hidden costs (5.27).

39 The Working Party advocates the introduction of experiments to test out provider markets. Experiments are not an easy option since they would require detailed and meticulous work to sort out all the problems of implementation (5.30).

40 The Working Party also considers that more than one experiment should be set up. At least one of these should be concerned with the more radical version outlined earlier (5.31).

41 **Health maintenance organisations** The recent evidence from the US indicates that the early benefits from HMOs are not being sustained. The intense competition is producing severe financial problems and doubts are being cast over the quality of services (5.32-35).

42 **Reimbursing primary care providers.** The present system of rewarding GPs is largely by capitation with elements of other methods added. On the basis of the available evidence, we consider that the present system should not be largely altered. We also strongly support GPs maintaining their role as the 'gatekeepers' to the system.(5.36-37)

43 **Conclusions** There is a lack of firm evidence that overwhelmingly argues the case for any of the alternative options discussed (5.38).

44 Provider markets appear to be a major alternative to the

present system. They address some of the current problems such as the poor linkage between funding and workload, large variations in efficiency and over and under capacity of facilities (5.39).

45 Because provider markets are such an unknown quantity and so little evidence exists about their likely effect, we propose they are approached on an experimental or 'demonstration project 'basis (5.40).

Chapter 6: Organisational and managerial issues

46 If the NHS is to thrive in a competitive environment, it needs certain freedoms in responding to market forces. It needs to be able to change its product range and the cost structure of items within it. It needs to be able to change the 'packaging' of the product and make any of these sorts of changes quickly (6.2)

47 Local flexibility in managing the relationship with clinical staff will be crucial in changing the pattern of resource use and delivery of services. Local health care organisations must be able to manage doctors' contracts and the work that doctors do (6.5).

48 In a market where there is an increased public/private mix, local flexibility in pay and conditions must be possible (6.6).

49 Similarly, if services are to be provided in an efficient and competitive way, then it will be necessary to loosen up the availability of capital for health services to enable providers to develop adequate standards of accomodation and cost-effective patterns of capital stock. Serious consideration should be given to the proposal that health authorities should be permitted to borrow funds (6.7-9).

50 The drive for improved efficiency and the need to compete in a mixed environment mean that each health district must be able to invest adequately in information systems. It will also be necessary to compensate those bearing the costs for teaching and research. Recruitment, training and retention of the most able managerial talent will also be fundamental to the successful implementation of plans for reform (6.10-12).

51 The move towards a mixed economy implies that a central organisation will be required for setting and monitoring essential standards in both public and private health care (6.13).

52 **Organisational implications** Major clarifications of roles and responsibilities are needed at the centre and at regional and district level within the NHS (6.15).

53 Considerable confusion has developed in recent years about accountability at the centre in relation to Parliament,

Government, and the DHSS. Despite earlier intentions, the Health Services Supervisory Board is not seen as the strategic central force for health services. While the achievements of the Management Board in certain areas have been considerable, its membership and role have become increasingly multi-faceted: part-political, part-executive and part civil service. If public accountability is to be served in the future, it will be important as a first step to separate out these legitimate but totally different functions, since merging them in one single body means that none is satisfactorily achieved. There is also concern about the separation of the management responsibility of the Management Board from the policy development responsibility within the DHSS (6.16-21).

54 A common focus of accountability and strategic direction for both the hospital and family pracitioner services would greatly enhance the possibility of innovative, consumer-sensitive delivery systems at local level (6.22).

55 It is our view that the limits of improvement within the current central management arrangements have been reached. The Working Party recommends that a realignment of the central organisation should be undertaken based on the following principles:

- Reaffirmation of the accountability of the NHS to Parliament through the Secretary of State and Ministers.

- Creation of a separate management board with no 'ex-officio' political or civil service members. The board would be accountable to the Secretary of State, either through a chief executive or corporately depending on the preferred model.

- The management board should be in direct managerial or executive relationship to the NHS and should be held responsible for advising ministers on the development of health services policy, and the implementation of policy, as well as for the performance of the system.

- The necessary civil service support for the Secretary of State and Minister should be organised separately from the management board (6.24).

56 Concerning roles and responsibilities at local level, the Working Party is of the view that local health authorities should be unequivocally established as the local board of management of health services, with individuals selected for their personal capacity and relevant knowledge and experience (6.28).

57 It would also be essential, therefore, to place truly powerful local bodies alongside the local boards for the purposes of representing consumers and allowing groups in the community to affect the health system as it operates in their locality (6.29).

58 There are powerful arguments for retaining a regional level in the English system. But any such regional level of authority should be clearly and exclusively managerial in focus, with a regional management board or group accountable to the central management board (6.30).

CST ON CHEQUERS.

001/3293

CONFIDENTIAL

other pps pl (letter from PGray, on BF)

FROM: CHIEF SECRETARY
DATE: 4th May 1988

CHANCELLOR

cc:
Paymaster General
Sir Peter Middleton
Mr Anson
Sir Terence Burns
Mr H Phillips
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Griffiths
Mr Call

PRIME MINISTER'S NHS SEMINAR

The Prime Minister's second NHS seminar took place at Chequers on Sunday, 24 April. The participants this time were mostly health authority chairmen and general managers and representatives of private sector health care organisations. A list of attendees is attached.

CST P.M's NHS SEMINAR 4/5

2 I found this seminar on the whole marginally less interesting than the one with the doctors. But, although no particularly original points emerged, there were some useful insights from the perspective of those managing health care whether in the public or private sectors. As in the previous seminar there was surprisingly little discussion of funding issues. Nor, despite all the recent publicity, was there much said about the internal market. There were good contributions from Sir Donald Wilson, Chairman of Mersey RHA, and Mr Doughty, Chairman of NW Thames RHA. On the other hand, Mr Tiley, Chairman of NW Herts DHS, spent most of his time attacking the Treasury for delays in approving capital projects and causing difficulties over the use of private finance. I have asked Mr Saunders to let me have a detailed note on the position on NHS capital projects, although I have already rebutted these criticisms to the Prime Minister.

now behind

3 Opening the seminar Sir Donald Wilson made a number of points which were taken up by other participants. He identified two separate strands in NHS debate: the levels and source of basic funding; and the structure of the NHS. Changing the structure could require legislation and preparatory pilot schemes. But much could be done without legislation by increasing the grip of management which could have an impact within months. The crux was having the right management information. This was not available at present but much better systems would be in place by the middle of next year. Mr Doughty agreed that clean and timely data was necessary and shared the view that progress was being made. Mr Carter, however, thought that some health authorities were still not fully implementing the Griffiths reforms. Mr West commented that one reason there was so little management information at present was the lack of adequate management resources.

4 Sir Donald raised the possibility of management buy-outs of hospitals and DHAs bidding for the opportunity to treat patients, with money following the patients. It was also important that the public realised the cost of operations and the quality and quantity of service that the NHS was providing.

5 The medical professions came in for considerable criticism. Sir Donald said that health service managers had tackled restrictive practices among catering and portering staff but these practices were still rife among doctors, nurses and PAMs. He was strongly supported by Mr West who said that consultants had to be responsible to DHAs with fixed term contracts and subject to sanctions by local managements. He favoured abolishing merit awards and special payments for domiciliary visits (which were in part a device for increasing pension entitlements). Any special payments should be at the discretion of the DHS. Mr West acknowledged that these changes would be very unpopular with the BMA but doctors were exploiting the system at present and the nettle

had to be grasped. Mrs Quinn, an ex-nurse who now runs a private hospital, commented that her experience was that doctors did behave differently in the private sector since they knew they had to follow their patients right through their course of treatment.

6 As in the previous seminar, there was a strong view that GPs were referring to hospitals patients whom they could just as well treat themselves. Mr Nicol wanted GPs to undertake more minor surgical operations and said that at present, despite all their training, many GPs would not even put stitches in a minor wound. I consider this emphasises the importance of not confining our Review simply to the HCHS. We need to take a thorough look at GPs' contracts to see what can be done to ensure the primary care service bears its proper share of the burden.

7 There was a good deal of support for more co-operation between the public and private sectors. Mr Smith of BUPA said that the private sector was very keen to have joint ventures with the NHS perhaps with the private sector building hospitals dedicated to particular specialist care. This could improve the quantity of treatment available. The private sector could also offer turnkey contracts for new capital projects. Mr Byrne of the Independent Hospitals Association was in favour of more competition for contracts between the NHS and the independent sector. From the health authority side Mr Doughty suggested having a private sector health care representative on DHAs and RHAs. (He also said it would be a good idea to have a Treasury official in the RHAs.)

8 Other comments worth noting were:

(i) Sir Donald Wilson thought there should be a clearer distinction between policy and strategy. In particular the planning process needed to be slimmed down. 10 year Forward Plans were not needed. This will be worth following up when we start considering more detailed reforms to the way the NHS is organised;

(ii) Mr Tiley said that RHAs needed hard-nosed businessmen not representatives of local interests and should certainly include the chairmen of the DHAs within their region. The Prime Minister thought this was a good point;

iii Mr Smith, DGM of Somerset Health Authority, said he was in favour of the internal market concept but cautioned against expecting too much from it. Only one quarter of a district's patient workload was movable - the rest consisted of acute or emergency activity which could not be easily transferred. Moreover, if the workload was mobile, the surgeons and support staff would also have to follow the patient.

(iv) Mr Smith also said that Somerset DHA did not wholly commit its revenue allocation but retained a portion centrally which could be used for new staffing or minor capital works as the need arose. The Prime Minister was attracted by this way of proceeding. A related point was made by Mr Nicol who suggested that RHAs should reserve some of their resources for acute services. DHAs would then bid for this money, for example to increase the number of hip operations they did. This could make major inroads into waiting lists.

(v) On the subject of long stay care Mr Byrne commented that half the clients of the independent sector were supported by Supplementary Benefit. he was very concerned that we should not let the Local Authorities near this.

JOHN MAJOR

DASAKO

Sir Donald Wilson
Chairman
Mersey Regional Health Authority
Hamilton House
24 Pall Mall
LIVERPOOL
L3 6AL

Mr D K Nicol
Regional General Manager
Mersey Regional Health Authority
Hamilton House
24 Pall Mall
LIVERPOOL
L3 6AL

Mr W R Doughty
Chairman
North West Thames Regional Health Authority
40 Eastbourne Terrace
LONDON
W2 3QR

Mr C R West
General Manager
Portsmouth and South East Hampshire District
Health Authority
St Mary's Hospital
Milton Road
Portsmouth
PO3 6AD

Mr R A Stokoe
District General Manager
North West Hertfordshire District Health Authority
St Albans City Hospital
Normandy Road
St Albans
AL3 5PN

Mr N R Tiley
Chairman
North West Hertfordshire District Health Authority
St Albans City Hospital
Normandy Road
St Albans
AL3 5PN

Mrs Sue Quinn
Executive Director
Portland Hospital for Women and Children
209 Great Portland Street
LONDON
W1N 6AH

Mr M Smith
Managing Director
BUPA Hospitals
Dolphin Court
Great Turnstile
Lincolns Inn Fields
LONDON
WC1V 7JU

Mr K T Burgess
Chief Executive
Shanning Group
Ashlyns Hall
Berkhampstead
Hertfordshire
HP4 2ST

Mr A J Byrne
Chief Executive
Independent Hospitals Association
Africa House
64-78 Kingsway
LONDON
WC2B 6BD

Mr Michael Carter, C.B.E.
Member
Somerset Health Authority
County Hall
Taunton
Somerset
TA1 4EJ

Mr I N Smith
District General Manager
Somerset Health Authority
County Hall
Taunton
Somerset
TA1 4EJ

I agree with Mr Griffiths' clear and thorough analysis. Were it not for the Prime Minister's keen interest, I doubt that DHSS would be pressing this, given their doubts at this stage about the treatment.

FROM: D P GRIFFITHS
DATE: 4 MAY 1988

1 MR SAUNDERS

2 CHIEF SECRETARY Their original bid was for £5m. But the Trust would respond that this was insufficient and stymied the whole project. Given their influence with the Prime Minister, I think it right to go straight to £6m now.

cc Chancellor 14/2
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Call

CYCLOTRON TRUST

4/5

Following your meeting with Sir Nicholas Bonsor and other members of the Trust on 31 March we have been considering the options for Government financial support for this venture. Together with DHSS we have discussed with Mr Hayes of Coopers and Lybrand the Trust's projections of income and expenditure for the cyclotron facility assuming various amounts and methods of Government support and various levels of revenue generated from private patients. The attached paper which has been agreed with both DHSS and Mr Hayes outlines and discusses the main options. I also attach a note by DHSS giving a medical assessment of the efficacy of cyclotron treatment: as you will see, they regard the case as very much "not proven".

2. We have sought to identify the least expensive option for the Exchequer consistent with giving the venture a reasonable chance of success. On the basis of our calculations we consider that, on balance, the best method of support is an initial capital contribution of £6 million - just under 60% of the costs of the facility. The rest of the funding would be obtained from charitable sources and a commercial loan. The NHS would also pay up to 60% of the direct running costs of the cyclotron if required (this would depend on the private patient revenue generated).

3. Mr Hayes has said that the Trust would be willing to pay the Government whatever profit the cyclotron makes through treating private patients and we think that should be a condition of our support. However, if the Trust retain none of the profits, they

will have no incentive to maximise the revenue from private sources. We should therefore take up their offer to allow the Government to appoint the finance director of the company which owns and operates the cyclotron, so as to exert some influence over the running costs of the operation and efforts to maximise the revenue from private patients.

4.The method of Government support recommended is considerably cheaper than guaranteeing the Trust a fixed annual revenue over and above the direct costs of treating NHS patients. The Trust would not require so large a commercial loan. Hence the lease repayment and interest burden will be much lower, making it easier for the cyclotron operation to break even and enabling greater profits to be generated. We are thus more likely to get at least some of our capital contribution repaid and, on an optimistic assumption of private patient revenue, we should more than get our money back.

5. The option also gives the Trust a good incentive to maximise the funding from charitable sources (as we want): the smaller any commercial loan needed, the better the viability of the venture even if the revenue from private patients is less than expected. The Trust is confident of raising at least £2.5m from its appeal. We and DHSS believe up to £3.5m or more should be in reach if it makes an effort. However, we cannot be certain that the Trust will achieve this target. If there was a significant shortfall, the Trust could be in difficulty since there is a limit to the size of the commercial loan they can obtain without a guaranteed revenue for the cyclotron. Limiting our initial capital contribution to £5.2 million would entail the risk that the Trust might have to approach us for extra funding which, in the circumstances, we would have little choice but to grant. This is a situation we would wish to avoid. The Trust are confident that, with a Government contribution of £6 million, they will be able to raise the remaining £4.4 milion required from other sources. We therefore consider a £6 million contribution the safer option.

6. However, we cannot guarantee the financial success of the project. If the cyclotron does not attract sufficient private patients, we might not only fail to get any of our capital contribution back but there would be a danger that the venture could collapse. Our worst case projection assumes that the cyclotron only attracts 40 private patients a year - a quarter of the capacity reserved for them. The project would still be just about viable, although in practice its continuation would inevitably be in question. It is difficult to predict the scale of private patient demand. The most likely scenarios would seem to be either that the cyclotron is very successful in this respect or never really gets off the ground. We are therefore in effect providing risk capital for the project (which justifies our receiving any profits).

7. As to the other conditions attaching to our support I recommend that:

(i) we concede this Survey bid now;

(ii) we do not increase the HCHS revenue provision to take account of any contribution towards the direct running costs of the cyclotron (if required);

(iii) we make clear to the Trust that no further support would be forthcoming.

8. I attach a draft letter to Mr Newton.

D P GRIFFITHS

DRAFT LETTER TO:

Rt Hon Tony Newton OBE MP
Minister for Health

CYCLOTRON TRUST

Following the meeting just before Easter our officials have been been discussing with the Trust various options for Government financial support for the cyclotron project. They have produced the attached note, agreed with the Trust, which outlines and assesses the main options.

On the basis of this assessment I am prepared to agree to the Government's contributing £5.6 million towards the capital costs of the St Thomas's cyclotron, matching the sum raised from charitable and other sources. I am also content that the NHS should meet up to 60% of the direct running costs of the cyclotron if this is necessary for the operation to break even. In return we should take up the Trust's offer to pay us whatever profit the cyclotron makes through treating private patients and to allow us to appoint the finance director of the company which owns and operates the cyclotron. You should, however, make it clear to the Trust that there will be no further Government contributions if their fund raising efforts fall short of target.

As regards the question of additional provision, I can undertake now to accept an agreed bid in the Survey in respect of the capital costs of the cyclotron. I should make clear, however, that I would expect you to absorb any consequential running cost contribution from your existing revenue provision. We shall need to consider in due course the treatment of any receipts accruing from this project.

I am sending a copy of this letter to No. 10

25.4.1

GOVERNMENT FINANCIAL SUPPORT FOR THE CYCLOTRON TRUST

The Project

1. The Cyclotron Trust plans to install a 60 MeV cyclotron in a new facility at St Thomas' Hospital alongside a 17 MeV cyclotron (a PET scanner) which is to be installed by St Thomas'. The larger cyclotron would be owned and operated by a limited company controlled by the Trust. Both cyclotrons together will form the world's first Medical Cyclotron Centre.

2. The Government has been approached for financial assistance regarding the larger machine which will be used for treating patients with cancer. The capital costs of this part of the project have been estimated at £10.4 million of which about a half is accounted for by the purchase price of the cyclotron. Running costs are estimated at £500,000 per year increasing in line with general inflation. Sixty per cent of the cyclotron's capacity would be reserved for NHS use with the remainder for private patients. In return for its contribution the Government would have the right to appoint the finance director of the company.

Financing Options

3.The Cyclotron Trust have assumed that they will be able to raise £2.5 million from charitable sources towards the cost of this machine. Treasury and DHSS believe this is a conservative assumption but accept it is unlikely that the Trust will raise more than £3.5 - 4 million. The rest of the capital costs, less any Government contribution, would be met by a commercial loan. The Trust are looking to the Government either for a capital contribution or a guaranteed annual income from the NHS or a mixture of the two.

4. We have examined four main financing options:

a. Option 1 would involve no capital contribution from the Government. However, HMG would guarantee the Trust annual revenue from the treatment of NHS patients of upto £1.75 million per year for a period of ten years. The actual sums paid each year would depend on the amount for income the Trust generated from private patients - the Government payment would be whatever was necessary for the Trust to break even on its operations up to the £1.75m per annum maximum.

b. Option 2 would involve an initial contribution on £2.5 million plus a guaranteed annual revenue of up to £1.5 million per year over ten years. Again, the size of the payment would depend on the income generated from private sources. Any overall profit by the Trust would be paid to the Government.

c. Option 3 would entail an initial contribution of £5.2 million (ie half the capital cost) and a guarantee that the Government would meet up to 60% of the direct running costs (ie excluding interest and loan repayments) of the cyclotron if necessary for the operation to break even. Again any overall profit made by the Trust as a result of income from treating private patients would be paid to the Government.

d. Option 4 is the same as Option 3 except that the initial capital contribution would be £6 million (just under 60% of the capital cost).

Discussion

5. We have carried out a discounted cash flow analysis for each of the options to determine which is the least expensive

for the Exchequer. The success of the Trust in generating income from the treatment of private patients is the main source of uncertainty in the projections and crucially affects the cost to the Government. We have therefore considered the options against three scenarios of revenue from private patients. The analysis relates to projections of income and expenditure for the two years that the cyclotron facility is being built and the first ten years of the cyclotron's operational life. After this period all the capital costs will have been paid off, limiting the expenditure to direct running costs including any maintenance costs.

6. The results of the discounted cash flow analysis are shown in the table below.

NET PRESENT VALUE EXCHEQUER COST (£'000)

	Private Patient Revenue Assumption		
Option	**Pessimistic**	**Central**	**Optimistic**
1	9,928	4,755	140
2	9,721	4,530	- 84
3	7,021	4,216	- 326
4	7,787	4,216	- 398

Note: Pessimistic case assumes 40 private patients a year paying £7,500 each. Central case assumes 160 patients paying £7,500. Optimistic case is 160 patients paying £12,500.

7. Options 3 and 4 are the cheaper on any assumption of private patient revenue (although it is only on the basis of the most pessimistic that they - particularly Option 3 - are cheaper by a substantial margin). This is because the Trust does not have to raise so large a commercial loan and the interest and repayment burden is correspondingly reduced.

8. However, if Option 3 were pursued, the Trust believe they would need to raise about £3.5 - 4 million to satisfy commercial sources of finance that on pessimistic assumptions of private patient revenue they will be certain of breaking even. Treasury and DHSS consider this is a feasible target for their fund raising but we cannot be certain that the Trust would achieve it. If there were a serious shortfall, the Trust might not be able to raise a large enough commercial loan to bridge the gap between the cost of the facility and the amount raised by the appeal and the Government's contribution. The Trust are confident that under Option 4 this potential funding gap would not arise.

HM TREASURY

3 MAY 1988

(M18Apr)

CYCLOTRONS

DHSS NOTE ON MEDICAL BENEFITS

A cyclotron generates neutrons or protons used to attack cancer cells, whereas conventional radiotherapy uses photons (x-rays or gamma rays).

Low-energy neutron therapy is of proven value in palliating a few uncommon cancers (eg of the head and neck). It improves local control of the tumours, it can be used even when patients have had previous radiotherapy and it may avoid disfiguring surgery; but its curative value has not been demonstrated. The Cyclotron Trust believes that high-energy neutrons will achieve better results; many in the cancer field are less optimistic (see Lancet Editorial of May 1986, attached). The Medical Research Council and the major cancer charities decided in 1986 that no general conclusions could be drawn from the research evidence, and commissioned 10-year trials of neutron therapy using a new high-energy cyclotron at Clatterbridge in the Wirral. Such subsequent evidence as has emerged both in the UK and abroad has not changed this assessment with which DHSS agrees.

Proton therapy may cure some cancers of the eye and skin; again, the research evidence is not conclusive and it was decided in 1987 to add proton therapy to the Clatterbridge trials.

THE LANCET

Fast Neutrons in Radiotherapy

USE of fast neutrons in radiotherapy is one of a number of manoeuvres designed to improve local tumour control, with the eventual aim of increasing cure rates. The underlying principles of neutron therapy are well established radiobiologically: hypoxic tumour cells are less radioresistant to neutrons than to X rays, there is less repair of sublethal and potentially lethal damage to cells, and the variation of radiosensitivity between different phases of the cell-cycle is reduced. The major rationale, however, is that radiosensitivity is less dependent on oxygenation status with neutrons than with X rays.

Since there is no method of direct measurement of hypoxic cells in human tumours—and in any event reoxygenation may occur during a course of fractionated irradiation—the importance of hypoxia as an obstacle to radiotherapy is not clearly established. Certainly there are alternative explanations for clinical radioresistance, including differences in intrinsic radiosensitivity of cells derived from different human tumour types.

Fast neutrons were first used to treat cancer patients in the United States almost 50 years ago.[1] Unfortunately, late damage of normal tissues was unexpectedly severe and this curbed enthusiasm for more than 20 years. In 1969, clinical studies were started in London[2,3] at the Hammersmith Hospital's Cyclotron Unit with encouraging results[2], although more normal-tissue complications were observed in patients treated with neutrons than with X rays[3]. To some extent, failure to predict the more severe complications with neutrons reflected the paucity of comparable late normal-tissue endpoints in laboratory animals.

Although the principle underlying neutron therapy is biological and not physical, it is clearly better not be hampered by having to use apparatus which is suboptimum by comparison with conventional X-ray equipment. The Hammersmith trials have laboured under the disadvantage of a fixed low-energy beam, whereas more recent studies in Edinburgh have had the benefit of an isocentrically mounted facility.

Unfortunately, the neutron trials carried out in Hammersmith and Edinburgh between 1971 and 1982 have produced discordant results—Hammersmith reported an advantage in favour of neutrons which was not confirmed by the Edinburgh workers.[4] In an attempt to understand the basis for the difference in what, in essence, should have been a reasonably straightforward prospective clinical comparison, the MRC Neutron Therapy Working Group has now analysed and published data from both centres.[5] In the Edinburgh series, local control rates with photons and neutrons were remarkably similar (42/60 and 43/60 patients, respectively), whereas at Hammersmith the photon results were strikingly inferior—13/44 compared with 34/51 for neutrons. These figures taken alone suggest that the discrepancy in the trials may be explained by inferior results with photons obtained at Hammersmith rather than by the superiority of neutrons. Unfortunately, there are differences in experimental design between the two centres which are difficult, if not impossible, to reconcile in a comparative analysis. The neutron facility was technically inferior at Hammersmith; the stage distribution of patients differed, with a higher proportion of advanced-stage patients at Hammersmith; and the neutron dose at Hammersmith was on average 5% higher whereas the photon dose was 10% lower. Moreover, Edinburgh patients were treated five times a week compared with three at Hammersmith. A major potential flaw in the Hammersmith study was the fact that whilst neutron therapy was supervised by the same team and delivered at Hammersmith, photon therapy was carried out not only at Hammersmith but also at a range of collaborating

1. Stone RS. Clinical experience with fast neutron therapy. *Am J Roentgenol* 1984; 59: 771–85.
2. Catterall M, Sutherland I, Bewley DK. First results of a randomized clinical trial of fast neutrons compared with X or gamma rays in treatment of advanced tumours of the head and neck. *Br Med J* 1975; ii: 653–56.
3. Catterall M, Bewley DK, Sutherland I. Second report on results of randomised clinical trial of fast neutrons compared with X or gamma rays in treatment of advanced tumours of head and neck. *Br Med J* 1977; i: 1642.
4. Duncan W, Arnott SJ, Orr JA, Kerr GR. The Edinburgh experience of fast neutron therapy. *Int J Radiat Oncol Biol Phys* 1982; 8: 2155–57.
5. Medical Research Council Neutron Therapy Working Group. A comparative review of the Hammersmith (1971–75) and Edinburgh (1977–82) neutron therapy trials of certain cancers of the oral cavity, oropharynx, larynx and hypopharynx. *Br J Radiol* 1986; 59: 429–40.

centres. In the analysis by the working group, four head-and-neck sites common to both trials were reviewed and an attempt was made to restrict the photon series at Hammersmith by excluding patients who had received low doses. Unfortunately, as a result, only modest numbers of patients were available for analysis. Even with such an approach, there remain substantial differences between the two series. In terms of overall mortality there was an advantage to photon-treated patients in Edinburgh, whereas the advantage at Hammersmith was in favour of neutron treatment. At Hammersmith, the complete-remission rate of patients randomised to receive photons was considerably lower than that achieved with neutrons, whereas in Edinburgh the two forms of radiation gave comparable results. The subsequent relapse-rate of neutron-treated patients at Hammersmith was lower than that of the photon-treated patients; such a difference was not observed in Edinburgh.

Similar conclusions to those reached in Edinburgh were reported from a multicentre trial in which the Edinburgh group cooperated with others in Amsterdam and Essen.[6] The RTOG Neutron Research Group in the United States carried out a randomised study of head-and-neck cancer, comparing photon therapy with mixed neutron/photon irradiation.[7] Although there was no overall advantage for mixed-beam irradiation, there was a difference in the complete response rate in patients with cervical lymphadenopathy in favour of mixed-beam treatment (69% and 55% respectively). In a small study of forty patients which compared neutrons and photons for advanced head-and-neck cancer, Griffin et al[8] reported an advantage for neutrons; however, the photon results were poor, with no survivors at 2 years.

Unless factors such as the 5% dose difference, fractionation schedule, and different stage distributions adequately explain the different results from Hammersmith and Edinburgh, it is difficult to be optimistic about the likely contribution of neutron therapy to the improved treatment of squamous carcinoma of the head and neck. This does not exclude the possibility that other tumour types may benefit from neutron irradiation—eg, when reoxygenation may be incomplete or when, for other reasons, there may be qualitative differences between neutrons and photons. Installation at Clatterbridge, Merseyside of a high-energy cyclotron with all the facilities for precise treatment planning should, over the next few years, provide a clear answer and define the role of neutron therapy in cancer treatment.

6. Duncan W, Arnott SJ, Battermann JJ, Orr JA, Schmitt G, Kerr GR. Fast neutrons in the treatment of head and neck cancers: The results of a multi-centre randomly controlled trial (RTO 00078). *Radiother Oncol* 1984; 2: 293–300.
7. Griffin TW, Davis R, Laramore GE, et al. Mixed beam radiation therapy for unresectable squamous cell carcinomas of the head and neck: The results of a randomized RTOG study. *Int J Radiat Oncol Biol Phys* 1984; 10: 2211–16.
8. Griffin TW, Davis R, Hendrickson FR, Maor MH, Laramore GE. Fast neutron radiation therapy for unresectable squamous cell carcinoma of the head and neck: The results of a randomized RTOG study. *Int J Radiat Oncol Biol Phys* 1984; 10: 2217–22.

The NHS Needs a Change

IN one of this journal's latest utterances about the declining support from the Government for the National Health Service we asked[1] what could be done by dismayed clinicians and others who were striving to maintain standards in adversity and who wished to protest. Write some brisk letters to MPs, we suggested, not very originally. We should have added, write to *The Times*. A letter[2] in that newspaper on May 13 from 12 consultants working in the health districts of inner London has had more impact than a dozen *Lancet* leaders. The consultants declared that the population of inner London is no longer receiving an adequate acute medical service. Severe cuts "have been imposed on a population that is rich only in the socially deprived, the elderly and those having special priorities such as single-parent families and those scourged by AIDS". The prospect of more cuts fills the consultants with dismay. Their outcry has been met with the customary Government denials and stretched statistics, put forward this time, with even less conviction than usual, by Mr Barney Hayhoe, the new Minister for Health, who may be wondering why he ever accepted the Prime Minister's invitation to defend her indefensible policy in running down this national asset. Mrs Thatcher must now emerge from behind the shelter provided by her subordinates and explain to the electorate why they should not dismiss her from office at the earliest opportunity—because, if for no other reason, she has deceitfully contrived the decline of their NHS. Whatever she may have said in the past, the citizens now know that the NHS is going down.

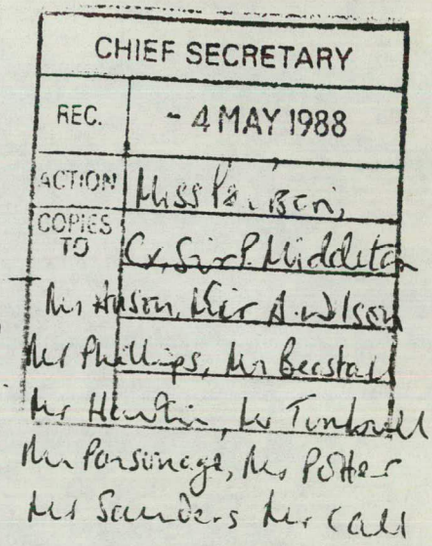
The Government continues to mouth one of its other deceptions—that the extension of private medical care is invariably beneficial to the NHS and its patients. When NHS waiting lists are disgracefully long in many areas and specialties, especially those well served by private hospitals? When it is admitted, though not very publicly, by many consultants that some of their colleagues are failing in their commitment to the NHS because they devote much of their time to private practice? (Why is the General Medical Council so reluctant to do its duty and call these traitors to account?) When the NHS has a backlog[3] of £1.7 billion for

1. Editorial. Money and the NHS: a new phase. *Lancet* 1985; ii: 1221–22.
2. Thompson RPH, Barnes PK, Croft D, Elkeles RS, Hopkins A, Knight RK, Parkins A, Pounder R, Sarner M, Slack WW, Wansbrough-Jones M, Williams R. Hospital concern at London cuts. *Times*, May 13, p13.
3. Bosanquet N. Public expenditure on the NHS: recent trends and the outlook. 1985. Institute of Health Services Management, 75 Portland Place, London W1N 4AN.

SECRET

CABINET OFFICE

70 Whitehall London SW1A 2AS Telephone 01-270



P 03100

Paul Gray Esq
Private Secretary
10 Downing Street

4 May 1988

Dear Paul,

REVIEW OF THE NHS

I attach a possible timetable and programme of work for the next stages of this Review, which the Group may find it helpful to have to hand at its next meeting on 9 May.

I am copying this letter and its attachment to the private secretaries to the Chancellor of the Exchequer, the Secretary of State for Social Services, the Chief Secretary, the Minister for Health and Sir Roy Griffiths and to Brian Griffiths and John O'Sullivan in the Policy Unit.

Yours.

Richard

R T J Wilson

Wilson → Gray 4/5

SECRET

SECRET

REVIEW OF THE NHS

OUTLINE TIMETABLE

Note by the Cabinet Office

1. The Group may wish to consider the outline timetable attached, which sketches out a possible plan for its further work.

2. Particular points for attention include:

   i. Links with PES. It will be important to ensure that the conclusions of the Review are taken into account in this year's Public Expenditure Survey.

   ii. Green Paper/White Paper. The Group will wish to consider in due course whether to undertake formal consultations on its proposals. One possibility would be to issue a Green Paper and use it as a basis for consultation. Another possibility might be to aim for a relatively short White Paper which outlines, as a matter of firm policy, the main features of the reforms which the Government will introduce, but leaves the detailed implementation to discussions with the main parties concerned, with a view to introducing legislation early in the Parliamentary Session 1989-90.

Cabinet Office

4 May 1988

SECRET

REVIEW OF THE NHS

OUTLINE TIMETABLE

9 May: Charting the way ahead. Paper by the Secretary of State for Social Services (already circulated).

: A Scheme for contracting out of the NHS. Paper by the Chancellor of the Exchequer (already circulated).

w/b 23 May: Structure and funding. Possible papers on:

i. where responsibility for buying health care should lie (RHAs, DHAs, the future of FPCs etc.);

ii. the machinery for funding health care (including the money following the patient), and for controlling costs (including new hospitals);

iii. how the new regime for hospitals would work in practice, and the arrangements for accountability;

iv. transitional steps which can be put in hand soon (eg improving information about costs, better audit arrangements).

w/b 6 June: Encouraging private sector involvement in:

i. the provision of health care. This could cover the greater use of the private sector as a resource (eg in the building of hospitals), private sector management (eg in the running of hospitals) and private sector expertise (eg in treating illnesses where NHS waiting times are long);

ii. the financing of health care. Further consideration of options on contracting out etc. following discussion of the Chancellor's paper.

w/b 20 June:	The professions. Papers on: i. consultants' contracts; ii. the role of GPs; iii. the training and qualifications of nurses; iv. pay and manpower planning.
w/b 4 July: w/b 20 July:	Further meetings as necessary.
w/b 1 August:	Circulation of first draft of Green Paper/White Paper to members of the Group before Parliament rises for Summer Recess.
September:	Two meetings of the Group to discuss the draft Green Paper/White Paper.
w/b 10 October:	Conservative Party Conference.
November/ December	Publication of Green Paper/White Paper (after Autumn Statement).

Cabinet Office

4 May 1988

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

~~pps pl.~~ Thanx Pup

CONFIDENTIAL

From the Minister for Health

The Rt Hon John Major MP
Chief Secretary to the Treasury
H M Treasury
Parliament Street
London SW1P 3AG

CHIEF SECRETARY
REC. - 9 MAY 1988
ACTION Mr Saunders
COPIES TO Cx, Mr Anson, Mr Phillips, Miss Chilton, Mrs Smee, Miss Pearson, Mr Spackman, Mr Turnbull, Mr Parsonage, Mr Baker, Mr Griffiths, Mr Sussex, Mr Call.

04 MAY 1988

Dear John.

PRIVATE FINANCE FOR NHS CAPITAL PROJECTS

Thank you for your letter of 8 April setting out Treasury's position on the use of private capital by the NHS.

You will not be surprised to learn that I was disappointed by your reply. I remain of the view that we should start from a predisposition to allow greater freedom for the NHS to use private sector or unconventional finance where value for money could be demonstrated in local terms and authorities could find the ongoing costs from within their (unadjusted) cash limits.

Rather than rehearse the points set out in my letter of 16 March I think that the best way forward is to take up your offer of considering specific proposals. I suspect that some schemes which might have had considerable benefits (and could demonstrate good value for money locally) will have been dropped without coming to you because of the apparent stiffness of the approval criteria. We will consider bringing some forward.

In addition my officials are in touch with yours to clarify the position on the details of control total adjustments.

I am copying this letter to the Prime Minister.

Yours ever.
Tony

TONY NEWTON

YdS/D.3

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Secretary of State for Social Services

CHIEF SECRETARY	
REC.	- 5 MAY 1988
ACTION	Mr Saunders
COPIES TO	Cx, Mr Anson
	Mr Phillips
	Mr Turnbull,
	Miss Pearson
	Mr Call.

CONFIDENTIAL

The Rt Hon John Major MP
Chief Secretary
HM Treasury
Treasury Chambers
Whitehall
London
SW1

Ch/relevant to our briefing meeting

4 May 1988

MOORE → CST 4/5

Dear John.

Thank you for your letter of 22 April in reply to mine of 11 April about the financial position of health authorities in 1988-89.

The NHS Review is of course extremely relevant to the question of longer-term funding for the National Health Service, and I certainly hope that we shall make good progress on this in the coming months. It is, as I am sure you will agree, unlikely that we could be in a position to make a public statement before the Autumn at the earliest. The link to the question of the adequacy of funding in 1988-89 is therefore, to say the least, tenuous.

There are some immediate steps which have to be taken. The decision to implement the Review Body awards in full, though it has been well-received, does not affect the fundamental position. We shall have to decide soon whether to approve short-term programmes from Regions which involve quite substantial service reductions which will be highly controversial once they are made public. We know too that the underlying overcommitment of health authorities will, as things stand, get worse over the year. If, as a Government, we are not to make available the additional resources which would avoid those consequences, we need to do so in full understanding of what they would be. We need also to be

E.R.

sure that all alternatives have been fully explored. Until that ground has been covered I must reserve my position on the question of additional funding.

In the circumstances it would be helpful to take up your offer of a further meeting, before decisions are taken. I suggest that this should be between you, with your officials, and Tony Newton, in his capacity as Chairman of the NHS Management Board as well as Minister for Health, plus the relevant members of the Board. This would provide an opportunity to explore direct with you not only what approval of the short-term programmes would actually mean, but what alternatives, other than additional funding, might be contemplated to mitigate either the immediate political damage from service reductions or the accentuation of the longer-term problems that could arise if we sought to prevent those reductions occurring.

Tony Newton's office will be in touch with yours about arrangements for the meeting. I should prefer that this take place before 18 May when I am due to meet Regional Chairmen, for whom I shall need to have a clear line.

JOHN MOORE

5.5.1

SECRET

FROM: R B SAUNDERS
DATE: 5 May 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir Peter Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Riley
Mr Griffiths
Mr Satchwell
Mr Tyrie
Mr Call
Mr Kuczys - IR

NHS REVIEW: PRIME MINISTER'S MEETING ON 9 MAY

I have already given you a note on the main paper, Mr Moore's "Charting the way ahead". This minute deals with the other two papers on the agenda.

Contracting out

2. I attach a few defensive points on your paper, based on comments which have been made to us in official discussions and on what I understand Mr Moore will be briefed to say.

3. In introducing the paper, the main point is perhaps that a fiscal incentive seems to fail to achieve the objective of attracting more private sector money into the financing of health care. If the contracted out rebate is set low, not many new people will seek private health insurance. If, on the other hand, the rebate is increased, more people will come forward, but the rebate will cover most of the cost of their premiums, so that they do relatively little "topping up". Either way, the new money brought in will not be large in relation to the deadweight cost. It may even result in a reduced net private sector contribution.

SAUNDERS PMS NOTE ON 9 MAY 5/5

Outline Timetable

4. The programme of work in this Cabinet Office note is reasonable, if rather ambitious. It may be that more than one meeting will be needed to go through the implications of Mr Moore's "self-governing hospitals" model. As my earlier note

indicated, there are some very big points which have to be worked up. The same is true of the professional manpower issues pencilled in for 20 June. Some things are already happening: we have been discussing nurse training and qualifications with DHSS for some time (see Mr Griffiths' submission of 29 February to the Chief Secretary), and DHSS Ministers are expected to write round with proposals next week; and the Primary Care White Paper included proposals for new contracts for GPs. But some of this, particularly in the area of primary care, may need to be looked at again as the Review develops, and much work will be needed on consultants' contracts.

5. Although decisions are not needed now, I would see advantage in some form of consultation about major structural reform. This would allow more time for people to get used to the ideas, and for detailed problems to be teased out and tackled before legislation is introduced. But it is important that consultation on the structural issues should not hold up action in those areas where we can start now: resource management, competitive tendering, audit, etc. This is a point you might make at the meeting.

6. You may be asked about the relationship between the Review and the Survey. There are two points here. First, some of the proposals emerging in, or as a result of, the Review will have expenditure implications. One obvious example would be extra IT expenditure resulting from acceleration of the resource management initiative. It is important that we get these fed into the Survey properly, so that their consequences are reflected in the plans announced in the Autumn Statement. But there is the more general point that we shall not want to concede more money to the DHSS in the Survey until they are committed to the reforms we are urging upon them. You will not want to say this in terms at the meeting. But you might indicate to Mr Moore that his Survey bids will inevitably be considered against the background of the Review and of repeated Government statements (not least by him) that the problems of the NHS are not just about money.

R B SAUNDERS

SECRET

CONTRACTING OUT - DEFENSIVE POINTS

Can't you deal with adverse selection by introducing an age-related rebate?

This will have little significant effect in an NIC-based system. This is because the big differentials are between the over-65s and those of working age. Within those of working age, there is relatively little scope for banding. Nor would this deal with non-age-related health differences.

A £50 rebate too mean?

A higher rebate would mean we were giving back to people more than would nationally be spent on them in the NHS. A higher rebate would considerably increase the costs of the system and - by narrowing the gap between the rebate and the typical private insurance premium - mean less scope for people putting in more of their own money by "topping up".

Can't you control the cost by controlling the size of the rebate?

The additional cost is the product of the rebate and the numbers contracting out. The more people who contract out, the greater the Exchequer cost.

Deadweight cost doesn't matter. It's only giving their money back to those who pay twice now.

They pay willingly - and in any case the premium covers extras not available in the NHS. There would be criticism that a significant sum of public money which could have been used to improve NHS services had instead been given to those who did not need it. And there could be knock-on effects in other areas, eg education.

Wouldn't the system be tighter if the rebate was paid direct to insurers rather than to those who contract out?

Doesn't affect the arithmetic.

Tax relief better than NIC rebate because amount would be related to level of cover and individual's health needs (since it is based on actual premium paid) and because it catches both the elderly and the working population?

But a general tax relief would undermine our policy of minimising special reliefs. And relating relief to premium size increases the risk of it simply feeding through to higher premiums.

Why not finance NHS completely from contributions?

If contributory principle is not to be seriously undermined, will be a substantial switch from tax to NICs. This will have major effects on income distribution, work incentives and efficiency of tax system.

This is a very effective rebuttal of the point alleged at the seminar. As to the capital approval system - about which the Prime Minister has expressed suspicion - the figures in para 3 speak for themselves. You might like to have this with you at the PM's meeting on Monday.

RP 14/2.

RR 5/5

From: J M SUSSEX
Date: 5 May 1988

1. MR SAUNDERS
2. CHIEF SECRETARY

cc PS/Chancellor
Sir Peter Middleton
Mr Anson — Sir T Burns
Mr H Phillips — Mr Spackman
Mr Turnbull — Mr Parsonage
Miss Peirson — Mr Griffiths
Mr Call

HEALTH AUTHORITY CAPITAL PROJECTS: APPROVAL PROCEDURE

At the Chequers NHS seminar on 24 April the issue was raised of alleged delays in health authorities gaining approval for capital projects. Some of these alleged delays were blamed on the Treasury. You asked for a background note on approval procedures for NHS capital projects and the Treasury's involvement (Miss Rutter's minute to Mr Saunders of 26 April). You also requested a description of the current position in respect of "turnkey" projects.

APPROVAL PROCEDURES: BACKGROUND

2. In NHS England, once a capital scheme has been identified, health authorities are obliged to follow the procedures laid down in the DHSS "CAPRICODE" manual. These procedures comprise a series of 7 stages. The first of these stages is "Approval in Principle". DHSS approval is required at this stage for all schemes with works costs over £5 million. Additional Treasury approval is required for all schemes with works costs over £10 million. Schemes over £25 million require Ministerial approval. Once approval in principle (AIP) has been granted, no further DHSS or Treasury approvals are required, unless the real costs of the project change by more than 10 per cent in real terms.

3. "CAPRICODE" was first introduced in 1974 and has been updated and revised since. Its purpose is to ensure the full and proper management of NHS capital projects. The use of "CAPRICODE", while not the only relevant factor, has contributed to the progress that has been achieved in reducing cost and time overruns. During the 1970s average real cost overruns on completed NHS capital projects

SUSSEX HEALTH AUTHORITY CAPITAL PROJECTS 5/5

were 12 per cent and time overruns 30 per cent; in the period from 1982 to 1987 average real cost overruns have been brought down to 6 per cent and time overruns to 7 per cent.

APPROVAL PROCEDURES: "DELAYS"

4. As a result of the delegated limits described in paragraph 2 above, only a minority of capital schemes require DHSS approval and even fewer come to the Treasury. Within the financial year 1987-88, the DHSS approved **seven** AIP submissions, of which the Treasury dealt with **four**. These four spent an average of 19 days between arrival in the Treasury and Treasury approval being granted; of which 13 days represented Treasury handling time and the remaining 6 days time spent by the DHSS and health authorities in providing further information and/or clarification.

5. An AIP submission will take a health authority some months to prepare. When DHSS approval is required the Department may then spend several months considering a submission's merits, as was confirmed by Mrs Currie in a written answer to a PQ by Sir Barney Hayhoe in April 1988 (a copy of the question and answer is attached). The quality of the AIP submission, its complexity and the wider issues it may raise, all affect the time taken by the DHSS and the Treasury. But it can be seen that the time spent in the Treasury is small relative to the total case preparation and approval process. Furthermore, a recently introduced Treasury initiative should streamline the process further: for the majority of AIPs not requiring Ministerial approval it is now sufficient for the Treasury to be shown merely a standardised-format summary of the project, rather than full documentation as before.

"TURNKEY" PROJECTS

6. "Turnkey" is the term applied to capital schemes where a consortium takes a service requirement set by the customer and then designs, builds and equips a unit to meet that requirement. The customer's only involvement is in specifying the service requirement and in receiving "the key of the door" when the scheme is complete.

7. The supposed advantage, to the customer, of "turnkey" projects is the speed with which the project is brought to completion. The DHSS and the Treasury are happy to consider such projects where they are shown to be the most cost-effective option. We understand that so far no "turnkey" contracts for NHS capital projects have been awarded, (none have come to the Treasury for approval). This is not because of refusal to countenance such contracts but rather for the following reasons.

a. With the "NUCLEUS" standardised hospital design, a relatively rapid design and construction process is already available.

b. Problems of ensuring consistency with health authorities' planning.

c. We understand that the sort of proposals that private consortia have so far been putting to health authorities typically involve a substantial financing element as well as design, construction and equipping. This is unlikely to prove cost-effective.

SUMMARY

8. NHS capital approval procedures exist for a good reason: to ensure proper control, including cost control, of projects.

9. The Treasury see only a minority of capital projects for approval.

10. The time that AIP submissions spend in the Treasury is small.

11. "Turnkey" projects will be countenanced where they can be shown to provide the most cost-effective solution.

J M Sussex

RG 0477P/2

'hursday 31 March 1988
Written Answer
Tuesday 12 April 1988

PQ 5707/1987/88
Han Ref Vol 131
Col 101-102

HOSPITAL DEVELOPMENT PROGRAMMES

235 Sir Barney Hayhoe (C Brentford and Isleworth):

To ask the Secretary of State for Social Services, what is the average time between the submission of plans for a major hospital redevelopment or development programme to his Department and Her Majesty's Treasury and their formal approval in part or whole, based upon the last 20 such cases.

MRS EDWINA CURRIE

Departmental approval in principle is required for all schemes with works costs of over £5 million. Treasury approval is required for schemes in excess of £10 million and for those which start a cycle of development of over £25 million in total.

Each scheme needs to be considered on its merits. Fourteen of the 21 schemes given approval in principle in the last two financial years were cleared within 12 months. Seven of these were cleared within about six months. The longest took approximately 21 months. The time taken can be greatly affected by the quality of the initial submision, the complexity of the scheme and the issues raised. In most cases the process involves detailed discussion with the Health Authority and revisions to the submissions.

SECRET

MP

BRIEFING MTG 6/5

NOTE OF A MEETING HELD AT NO.11 DOWNING STREET

AT 11.00am ON FRIDAY 6 MAY 1988

Present: Chancellor
Chief Secretary
Sir Peter Middleton
Sir T Burns
Mr Anson
Mr H Phillips
Miss Peirson
Mr Saunders
Mr Parsonage
Mr Call

NHS REVIEW: BRIEFING MEETING

The Chancellor began by circulating an article by John Studd, a Consultant Pediatrician at Kings College Hospital, London. The article (attached) outlined Mr Studd's thesis that, in order to speed up the development of the private health sector, and meet what he saw as significant unsatisfied demand for health care, consultants' NHS sessions should be halved, leaving them to pick up the rest of their income from private practice. There would therefore be a doubling of the number of NHS consultants, met by promotions from the bottle-neck of senior registrars. Mr Studd accepted there would be problems - hostility from the BMA, the need to protect pension entitlements etc - but he thought the proposal had the advantage, from the doctors' point of view, of increasing the number of NHS consultant posts, which were seen as most prestigious. Studd had undertaken to write setting out these ideas in more detail, and the Chancellor said he would like officials to look at the proposal. It would be necessary to examine the evidence supporting Studd's claim that the supply of consultants was restricting the growth of the private sector. Would there be sufficient public demand for a greatly increased number of private

would be returning to the present system where health authorities lobby for more Government money. The system of monopoly buyers was preferable to competing HMOs on cost control criteria, but offered less consumer choice. The Chancellor said he saw no advantage in setting up competing public sector buyers, with national coverage: there would still be significant elements of choice for the public, eg in their choice of a GP, and also in the choice between State and private sector care.

5. Generally it was felt that there was a danger that the new structure would look very much like the old. The buyers might be as politicised as health authorities currently are, and, for example, might not make a priority out of reducing waiting lists.

6. Sir P Middleton said it would be important to ensure that if new public sector buyers were created, the regional and district health authorities should be abolished: we should not merely add another level of bureaucracy. Miss Peirson pointed out that the creation of new buying authorities would inevitably involve greater numbers of administrators, since there would now be two layers of administration receiving and distributing money - the buyers, and the hospitals.

7. The Chancellor asked how the Treasury paper on contracting out had been received by the Officials' group. Mr Phillips reported that its exposition of how a scheme might work had been seen as positive, but the conclusion that opting out could actually be counter-productive had come as a surprise. DHSS were still fairly attached to the notion of contracting out. Mr Phillips would try to find out where the Policy Unit stood.

8. The Chancellor asked whether officials now saw any mileage in the earlier proposals that some, fundamentally cosmetic, surgery might be hived off from the NHS to the private sector. Mr Anson said that they had concluded that the number of cases involved was small relative to the totals. Definitions would be difficult to draw, and contentious.

consultants? The practicalities of the scheme would also have to be considered. Would it be practicable/desirable for GPs to move into the gaps created by newly promoted senior registrars? How would the scheme treat doctors who were "conscientious objectors" to private practice?

2. The Chancellor also mentioned that he had seen Mr Moore's latest letter repeating his bid for extra resources in the current year. He hoped we could continue to resist this. The Chief Secretary said that he would be replying, turning down the suggestion that he should meet Mr Newton and the NHS management board. It was for Mr Newton to put together the case and then present it to Treasury Ministers.

3. The Chancellor invited reactions to Mr Moore's paper. Mr Anson said that, although the paper focused on the very long term, it would be possible for the Treasury to capitalise on the paper's references to changes that could be made in the short term, in order to initiate long-term reform: he had in mind encouraging the existing health authorities to act as "buyers", buying in, for example, radiography and blood testing services from the private sector. It was agreed that the DHSS paper was very vague about what was really meant by the notion of buyers. It would be important to press for clarification: was this a real structural change, or merely a relabelling? The Chancellor said that he did not share DHSS doubts about the ability of small hospitals to be self-governing. He felt the presumption should be that hospitals should become self-governing, although clearly there would have to be exceptions for the smallest - cottage hospitals etc.

4. Sir T Burns said that he had reservations about the assumption that the new buyers should have a monopoly in any given area: this would offer neither competition nor choice. Mr Parsonage pointed out that the advantage of giving power to the buyer was the downward pressure this would create on costs. However, the pressure on the buyer came from the tight budget that would be set by Government: Mr Call pointed out that there was a danger that we

9. Finally, there was a discussion of the outline timetable for the group. The Chancellor said that, subject to the Chief Secretary's views, he would be in favour of as "white" a paper as possible. The review had already almost taken the form of a consultation process. It would be desirable to be able to announce the conclusions of the review by the time of the Party Conference, when the Chief Secretary would need to know with some certainty what was agreed, and how it should be reflected in the Survey. In effect, this meant that the group would need to agree the broad outline of its conclusions by the end of July: there would not be time for further substantive discussions in September. It might also be appropriate to involve territorial colleagues in July, but there was no case for a wider discussion at that point. The Chief Secretary said it might be appropriate to issue a Green Paper on any major structural reform proposed, with a White Paper for the short term elements of an evolutionary package.

MOIRA WALLACE

Circulation:

Those present
PS/Paymaster General
Mr Turnbull
Mr Gieve

6 May 1988

The private sector: salvation or parasite?

John Studd, Kings College Hospital, London

It must be an unique event to have two reports vital for the understanding of our medical services published from our colleges within one month. In essence the Royal College of Physicians has stated that we are the unhealthiest nation in the Western world with the lowest life expectancy after age 45 and an appalling record for most major diseases, from carcinoma of the lung, coronary thrombosis to carcinoma of the cervix (Faculty of Community Medicine, 1986).

The lip service of successive governments to the importance of medical standards can be seen to be as fraudulent as the service given to routine surgical problems of hip replacement, cataracts, infertility and everything else. The 3–6 months waiting lists for most specialties in virtually all parts of the country has been tolerated by wretched patients and their families for too long.

In spite of these dangerously long waiting lists for consultations and admissions we have over-trained "juniors" waiting for consultant posts which are being frozen. But we are told that the NHS is efficient. It is certainly a medical service on the cheap, receiving the least percentage of GNP of any country in the Western world and it is run by fewer doctors per unit population than any advanced country – except Turkey (BJHM, 1985). Any efficiency is a result of the great effort made by health-care personnel faced with shameful underfunding. It is the desperate efficiency of starvation.

The magnificent report of the Royal College of Surgeons (1986) has carefully quantified this in terms of manpower: there are 12 consultant surgeons per 100 000 population in West Germany, 11 in Belgium and the USA, 6 in Holland and 2 in the UK. No doubt consultant surgeons have different roles in different systems. The higher European figures may be excessive but Britain's lack of consultant posts cannot be defended and should not be tolerated, particularly when we already have well-trained specialists available to fill such posts.

We should not be too hasty to celebrate the DHSS/JCC manpower initiative (DHSS/JCC, 1985) approving the immediate appointment of 50 consultant surgeons and 50 consultant physicians and a 2% consultant expansion per year. Even if it happens it will be but a drop in the ocean and we can all remember recent recommendations of consultant expansion in the Short Report which came to nothing.

These are the limitations imposed by a monopoly employer. No government of whatever persuasion has had the will or the financial means to correct this deficiency. It will not be possible for future governments to find adequate funds from public expenditure, however seductive their statements in opposition. How, then, can one escape the conclusion that the only way forward is through other means of alternative funding?

We lack the enormous potential of patient care, income, employment of medical and paramedical personnel and the development of research and teaching institutions that are made possible by a large thriving and above all respectable private sector. Without doubt there are abuses in the small poorly defined private sector in the UK. These allow opponents to refer to the private sector as "parasitic" and even an intemperate *Lancet* editorial (1986) to state that those working in it are "traitors". They can easily be eradicated by firm management.

Once we can overcome our political and sentimental objections to a predominantly insurance-supported private sector, its manpower potential will be considerable, as will be the effect on the health of the nation. We must open the debate and for the future quality of British medicine we must get the formula right. I would make the following suggestions to allow us to improve the existing NHS by exploiting the vast potential of the private sector.

- Encourage established consultants with private practice commitments to drop NHS sessions to enable the creation of new NHS consultant posts.
- Appoint more 5–8 session NHS consultant posts with the income being augmented by research or private sessions.
- Promote accredited senior registrars (why not *all* senior registrars?) into 8-session consultant posts with the other sessions made up as above. The ability to "pick up" the lost income will no doubt vary in different locations and different specialties but it will always be present in an expanded private sector.
- Prevent existing consultants from blocking new appointments when funds are available.

● Encouraging the use of improved NHS pay beds with the revenue returning to hospitals or even the appropriate departments. This is essential to combat the excellent foreign private hospitals which make up the majority of the private sector and the loss of substantial income to the USA.

These moves will almost double the number of consultants and, apart from the creation of more surgical lists, will cost virtually nothing. At the same time they will ease the problem of excessive training time and the woefully inadequate medical service offered to the majority of patients in the country. They will also introduce some degree of flexibility into the system to allow for the aspirations of those who are either research or clinically orientated, the workaholics, those who welcome a quieter life and the married women who would put a great deal of energy and skill into their part-time posts.

There is a considerable potential for good to be had from the private sector as soon as we can escape from the dream-world of adequate funding from public sources. We should encourage a skilled, prestigious international service. The standards must be high and the profits used to support, in these various ways, the demands of the NHS. It is vital that any increased resources produced by the private sector are not used as an excuse to cut and maim the NHS even further.

There is such a great tradition of good medical education and standards in this country that one can only despair at the events of the last decade. I believe that we have a last chance to enjoy mutual support within the two services. Unless we grasp this we will end up with a second-rate private sector run by foreign medical companies and the worst health service in Europe.

British Journal of Hospital Medicine (1985) Editorial. Refuge in the private sector. *BJHM*, **33**, 7
DHSS/JCC Manpower Initiative (1985) *British Medical Journal*, **293**, 147–152
Faculty of Community Medicine (1986) Health for All by the Year 2,000. Faculty of Community Medicine, London
Lancet (1986) Editorial. The NHS needs a change. *Lancet*, i, 1190
Royal College of Surgeons of England (1986) Commission on the Provision of Surgical Services

The ethics of donor supply

006/4206

cc:
Chancellor
Mr Anson
Mr H Phillips
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Griffiths
Mr Call

Treasury Chambers, Parliament Street, SW1P 3AG

The Rt Hon Tony Newton OBE MP
Minister for Health
Department of Health and Social Security
Richmond House
79 Whitehall
London
SW1A 2NS

6th May 1988

Dear Minister

CYCLOTRON TRUST

Following the meeting just before Easter our officials have been discussing with the Trust various options for Government financial support for the cyclotron project. They have produced the attached note, agreed with the Trust, which outlines and assesses the main options.

On the basis of this assessment I am prepared to agree to the Government's contributing £5.6 million towards the capital costs of the St Thomas's cyclotron, matching the sum raised from charitable and other sources. I am also content that the NHS should meet up to 60 per cent of the direct running costs of the cyclotron if this is necessary for the operation to break even. In return we should take up the Trust's offer to pay us whatever profit the cyclotron makes through treating private patients and to allow us to appoint the finance director of the company which owns and operates the cyclotron. You should, however, make it clear to the Trust that there will be no further Government contributions if their fund raising efforts fall short of target.

As regards the question of additional provision, I can undertake now to accept an agreed bid in the Survey in respect of the capital costs of the cyclotron. I should make clear, however, that I would expect you to absorb any consequential running cost contribution from your existing revenue provision.

We shall need to consider in due course the treatment of any receipts accruing from this project.

I am copying this letter to the Prime Minister.

Yours sincerely,

pp JOHN MAJOR

(Approved by the Chief Secretary and signed in his absence)

25.4.1

GOVERNMENT FINANCIAL SUPPORT FOR THE CYCLOTRON TRUST

The Project

1. The Cyclotron Trust plans to install a 60 MeV cyclotron in a new facility at St Thomas' Hospital alongside a 17 MeV cyclotron (a PET scanner) which is to be installed by St Thomas'. The larger cyclotron would be owned and operated by a limited company controlled by the Trust. Both cyclotrons together will form the world's first Medical Cyclotron Centre.

2. The Government has been approached for financial assistance regarding the larger machine which will be used for treating patients with cancer. The capital costs of this part of the project have been estimated at £10.4 million of which about a half is accounted for by the purchase price of the cyclotron. Running costs are estimated at £500,000 per year increasing in line with general inflation. Sixty per cent of the cyclotron's capacity would be reserved for NHS use with the remainder for private patients. In return for its contribution the Government would have the right to appoint the finance director of the company.

Financing Options

3.The Cyclotron Trust have assumed that they will be able to raise £2.5 million from charitable sources towards the cost of this machine. Treasury and DHSS believe this is a conservative assumption but accept it is unlikely that the Trust will raise more than £3.5 - 4 million. The rest of the capital costs, less any Government contribution, would be met by a commercial loan. The Trust are looking to the Government either for a capital contribution or a guaranteed annual income from the NHS or a mixture of the two.

4. We have examined four main financing options:

a. Option 1 would involve no capital contribution from the Government. However, HMG would guarantee the Trust annual revenue from the treatment of NHS patients of upto £1.75 million per year for a period of ten years. The actual sums paid each year would depend on the amount for income the Trust generated from private patients - the Government payment would be whatever was necessary for the Trust to break even on its operations up to the £1.75m per annum maximum.

b. Option 2 would involve an initial contribution on £2.5 million plus a guaranteed annual revenue of up to £1.5 million per year over ten years. Again, the size of the payment would depend on the income generated from private sources. Any overall profit by the Trust would be paid to the Government.

c. Option 3 would entail an initial contribution of £5.2 million (ie half the capital cost) and a guarantee that the Government would meet up to 60% of the direct running costs (ie excluding interest and loan repayments) of the cyclotron if necessary for the operation to break even. Again any overall profit made by the Trust as a result of income from treating private patients would be paid to the Government.

d. Option 4 is the same as Option 3 except that the initial capital contribution would be £6 million (just under 60% of the capital cost).

Discussion

5. We have carried out a discounted cash flow analysis for each of the options to determine which is the least expensive

for the Exchequer. The success of the Trust in generating income from the treatment of private patients is the main source of uncertainty in the projections and crucially affects the cost to the Government. We have therefore considered the options against three scenarios of revenue from private patients. The analysis relates to projections of income and expenditure for the two years that the cyclotron facility is being built and the first ten years of the cyclotron's operational life. After this period all the capital costs will have been paid off, limiting the expenditure to direct running costs including any maintenance costs.

6. The results of the discounted cash flow analysis are shown in the table below.

NET PRESENT VALUE EXCHEQUER COST (£'000)

	Private Patient Revenue Assumption		
Option	**Pessimistic**	**Central**	**Optimistic**
1	9,928	4,755	140
2	9,721	4,530	- 84
3	7,021	4,216	- 326
4	7,787	4,216	- 398

Note: Pessimistic case assumes 40 private patients a year paying £7,500 each. Central case assumes 160 patients paying £7,500. Optimistic case is 160 patients paying £12,500.

7. Options 3 and 4 are the cheaper on any assumption of private patient revenue (although it is only on the basis of the most pessimistic that they - particularly Option 3 - are cheaper by a substantial margin). This is because the Trust does not have to raise so large a commercial loan and the interest and repayment burden is correspondingly reduced.

8. However, if Option 3 were pursued, the Trust believe they would need to raise about £3.5 - 4 million to satisfy commercial sources of finance that on pessimistic assumptions of private patient revenue they will be certain of breaking even. Treasury and DHSS consider this is a feasible target for their fund raising but we cannot be certain that the Trust would achieve it. If there were a serious shortfall, the Trust might not be able to raise a large enough commercial loan to bridge the gap between the cost of the facility and the amount raised by the appeal and the Government's contribution. The Trust are confident that under Option 4 this potential funding gap would not arise.

HM TREASURY

3 MAY 1988

Ch/

Hayden Phillips rang to report a chat with John O'Sullivan. Main points:

- he's inclined to agree with us on NIC rebates and won't advise PM to dispute, but
- he thinks some gesture would be useful, and is ∴ attracted to tax relief for elderly.
- Most of his briefing will focus on the DWP&S paper

O'Sullivan suggested to Hayden that they might have another word after the weekend, in which case Hayden will let you have a note.

MPow

6/5

week.9.5/m.1

SECRET

FROM: H PHILLIPS

DATE: 9 May 1988

CHANCELLOR

cc Chief Secretary
Sir P Middleton
Mr Anson
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Call
Mr Parsonage

NHS REVIEW MEETING: 9 MAY

You asked me to have a word with Mr O'Sullivan at No.10. Miss Wallace will have reported to you the essence of our conversation but I thought I should record it for the Chief Secretary and others. This notes also adds one point which you may both wish to bear in mind for today's discussion.

2. Mr O'Sullivan told me that he would be briefing the Prime Minister in support of our objections to a NICs-based rebate scheme to encourage private provision of healthcare. He said, however, that he was likely to favour some tax relief on health insurance premiums for the elderly, not because he did not accept the risk that this would open up other policy areas to the same argument or complicate the tax system, but simply as a way of doing something to reduce the cliff-edge between public and private provision.

3. He said he expected the main weight of today's discussion would concentrate on Mr Moore's paper. I agreed with that. I said that in view of the serious reservations which your paper had set out about the impact of rebate or tax relief schemes the better course might be to see how reform of the NHS in terms of increased competition went and look at other ways of buttressing the provision of private healthcare than by some sort of fiscal injection. He said he though that might be a possible approach.

4. The additional point to mention, which tends to reinforce our views, is the announcement at the end of last week of the new low cost health insurance scheme introduced by BUPA. You will have seen the article in last week's Economist (copy attached) but I also attach a copy of BUPA's short handout announcing the scheme. This is targeted both on the 65-75 age group, and those between 18 and 29. If the market is now responding itself to its own rigidity in private cover then it seems to me we should be looking at ways other than tax relief or rebates to support this welcome development.

HP.

HAYDEN PHILLIPS

4 May, 1988

BUPA LAUNCHES NEW LOW-COST HEALTH CARE SCHEME

A new, low-cost health care scheme providing insurance cover and hospital care was launched today by BUPA.

The scheme - known as Budget BUPA - includes cover for the most common NHS waiting list operations, and is designed to attract thousands more people into private health care.

By reducing costs and by extending the upper age limit for first obtaining cover from 65 to 75, Budget BUPA will for the first time make private health care available to large numbers of elderly people. The scheme is also designed to introduce younger people between the ages of 18 and 29 to private health care.

Under the new scheme, premiums have been designed to reduce the cost of health cover by as much as a third, depending on age, and a system of excess charge options has also been introduced which reduces premiums even further. A 64 year old man joining the scheme now could pay as little as £10.35 a month, whereas under existing schemes he would have paid between £12.50 and £48.20; a 20 year old joining now could pay as little as £3.87 a month - the equivalent of less than a pint of beer a week - a man of 40 with a wife and two children £30 per month; and a 70 year old couple £33.80 per month.

The new scheme has been made possible because BUPA negotiated reduced rates for operations with 85 specially selected private hospitals and NHS pay bed units throughout the country.

more

For further information: Public Relations Officer 01-353 5212
BUPA Head Office Provident House Essex Street London WC2R 3AX

All the most common operations are covered, including the majority on NHS waiting lists. The operations range from hernias, varicose veins and cataracts to complex hip replacements and heart surgery.

Budget BUPA offers subscribers:

* cover for surgical treatment at premiums substantially below those of other existing schemes.

* a further reduction on premiums to those opting to pay the first £250 - £1,000 of treatment, under an excess charge system.

* treatment within 5 weeks in a BUPA-selected private hospital or local NHS pay-bed unit.

* more specific age-related premiums, with narrower, five year age bands, making cost jumps between age bands less dramatic.

* a telephone help line and an information guide on the scheme to ensure a full understanding of the medical conditions covered.

To assist in achieving the low premiums, the maximum benefit limit is £15,000 per person per year. No payment is made for non-surgical, out-patient treatment, or diagnostic investigations which do not result in surgery.

more

Announcing the new scheme today, Roy Clarke, managing director of BUPA insurance, said: "Budget BUPA is a key element in our strategy for substantially increasing the number of people covered by private health care. It fits in well with the emerging philosophy that people should take more responsibility for their own health care and that of their families.

"We have kept the DHSS informed of our plans and we believe Budget BUPA is consistent with the government's wish to encourage more self help in health care, and to introduce the advantages of commercial enterprise.

"By involving general practitioners, consultants, private hospitals and NHS pay bed units in a commercially-based scheme, we are helping to break down unproductive demarcations between the NHS and the private sector. This provides further opportunities for income generation within the NHS, and overall should result in higher quality health care for many more people".

ENDS

Issued on behalf of BUPA by Charles Barker Traverse-Healy.

For further information please contact:

Philip Codd
BUPA
Tel: 01-353 5212

(Regional papers please contact nearest BUPA Sales Branch. Names and telephone numbers enclosed.)

Private health

Competitive cure

IF PEOPLE are worried about the National Health Service, they might be expected to turn to private health care. They have done so: some 10% of the population now has private health insurance, compared with 5% in 1979. But the increase may be slowing, for a good old-fashioned reason: price. Premiums for people of all ages have doubled in real terms in the past eight years. The rise has been fastest for the over 65s (see chart), who often find that they have to pay more just at the point that their employers have stopped helping with their premiums.

The main cause of higher premiums has been escalating private health-care costs, something more familiar to Americans than to Britons. The British insurers have been slow to bring in the sort of cost-containment measures or new insurance packages that could make their product cheaper and more attractive. But on May 4th the biggest insurer, BUPA, came up with its own response, called "Budget BUPA".

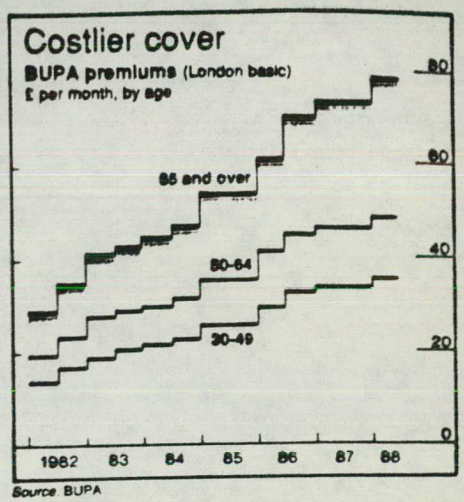
Budget BUPA is a special limited-cover insurance package with premiums as low as a third of the normal rate. Another unusual feature is that old people can join right up to the age of 75, though they cannot expect treatment for a condition they have already. The scheme has some formidable catches: patients who need non-urgent care may wait for up to five weeks, treatments like organ transplants and kidney dialysis are excluded, and there is a ceiling on payments of £15,000 a year, an optional "excess" or client co-payment of up to £1,000 and a restricted choice of hospital. Still, 85 private hospitals (including those owned by BUPA itself) have accepted tightly negotiated fixed-price terms for surgical procedures. The insurers hope most NHS hospitals with "paybeds" will do so too.

Despite the catches, the scheme will pull in new clients—for it is cannily aimed at a gap in the market that is the NHS's weakest point: long waiting lists for routine surgery for such things as hernias and artificial hips. BUPA is introducing it, not out of a sense of public duty, but because it has been squeezed by rivals: its share of the market has fallen from 70% to 60% in just six years. Most of the business has gone to aggressive commercial insurers.

Competition has been fiercest for the fast-growing company market, which now accounts for over half of all private health insurance compared with less than 40% in 1977. The BUPA scheme is aimed more at individuals than at companies: unlike normal health-insurance schemes there is no discount for group membership. So companies will go on shopping around for better private health deals.

The best such deals are usually tailored packages arranged by third-party intermediaries. Administrative costs can be much lower, and benefits can be adjusted to meet the wishes of individual companies (or their employees).

Bigger companies are going further: operating a form of self-insurance with a stop-loss provision through captive insurers. One of Britain's fastest-growing intermediaries, a Bristol-based firm called Medisure, does this for Bank of America. ICI and the Maxwell Communications Corporation have similar arrangements. Companies cannot simply take the risk themselves, because payment of an employee's hospital bills would count as a taxable benefit; but several are looking carefully at trusts that might get round the Inland Revenue's rules.



DAILY EXPRESS Monday May 9 1988

EXCLUSIVE: NEW HEALTH CASH WILL PUT MORE SKILLED NURSES ON WARD

Maggie plans £200m tonic for the hospitals

EXCLUSIVE
By ROBERT GIBSON
Political Editor

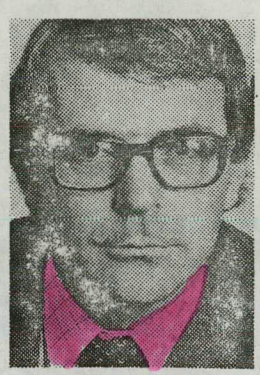
MRS THATCHER has earmarked another bumper bonus—of around £200 million—for Britain's hospitals as further proof that the NHS is safe in her hands.

The cash is meant to prevent bed or ward closures this winter and will enable skilled nurses to be taken on for acutely-needed tasks like helping in children's surgery.

The bonus should be announced in July, along with an interim report on Mrs Thatcher's planned Health Service shake-up.

Along with a £100 million pay-out last December, plus £750 million for the nurses, the transfusion will mean that the Health Service has never had more cash spent on it.

Mrs Thatcher has been persuaded that the Health Service has been under-allocated since she returned to power last June.



Major: Backing

Moore: Boost

She is determined to avoid the public relations pitfalls of last winter, when she was forced to announce a £100 million emergency injection after public pressure to avoid bed and ward closures.

By announcing the extra money before autumn, Mrs Thatcher will meet health problems while defusing any well-orchestrated Opposition campaign to further exploit Government's problems on social issues.

Nurses also feel that the timing of the award is vital to deflect almost certain criticism of planned Health Service reforms.

A senior Whitehall source said: "There seems little point in delaying the announcement of the cash until late in the year when the weather is cold and wet and everything looks bleak so that Labour can start trotting out a list of hard cases caused by cutbacks."

The cash injection for Health Secretary John Moore will have won the backing of Chief Secretary to the Treasury John Major.

Yet the British Medical Association said last night that it would be looking for an extra £300 million to meet the shortfall for the current financial year.

A spokesman said: "This would prevent any bed and ward closures and would enable nurses to be taken on in acute areas so that services that have been shut down because of cuts could be reopened."

It is in the acute sector that the Government has taken such a hammering—with reports in the winter of babies dying for lack of operating facilities.

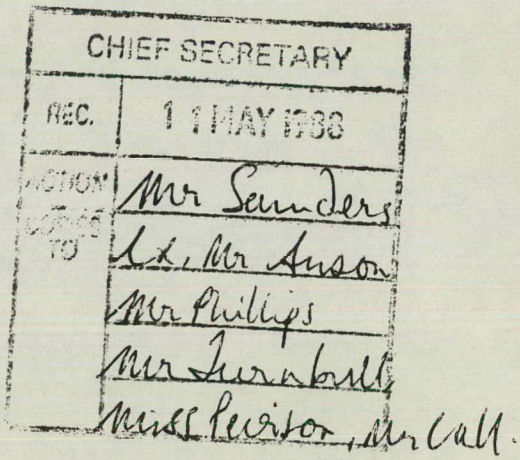
The BMA claims tht the Health Service needs an immediate £1.5 billion boost to cure its long-term ills.

But the £200 million will go a long way towards satisfying health lobbies.

Meanwhile, the Government health review is now well under way and likely to call for younger, wealthier people to demand less from the NHS.

Patients could have the right to demand treatment within a set period. If the NHS cannot provide this, the local health authority may have to pay for the patient's private treatment.

CONFIDENTIAL



Prime Minister

10/5/88

You will wish to be aware of my plans for publishing the NHS Management Board's Final Report on its Review of the Resource Allocation Working Party (RAWP) Formula.

The Review was initiated in December 1985 with the aim of improving the existing resource allocation arrangements. An interim report, published in December 1986, made recommendations for further analysis and research; the final report now describes the outcome of this work programme and recommends revisions to the formula. The Review has been the subject of considerable NHS and Parliamentary interest, and publication of the final report is expected. But the RAWP work inevitably touches on issues which have been raised in our wider Review of the NHS and we need to handle publication in a way which makes clear the distinction between the two.

The RAWP Report itself makes some useful progress; it sets the formula on a sounder analytical basis and takes some better account of service costs (in so far as the all too familiar data limitations allow). The net effect of the recommended changes is

E.R.

an overall reduction in the range of Regions' distances from target. Very broadly, the Regions of the North and the Midlands now appear very close to target, while the Thames Regions collectively are also closer to target than before. Although the remaining disparities between Regions will require some continuing process of redistribution, mainly because of population movements and the faster growth in the elderly population in some Regions, the general direction of the changes is helpful, not least as it will enable us to improve the resource position of the Thames Regions.

↑ i.e. not have to scale it down even further.

This is not to deny that some aspects of the Report will prove controversial. The measurement of need for health care is a subject which inevitably attracts debate, [between HMT & DHSS!] and one where definitive proof is rare. Any change in the balance of resource allocation across the country is also likely to draw some adverse comment from losing areas. Officials have however been working with the Regions concerned to ensure the Report as fair a wind as possible. My judgement is that the best course now is to aim for early, low key publication of the Report, accompanied by a statement making it clear that the Government accepts its recommendations, but is prepared to phase their impact on annual allocations so as to minimise the disruption to health authorities' existing plans.

An announcement on these lines of a short term revision of the existing formula need not prejudice our wider Review. Indeed the

F.R.

capitation-based core of the RAWP formula could offer a starting point for a number of different models. In addition the RAWP Review's attempts to improve the measurement of consumer need and take better account of service costs are, in a limited way, consistent with some of the themes of our wider Review. I suggest therefore, that our statement on the RAWP Review should simply make it clear that we are making practical improvements within the existing resource allocation framework, and that these improvements are without prejudice to the outcome of the wider Review.

I have it in mind to issue an early publication of the Report with a written Parliamentary answer along the lines I have described. If you agree with this general approach, I will ask my officials to liaise with yours on the terms of the announcement and its reference to the NHS Review.

A copy of this letter goes to Peter Walker, Tom King, Malcolm Rifkind, John Major and to Sir Robin Butler.

10 May 1988

JM

MP

Where's the annex?

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

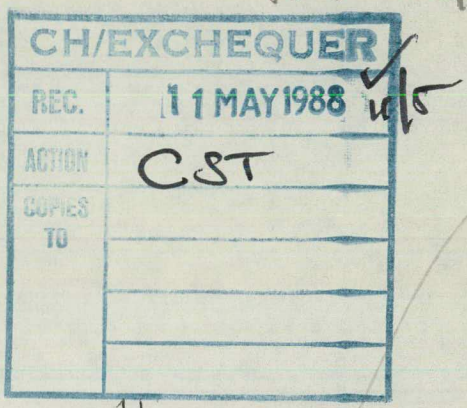
Telephone 01-210 3000

From the Secretary of State for Social Services

CST PROVIDING ANX

TL 12/5

BF 1875



MANAGEMENT IN CONFIDENCE

David Crawley Esq
Private Secretary to
The Rt Hon Malcolm Rifkind MP
Secretary of State for Scotland
Dover House
Whitehall
LONDON
SW1A 2AU

11 May 1988

Dear David,

BF 2075 MU NOTAS ~~YET~~ TL

Any advice yet?

I am writing about changes my Secretary of State proposes in the management of the four special hospitals at Broadmoor, Moss Side, Park Lane and Rampton.

The Secretary of State has been reviewing the current management arrangements for the hospitals to decide whether any changes are needed to meet management and policy objectives for the special hospitals service and to provide stronger management and policy links with psychiatric provision elsewhere in the National Health Service and with the Prison Service and Prison Medical Service. He has concluded that changes are needed, and his proposals are set out in the annex to this letter. Because of the Home Secretary's particular responsibilities and interests in relation to the powers of the courts and the treatment of mentally disordered offenders, he has been informed of the proposals and has given his support.

My Secretary of State would welcome any comments your Secretary of State has on the proposals.

E.R.

Copies of this letter go to private secretaries to the Chancellor, the Lord Chancellor, the Home Secretary, Secretary of State for Wales and the Secretary of State for Northern Ireland.

Geoffrey Podger

GEOFFREY PODGER
Private Secretary

MANAGEMENT IN CONFIDENCE

THE SPECIAL HOSPITALS SERVICE

Hospitals

1. The Secretary of State for Social Services is responsible for providing the Special Hospitals Service through four hospitals - Broadmoor, Moss Side, Park Lane and Rampton. The hospitals have been managed directly by the Ministry of Health and DHSS since the Home Office Board of Control was replaced by the Special Hospitals Service in preparation for the Mental Health Act 1959. Under Section 4 of the National Health Service Act 1977, the Secretary of State is required "to provide and maintain establishments (referred to as "special hospitals") for persons detained under the Mental Health Act"...."who in his opinion require treatment under conditions of special security on account of their dangerous, violent and criminal propensities".

Patients

2. The hospitals form a single national service and provide treatment for nearly 1,700 patients. Patients are admitted direct from the courts or transferred from prisons or other hospitals. Admissions are determined centrally by the DHSS, through a multi-disciplinary Admissions Panel.

Management

3. The Secretary of State for Social Services is responsible ultimately for the management of the hospitals and the care of the patients. He is advised on all matters pertaining to the Special Hospitals Service by a multi-disciplinary group of DHSS officials comprising the Special Hospitals Service Board (SHSB).

4. Local management boards have been established for the hospitals, and all management functions have been delegated to them except patient admissions, employment and the allocation of resources. The local management boards are special health authorities (SHAs). There is one each for Broadmoor and Rampton, and a combined one for Moss Side and Park Lane which share a single site. The local management boards are supported by Hospital Management Teams (HMTs) comprising a Medical Director, Chief Nursing Officer and Administrator. The HMTs are led by the Medical Director. They are accountable to DHSS for

the exercise of the HMT management responsibilities which DHSS still discharges directly. They are accountable to the local management boards for the exercise of the functions for which the local management boards have delegated responsibility.

Need for change

5. There is an urgent need to develop a coherent policy for the Special Hospitals Service, in itself and in relation to other services on which it has a direct bearing - the hospital and community psychiatric services; the prison service and the prison medical service. There is a need to end the geographical, service and professional isolation of the Special Hospitals Service and ensure that the hospitals are regarded as part of the spectrum of psychiatric treatment. Unless the present management weaknesses are corrected, this policy requirement will not be met.

Proposals for change

6. The following changes are proposed to correct the existing management weaknesses and more effectively meet the policy requirement:

(a) create Special Hospitals Service SHA: create a shadow SHA, drawing on the SHSB, local management boards and DHSS staff, pending the necessary legislative change, to be responsible for overseeing the necessary management of change at all levels;

(b) appoint General Managers: in each of the special hospitals, counting Moss Side and Park Lane as one hospital for this purpose, following open advertisement along NHS lines;

(c) review functions of SHSB and local management boards to determine future management arrangements in context of establishment of Special Hospitals Service SHA;

(d) develop national policy: for the future of the Special Hospitals Service, which is flexible enough to be implemented either through a central SHA or as part of the NHS, or both. This would require an appropriate budget, which would be managed by the central SHA through the General Managers in the hospitals.

7. The key elements are to establish a central SHA and to appoint General Managers in the hospitals. By establishing a central SHA, the Special Hospitals Service would be given the strengthened management and policy advice which it needs. The objective would be to link the Special Hospitals Service more closely to the NHS, either through complete integration over time or through a preferably time-limited central body which could consider and recommend long-term policy and management arrangements. By appointing General Managers, the Special Hospitals Service would be brought into line with the rest of the NHS and provided with a function which is necessary for effective decentralisation of day-to-day management of the hospitals and delivery of central management and policy requirements.

Timing

8. There is a strong operational and policy requirement for early strengthening of the management arrangements. The aim is therefore to appoint General Managers by the autumn of this year and create the Special Hospitals Service SHA by 1 April next year. Work on a national policy paper to guide the future direction of the Special Hospitals Service will be carried forward in parallel.

Resource consequences

9. It is not envisaged that the proposed changes would make additional demands on resources, the aim being to introduce tighter and more effective control of existing resources. The proposals are designed to be met from the present revenue budget of the Special Hospitals Service (£59m for 1988/89). Better use of resources, particularly capital resources (£12m for 1988/89) and manpower (3318 staff at 1.4.89) should produce either savings over the longer term or an improved quality and quantity of service.

I agree
RR
12/5

From: J M Sussex
Date: 12 May 1988

1.MR SAUNDERS
2.CHIEF SECRETARY

cc Chancellor
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Call

REPORT ON THE REVIEW OF THE RAWP FORMULA

John Moore has sent you a copy of his 10 May minute to the Prime Minister concerning his plans for publishing the NHS Management Board's Final Report on its Review of the Resource Allocation Working Party (RAWP) Formula.

2. The Report is a purely technical review of the RAWP formula, which was set up in December 1985. It proposes a large number of detailed changes to the formula, whose overall result is that regions turn out to be nearer to their RAWP targets than they appear to be with the present formula. There will thus be less pressure with this formula for major redistribution of the sort which has led to so many complaints from the Thames regions in recent years.

3. Mr Moore proposes an early, low-key, publication of the Report with a written Parliamentary answer. This will state that the Government accepts the Report's recommendations.

4. We have been kept in touch with the review and contributed technical advice at an earlier stage. We are content with the substance of the recommendations. The only question seems to be whether publication now might be taken as signalling that the present system will continue and that the NHS Review will not be proposing major change. We think, however, that this danger can be avoided so long as publication is handled in the right way. Mr Moore's minute indicates that he is aware of this issue and in his announcement at the time of publication of the Report he intends

[redacted] distance this from the NHS Review. The review of RAWP has already attracted interest and publication is widely expected.

5. I recommend that you should write to Mr Moore agreeing to his publication plans but asking that Treasury officials be consulted about the terms of the announcement. A draft letter is attached.

J M Sussex

DRAFT

Rt Hon John Moore MP
Secretary of State for Social Services
Richmond House
79 Whitehall
LONDON SW1A 2NS

May 1988

REVIEW OF THE RAWP FORMULA

Thank you for copying me your minute to the Prime Minister of 10 May. I am content with the recommendations of the Final Report of the RAWP Formula Review and with your plans for the Report's publication. In particular, I agree with the need to stress that acceptance of the Report's recommendations in no way prejudices the outcome of the wider Review of the NHS.

I would be grateful if you would ensure that my officials are consulted on the details of the announcement that is to accompany publication.

Copies of this letter go to the Prime Minister, Peter Walker, Tom King, Malcolm Rifkind and to Sir Robin Butler.

004/3294

CONFIDENTIAL

Chancellor
Mr Anson
Mr H Phillips
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Sussex
Mr Parsonage
Mr Griffiths
Mr Call

Treasury Chambers. Parliament Street. SW1P 3AG

The Rt Hon John Moore MP
Secretary of State for Social Services
Department of Health and Social Security
Richmond House
79 Whitehall
London
SW1A 2NS

17th May 1988

Dear Secretary of State,

REVIEW OF THE RAWP FORMULA

Thank you for copying me your minute to the Prime Minister of 10 May. I am content with the recommendations of the Final Report of the RAWP Formula Review and with your plans for the Report's publication. In particular, I agree with the need to stress that acceptance of the Report's recommendations in no way prejudices the outcome of the wider Review of the NHS.

I would be grateful if you would ensure that my officials are consulted on the details of the announcement that is to accompany publication.

I am copying this letter to the Prime Minister, Peter Walker, Tom King, Malcolm Rifkind and to Sir Robin Butler.

Yours sincerely

JOHN MAJOR

FP

(Approved by the Chief Secretary and signed in his absence)

mjd 3/14lm

SECRET

FROM: MISS M P WALLACE
DATE: 12 May 1988

MR PHILLIPS

cc Chief Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Miss Peirson
Mr Turnbull
Mr Gieve
Mr Parsonage
Mr Saunders
Mr Call

NHS REVIEW

The Chancellor has asked us to fix a meeting next week, quite separate from our regular briefing sessions, to take stock generally of the progress of the review so far, and what our next steps should be.

2. Specifically, the Chancellor thinks it would now be useful to discuss the various elements which we think might feature in an Autumn package, and decide which we need to do more work on within the Treasury. I should be grateful if you could provide a check list of possible runners, as a basis for discussion.

3. This office will in touch to confirm the timing of the meeting.

MOIRA WALLACE

THE INDEPENDENT

NHS officials back private borrowing

By Nicholas Timmins
Health Services Correspondent

THE National Health Service would take advantage of changes in Treasury rules which allowed private money to finance public building and developments, NHS finance officials said yesterday.

Ministers are preparing to challenge the Treasury's strict rules on public sector borrowing, with a possible new £1bn British Rail link to the Channel Tunnel seen as a possible test case.

David Poynton, chairman of the NHS Finance Officers' Association, said: "There are many, many health authorities who, but for lack of capital, could release significant amounts of money to be spent on patient care.

"There are plenty of schemes where if we had private capital available we could replace old and out-dated buildings and facilities and where the revenue saved would quickly pay back the borrowing and then be available to expand services."

Such borrowing is normally ruled out by the Treasury on the grounds that it is regarded as public borrowing if the Treasury is in any way underwriting the risk in the project. Peter Le Fleming, general manager of the South East Thames region, said: "Health ministers appear very sympathetic to the idea that we should be able to borrow, or get private developers to put money up front, and we have now been asked to work up one or two schemes in detail."

There are signs that the Treasury rules on borrowing are being relaxed on a small scale.

At North West Thames region's hospitals in Ashford, Middlesex and Welwyn Garden City, an energy company, Emstar, is putting up the capital to replace boilers and control equipment which will produce savings to be split between the company and the NHS. The region said there were many other schemes which would pay back borrowed capital and save revenue if private capital could be used to get them off the ground.

The Guardian

Promoters of NHS lottery still await clearance for £200,000 draw

David Brindle
Social Services Correspondent

THE privately-promoted National Health Service lottery, launched with much fanfare last month and endorsed by the Prime Minister, has not been given clearance to go ahead as the organisers claimed.

The London Borough of Kensington and Chelsea, which was said to have registered the scheme as 100 separate local lotteries to sidestep a legal limit on prize money, said yesterday the plans were not due to be considered until May 24 — the eve of the first televised lottery draw.

The authority said: "Our legal department has to ask certain questions which they have not got the answers to."

About four million lottery coupons have already been distributed and people are entering the competition. But the organisers admitted last night that the scheme was not registered, as required by law, even though the coupons say it has been registered with Kensington.

The Gaming Board, which has a statutory responsibility to oversee bigger lotteries, would not comment on any possible offence but said it remained "very concerned" about the scheme.

The Home Office said: "The application for registration was incomplete and needed further information."

The lottery is offering a maximum weekly prize of £200,000. Of total stake money, 50 per cent is earmarked for prizes, 35 per cent for distribution among health authorities and 15 per cent for overheads, including a profit margin put at about 3 per cent.

Mr Roger Cummins, who devised the lottery and founded Loto, the company set up to run it, said Kensington and Chelsea had no choice but to register the 100 competitions.

He said the authority, under pressure from "vested interests", was exceeding its powers by seeking to establish the status and constitution of Loto and of the National Hospital Trust, the group set up to allocate money to the NHS.

Daily Telegraph

NHS lottery: not the ticket

NHS LOTTERY coupons now fluttering through the letterboxes of five million British "sample" households are being greeted with considerable despair. It would seem that the crucial test of goodwill towards a national lottery to supplement the taxpayers' contribution to the health service is being poorly presented.

As anyone who has opened one of the gaudy leaflets will have discovered, entering this numbers game, which is supposed to have mass appeal, is not simple.

"To win the maximum amount you must stake 100 x 1p on each frame," say the instructions. How to stake a lesser amount is not mentioned. A maze of rules and instructions follow.

Having spent 30 minutes trying to work out how to enter, I sent my own ticket to the Michael Peters company, specialists in the presentation of often complex information, such as company reports.

"It's a disaster, the most dreadful piece of design I have ever seen," was the professional opinion of Glenn Tutssel, its creative director. "The presentation of this leaflet makes it virtually impossible to see what they are trying to communicate. I know that these things need to be produced cheaply but that is no reason for them to be produced badly."

As Tutssel puts it: "I regard myself as reasonably intelligent but I just can't understand it. This is the kind of thing that goes straight into my dustbin. The audience that this is going out to is, quite honestly, going to be lost."

Roger Cummins, the lottery specialist behind the scheme, told me yesterday: "Lottery games are always regarded at the outset as being incredibly complicated. I am afraid that it's a universal malady. You measure your success by the number of bets that have been sent in that work. In France the failure rate is about 15 per cent whereas in our tests it was only one per cent. We are quietly confident."

FINANCIAL TIMES

Unions back tax-funded basis for health care

BY ALAN PIKE, SOCIAL AFFAIRS CORRESPONDENT

STRONG support for retaining the tax-funded basis of financing the National Health Service was given by unions in evidence to the Commons Social Services Committee yesterday.

Mr Rodney Bickerstaffe, general secretary of the National Union of Public Employees, said [illegible] through general taxation [illegible] per to collect than other [illegible]s, equitable, ensured [illegible]ent regardless of ability to pay [illegible] was shown in opinion polls to enjoy public support.

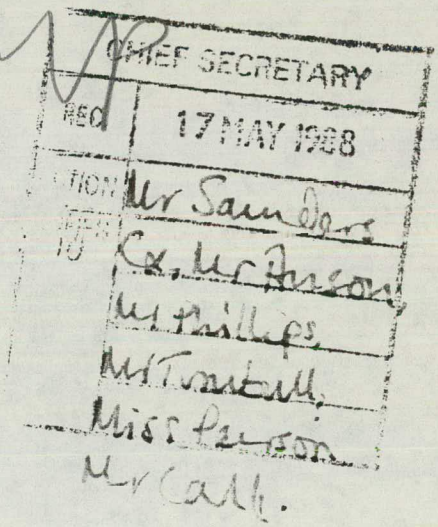
"Other countries have been reducing the relative size of private health insurance because of spiralling costs and because it is seen to be relatively inefficient compared with our system."

Nupe told the committee that the most serious and immediate problem of the NHS was long-term chronic under-funding. Radical changes were needed to adapt the service to future health demands but the immediate priority was more money.

This view was supported by the Royal College of Nursing, which said the evidence for chronic under-funding was clear. The college described a statement by Mr John Moore, Social Services Secretary, to a previous meeting of the committee that alleged funding shortfalls failed to take account of increases in productivity as "difficult to reconcile with reality."

CONFIDENTIAL

PRIME MINISTER



I have read John Moore's minute on his plans for publishing the Review of the Resource Allocation Working Party formula.

We have similar arrangements for allocating resources to health authorities in Wales using a formula which in many respects is similar to that used in England. I have asked the Welsh Resource Allocation Working Group to look at a number of aspects of the operation of the formula and it would be very helpful if the findings of the RAWP review could be made public so as to help them in their work. Like John I take the view that publication need not prejudice the outcome of the wider review and I therefore support him in his suggestion that the RAWP report be published as soon as practicable.

A copy of this minute goes to John Moore, Tom King, Malcolm Rifkind, John Major and to Sir Robin Butler.

13 May 1988

P W

13.5.3

CONFIDENTIAL

FROM: R B SAUNDERS
DATE: 13 May 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir Peter Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Satchwell
Mr Tyric
Mr Call
Mr Kuczys - IR

THE POTENTIAL ROLE OF PRIVATE HEALTH INSURANCE

You probably saw the press reports earlier this week about this paper which has been prepared for the Institute of Health Services Management by Mr George Orros, a consulting actuary, as part of their own study into health service organisation and funding. We have now got hold of a copy.

2. The main message of the report is the rather obvious one that, even if the private sector made quite dramatic inroads into cold surgery and acute care for those of working age, the overall impact would be limited, given the proportion of resources devoted to the elderly and other long term care. Much of the press comment, however, focussed on the detailed working underlying this, and in particular his conclusion that the present 14% proportion of total health expenditure financed by the private sector is unlikely to increase much beyond about 20%. I attach a short note about these results. As you will see, his figures are in reality illustrative rather than exact, and so offer little if any help in evaluating different policy options.

3. Having read the report in full, however, I think the most interesting bit is not his computer model, but the background section on the present state of the private health insurance market in the UK. I attach a copy and you may like to skim it. It provokes several thoughts about how more private health insurance might be encouraged, without running into the sort of problems we found in looking at schemes for contracting out.

SAUNDERS POTENTIAL ROLE OF PRIVATE HEALTH INSURANCE 3/5

a. Very few of the elderly have health insurance (paragraph 12). As we thought, therefore, these would be the most obvious group on which to target the tax relief. But its impact would be muted unless the insurance companies started offering insurance packages tailored for the elderly at a lower cost than they do now.

b. Employer paid insurance is another obvious area for expansion. Personally, I think the case for tax relief is less clear cut here; the sector is growing fast and will continue to do so. Employer-paid health care does not have to be through an insurance intermediary, as the report points out, but it is a bit unfair on page 15 to say that this is "currently being obstructed by the Inland Revenue". The position is that, so long as a scheme is set up correctly, prohibitive tax charges on employees who need expensive treatment can be avoided. But clearly we need to do more to get this message across.

c. The high esteem in which the NHS is held generally means that there is consumer resistance to the idea of private health insurance. If this is so, then it suggests we should be seeking to encourage a more symbiotic relationship between the public and private sectors, with an increasing emphasis on pay and amenity beds as a means of income generation, and a greater readiness for health authorities to buy services from the private sector.

d. As pages 18 and 21 indicate, there are already products in place which could provide insurance against new and higher NHS charges. But we need first to get over the objections of the Prime Minister and DHSS Ministers to the principle of charging.

e. Generally, as page 23 indicates, the private health insurance industry could do a lot to increase its coverage by the development of more imaginative products for all age groups, not just the elderly. We should take opportunities to encourage them.

R B SAUNDERS

POTENTIAL ROLE OF PRIVATE HEALTH INSURANCE: SUMMARY OF SIMULATION RESULTS

Mr Orros postulates 4 alternative scenarios

Base - no change; private hospitals account for 4% of in-patient days (10% in 30-49 age group)

A - retain NHS in present form, encourage private sector by exhortation and expanded use of pay beds. He assumes this will lead to 4% of acute treatment currently given by NHS (14% of cold surgery) switching to private sector

B - hypothecated health contributions with contracting out (rebate equivalent to 10% of full contribution). He assumes 10% of NHS acute treatment (30% of cold surgery, 50% for those of working age) switches across as a result. The private acute sector more than doubles in size.

C - Public sector health management units, with encouragement for insurance topping-up. He assumes 14% of NHS acute treatment (40% of cold surgery, 60% for those of working age) goes private.

He takes no account of deadweight Exchequer costs in Scenario B and offers no justification for what looks a very high elasticity of demand. Nor does he offer a convincing explanation of why there should be such a dramatic increase in private treatment under Scenario C with no financial incentive. The results can be summarised as follows (including an allowance for deadweight cost in Scenario B):

	% of GDP spent on health care		
	Public	Private	Total
Base	5.2	0.7	5.9
A	5.2	0.8	6.0
B	5.3	0.9	6.2
C	5.2	1.1	6.3

Although the postulated effect on the private acute sector (particularly cold surgery for those of working age) is quite large, it is much less significant in the context of health expenditure in total. This is because the majority of existing private expenditure is on over-the-counter drugs and non-acute care, and because the assumed effects on the elderly are somewhat limited.

Section 2

PRIVATE HEALTH INSURANCE IN 1988

2.1 OVERVIEW

Private health insurance is a broad concept, encompassing a wide range of insurance products associated with private healthcare provision, including:

- Medical expenses insurance

  Indemnity coverage (ie reimbursement of costs incurred) for 'private' hospital accommodation and for 'private' medical and surgical treatment. By 'private' we mean any situation in which the patient pays for the cost of the healthcare provision.

- Hospital cash insurance

  A cash contingency benefit which is payable in the event of an overnight stay in a public or private hospital. The cash benefit is payable on the contingency of an overnight hospital stay and is not an indemnity payment or a reimbursement of any expenses. There are two types of hospital cash insurance:

  -- NHS Hospital Cash, which is payable only for a NHS public bed.

  -- Hospital Cash, which is payable for any public or private hospital bed.

- Health cash insurance

  A cash contingency benefit which is payable in the event of a health related contingency, but is not hospital cash insurance. Health cash insurance includes:

  -- Pregnancy Cash Benefits, which are payable in the event of a pregnancy lasting 28 weeks or more.

  -- Maternity Cash Benefits, which are payable in the event of childbirth.

  -- Cancer Cash Benefits, which are payable in the event of diagnosis of specific malignant tumours.

  -- Recuperation Grants, which are payable following an in-patient hospital stay of a specified minimum duration.

  -- Chronic, Mental or Geriatric Care Grants. These are lump sums which are payable when an eligible patient is admitted to an approved hospital or registered nursing home for an in-patient stay of a specified minimum duration.

In practice, there is a spectrum of private health insurance products, ranging from products which emphasise private treatment in luxury private hospitals to products which provide only small daily cash benefits in the event of an in-patient hospital stay of a specified minimum duration.

In addition to the private health insurance market, there is a large and growing private uninsured healthcare market, including non-acute care, abortions and cosmetic surgery. It is estimated that private health insurance accounts for only 50% of total private healthcare treatment expenditures, the remainder being made up by uninsured private healthcare treatment. Although uninsured private healthcare treatment is clearly a significant expenditure item, it is outside the scope of this Report, the focus of which is the potential role for private health insurance to increase private healthcare provision.

2.2 MEDICAL EXPENSES INSURANCE

2.2.1 PROVIDENT ASSOCIATIONS

The medical expenses provident associations have existed alongside the NHS ever since its inception in 1948. In fact most of the existing provident associations pre-date the formation of the NHS.

The provident associations evolved during the 1920s and 1930s to provide insurance against the costs of hospital treatment. The provident associations were formed on a regional basis and had strong links with the medical professions and with voluntary hospitals. Contributors to a provident association, or provident club, had a moral (if not legal) right to treatment in the voluntary hospitals associated with the provident association. At that time the hospital system consisted of voluntary hospitals run and administered by charitable bodies, and County Council and Municipal Hospitals under the administration of local authorities. Financing was partly through charity, rates and taxes, and partly through patients' fees and donations collected by the provident clubs and associations and the friendly societies. Private hospital treatment was available in nursing homes and in the pay bed wings of voluntary hospitals. Private facilities were financed through charges to patients, who would also be required to pay the bills of the specialists and surgeons who attended them.

With the formation of the NHS came a major rationalisation of the provident associations and clubs. A majority of the smaller provincial associations amalgamated to form an almost nationwide association; this association is now the major medical expenses insurer in the UK. Other provident associations continued on a regional, and later a national, basis. Nowadays there are several provident associations offering medical expenses insurance; however, only three of these are currently insuring more than 200,000 persons.

Medical expenses insurance (provident) in 1988 falls far short of providing insurance coverage for a comprehensive private healthcare delivery system. In certain areas the healthcare delivery system is somewhat complementary to, and dependent upon, the public facilities of the NHS. Private treatment commences with a referral from the insured's general practitioner (GP). To be reimbursable under an insurance plan, treatment must be given by or under the direction of a doctor who has attained NHS consultant status. Accident and emergency treatment is usually undertaken under the NHS. Private hospitals are often unable to match the facilities of the NHS for intensive care and other complex treatment. Medical expenses insurance, as currently offered, is a supplement to, rather than a replacement for, the NHS.

The restrictions on benefits eligibility are relatively severe, in comparison to other major European Community countries. In the UK, benefit eligibility is generally restricted to "treatment" which must be given or personally controlled on a day-to-day basis by a specialist. Treatment is defined as surgical or medical procedures the sole purpose of which is the cure or relief of acute illness or injury. Furthermore, the amounts payable are a reimbursement of charges incurred, to the extent that the charges are reasonable and incurred necessarily and exclusively for receiving the specialist treatment. The chargeable services must have been provided in the United Kingdom or, if the patient was temporarily overseas, confined to the immediate needs of a medical emergency arising incidentally to the main intended purpose of the overseas travel. In the event of claims for home nursing, the benefit is claimable only for the services of qualified nurses in the patient's own home immediately following in-patient treatment and when all such services are provided on the recommendation of the specialist who treated the patient and not otherwise. Home nursing benefits are payable only when all charges are reasonable and necessary, and are exclusively for exercising nursing skills of a nature of which only qualified nurses are capable.

Medical expenses insurance (provident) policies currently contain a wide range of benefit exclusions, typically:

- Medical conditions existing or foreseeable at the date of enrolment or the recurrence of past medical conditions, unless full particulars have been given in writing and upon enrolment such medical conditions have been accepted by the insurer for benefit.

- Accommodation or treatment received in health hydros, nature cure clinics or similar establishments or private beds registered as a nursing home attached to such establishments.

- Cosmetic treatment whether or not for psychological purposes.

- Pregnancy or childbirth.

- Any dental condition not involving an oral surgical operation. Routine dental treatment (though certain major dental operations would be covered).

- Treatment received outside the United Kingdom where the purpose of being abroad is wholly or in part to obtain such treatment.

- Charges for accommodation and nursing in any nursing home or a hospital which for any reason is, or has effectively become, the place of domicile of permanent abode.

- Expenditure arising from any consequence whether direct or indirect of nuclear or chemical contamination, war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, riot, civil disturbance, rebellion, revolution, insurrection or military or usurped power.

- Investigations and treatment of infertility.

- Alcoholism or conditions arising therefrom or associated therewith.

- Drug abuse or conditions arising therefrom or associated therewith.

- Regular or long term renal dialysis in chronic renal failure or end stage renal failure.

- Primary healthcare services.

- Private consultations or treatment from doctors who do not have NHS consultant status.

- Routine health checks.

- Out-patient drug .

- Cosmetic treatment.

- Home nursing not related to treatment by a specialist.

- Convalescence.

- Normal maternity.

- Appliances (spectacles, hearing aids, wheelchairs, etc).

- Treatment for AIDS related conditions which commences during the first five years of membership;
  or
  AIDS and AIDS-related conditions other than for the initial diagnosis and associated initial treatment. Claims as an in-patient must not exceed 42 days.

2.2.2 NON-PROVIDENT INSURANCE COMPANIES

The introduction of non-provident insurance companies into the medical expenses insurance market is a relatively recent phenomenon. With one notable exception, medical expenses insurance was solely the province of the provident associations until 1980. Since that time a number of general insurance companies have entered the market, attracted by the continued growth and the underwriting surpluses reported by the provident associations. Another major factor in the market has been the large increase in the number of private hospital beds available from commercial organisations which have entered the private healthcare provider market.

The number of non-provident medical expenses insurance companies has increased from one in 1980 and five in 1984 to eight in March 1988. In addition, there is a professional reinsurance market which is able and willing to accept underwriting risk from the medical expenses insurance market. Some of the recent market entrants have been major financial services institutions, who have adequate capital to finance rapid growth should the business opportunities arise.

The products offered by the non-provident medical expenses insurers are similar to those offered by the provident associations, but tend to be more innovative:

- Some offer no claims bonuses to individual policyholders, an innovation taken from private motor car insurance.

- Some offer non-smoker discounts, an innovation taken from life assurance policies.

- Some offer discounts for excesses (front-end deductibles), where the claimant pays up to a fixed monetary amount in respect of each claim, subject to an annual limit.

- Some offer discounts for co-insurance, where the claimant pays a percentage of each claim, subject to an annual limit.

- One insurer links co-insurance with utilisation of non-preferred hospitals, whereby there is a financial incentive to use the approved preferred hospitals.

- One insurer restricts benefit entitlement to specific diagnoses, such as breast and cervical cancer.

- One insurer offers primary care to specified ethnic groups, where these ethnic groups have traditionally found it difficult (perhaps for language reasons) to utilise fully normal NHS services.

- One insurer includes funeral expenses cover as part of a specialist medical expenses product package for the elderly.

It would be unfair to suggest that the provident associations have not offered product innovations. Similarly, it is hardly surprising that some of the recent market entrants have majored on product innovations in order to establish a clear identity and/or to gain market share.

2.2.3 MARKET SIZE

Around 11% of the UK population now have medical expenses insurance, representing over 6 million insured. The market penetration is not, however, uniform throughout the population:

- Professional and managerial occupations are heavily penetrated (over 25%) whereas the unskilled and the unemployed are not (under 5%). The relatively high insurance take up by professional and managerial occupations is associated with the predominance of company paid insurance.

- Recently retired people aged 65 to 74 have little insurance (around 6%), even though they have a high perceived need for private healthcare to supplement NHS services. This low level of insurance penetration is associated with the lack of desire by some insurance companies to offer recently retired people relevant private health insurance products at affordable prices.

- Long retired people age 75 or over have almost no private health insurance (under 3%) and have the greatest need for healthcare, but generally cannot afford the cost of current private health insurance products. Insurance penetration would increase significantly if the insurers were to offer relevant restricted benefit products at affordable prices.

- Insurance penetration is relatively high in the affluent South East and relatively low in the South West, Scotland, Wales and Northern Ireland, which may be associated with the high penetration of private hospitals and specialists in the South East.

- Company paid insurance is generally restricted to management and their dependants, rather than being made available to the entire workforce. An increasing number of companies have voluntary group insurance arrangements for employees and/or dependants not covered by company paid insurance.

- Individual insurance is generally significantly more expensive than company paid insurance and is thus less affordable and less popular. Some insurance companies offer restricted insurance benefits to individuals, in order to make the insurance product more affordable.

The market size at the end of 1987 for provident and non-provident medical expenses insurance is estimated to be as follows:

Number of policyholders	2.7 million
Number insured	6.1 million
Average premiums per policy	£280
Average premiums per person	£125
Insurance Premiums	£740 million
Insurance Claims	£615 million

The above estimates include all insurers whose primary focus is medical expenses, even though most such insurers also include limited hospital cash insurance and occasionally health cash insurance in their benefit schedules. Conversely, we have excluded the hospital contributory schemes, whose primary focus is hospital cash and health cash insurance, but which also include limited medical expenses indemnity coverage in their benefit schedules.

The focus of private health insurance is on the family unit, and the need for the head of household to ensure that the family unit will receive the acute healthcare treatment they need within a reasonable time period. Market research surveys often indicate that the buying decision was prompted by the need to protect the dependants, rather than to protect than the policyholder. Buyers often feel guilty about forsaking the NHS to purchase private health insurance, and alleviate their guilt feelings by emphasising the risk protection for their dependants. In the event that private health insurance products emerge which complement, collaborate and support the NHS, then it is likely that these guilt feelings will subside and a mass market will emerge.

The medical expenses insurance market is currently focused on voluntary group and company paid group insurance, rather than on individuals. Approximately 75% of the insurance business is group business of one form or another. This high market share for group insurance products is reinforced by the traditional elitist image of comprehensive private health insurance and the lack of relevant products for the individual purchase mass markets at affordable prices. As a result of the increasing affluence of individuals, the structural and financial difficulties of the NHS and the introduction of new market entrants with major distribution capabilities for individual insurance, it is likely that the individual private health insurance market will grow rapidly over the next few years.

An increasing number of employers are taking a view that they have a duty to look after the healthcare needs of all their employees, rather than just the senior management and their dependants. The private health insurers can facilitate this process by customising a complete healthcare package to meet employer healthcare requirements for all employees, rather than just trying to sell one product to the whole workforce. The product package could include non-insurance items, such as health screening, lifestyle counselling and an occupational health focus.

The large company paid group market is also likely to grow rapidly in uninsured private healthcare, due to the following reasons:

- The relatively recent introduction of fixed price surgery by private hospitals makes it easy for employers and employees to purchase acute healthcare as and when required in respect of pensioners or dependants who are excluded from the company paid private health insurance contract.

- The move towards profit sharing and self insurance by larger companies (ie with 500 or more insured employees) makes it cost effective to purchase insurance in respect of claim "catastrophes", rather than foreseeable routine claims. This claims catastrophe insurance is called specific and aggregate stop loss insurance, and a growing market is emerging for such insurance cover.

- The move towards self insurance by large companies is currently being obstructed by the Inland Revenue, who appear to wish to tax employees in self insured medical expenses insurance trusts in respect of their "insurance claims" rather than their "notional insurance premiums". The rationale for this approach appears to be that the benefit in kind cannot be an insurance premium (since the group is self insured) and so it must be the claims for reimbursed medical expenses. This negative attitude is holding back a rapid expansion in large self insured group insurance contracts and discourages large employers from extending membership eligibility to most (if not all) employees. In the event that the Inland Revenue modify their attitude accordingly, it is likely that rapid expansion will take place in uninsured private acute healthcare provision by large employers.

- The increasing interest in occupational health (encompassing health and safety issues, health screening, lifestyle counselling, healthy nutrition and exercise) by large employers will lead to an increased demand for privately funded healthcare provision. This will create business opportunities for both public and private healthcare provision.

2.3 HOSPITAL CASH INSURANCE

Hospital cash insurance is offered primarily by life, general and composite insurance companies, as either an ancillary benefit (eg to a life assurance policy) or as a stand-alone product. It is also offered by most hospital contributory funds and by the medical insurance provident associations. It is a relatively cheap product (around £5 per month) which pays cash benefits for each day in hospital.

Hospital cash insurance is offered by a large number of insurance companies which do not also offer medical expenses insurance. Typical product features include:

- Daily cash benefits after three days in hospital.
- Double benefits in the event of the claim being caused by an accident.
- Convalescence benefit of half the in-patient hospital cash benefit, for half the number of in-patient hospital days.
- Lump sum convalescence benefit, equal to half the total of the in-patient hospital cash benefits.
- Choice of three levels of daily hospital cash benefit.
- Reduced daily cash benefits after age 75.
- Double benefits if both husband and wife are in hospital at the same time.

Hospital cash benefits are included in the product packages offered by the "hospital contributory schemes" and the "hospital Saturday funds". The hospital cash benefits are payable at the appropriate nightly rate for continuous treatment as an in-patient in a public or private ward of a recognised hospital or registered nursing home for an acute illness or as a casualty admittance immediately following an accident.

Hospital cash benefits are also offered by most of the medical expenses insurers, as part of a medical expenses insurance package. A typical benefit would be a daily cash amount in respect of eligible in-patient treatment in a NHS public bed or amenity bed. The rationale here is that had the patient had private hospital accommodation then the insurance claims would have been substantially higher. Some medical expenses insurers also offer the option of additional hospital cash benefits, whereby the policyholder can opt for daily cash benefits in respect of each night in any public or private hospital bed for eligible treatment.

The market size at the end of 1987 for hospital cash insurance is estimated to be as follows:

Number of policyholders	0.9 million
Number insured	2.0 million
Average premiums per policy	£50
Average premiums per person	£22
Insurance Premiums	£45 million
Insurance Claims	£20 million

The above estimates include all insurance products whose primary focus is hospital cash, even though most such products also often include personal accident benefits and health cash insurance. The estimates exclude medical expenses insurers, the hospital contributory schemes and the "hospital Saturday funds".

The hospital cash insurance market is primarily an individual purchase market, with a focus on individuals buying risk protection for themselves and their families. As a result of the increasing affluence of the population, the perceived need for hospital cash insurance is at best static and probably reducing. This lack of interest is compounded by lengthy NHS waiting lists for hospital admission and the shortening length of stay once hospital admission has been secured. Insurance companies have responded to the situation by packaging hospital cash benefits with other products, such as personal accident insurance, sick pay insurance and life assurance, with mixed results.

In the event that Government decide to introduce hotel charges for in-patient hospital stays (eg patient contributions for bed linen, catering or nursing), then there would be resurgence of interest in hospital cash insurance. The insurance could then be positioned as a tangible benefit which is helping the Government increase the funding for healthcare. Much would depend, however, on the size of any hotel charges; if they are too low then it would not be worthwhile to insure against the risk of incurring such charges. The introduction of appropriate hotel charges will also encourage major composite insurance companies who have been offering hospital cash insurance for years to step up their marketing efforts.

2.4 HEALTH CASH INSURANCE

Health cash insurance is offered primarily by the hospital contributory schemes and hospital Saturday funds, which are now organised under the umbrella of the "British Health Care Association". A typical product package would include the following benefits:

- Hospital cash in respect of an acute in-patient stay at a recognised hospital or a registered nursing home.

- Hospital cash for up to 6 months in respect of an approved convalescent home.

- Recuperation grant, which is payable once an in-patient stay at a recognised hospital, registered nursing home or an approved convalescent home has lasted 14 nights.

- Maternity cash benefit, which is payable in respect of each child born (provided that the policy has been in force for 10 months or longer).

- Optical cash benefit, which is payable whenever a new prescription for spectacles or contact lenses is necessary.

- Dental benefit, which is payable for up to half the actual amount paid to the dentist, subject to an annual maximum.

- Consultation fee benefit, which is an indemnity payment in respect of a consultation with a NHS consultant for a pathological or radiological investigation, but not for treatment.

- Home help charges benefit, which is an indemnity payable in respect of local authority home help charges.

- Long term chronic or mental illness or geriatric care benefit, which a single lump sum cash benefit once the patient has been admitted to a recognised hospital or registered nursing home for continuous treatment of 14 nights or over.

Health cash insurance benefits are also offered by some of the medical expenses insurance companies (provident and non-provident) for some of their products. Typical health cash benefits would be:

- Maternity cash benefit, which is payable in respect of each child born (provided that the policy has been in force for 10 months or longer).

- Optical cash benefit, which is payable whenever a new prescription for spectacles or contact lenses is necessary.

The market size at the end of 1987 for health cash insurance is estimated to be as follows:

Number of policyholders	2.8 million
Number insured	6.2 million
Average premiums per policy	£25
Average premiums per person	£11
Insurance Premiums	£70 million
Insurance Claims	£50 million

The above estimates include all insurance products whose primary focus is health cash benefits. The estimates were based on the hospital contributory schemes and the hospital Saturday funds. These provident organisations were members of the British Hospitals Contributory Schemes Association (1948), which has recently changed its name to the British Health Care Association.

Health cash insurance, as offered by members of the British Health Care Association, is sold primarily on a voluntary basis to large employers with trade union representation. It does not position itself as paying for private healthcare treatment. Instead, it helps "ordinary working people" to cope financially when they or their families are ill and need to use NHS services. Health cash insurance is also available to individuals and families, but they form the minority of purchasers. The majority of subscribers pay via payroll deduction as part of a voluntary group arrangement set up by their employer and/or trade union representative.

In the event that Government decides to introduce hotel charges for in-patient hospital stays, or to increase the charges for primary healthcare services, there would be a resurgence of interest in health cash insurance. The recent Health and Medicines Bill might stimulate demand for the purchase of health cash insurance.

2.5 PRIVATE HEALTH INSURANCE

The total market size of the private health insurance industry at the end of 1987 is estimated to be as follows:

	Medical Expenses	Hospital Cash	Health Cash	Private Health
Number of policies (million)	2.7	0.9	2.8	6.4
Number insured (million)	6.1	2.0	6.2	14.3
Average premiums per policy (£)	280	50	25	134
Average premiums per person (£)	125	22	11	60
Insurance Premiums (£ million)	740	45	70	855
Insurance Claims (£ million)	615	20	50	685

The private health insurance industry is dominated by medical expenses insurance, which is the fastest growing component and is still a specialist industry, with fewer market players than for hospital cash or health cash insurance. In the past, this specialism may have been justified by the dominating influence of the NHS and the political sensitivities surrounding medical expenses insurance. Nowadays, however, there is a growing realisation that the NHS cannot meet all the healthcare delivery expectations of the population, and that there is an increasing role for private healthcare.

There is a broad spectrum of organisations offering private health insurance. They range from the local non-profit mutual hospital contributory schemes, whose boards of governors and some of their officials generally carry out their duties on a voluntary basis, to major financial services institutions, whose directors are charged by their shareholders to provide a commercial return on their investment. There appears to be an inevitable shift away from the local non-profit mutual organisations, towards the national or multi-national major financial services institutions offering high quality services on a competitive commercial basis.

The private health insurance industry in 1988 can be characterised as:

- An immature industry which has still to find its role in a mixed public/private healthcare delivery system.

- An evolving industry with a small number of major market players who appear to have been content to maintain the status quo.

- A narrow definition of contingencies under which private health insurance benefits are payable, the emphasis being on acute elective conditions requiring specialist intervention rather than chronic, long term, geriatric or primary healthcare.

- A focus on pay-as-you-go short term insurance rather than any long term pre-funding of healthcare insurance requirements, thereby making it difficult for the elderly to maintain their private health insurance cover.

- A growing interest from major financial services institutions to enter the private health insurance market, the feeling being that the market is becoming too large to ignore and is going to be much larger in the 1990s.

- An industry on the verge of moving from attempting to survive independently of the NHS to one which will actively complement the NHS and collaborate with the NHS.

Bf 2315

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

16 May 1988

I attach a copy of a letter the Prime Minister has received from Frank Field, MP.

I should be grateful for an urgent draft reply for the Prime Minister's signature to reach me by Tuesday 24 May.

Could you please co-ordinate your draft reply with Moira Wallace (H M Treasury), to whom I am copying this letter.

M. E. Addison

Mrs. Flora Goldhill,
Department of Health and Social Security

Mr Saunders

PS/CST
cc PS/Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Miss Wallis - NCU

Please note target date.

70b
34

funding by HS

TREASURY — MCU
18 MAY 1988
SX1
CC APS/CHX
PM
22898/88

The Frank Field letter mentioned at this morning's meeting. Apologies that it was misactioned.

mpw
1915

From Frank Field MP, Chairman, Social Services Committee

COMMITTEE OFFICE
HOUSE OF COMMONS
LONDON SW1A 0AA
01-219 (Direct Line)
01-219 3000 (Switchboard)

SOCIAL SERVICES COMMITTEE

Rt Hon Margaret Thatcher MP
The Prime Minister
10 Downing Street
London SW1

16 May 1988

Dear Prime Minister

We were interested to read in this morning's Times newspaper, extracts from two working papers apparently prepared for the Government's review of the NHS by DHSS and the Treasury, respectively. Since these papers appear to be in the public domain, I hope you will feel able to let the Social Services Committee have copies. We have, as you will know, taken a great deal of evidence from organisations and individuals inside and outside the NHS in the course of our inquiry into the long-term development and funding of health services. Before we complete our report, it would, I believe, be sensible for the Committee to be able to study the Government's contribution to the debate.

Yours

Frank Field

BF 2015

(FF)

THE TIMES

State vouchers call to offer patients full private cover

By Jill Sherman, Social Services Correspondent

People should be able to opt out of the health service and buy private insurance with a state-funded voucher, a report published today says.

"Everyone, rich or poor, could become a private patient", the report, from the Institute of Economic Affairs, says.

Those dissatisfied with the health service should be given age-weighted vouchers representing the tax they had paid towards the service. In return they would have to give up any claim to free health service and take out insurance to cover private provision, including emergency services.

People opting out would not exchange their voucher directly with a private health insurer but would give the credit to a "health purchase union", which would be responsible for negotiating competitive deals with insurance companies.

The Government would continue to fund services for the poor to an acceptable standard, Dr David Green, director of the institute's health unit, the report's author, says.

Dr Green argues that the Government should not attempt both to finance and produce health care services. "Instead it should finance health care for those in need to ensure that everyone has the power to buy health insurance cover, but it should not attempt to pay for all health-care services from taxation."

The opting out proposal is also supported in a report from the Conservative think tank, the Centre for Policy Studies, by Mr John Redwood, Conservative MP, published yesterday. Mr Redwood suggests earmarking over 50 per cent of income tax into a national health tax.

Individuals and companies could be offered rebates if they were prepared to contract out all or part of their risks to a private insurance scheme. "The rebate could be varied according to age and the degree of cover which the person wished to keep with the NHS".

However, individuals would not be given a 100 per cent rebate as they would still have to pay a substantial contribution to help pay for those on lower incomes and the elderly.

The report predicts that if 3 or 4 per cent rebate was given, 20 million people might contract out of the state scheme, boosting private health care finance as a proportion of GDP from 0.6 per cent to 2.5 per cent.

Mr Redwood has extracted key figures from the Department of Health and Social Security's computerized performance indicators to illustrate the variation in costs and efficiency among the 191 health districts.

While Bloomsbury in central London, for example, employs 763 senior doctors in general medicine to treat 100,000 patients Gloucester health authority only needs to employ 71 doctors for this workload.

However, while ministers claim that the variance means that some authorities are more efficient than others self-service managers point out that the differences can be explained by other factors.

Teaching hospitals in London are bound to have higher costs and more staff than district general hospitals in the rest of the country as they train a high proportion of doctors with the latest technology.

Demographic profile and deprivation also have to be taken into account. A health authority with an elderly working class population will spend more per patient than a district with a young middle class population.

Mr Redwood supports an expanded partnership between the health service and the private sector and says that operations should be carried out where they can best be performed. He favours an internal market where hospitals can buy and sell operations to each other.

Everyone a Private Patient: An Analysis of the Structural Flaws in the NHS and how they could be Remedied (Institute of Economic Affairs, 2 Lord North Street, London SW1P 3LB; £7.50, 50p post and packing).
In Sickness and in Health: Managing Change in the NHS (Centre for Policy Studies, 8 Wilfred Street, London SW1E 6PL; £4.60, including post and packing).

Cost of treating the average in-patient

	£
Scarborough	456
Chester	494
SE Staffordshire	514
Worcester	542
Scunthorpe	543
Huddersfield	545
S Bedfordshire	545
Bromsgrove/Redditch	546
Medway	550
Torbay	551
Cen Birmingham	1073
Tower Hamlets	1078
West Lambeth	1098
Riverside	1102
N Manchester	1107
Dartford/Gravesham	1117
Lewisham/N Sthwark	1126
Wandsworth	1128
Bloomsbury	1146
Paddington	1158
Hampstead	1304

Senior doctors needed to treat 100,000 in-patients

Gloucester	71
Frenchay	84
S Warwickshire	89
Eastbourne	103
Blackpool,Wyre	103
Mid Staffordshire	105
Tameside & Glossop	105
Rugby	105
Wigan	117
SE Kent	121
Riverside	181
Huntingdon	517
Hull	521
Aylesbury	529
Tower Hamlets	544
Wycombe	558
Harrow	591
Hampstead	608
Cambridge	667
Bloomsbury	763

10/2

THE TIMES Monday, May 16, 1988

Patients may be allowed to quit the NHS

Moore plans reforms to permit contracting out

By Nicholas Wood, Political Correspondent

Mr John Moore has recommended a massive shake-up of the NHS in a confidential policy paper discussed by the Prime Minister and senior ministerial colleagues last week.

The Secretary of State for Social Services wants two far-reaching and controversial changes to the existing system of health care funded by taxation and delivered by the state.

The first is an overhaul of the structure of the NHS in which the delivery of services and their purchase are separated. The 191 district general managers would become free-standing budget holders buying services from competing public and private hospitals, depending on cost and quality.

The right to contract out of the NHS is also recommended and in return for taking out private health insurance a taxpayer would make a lower contribution to the tax-funded service.

It is understood that Mr Moore's paper was broadly approved at the meeting chaired by Mrs Thatcher and attended by Mr Nigel Lawson, the Chancellor of the Exchequer, and other Treasury and health ministers.

People disatisfied with the National Health Service should be allowed to opt out and buy private health insurance, say two reports out today. They propose a new system in which those who wish could be repaid the proportion of income tax they have contributed towards the cost of the NHS.....Page 3

Crucially, a parallel paper from Mr Lawson dropped previous Treasury opposition to contracting out and accepted it in principle. The paper went on to discuss the various mechanisms by which it could be implemented.

More work has been commissioned from officials at the Department of Health and Social Security, the Treasury and the Downing Street policy unit on putting these ideas into practice.

The *ad hoc* working group, which also includes Mr Tony Newton, the Minister of Health, Mr John Major, the Chief Secretary to the Treasury, and Sir Roy Griffiths, deputy chief executive of the NHS management board is expected to meet again soon. It hopes to produce a White paper by the autumn at the latest in time for a formal announcement at the Conservative Party conference.

Last week's meeting was the third to discuss the progress of the health review and the first at which the beleaguered Social Services Secretary has declared his hand.

It suggests that in spite of his faltering public performances over the Government's record on the NHS and social security changes, behind the scenes he is making headway in tackling the biggest political problem of the Government's agenda.

His prospects of rebuilding his ministerial career will be helped by the fact that his ideas are closely in tune with those of the Prime Minister and her influential Downing Street policy advisers.

The Treasury paper is also being seen as highly significant because past attempts to give private health insurance a boost through tax relief on premiums have foundered on the rock of its unbending opposition.

The widespread introduction of health charges and the setting up of American-style health maintenance units are understood to have lost favour with ministers and are now not seen as serious contenders for the proposed package of reforms.

Mr Moore's paper does not detail the mechanism for opting out, but Mr Lawson's sets out three possibilities — the use of the existing National Insurance fund which already contributes 10 per cent of the £20 billion a year cost of the NHS, a revamped NHI fund in which all the taxes raised would be diverted to running the NHS and a voucher system.

Under all such schemes, those wishing to insure privately would pay less towards the state scheme, so avoiding the present situation where such people pay twice for health care.

The form of contracting out would be similar to that introduced for pensions, whereby people joining company schemes make a lower contribution to the state earnings-related scheme.

Mr Moore's paper says that the two changes should be introduced simultaneously.

It argues that contracting out is necessary to defuse the political problem of the Government being the sole paymaster of health care, and so leaving itself wide open to the inevitable charge in a time of rising demand but limited resources that the NHS is being starved of cash, and that ministers do not care about the well-being of the population.

Continued on page 24, col 2

Continued from page 1

Although the spotlight of media and political attention has recently passed to other issues, the Government has been assailed on all sides for failing to provide enough money for the NHS.

Ministers responded by pointing out that it was the paucity of cash spent in the private sector that largely explained why Britain's overall spending on health care was lower than in other comparable countries.

Contracting out is intended to make up this shortfall by helping people with the means to do so to seek treatment privately while not jeopardizing the standards of care available to the poor. Indeed, ministers believe that with the state safety net firmly in place everyone would benefit from more buoyant revenues coming into health care.

Under the structural reorganization advocated by Mr Moore, the NHS budget would be divided up between the 191 district general managers.

The new arrangements would greatly enhance their role, leaving them free to choose between a variety of health providers on medical and commercial grounds.

For instance, they would be free to buy all the hip relacement operations in a particular area from a private hospital rather than one in the NHS if the price and quality were right.

10/5

ps2/67M

SECRET

~~BF 18/5~~

FROM: MISS M P WALLACE
DATE: 16 May 1988

MR R B SAUNDERS

cc PS/Chief Secretary
PS/Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mr Culpin
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Satchwell
Mr Tyrie
Mr Call

Mr Kuczys - IR
PS/IR

THE POTENTIAL ROLE OF PRIVATE HEALTH INSURANCE

The Chancellor was most grateful for your minute of 13 May.

2. He notes your doubts about the case for tax relief for employer-paid insurance, but he has commented that he would far rather give this a boost (and so, it seems, would Sir Roy Griffiths) than go down the contracting-out (NICs) road.

3. The Chancellor would be grateful for an early note on the work that is being done for our next Review paper on benefit-in-kind exemption for employee schemes. He has noted (Section 2.2.3 of the Orros paper) that the great majority of company schemes are restricted to management and their dependants. He would be grateful if the note could consider the case for restricting a benefit-in-kind exemption to company schemes which cover all employees.

MOIRA WALLACE

CONFIDENTIAL

FROM: D P GRIFFITHS
DATE: 16 MAY 1988

16/5

1. MR SAUNDERS
2. CHIEF SECRETARY

cc Chancellor
Paymaster General
Mr Anson
Mr G H Phillips
Miss Peirson
Mr C Kelly
Mr Turnbull
Mr Gieve
Mr Gilhooly
Mr Call

ADDITIONAL PROVISION FOR THE NHS IN 1988/89: MEETING WITH MR NEWTON 17 MAY 1988

I attach a brief for this meeting.

D P GRIFFITHS

CONFIDENTIAL

MEETING WITH MR NEWTON TO DISCUSS IN-YEAR BID FOR ADDITIONAL RESOURCES FOR NHS

BRIEF

Tactics

Concentrate only on the question of planned service reductions, thereby limiting the size of the alleged resource gap. Then argue that service reductions can be avoided by reallocating money already in the system.

Line to Take

1. Problem relates to service reductions planned by health authorities. Do not accept that the other elements making up the £200m bid - maintenance shortfalls, income and expenditure deficit - have to be dealt with now. Scale of the problem is really therefore only some £50 million.

2.Too soon to say for certain if any money needed. But, on the face of it, by judicious redirection of existing resources, problem of planned service reductions can be overcome.

3. First, there is the £538m additional resources already provided for the HCHS (England) for the Review Body awards, particularly the nurses clinical grading review. Until disposition of this money clear, cannot say what position will be in 1988/89. Health authorities have considerable discretion as to how the regrading is carried out. They should be encouraged to take a hard-nosed approach - as they no doubt already are.

4. Second, there is the money from Cost Improvement Programme savings, half of which has been provisionally allocated for costs of pay increases. Sensible pay settlements with the ancillary workers would leave some of this to maintain services. Surprised therefore to see you are considering proposing such a generous pay offer.

5. Third, I note that the amount of planned service reductions identified in the Management Board survey [ie £49m - see Background note] is more than matched by the planned discretionary service developments, mostly in the RAWP gaining regions. Should consider scope for redistributing this latter money to avoid service reductions, particularly in light of Review of RAWP formula which justifies slowing down the RAWP process. Do not consider it is too late in the financial year to make what is only a small change - ½% of the total.

Defensive

Not Just Service Reductions. Other Problems Must Be Dealt With Now

Cannot agree that any cuts in maintenance budgets need to be made good this year. Plenty of scope for savings in estate management which could be used for improved maintenance. Nor is an increase in creditors an issue which has to be tackled this year.

Service Reductions Will Be More Like £64m than £49m

Too early to be certain about the scale of any contingent service reductions. But additional funding for the Review Body awards will provide a cushion against service reductions if authorities get into difficulties with their cost improvement programmes.

Use of Review Body Award Money For Other Purposes Would Be Spotted

Precise cost of regrading exercise uncertain, nor is regrading process itself absolutely predictable. Review Body itself said that the actual cost of its recommendations might well differ from its estimates. Quite understandable if outturn is different from forecast. Authorities therefore have considerable latitude.

Fairly High Pay Increase For Ancillaries Inevitable

Should go for a tight settlement - 6½% too high when equivalent Civil Service grades likely to settle for 4½%.

Too Late To Redistribute Money Between Regions - Would Cause Outcry

Only looking at very small sums in comparison with size of overall budget - especially if the redistribution is part of a package of measures (use of Review Body award money etc). With the report of the review of RAWP formula just about to be published we are in a good position to justify some corrective action to slow down the RAWP process.

Background

1.The bid of £200 million is based on the results of a survey (by Mr I Mills of the NHS Management Board) of health authorities' plans for this financial year. DHSS believe that without the additional money there would be service cuts of around £64m (£49m of which have already been identified by authorities and a further £15m which the NHS Management Board believe authorities will have to undertake to remain within budget); an increase in the overall shortfall between revenue and expenditure of around £66m (ignoring surpluses of some £19m in some authorities which will be spent on maintenance) which will be funded by further delaying payments to creditors from an average of 45 days to an average of 52 days "close to responsible limits"; and cuts in maintenance budgets of £60m. DHSS also consider that the Thames regions need an extra £10m for their maintenance budgets "because they are considered to be at dangerously low levels".

2. DHSS have not made a case for emergency funding to deal with the forecast maintenance cutbacks and increasing creditors. Things may not be getting any easier for authorities in this respect but there is no call for immediate action - we can certainly afford to complete the NHS Review before examining the case for further funding.

3. The pressing issue is therefore the forecast service cuts which DHSS believe might start to take effect as early as July. More than half the planned service reductions are in the Thames regions. In contrast the survey of authorities plans has indicated that some discretionary service developments of £53.4m are planned mostly in the RAWP gaining regions.

4. DHSS argue that it is not possible to redistribute this money as the service developments form important and publicised parts of health authority plans, reflect local expectations and can involve legal commitments such as the advance hiring of staff or contractors. Cancellations at this stage would therefore be conspicuous and controversial. We consider that DHSS are over

stating these problems and that some at least of the service development money could be redeployed without too serious cosequences. The report on the review of the RAWP formula (whose import is that authorities are closer to the RAWP targets than previously thought) provides ample justification for a slowing down of the RAWP process.

5. The Review Body's costing of the nurses clinical grading review was only an approximate one and the uncertainty applies even more to the distribution of the pay award money among the health authorities. Individual authorities are very likely to get either more or less than they need this year to regrade the nurses. If they get more and are among the RAWP losing regions, this extra money could solve the problem of service cuts. But even if they get less, they still have the option of going slow on the regrading to give themselves room for manoeuvre. the authorities themselves have probably already realised this but there is room for some quiet reinforcement of this message by DHSS.

6. Some £75m of the forecast cost improvement programme savings have been earmarked for the cost of pay increases above those assumed and provided for in the Survey. With the full funding of the Review body awards the call on these funds is now limited essentially to the ancilliary grades. We will not get away with the low increases of previous years but the lower the rise the more of the £75m available to help maintain services.

ST2
16 May 1988