PO-CH/NL/0102

PART F

Part F.

SECRET

(Circulate under cover and notify REGISTRY of movement)

APPOINTMENTS IN CONFIDENCE

Begins: 3/6/88

Ends: ~~3/6/88~~ 14/6/88.

PO -CH /NL/0102

PART F

Chancellor's (Lawson) Papers:

THE NATIONAL HEALTH SERVICE REVIEW

Disposal Directions: 25 Years

9/8/95.

PO -CH /NL/0102

PART F

mjd 3/146m

SECRET

3/6/88.

Treasury Chambers, Parliament Street, SW1P 3AG
01-270 3000

PRIME MINISTER

NHS REVIEW: TAX RELIEF

As requested, I attach a paper, for discussion at our meeting on 7 June, on two possibilities:

- exemption from tax as a benefit in kind of premiums paid by employers under company schemes; and
- tax relief for private medical insurance premiums paid by the elderly.

The paper shows that any relief for employees in company schemes would be unlikely to prove cost effective; and it would lead to pressure, which in my view would be very hard to resist, to do something for other employees and the self-employed - not to mention tax incentives in other areas, for which there is considerable pressure.

More generally, these schemes tend to share the disadvantages of contracting out which I addressed in my minute of 22 April; helping those who can already afford private health insurance and at the end of the day failing to deliver a net increase in private sector provision.

My conclusion is therefore that, if we are to do anything in the way of encouraging private medical insurance through the tax system, it should be confined to the second option. While in general our tax policy is one of the lowest possible rates on the broadest possible base, tax relief for the elderly could be presented as a

well-targeted special case designed in particular to help people stay in insurance schemes at the point where at present they tend to be priced out.

I am copying this minute, and attachment, to John Moore, Tony Newton, Sir Robin Butler and Sir Roy Griffiths.

Moir Wallace

pp **[NL]**
3 June 1988

(Approved by the Chancellor and signed in his absence)

TAX RELIEF FOR PRIVATE MEDICAL INSURANCE

Note by the Chancellor of the Exchequer.

1. At the meeting on 9 May I agreed to provide a paper on two possibilities identified by the Group: tax exemption for employees on premiums paid by employers under company schemes; and tax relief on premiums paid for private medical insurance for the elderly.

Benefit-in-kind exemption

2. I have looked at the case for exempting from taxation, as a benefit-in-kind in the hands of the employee, premiums paid by employers under a company scheme.

3. Company schemes covering employees are already growing quite satisfactorily - in recent years the number of employees covered has been rising at about 3 per cent per year.

4. One factor is this growth in undoubtedly the fact that there is already a substantial fiscal incentive for employers to introduce such schemes. As compared with a corresponding amount of cash pay, the employer saves NIC - at 10.45 per cent - on the cost of the premium. And where the employee is below the Upper Earnings Limit, there is also a saving of his own contribution - up to 9 per cent.

5. This growth in employer schemes means that a tax exemption would have a considerable deadweight cost - some £80 million, and rising. And its effectiveness in expanding cover could be very speculative, since the incentive would be indirect - the employee's tax position would be improved, but not the position of the employer who has to pay the premium. It is most unlikely that the overall effect of a scheme of this kind would be other than a net reduction in private spending on health care once the cost of the tax relief is taken into account.

6. Moreover, while a benefits-in-kind exemption would build on the existing success of company schemes, it would be extremely difficult to justify limiting a tax relief in that way, because it would put employees lucky enough to have a company scheme at a (further) advantage compared with everyone else who paid for their own insurance - not merely other employees, but also the self-employed. And it could have wider repercussive effects, with pressure to exempt other "worthy" benefits in kind (such as workplace nurseries).

7. My conclusion is that this proposal is unlikely to be good value for money and it would be very difficult to defend the discrimination, which it necessarily implies, in favour of employees in the big company schemes and against other employees and the self-employed.

Tax Relief for the Elderly

8. These difficulties are not so evident with a relief for the elderly. The elderly are heavy users of health services. At the same time, they are less likely to be covered by private medical insurance than the population as a whole.

9. The reasons for the low coverage are:

- In the past, insurers have been reluctant to provide cover for new subscribers over 65. (However, BUPA have recently introduced a new scheme, albeit with fairly limited cover, for new subscribers up to 75).

- The price of insurance, even for existing subscribers, rises sharply from age 65 onwards.

And the restrictions in the cover tend to bite harder on the elderly than on others.

- Some of the major requirements of the elderly (eg for long-term care) are not at present insurable on any terms.

10. The combination of these factors means that the elderly represent a very heavy call on NHS resources. Many of those with private medical insurance drop out on reaching retirement. The question is whether tax relief on their private medical insurance premiums would provide a practical, cost-effective and politically sustainable method of retaining them within the private sector for at least some of their needs, or even of attracting new elderly subscribers.

11. On the practicalities, a tax relief scheme for the elderly could be operated by the Revenue on the lines of the MIRAS scheme for mortgage interest relief. That is, relief would be given to subscribers "at source", by reduction of the premium, with the Revenue reimbursing the insurance providers direct. The relief could best be targeted on those who find it difficult to afford medical insurance now, by making it available only at the basic rate of tax. And if the relief were to be made available on all qualifying policies where the person insured was over 60, regardless of who paid the premiums, people of working age might be encouraged to pay for their parents' insurance.

12. A number of detailed questions about exactly what policies would qualify for relief would need to be discussed by officials in the Inland Revenue and DHSS.

13. The cost-effectiveness of the relief would depend on the deadweight cost of giving relief to existing subscribers; and on the extent to which it encouraged existing subscribers to maintain their cover on reaching 60

(or attracted new subscribers, both under 60s and over 60s).

14. The deadweight cost of relief at basic rate only for the over-60's would be £25 million. The behavioural effect - the increase in the number of subscribers as a result of giving relief - is however very uncertain. If the increase was only marginal, then the extra money going into private health care would be less than the cost of tax relief. In that case, the relief would not represent a good buy. An increase of at least a third in the number of over-60s covered would be needed before we began to achieve "value for money" from the change.

15. While any view of the behavioural effect is necessarily uncertain, I believe there are some grounds for optimism, provided we do not take too short-term a view:

- As I have already noted, we need to take account of those currently under 60. Where they have cover now, they may be more inclined, with tax relief, to keep up their subscriptions after they retire. And those who do not have cover may be more inclined to start, if they feel that tax relief will mean they can afford to continue into old age.

- We are starting from a very low base. Since only 4 per cent of the over-60s have private medical insurance now, an increase of a third means only another 1.5 per cent of that age group.

- it is encouraging that BUPA have recently started offering cover, albeit restricted, for new joiners over 65; but for other schemes the maximum enrolment age is still normally 64 or less. If tax relief were given, DHSS should make clear to private insurers that it was now up to them to go out and get the business.

16. On the wider political implications, the introduction of this relief would, of course, be an exception to the general tax policy we have pursued - of reducing special reliefs for particular sorts of expenditure, and of cutting tax rates across the board, so as to leave people to make their own decisions about what they do with their money. If exceptions to this general rule are made, it is important that they can be tightly ring-fenced. A relief targeted on the elderly would be well understood and should not give rise to irresistible pressure for extension to other groups.

17. My conclusion, therefore, is that a scheme of tax relief for the over-60's - in contrast with a benefits-in-kind exemption - is practical, politically attractive and containable; and, while there is no guarantee that it will be cost-effective, there is some reason to be optimistic about the effect in the longer term.

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WHITEHALL LONDON SW1A 2ER
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01-270 0549 (Direct Line)

FROM THE PRIVATE SECRETARY
TO THE SECRETARY OF STATE
FOR WALES

MANAGEMENT IN CONFIDENCE

CT/5307/88

3 June 1988

Dear Geoffrey

THE SPECIAL HOSPITAL SERVICE

I am responding to your letter of 11 May to David Crawley about changes to the present management arrangements and the development of national policy for the special hospitals at Broadmoor, Moss Side, Park Lane and Rampton.

My Secretary of State welcomes the general thrust of these proposals as set out in the annex to your letter. It is important to ensure that these hospitals are far better integrated into the overall patterns of psychiatric provision and that the discipline of general management is introduced.

Since the special hospitals provide a service for people from Wales, it is obviously vital that the changes are made in a manner consistent with the development of psychiatric services in the Principality. Your Department has been informed of my Secretary of State's recent announcement for the go-ahead for two medium secure units in Wales and proposals for a further two. We also expect soon to appoint a medical and a nursing specialist who, in the context of our recently published strategic proposals for mental illness services in Wales, will advise the Secretary of State on operational policies for forensic psychiatry, including the inter-relationship between the medium secure units, main-stream service provision and the special hospitals in England.

Your Secretary of State's proposals come, therefore, at a very important juncture of service development in Wales and my Secretary of State asks that Welsh Office officials should be consulted fully about the details of the changes and, in particular, involved in the proposed development of national policy. The relevant contacts here are Mr S H Martin and Mr L Conway, respectively Head of and Grade 7 in our Health and Social Services Division 3.

/Copies ...

G Podger Esq
Private Secretary to
The Rt Hon John Moore MP

/ Copies of this letter to to private secretaries to the Secretary of State for Scotland, the Chancellor of the Exchequer, the Lord Chancellor, the Home Secretary and the Secretary of State for Northern Ireland.

Yours sincerely

John Shortridge

J D SHORTRIDGE

SECRET

Inland Revenue

Policy Division
Somerset House

FROM: C W CORLETT
FAX No. 6766
EXTN. 6614
3 June 1988

PRIVATE SECRETARY TO THE CHANCELLOR
(MISS WALLACE)

NHS REVIEW : TAX RELIEF

1. I attach the Chancellor's paper, revised in the light of the comments contained in your note of 2 June. Some further small amendments have been necessary as a result of switching the order of the options.

2. I also attach the draft cover note, again with a couple of consequential amendments.

C W CORLETT

---

cc PS/Chief Secretary
Paymaster General
Financial Secretary
Sir Peter Middleton
Mr Anson
Sir Terence Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Culpin
Mr Parsonage
Mr Saunders
Mr Call
Mr Battishill
Mr Isaac
Mr Beighton
Mr Kuczys
Mr Davenport
Mr Walker
PS/IR
Mr Corlett

Ch/ I have kept copy and shall get minute retyped for your signature post-Reagan, and I shall check that all drafting amendments taken on. Can I just check that you are content with new passage we asked for at x?

mpW 3/6.

Thanks. A few changes.

SECRET

DRAFT

DRAFT MINUTE FROM THE CHANCELLOR TO THE PRIME MINISTER

cc: Secretary of State for Social Services
Minister of State (Health)
Sir Robin Butler
Sir Roy Griffiths

NHS REVIEW: TAX RELIEF

As requested, I attach a paper, for discussion at our meeting on 7 June, on two possibilities:

- tax relief for private medical insurance premiums paid by the elderly; and
- exemption from tax as a benefit in kind of premiums paid by employers under company schemes.

The paper shows that any

My conclusion is that, if we are to do anything in the way of encouraging private medical insurance through the tax system, it should be confined to the second ~~first~~ option. While in general our tax policy is one of the lowest possible rates on the broadest possible base, tax relief for the elderly could be presented as a well-targeted special case designed in particular to help people stay in insurance schemes at the point where at present they tend to be priced out. Any relief for employees in company schemes would be unlikely to prove cost effective; and it would lead to pressure, which in my view would be very hard to resist, to do something for other employees and the self-employed - not to mention tax incentives in other areas, for which there is considerable pressure.

More generally, these schemes tend to share the disadvantages of contracting out which I addressed in my minute of 22 April; helping those who can already afford private health insurance and, at the end of the day, failing to deliver a net increase in private sector provision. ~~At least a tax relief confined to the elderly minimises these pitfalls.~~

I am copying this minute, and attachment, to John Moore, Tony Newton, Sir Robin Butler and Sir Roy Griffiths.

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FINANCIAL TIMES

Health care managers urge radical experiments within NHS

By John Gapper

HEALTH care managers yesterday called for "radical experiments" within the National Health Service, and said its efficiency might be increased if responsibility for providing care was removed from health authorities.

The proposal for experiments with "provider markets," under which authorities might act only as purchasers of services, and hospitals become independent institutions, is timed to coincide with the Government's review of the NHS.

The suggestion, made by a working party of the Institute of Health Service Management, is among the most fundamental proposals for NHS reform yet made by a group directly involved in the running of the service.

It envisaged the creation of a free market in health care in which authorities might buy and sell services and acquire the capacity to provide a quote for such contracts as the performance of 200 hip operations.

The working party's 80-page report on the future of the NHS was unveiled yesterday in Bournemouth at the annual conference of the institute, which represents 7,000 managers in the NHS and private health care.

Mr Tony Newton, health minister, told the conference that the Government would consider carefully the institute's proposals for reform, but he warned against expecting it would "turn the NHS on its head."

The report did not include a suggestion considered by the working party that NHS patients should be allowed to bypass queues by paying extra. The proposal caused some controversy when it was made public last month.

However, the report said the NHS should allow its patients to buy services like private rooms or better food. If this potential source of income was ignored, it would accelerate the development of a two-tier health system.

Mr Ken Jarrold, district general manager for Gloucester Health Authority, said at a press conference that Britons realised private health care was here to stay and they wanted more choice in the standard of care within the NHS.

The report said the principle of a comprehensive public service free to all at the point of delivery should be protected, and the extensive use of private health insurance was not suitable, because it would threaten this.

It called for NHS managers to be allowed flexibility to vary staff pay and conditions locally in order to recruit and retain staff more effectively. The role of pay review bodies and Whitley Councils should be reviewed, it said.

It recommended that the NHS management board be given direct responsibility for the running of the NHS, and its Civil Service support be separated from that given to the Secretary of State for Social Services.

THE GUARDIAN
Friday June 3 1988

NHS chiefs call for care à la carte

David Brindle
Social Services Correspondent

HEALTH service managers have suggested that hospitals should invite NHS patients to pay for a range of non-clinical "top-up" services such as single rooms, televisions and videos, *à la carte* meals, and even secretarial help.

The proposals, published yesterday by the Institute of Health Service Management, stress that it would be foolish to jettison the NHS's founding objectives of equality of access, equity, comprehensiveness and free service at the point of delivery. But IHSM leaders came close to admitting that they were giving a lower priority to the principle of equal treatment for all.

Mr Ken Jarrold, general manager of Gloucester health authority and one of the authors of the plans, which will be submitted to the Government's health service review, said that the NHS could no longer strive to be an island of equality in an otherwise unequal society.

"The health service has to be a reflection of the society it is in and the society it serves, and it is very, very clear that in this country equality has not been a guiding principle for a good many years," he said.

Ms Barbara Young, the outgoing president, said: "If we don't give people the opportunity to have some consumer choice they may well vote with their feet and go to support the private insurance market."

The institute has rejected a proposal for patients to be able to pay for quicker treatment. But its call for top-up services will be seen by some as a clear move towards two-tier care.

Its plans, which were presented to its conference in Bournemouth yesterday, also call for an expansion of facilities for private patients. The institute says that this need not be at the expense of NHS care, and could deal a telling blow to the private health insurers.

The proposals, drawn up by a working party which included external figures such as Mr David Willets, director of the rightwing Centre for Policy Studies, back continued funding of the NHS from general taxation, but say that further consideration should be given to a designated NHS tax or public health insurance. They also call for experiments with the internal market, under which health authorities would become purchasers of care from independent providers in the state, voluntary and private sectors.

Alternative Delivery and Funding of Health Services, IHSM, 75 Portland Place, London W1N 4AN, £4.95.

BACKGROUND PAPERS

TOPPING-UP CHARGES

ps2/19M

CONFIDENTIAL

FROM: MISS M P WALLACE
DATE: 3 June 1988

MR SAUNDERS

cc PS/Chief Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Call

TOPPING-UP CHARGES:
INSTITUTE OF HEALTH SERVICE MANAGEMENT PROPOSALS

The Chancellor has asked me to circulate the attached article from today's Guardian, which is relevant to our briefing meeting on Monday.

MOIRA WALLACE

FINANCIAL TIMES

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Alternative Delivery and Funding of Health Services, IHSM, 75 Portland Place, London W1N 4AN. £4.95.

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

SECRET

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1A

3 June 1988

Dear Paul,

NHS REVIEW

I attach a copy of my Secretary of State's Paper on 'A Mixed Economy of Care' for discussion at the NHS Review meeting on Tuesday 7 June.

I am copying this letter and the attachment to the Private Secretaries to the Chancellor and the Chief Secretary and to the Minister for Health, to Sir Roy Griffiths and to Professor Griffiths and Mr O'Sullivan in the No 10 Policy Unit.

Yours sincerely,

Geoffrey Podger

GEOFFREY PODGER
Private Secretary

SECRET

A MIXED ECONOMY OF HEALTH CARE

Note by Secretary of State for Social Services

My officials have prepared the attached paper which analyses the private sector involvement in health care and identifies areas for expansion and cooperation.

2. Two points emerge clearly from this paper.

first, we are still some distance away from our aim of a genuine mixed economy of health care, though progress has undoubtedly been made in recent years.

second, we were right in our earlier discussions to focus on fiscal incentives as a significant option in our wish to encourage growth in the private health sector.

3. I believe that the development of a more effective mixed economy will be an important part of our review proposals. But we will need to display proposals for action which will turn our policy aims into reality. I propose therefore that we now ask officials to prepare an action plan for:

* removing or at least reducing the obstacles to better cooperation that have been identified

* developing a better framework for effective trading between the private and public sector, including provision of better information about comparative costs

* encouraging the private sector to work together in developing and presenting the contribution they can make to better health care. Unlike the pension industry, health providers do not have a good record of working together in dealing with Government or the media.

4. We will be considering the role of fiscal incentives when we take the Chancellor's further paper. The clear impression the industry give at present is that they are not planning for a major expansion beyond their current areas of activity. My assessment is that without some fiscal stimulus this situation is unlikely to change.

5. It will be very desirable for fiscal incentives to apply to most sections of the community, either directly to individuals or through employers and not just the elderly. If we conclude that we should not change the present tax exemptions for company scheme benefits, I suggest we look again at the possibility of developing a system of contracting-out limited to cold elective surgery.

6. I invite colleagues to agree that

* officials be asked to prepare an action plan on the lines I have indicated (para 3)

* fiscal incentives will be an important part of our strategy for developing a more effective mixed economy of health care.

ENCOURAGING PRIVATE SECTOR INVOLVEMENT IN HEALTH CARE

Introduction

1. Paper HC4 compared the main characteristics of the private and public health sectors in the UK. While there are obvious differences in the nature of the businesses and in the relationships with consumers and staff, none of these need be a bar to further growth in private care or to greater co-operation between the two sectors. On the contrary, there is considerable scope for the private sector and the NHS to develop in ways that are complementary to each other. This paper suggests how this development can be encouraged.

Objectives

2. Present policy has two broad objectives:-

- to increase the total amount of health care available to the population by encouraging people to put more of their own money into it;

- to foster cost-effective co-operation between the health service and the private sector to enable more NHS patients to be treated.

3. On the first there has been considerable progress. The number of people covered by private insurance has increased substantially in the 1980s from 2.75 million in 1979 to 5.25 million in 1986. During the same period, the number of private sector hospital beds has increased by over 50 per cent, reaching over 10,000 beds in January 1988. (These are in private hospitals with operating theatre capacity and compare with 130,000 acute beds in the NHS). On the second objective there remains more scope for progress.

and has continued to grow!

Why growth has not been greater

4. There is a rational limit to the size of a private sector given a predominantly free state service - but there is no reason to believe that that ceiling has yet been reached. There are other barriers which have prevented further growth. These include:-

(a) Ideological Some health authority members and NHS staff (management and medical) object to the private sector on political or ideological

grounds. For these "care" and "profit" are often regarded as irreconcilable (but attitudes are changing as this week's report by the Institute of Health Service Management shows).

(b) Cultural After 40 years the NHS does not think beyond its own borders.

(c) Financial The public and NHS regard the private sector as (prohibitively) expensive. In part this results from the lack of comparative cost data.

(d) Commercial practice The private sector have been poor at marketing their services. There has been no united attempt to show NHS managers and the public what could be provided. When approached private hospitals tend to offer full cost individual treatment rather than volume contracts at marginal costs.

(e) Commercial judgement The private sector has consciously limited its insurance coverage to the soft end of the market - predominantly white collar workers covered for elective surgery.

(f) Medical profession The prime reason for high private sector charges is the element for the consultants' medical fee. Consultants operate a closed shop with nationally negotiated rates. All work is done by consultants many of whom would not perform the same operations in the NHS. This makes private practice very lucrative and attractive for consultants but severely limits the ability of the private sector to compete.

Progress is being made in overcoming most of these barriers. Yet there is still considerable scope for further development.

Scope for development

5. The private sector takes decisions on a commercial basis taking account of its perceptions of market opportunities. The Government can do more to stimulate the development of the market opportunity and then encourage and assist the

private sector to move into it. There is a role for fiscal incentives. The following paragraphs look at other action possible to overcome each of the barriers described above.

Co-operation between public and private sectors

6. Cultural habit and ideological animosity can be overcome by demonstrably effective co-operation. To date co-operation between the two sectors has been patchy. There are now signs that attitudes are beginning to change. The Health and Medicines Bill will, for the first time, allow health authorities to operate in a commercial framework. The waiting list initiative, emphasis on income generation and the present policy of fostering co-operation have borne fruit and led to a number of imaginative schemes. There is considerable scope for building on and expanding these initiatives, many of which lend themselves to the kind of contractual arrangement which underpinned the self-governing hospital model. Specific examples include:-

(i) NHS buying more treatments from the private sector The private sector has much spare capacity which ought to allow it to sell packages of treatment to the NHS at marginal rates. These projects could assist with waiting lists or form the basis of longer term contractual agreements following competitive tendering.

(ii) NHS selling clinical services to the private sector A number of NHS hospitals already generate income by selling support services - such as pathology and X-ray services - to private hospitals. This can be extended to include clinical services such as the provision of breast screening, infertility clinics, and physiotherapy services, particularly where existing NHS facilities are under utilised.

(iii) Expansion of NHS private sector facilities Currently there are some 3,000 pay beds in the NHS. The Health and Medicines Bill will allow for commercial charging. The competition could lead to pressure on the private sector to reduce costs to maintain market share.

(iv) Joint use of resources Expensive equipment or minor capital developments can be shared. Current examples include the installation of a Magnetic Resonance Image Scanner, joint ventures to build day surgery units

and a proposal by a private company to build a private hospital on NHS land adjacent to a new NHS hospital in return for a substantial contribution to capital costs.

(v) Private sector involvement in education and training The private sector could be encouraged to co-operate with the Royal Colleges to play a greater role in health service medical training in its acute hospitals. Similarly, the DHSS is already discussing with the private sector scope for increasing its contribution to nurse training.

(vi) Staffing interchange Greater exchange of staff between the NHS and the private sector, on a secondment basis, would allow the NHS to develop a greater sense of what the private sector can offer. It would also serve to educate the private sector about the needs and limitations of the NHS.

(vii) Private sector management of NHS hospitals One approach towards independent hospitals may be to introduce private sector management or managers on a pilot basis. The Group may want to return to this issue as part of a wider "programme of change".

Better marketing

7. The private sector has not been astute or united in selling its services to the NHS. It is diverse and needs to be encouraged to develop a more effective representative role. The perception remains that it is expensive. There is a lack of reliable data comparing costs between the two sectors. What data does exist tends to confirm the NHS view that the private sector is more expensive for comparable services (annex A). Yet there is scope for the private sector to make better use of its existing capacity.

8. The rapid growth of the private sector in the early 1980s was concentrated geographically in the south east and was highly dependent on the short term profit from overseas patients. There is still over capacity of some 3,500 beds which is only slowly being rationalised. The private sector will only grow in total size when existing capacity is better utilised. It should, however, enable the private sector to offer packages of treatment to the public sector at marginal costs. NHS waiting lists offer the opportunity of guaranteed volume at

times of otherwise low occupancy. The private sector can be encouraged to make more of this marketing opportunity, and the NHS to respond.

Expanding the market

9. The commercial judgement of the private sector about the scope for expanding the market has been notably cautious. The market can be expanded in two ways:-

- increasing the pool of people who would benefit from private care;

- expanding into new areas of care.

The private sector has tended to concentrate on the insured population, yet there is also opportunity to promote the cash purchase of care. There is more scope for including elderly and middle income groups through excess or limited coverage insurance schemes. While these are commercial judgements there are already signs of expansion. Closer co-operation with the public sector should help to break down the psychological barriers that deter some patients from using the private sector.

10. The rapid growth of the private health sector has been concentrated in two areas: elective acute surgery and nursing homes for the elderly. The latter reflects the private sector's response to the market created by the availability of social security board and lodging payments.

11. There is also scope for expansion into other major areas of hospital care including private sector psychiatric and mental handicap care. Few people will want to insure themselves against these but they could be developed further and marketed at competitive rates to health authorities. The scope for expansion of private primary care is probably more limited. There is little consumer pressure for an alternative to public sector general practice and the White Paper on Primary Care already includes proposals for making general practitioner services more consumer orientated.

The involvement of the medical profession

12. In many cases the customer for the private sector hospital is not the patient but the subscribing consultant who can often choose which private

hospital to use. This necessarily limits the scope for reductions in medical fees to enhance competitiveness. When looking further at the medical profession, the Group will want to consider the scope for reducing this restrictive practice and for increasing the potential supply of clinicians through action on consultant contracts.

Annex A

PUBLIC/PRIVATE SECTOR COST COMPARISONS

1. Comparisons of efficiency and unit costs between the two health care sectors need to take account of variations in unit costs; quality of hotel care; and accounting practices. There is also likely to be some discrepancy between private patient charges and the actual cost per case as overall cost recovery from insurers does not require precise allocation of costs to patients.

2. There is little objective research available. A controlled DHSS study (1982) of three common surgical procedures in six NHS hospitals and three private non-profit hospitals suggested that the average cost per case was considerably higher in private hospitals. This was mostly due to doctors' fees per case in the private sector (where most medical care is provided by consultants) being nearly four times higher than salary cost per case in the NHS. Excluding medical costs, the NHS was 10 per cent cheaper for two of the conditions, though differences in the quality of hotel services may account for this.

3. A recent BUPA survey (see table below) has confirmed this picture. It indicates faster growth in charge per case in independent hospitals than in cost per case in smaller NHS acute hospitals, due mainly to increased medical fees and salaries in the private sector. The charge per case in the private sector is shown to be considerably higher than cost per case in NHS hospitals, again due mainly to differences in medical costs.

4. The evidence suggests that the NHS is cheaper and has a better record of cost containment. However, this does not take account of variations in case mix: the NHS tends to treat older people and those with more complicated conditions. Nor does it reflect the absence from NHS costs of capital cost recovery. However, this would not invalidate the argument that the NHS is currently cheaper. In addition, it is not clear to what extent variations in charges in the private sector reflect variations in true costs as the latter are often "loaded" on to items which meet with least customer resistence so as to maximise income and circumvent insurers' measures to reduce costs.

5. An comparison of the costs of NHS and private sector provision of renal dialysis units also indicates that NHS costs are comparable or lower, taking account of capital costs and NHS support to some private units. The more activity within a given capacity, the lower the unit costs tend to be. A comparison of relative efficiency is complicated by the unknown profit element in the private sector. The NHS has so far been unable to match competitive deals offered by the private sector, but the evidence suggests that profits have been kept low to obtain NHS business and this is unlikely to be sustainable in the long-term. It is unlikely that the NHS can obtain substantial savings from greater private sector involvement.

6. A different picture emerges from a study of the costs of private nursing home care compared to NHS geriatric care. This suggests that good quality care costs as little as two thirds that of equivalent care in a NHS geriatric hospital. American research supports this finding.

Table: Cost comparison between the public and private sector

	Charge/case in independent acute hospitals*			Revenue cost/case in NHS acute hospitals (300 beds)		
	1980	1985	% change	1980/81	1985/86	% change
	£	£		£	£	
Medical fees and salaries	179	270	51	65	84	29
Other	357	690	93	551	643	17
Total	536	960	79	616	727	18

* Source: BUPA

SECRET 3/6/88 -

TAX RELIEF FOR PRIVATE MEDICAL INSURANCE: BACKGROUND BRIEF

BACK-GROUND BRIEF

A. RELIEF FOR CONTRIBUTIONS BY THE ELDERLY:

Factual

i. Income tax relief at the basic rate would be given to those aged 60 and above. Married couples' policies would qualify provided one partner was over 60.

ii. Operationally scheme would be:-

- special Inland Revenue unit (along lines of present MIRAS unit) dealing direct with insurance providers

- elderly to pay premiums for self and/or spouse net of tax relief whether or not they are taxpayers: normally no need for contact with Revenue

- premiums paid for elderly (eg by son/daughter) also to qualify for relief

- Need for Revenue or DHSS to check that policies offered by insurers acceptable.

iii. Numbers 500,000 - around 4 per cent of over 60s - currently covered by private medical insurance; but only 3 per cent over 65s covered.

iv. Small staff cost - about 10 units in Inland Revenue.

v. Exchequer cost £25 million for present level of provision (covering just over 4 per cent of over 60s). Includes about £1 million public expenditure subsidy to non-taxpayers. Cost would increase to £33 million if

further 1.5 per cent of over 60s subscribed (the point at which it begins to become cost-effective).

vi. Net benefit (ie Exchequer cost more than balanced by increase in insurance subscription) if number of over 60s covered rose from present level to 5.5 per cent or above.

vii. Timing. New relief could be introduced late 1989 (possibly) or early 1990, given announcement by March 1989. Allows:-

- legislation in 1989 Finance Bill, regulation shortly afterwards;
- time for insurance providers to set up arrangements for giving relief at source;
- time for setting up new Inland Revenue unit and procedures.

Positive

i. Both taxpayers and non-taxpayers to benefit from reduced premiums.

ii. Elderly readily identifiable and deserving target group, and heavy NHS users.

iii. Scheme simple to operate, and cost modest.

Defensive

i. Extend relief to others (eg non-aged)?

Elderly most under-provided with private medical insurance and group for whom insurance most expensive.

ii. Elderly cannot get medical insurance anyway?

New cover for over 65s not provided by all insurers (although they usually allow existing subscribers to continue beyond age 65). But BUPA subscribers recently started offering new cover to non-aged subscribers. Giving relief from age 60 will give elderly opportunity to join scheme before age 65 and continue afterwards. Relief may prompt insurers to promote new cover for elderly more widely.

iii. Compliance costs for insurance providers?

Giving relief for elderly will add to insurers' costs; but arrangements to be kept as simple as possible. Insurers to get significantly more business as result of relief, so no ground for complaint.

iv. Relief will encourage rise in premiums/medical fees rather than reduce pressure on NHS?

Some effect possible; but given that relief available only to limited target group, across-the-board effects of this nature unlikely to reduce effect on NHS significantly.

v. Modest Exchequer costs (much of which deadweight) indicates measure of little real help?

Measure to be seen as only part of larger package. Long-term cost depends on take-up.

vi. Surely not too expensive to extend relief to non-aged?

Exchequer cost of giving relief at basic rate for present level of insurance premiums paid by individuals £120 million. Any increase in demand would raise cost proportionately.

B. BENEFITS IN KIND

Factual

i. Basis of the present income tax charge: directors and employees whose earnings (including benefits and expenses) exceed £8,500 are liable to income tax on the benefit of medical insurance cover provided by an employer.

ii. NIC incentive for employer-provided cover because there is no specific exemption for medical insurance premiums - with few exceptions, all benefits in kind are exempt from NICs.

iii. Value of the present NIC exemption: the benefit to employers is about £30m; and for employees about £10m.

iv. By 1989-90 there should be about 1m employees covered by employer policies. Of these some 835,000 will be taxable. The rest are either below the P11D limit (110,000) or make contributions which reduce their liability to nil (55,000).

v. Present system "neutral" as between the employee who pays his own premium and the employee who is a member of a company scheme. A basic rate employee who pays a premium of £100 requires a gross income of £133 (tax £33) to give him the necessary net income. If an employer pays the £100 premium, and £100 less as cash pay, the employee will be in exactly the same position since he requires £33 gross pay (tax £8) to have the £25 to pay the tax on his benefit in kind of £100.

Defensive

i. Behavioural effects of benefits in kind exemption?

American evidence suggests that the immediate increase

in demand would be unlikely to outweigh the deadweight cost. In practice, the effect could be even more muted since the employee gets the tax reduction and the employer has to pay the premium. Thus the effect is likely to be longer term and indirect through pay negotiations.

ii. What about the position of employees aged 60 and over whose employer provides cover, if there is a relief for the elderly?

If a general relief for the elderly is introduced, there ought perhaps to be a corresponding exemption from the benefit in kind charge (at the basic rate) for employees aged 60 or over. (We have not had an opportunity to think through all the operational implications of this. It looks feasible, but messy. The cost would be about £5 million. The numbers would be much reduced if the age limit were pitched at 65 rather than 60).

iii. Benefits in kind charge discriminates against those receiving employer-provided cover?

No. Benefits-in-kind charge not a special tax on employer-provided medical cover, but simply ensures that the tax system applies fairly as between employee who receives part of his pay in benefits, and the employee or self-employed person who is paid in cash and buys his own insurance.

3.6.1

SECRET

FROM: R B SAUNDERS

DATE: 3 June 1988

CHANCELLOR

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

NHS REVIEW: MEETING ON 7 JUNE

There are two main papers on the agenda for this meeting. I understand that Mr Rifkind will also be attending, and so his minute to the Prime Minister of 26 May will no doubt also be discussed.

Tax relief

2. You already have briefing by the Inland Revenue on your paper.

3. We think Mr Moore may try to resurrect the idea of contracting out of National Insurance, probably in his covering note to the DHSS paper about encouraging the private sector (see below), although the subject may more naturally come up when your tax relief paper is discussed. We understand that he favours a package involving: greater hypothecation of national insurance contributions to the NHS, with an increase in the Treasury supplement to the National Insurance Fund so that tax and NI rates do not change (as in your paper); and an age-related rebate for those who contract out of elective surgery. The average rebate would be £40 a year, and would be between 23 and 30% of an undiscounted "budget BUPA" premium (the recently introduced cut-price scheme for elective surgery), according to age and circumstances.

4. This is not in fact all that different to the scheme described in your paper, and rejected at the meeting before last. The same objections apply:

- it will not succeed in getting more private money into health care; instead it will just be a way of putting in more public money;

- if more public money is to be made available, there are higher priorities for using it than this. Mr Moore has just sent in PES bids of £1.8bn next year. They do not include any subsidy to private medical insurance. Which bids would he propose to drop in order to make room for this?

- the scheme is likely to be seen as divisive.

A mixed economy of health care

5. Although I have not yet seen the final version of this DHSS paper, the early drafts suggest it is going to be a very feeble effort. The earlier drafts have simply bemoaned the lack of contribution by the private sector, discussed in very tentative terms the possible explanations of this, drawn attention to some recent encouraging developments (the increase in those covered by private health insurance and the emergence of joint public/private sector ventures). But no positive proposals are made for the future - other than encouraging the private health sector to form a trade association, and more secondment of staff between the NHS and the private sector. In his cover note, Mr Moore comes back yet again to fiscal incentives.

6. There is in fact a lot more that the Government could do.

a. It could launch a drive to extend contracting out and competitive tendering into clinical areas, as you suggested at the last meeting - and was agreed. This could cover both clinical support services (pathology, radiology, etc) and certain production-line operations, as has already been done with some of the money made available in the last Survey to

tackle waiting lists. Cost-effectiveness must remain the criterion, of course, but health authorities should be able to get some good deals for using marginal unused capacity in the private sector.

b. A similar drive could be launched for the NHS to sell services more actively to the private sector. Some of this is likely to form part of the income generation initiative. But greater impetus could be put behind it. It could include not only making sophisticated facilities available to ensure their full capacity is exploited (eg at week-ends) but also encouragement to increase the numbers of pay beds, particularly once the Health and Medicines Bill becomes law, allowing market-related fees to be charged, rather than simple cost recovery. Such new beds should of course be located in private wings rather than as part of NHS wards, which tends to be an unsatisfactory arrangement for all concerned.

c. What are DHSS doing to promote joint ventures, eg shared facilities financed jointly by the public and private sectors, rather than simply responding passively to proposals coming forward from health authorities?

d. Action could be taken to deal with the restrictive practices operated by the medical profession which inhibit competition in the provision of private health care - for example, the nationally-agreed standard fee scales, and the power which consultants exercise over which hospital to use. The medical profession enjoy at present a block exemption from the restrictive trade practices legislation. A DTI Green Paper in March proposed removing all such block exemptions which would then have to be justified afresh. This gives us a way in.

e. More part-time consultant posts might be introduced, on the lines suggested by Mr Studd.

7. In this way, a credible package for promoting closer co-operation between the public and private sectors might be devised. So far we have had only rhetoric from Mr Moore about the "sterile distinction" between the two. Unfortunately, DHSS do not appear to be able to think very constructively about this at the moment.

Mr Rifkind's paper

8. We thought that Mr Rifkind's note to the Prime Minister was, within the limits it set itself, a useful contribution. It sets out a number of specific ideas and initiatives which chime in well with many of the themes to have emerged so far in the Review: the idea that patients should be treated a bit more like customers; the need to get consultants to carry out clinical audit and take more responsibility for management decisions; and the suggestion that some internal market experiments might be started in the next financial year.

9. The structure of the Scottish Health Service is also in many ways more rational than in England - a single tier of 15 Health Boards combining the functions of districts and FPCs. (A similar point could be made about Wales, where the boundaries of the single tier of health authorities coincide with those of local authorities, making co-ordination in community care, etc very much easier.) You might ask the DHSS whether they feel that the health service in England has something to learn from the Scottish organisation.

10. Having said all that, however, some of Mr Rifkind's note needs to be taken with a pinch of salt, for example:

a. the passage about patients and their charter on the second page is a thinly-disguised expenditure bid.

b. The sentence on the third page "the programme of competitive tendering will continue that process and should be extended" is a bit rich given that the Scots have been dragging their feet on competitive tendering for some years and are only now being prodded into action.

R B SAUNDERS

st2.121

In short, it's very dear but DHSS are hopefully pointing in the right direction. There have been various academic studies over the years, but I gather they have been in general inconclusive.

RCMS 3/6

FROM: R C M SATCHWELL
DATE: 3 June 1988

1. MR SAUNDERS
2. CHANCELLOR

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

NHS REVIEW: PREVENTIVE MEDICINE

1. You asked (Miss Wallace's minute of 1 June) whether any analysis had been done on the cost-effectiveness of health promotion and health education.

2. The NAO published a report "NHS: Preventive Medicine" (attached for you only) in February 1986. Its main conclusion was that although some immunisation programmes had been successful in the past (eg diphtheria), it was difficult to assess the overall cost-effectiveness of DHSS' health service preventive programmes due to a lack of information about both their costs and benefits. The PAC took up this theme in their own report on preventive medicine published in July 1986 (again attached for you only). It recommended (para 25i) that:

> "Information on the costs and benefits of preventive programmes would aid the determination of priorities and resources for prevention. We suggest that DHSS should give greater commitment to evaluating the cost effectiveness of their preventive programmes, starting with those which are more capable of measurement".

3. In response to the PAC report, DHSS appointed Coopers and Lybrand as consultants to help them ascertain whether an operational research model could be devised which would enable the Department both to evaluate the cost-effectiveness of specific health prevention programmes and to weigh up the cost effectiveness of different programmes. The feasibility study has

been completed and was sufficiently promising that the developmental phase is now underway. DHSS have identified two programmes as being of particular merit for this kind of analysis: the prevention of smoking amongst teenagers and cervical cancer screening. Expert working groups are currently being set up to agree input weightings.

4. This is very much a long-term exercise. DHSS hope that eventually the model will be advanced enough to assist in the formulation of health policy at national level, and perhaps even help in service planning at regional level, so that regions can weigh up the benefits of prevention services versus treatment and better tailor those services to fit local needs. But they are a long way away from that at the moment.

pp R C M SATCHWELL

Saturday June 4 1988

prep health

FINANCIAL TIMES

Chancellor tells doctors to cut costs

BRITAIN'S doctors were last night challenged by Mr Nigel Lawson, Chancellor of the Exchequer, to become more cost-conscious and put the National Health Service's house in order.

He called on doctors in particular to "exercise restraint" in handling NHS resources.

Mr Lawson told the British Medical Association at Leicester Royal Infirmary that the health service had much to learn from the example of private medicine arguing it led to greater competition and efficiency.

Mr Lawson ruled out any immediate fundamental reforms, saying they would depend on the outcome of discussions on the current primary care White Paper. However, he launched an attack on the "sheer size" of the NHS and the way it was managed.

Mr Lawson said it was a "serious failing that management information systems are in general less than comprehensive.

"There needs to be detailed, up-to-the-minute and easily accessible information. Without that, it is difficult if not impossible to maximise efficiency while delivering an adequate service to the patient."

Pilot exercises in resource management, launched in five areas, were "generating considerable enthusiasm" and should be extended across the NHS.

The Chancellor called for more co-operation between health authorities and private medicine.

"An expanding private sector presents an opportunity, not a threat, to the NHS," he said.

"Those who go to the private sector directly relieve the burden of demand on the NHS. And the number with the potential to do so is growing.

"This growth is a welcome development. But I believe that even more could be achieved by the development of more imaginative health insurance products."

Mr Lawson said doctors had "crucial responsibility" to ensure resources were put to their best use.

The Guardian

Health pay accord 3

Health service negotiators have agreed to union demands for pay rises of £6.25 or 5 per cent — whichever is the greater — for more than 120,000 administrative and clerical workers.

The Guardian

Lawson counsels caution on radical changes for NHS

20

Christopher Huhne
Economics Editor

MR NIGEL Lawson, the Chancellor, yesterday gave warning that the Government should be cautious in its approach to the review of the National Health Service in a speech marking Treasury opposition to some of the more radical ideas for change.

Mr Lawson backed health service charges, not merely as a way of raising revenue but also to limit demands on the NHS. He also raised the possibility that clinical services could be contracted out to a growing private health sector.

The Chancellor appeared to stamp on one of the favourite ideas of free marketeers. Proposals for an "internal market" within the NHS, under which health authorities could buy and sell services from each other rather than provide them directly, were theoretically attractive, "but all experience has shown that we need to be cautious in approaching major organisational change in the public services".

In a speech at Leicester Royal Infirmary to the county division of the British Medical Association, dealing with a subject outside his departmental responsibility, Mr Lawson appeared to signal that he was not just the man who pushed interest rates up and down.

He welcomed the growth of private medicine, but said nothing about the desirability of tax relief on insurance payments, a change touted by the Social Services Secretary which the Treasury has long opposed. Mr Lawson put the ball back firmly in the court of the private medical sector, saying that even more could be achieved by development of more imaginative health insurance products.

The expanding private sector presented an opportunity, not a threat, to the NHS. Once the health service had a clearer idea of its costs, its managers should be able to develop competitive tendering, to consider whether contracting out some clinical services to the private sector would give better value.

Mr Lawson robustly defended health charges, citing Aneurin Bevan's complaint of the "cascades of medicine pouring down British throats". Since those days, he said, charges had been seen to play a useful part in "bringing home to the public the cost of health care and deterring unnecessary demands on the service".

THE INDEPENDENT

Lawson presses case for private health care

NIGEL LAWSON called last night for a greater private sector role in health care with more "contracting-out" of National Health Service clinical services and a wider range of private insurance schemes.

But the Chancellor warned that efforts to contain NHS costs could bear on medical decisions in future, as doctors balanced clinical freedom against the need to marshal cash resources.

Mr Lawson offered no hint of future Treasury incentives for private insurance, and said news of fundamental reforms would have to await completion of the Government's NHS review. But he strongly supported the growth of "imaginative" schemes to stimulate the market and cover such groups as the elderly.

2 By John Pienaar

He was also notably enthusiastic, in his speech to the Leicestershire British Medical Association, on the scope for greater use of private clinical services by the NHS. Monitoring of health care costs were the "most promising development so far" in the NHS. "Armed with better cost information, NHS managers should be able to develop and even extend the policy of competitive tendering, and to consider whether contracting some clinical services out to the private sector would give better value for money."

4/1

CONFIDENTIAL

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

6 June 1988

Dear Geoffrey,

REVIEW OF RAWP

Your Secretary of State and the Minister for Health came to see the Prime Minister this afternoon to discuss the handling of the report on the review of the RAWP formula, on which you sent me a further letter on 26 May.

Following discussion, it was decided that, although the Report should be published, no firm Government response to its recommendations should be made at this stage. Instead, your Secretary of State would make clear that, since the review of the RAWP formula had been established, the Government had embarked on the wider review of the NHS; and it would not therefore be appropriate for the Government to respond to the RAWP review recommendations pending any proposals coming forward from the wider review. The Prime Minister invited your Secretary of State to consider further the precise form of words to be used. It was also agreed that the Minister for Health should consider further the handling of the resource assumptions to be given to health authorities in drawing up their preliminary plans for 1989-90.

I am copying this letter to Jon Shortridge (Welsh Office), David Watkins (Northern Ireland Office), David Crawley (Scottish Office), Jill Rutter (Office of the Chief Secretary to the Treasury) and to Trevor Woolley (Cabinet Office).

Yours,

Paul

Paul Gray

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

CONFIDENTIAL

ps2/22M

UNCLASSIFIED

FROM: MISS M P WALLACE
DATE: 6 June 1988

MR R B SAUNDERS

cc Mr Phillips
Miss Peirson

POLICY ISSUES IN AMERICAN HEALTH CARE

The Chancellor has seen your minute of 2 June. He sees no difficulty in your attending this seminar.

MOIRA WALLACE

ps2/33M

CONFIDENTIAL

PMP.

FROM: MISS M P WALLACE
DATE: 6 June 1988

PS/CST

NOTE FOR THE RECORD

cc Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Parsonage
Mr Call

HEALTH: GERMANY

... I attach a fact sheet produced by our Embassy in Bonn which summarises the state of play on the German health reform proposals. More detailed briefing exists, and was sent to DHSS a while ago - the Embassy will be sending us our own copies now.

2. However, according to the Labour Attaché at the Embassy, none of this briefing covers the question of who will decide the borderline between essential and inessential, and how. This question greatly exercises the health insurance offices, who are currently being consulted, along with other interested parties, on the basis of a massive consultative document. Subject to checking with the Health Ministry, the Labour Attaché's understanding was that the doctors would be expected to make the day-to-day decisions about what was inessential, but the insurer would be involved in cross-questioning a random sample, plus any suspicious cases, to ascertain whether they had followed the principles laid down. The insurers are complaining that they do not have the resources to carry out this monitoring function.

3. The Labour Attache has undertaken to find out more about where the borderline would be drawn. But, on the basis of the press reports, examples of treatments which would no longer be provided free are:

homoeopathic treatment, acupuncture, camomile baths (!), and visits to spas.

But the most controversial proposals seem to have been:

(i) the proposal to refund only half the cost of taxi travel to and from hospital (anecdotes of flagrant abuse);

(ii) the proposal to do away with the prescription charge, but offset the cost by providing free a very limited list of generic drugs - the public are concerned that the list will include only, say, one or two "pain killers" and that if they want to choose an alternative, they will have to pay the full cost.

MPW.

MOIRA WALLACE

010 49 228 234061

Ambassador

WEST GERMANY: HEALTH REFORM PROPOSALS 1988

Overview

1. The Federal Social Security Minister Blüm presented a draft on the structural reform of health funding in January. It was cleared by Cabinet and had its first reading on 6 May. There is considerable opposition to the proposals and we do not expect legislation to be cleared until the Autumn. Target for implementation is January 1989 and the deadline for the completion of the Parliamentary process is, therefore, Christmas.

2. Problems which the reform seeks to address

Health insurance funds must be able to finance medical provision to the present high standards, but the present system is of its very nature demand led and inflationary. Contributions to the various types of health insurance offices have been escalating in line with claims, while people in need of long-term nursing and their families receive insufficient help.

3. Main thrust of the initiative

Essentially the reform proposals seek to cut costs, redirect finances, and stabilise the system. The draft proposals are bulky and extremely detailed. The main points to note are as follows:

a) Contributions should be cut and stabilised. At present they are running at 6% of gross salary for employees, matched by an equal figure by the employer.

b) Payments by the health insurance offices will be restricted to treatment and medicaments which are regarded as strictly necessary.

c) Priority will be given to preventative medicine, the fight against major diseases such as cancer, AIDS, heart diseases; and to the needs of people having to nurse relatives at home.

d) "Non-essentials" will be cut out eg. funeral allowance will be eliminated, spa cure
will receive a reduced subsidy and "petty" articles such as bandages will have to be pa
for by patients.

e) Fixed price systems will be introduced to cut the costs of medicaments and applian
At the same time, patients will no longer be required to pay the prescription charge.

f) Individual patients will have to pay for "non-approved" medicines and part of the
cost of their travel to hospital ~~and recovery~~.

g) Surplus capacity in hospitals will be trimmed, in-patient stays reduced and the need
spa cures more rigorously checked. Efficiency, economy and patient need will be the
words.

h) Insurance systems will be harmonised.

4. Measure not included by this reform proposal

Economies in hospitals are to be tackled separately next year and many critics of the
health reform feel that this should have been the first step.

5. Opposition to the reform

The reform has stirred a lot of opposition amongst all the players - political parti
the Länder; dentists and doctors who stand to lose income; pharmacists whose sales will
be affected by the exclusion of "non-approved" medicines; the pharmaceutical produce
who expect a 40% cut in their market; the local authorities and others who run hosp
taxi drivers - who rely heavily upon the business of taking people to hospital; the h
insurance offices - who will have to be much more interventionary; the rest cure establi
and rural communities; pensioner groups; trade unions; and employers. They all agree
that reform is necessary, but there is no agreement on what should be done. All have
been vocal - hence the extensive media coverage of the many detailed issues involved

6. Political interest

Blüm's reform pleases no-one, there are tensions in the Coalition and Kohl keeps the subject at arm's length. The present mood of the Länder and the make up of the Bunde rat may make it difficult to get the reform through. But failure to reform would ma the Government's position even worse.

7. British interests

a) The DHSS have asked for detailed reports because of the NHS reforms. (This is n a one-sided interest - representatives from the German Select Committee on Employment Social Affairs visited Britain in March).

b) The British pharmaceutical industry has engaged in extensive lobbying because o risks to their markets here.

Ann Le Sage

20 May 1988

Mrs A Le Sage

Mara 10.30 am Friday.
Jules - can ya let me know when we have fixed the plumbing.
Thanks M.

week.1.6/m.1

BF 9/6

SECRET AND PERSONAL

Moira
11.30am Friday
CST Moore Newton at
Nell. Julie.

FROM: H PHILLIPS
DATE: 6 June 1988

CHANCELLOR

Julie - do we have a confirmed time for the Moore/Newton/CST meeting yet? (If we do I'll minute Hayden). M. (phoned him instead)

cc Chief Secretary
Sir P Middleton
Mr Anson

NHS REVIEW

You should know that on Friday evening the Deputy Secretary leading for DHSS on the Review telephoned me to say that Mr Moore would appreciate a bilateral discussion with you and the Chief Secretary (and one or two officials on either side) before the Prime Minister's next meeting in the week beginning 27 June.

2. The reason given to me was that the agenda for that meeting was very full and some clearing of the ground was desirable. Obviously he wants to make sure that the papers he does bring forward are likely to win a good deal more of your support than those so far produced by DHSS.

3. I asked if Mr Moore would raise this in the Prime Minister's meeting or directly with you on some other occasion. He will not do the former, and I got the impression that I was meant to be the messenger.

4. In terms of getting the work done well there may be something to be said for such a meeting, although there will in any event have to be a lot of official contact, and the main paper for the first meeting in July has, in effect, got to be a joint document. In any event the Chief Secretary ought to talk to Mr Moore in the next couple of weeks on vfm audit (one of the issues for the next meeting) and it may be simplest to expand that agenda.

5. You may want to have a word about this at the end of your meeting this morning, but I have not copied this note to all those who normally attend.

pp M L Reader.

HAYDEN PHILLIPS

SECRET

Lewis → Chx 6/6

Inland Revenue

Policy Division
Somerset House

not minuted 6.:

COPY NO OF
FROM: P LEWIS
EXT: 6371
DATE: 6 JUNE 1988

CHANCELLOR

I agree with para

NHS REVIEW: TAX RELIEF

1. There is a point on the interaction between a tax relief for the elderly, and a benefits-in-kind exemption, which you may like to be aware of before tomorrow's meeting.

2. Your paper looks at these two proposals separately. But if the decision is to go for a tax exemption for the elderly, there is then the question of whether there should be a corresponding, limited, benefits-in-kind exemption.

3. One of the main arguments against a general benefits-in-kind exemption is that it would be unfair to those employees and the self-employed who had to pay their own insurance premiums. But for the elderly, those arguments would be turned on their heads if a relief were introduced for the elderly who pay their own premiums, but we continued to charge, as a benefit in kind, those whose premiums are paid by their employer. To preserve income tax neutrality between cash pay and benefits there would thus be a strong case for accompanying any relief to the elderly by a corresponding, and equally limited, exemption from the benefits charge where relief would have been due had the employee paid his own premium.

---

cc Chief Secretary
Financial Secretary
Sir P Middleton
Mr Phillips

Mr Isaac
Mr Corlett
Mr Lewis
Mr Kuczys
Miss Rhodes

PSIR

4. Such a relief would mirror the present benefits-in-kind treatment of cheap mortgage loans. You will recall that in such cases the benefits in kind charge is forgone if the interest is paid for a purpose which qualifies for tax relief.

flagged X behind

5. As mentioned in your briefing, such an exemption would cost (at present levels of provision) about £5m - some 80,000 people would benefit. The administration of such a relief, particularly if limited - like the main relief - to the basic rate, looks awkward. (We would need to work up the details in parallel with the main relief).

6. Even if you agree that a limited benefits in kind exemption should accompany the introduction of any relief for the elderly, you might feel it be better not to volunteer it tomorrow. Accepting a limit benefits exemption might make it more difficult to obtain agreement to rule out a general exemption. This consequence of relief for the elderly could then emerge at some convenient later stage.

P LEWIS

week.1.6/m.2

SECRET

FROM: H PHILLIPS
DATE: 6 June 1988

CHANCELLOR

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

Ch/ see also new note from Lewis behind

report 6/6.

NHS REVIEW: A MIXED ECONOMY OF HEALTHCARE

You asked for a note of the key points which you wanted to register at the Prime Minister's meeting tomorrow as worth serious follow-up by officials which either arise from or are related to Mr Moore's paper.

2. First, we should pick up vigorously the references, in paragraph 4 (f) of Mr Moore's paper, about the medical profession. We need to take action to tackle the restrictive practices operated by the medical profession which inhibit competition in the provision of private healthcare - for example, the nationally-agreed standard fee scales, and the power which consultants exercise over which hospital to use. The medical profession enjoy at present a block exemption from the restrictive trade practices legislation. A DTI Green Paper in March proposed removing all such exemptions which would then have to be justified afresh. This is a start. Another is the decision to refer the supply of the services of medical practitioners in the UK to the

MMC (in respect of agreements and practices relating to advertising). Moves to tackle restrictive practices should be linked to some structural reform in relation to consultant posts eg introducing more part-time consultant posts but the costs and benefits would need to be carefully assessed. Both of these aspects of dealing with the supply of doctors should be covered in the paper on consultants' contracts and allied matters which the group is meant to take at its meeting in the week of 27 June.

3. Second, a more determined drive is needed for the NHS to sell services more actively to the private sector. Two particular aspects of development should be pursued here: more NHS pay beds, both as a means of generating income and stimulating the private sector; and offering NHS patients the opportunity to pay for a range of non-clinical services such as single rooms, televisions and videos etc. (This is supported by the Institute of Health Service Managers). In these two areas we should move to allow market-related fees to be charged rather than dealing either in nominal charges or simple cost recovery.

4. Third, we need a detailed assessment of the spare capacity available in the private sector to allow it to sell more treatments to the NHS. This should be particularly focused on assisting with waiting lists and times so that the patient sees early benefits in enhanced mixed healthcare economy.

5. Fourth, follow-up work should be done on the promotion of joint ventures which are not simply designed as ploys to enable health authorities to escape from proper public expenditure and

financing controls. This could focus particularly on the full and economic use of NHS land.

6. Fifth, and this picks up a point you underlined at the previous meeting, the Government should launch a drive to extend contracting-out and competitive tendering into clinical areas. This could cover both clinical support services (pathology, radiology, etc) and certain production-line operations - your point about hip replacements. This is the sort of the thing the patient wants done well although it may be extremely unglamourous for the NHS consultant.

7. I think this is a sufficient list. You might like to say that if that work is accepted, together with the package of proposals set-out at the last meeting, Ministers will be able to examine by the beginning of July an overall package. You may want to emphasise that before final decisions are taken it would obviously be right not only to be clear about the costs and benefits of the measures which you have examined as a whole, and about how they will be received, but about what palpable changes in practice will be felt by the patient.

HP.

HAYDEN PHILLIPS

FH6/68M

CONFIDENTIAL

mmp (NHS)

FROM: MISS M P WALLACE

DATE: 6 June 1988

PS/CHIEF SECRETARY

cc Mr Anson
Sir Anthony Wilson
Mr H Phillips
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Griffiths
Mr Call

INDEPENDENT AUDIT AUTHORITY

The Chancellor was most grateful for the Chief Secretary's minute of 2 June, enclosing a note from Mr Froggatt, which he found most interesting.

MOIRA WALLACE

3633/10

CONFIDENTIAL

FROM: P J CROPPER
DATE: 6 June 1988

CHANCELLOR

cc Chief Secretary
Financial Secretary
Paymaster General
Economic Secretary
Mr Tyrie
Mr Call

NATIONAL HEALTH SERVICE

I read the draft of your Leicestershire BMA speech as one who has remained outside the circulation list for papers on the current NHS review, and who can therefore look at it somewhat as a man in the street.

2. The Government has given no clue whatever as to the proposals likely to emerge from the review. "I have sketched out some of the ways in which I suspect we should be moving. Whether more fundamental reform is needed must await the conclusion of the Government's review. But, whatever the outcome.....". Here is an intensely secret operation, going on within a very small circle, which is going to come up with one among a number of substantially different possible solutions.

3. Are we entitled to expect that the rest of the population will respond obediently and receptively to whatever it is that emerges from the review? I have a horrid feeling that, just because most people with an interest in the matter have been totally excluded from the deliberations, their immediate instinct will be to oppose whatever it is that the Government proposes. I feel it in my own bones.

4. Royal commissions may be slow, but at least they carry a measure of consensus. Which helps when it comes to implementation. Is there no half-way house?

P J CROPPER

Agreed not.

MC5.72

pps pl: ~~NHS~~ Health: Germany

FROM: MARK CALL
DATE: 7 JUNE 1988

CHANCELLOR

cc Chief Secretary

HEALTH SERVICE REFORM OVERSEAS

At Monday's NHS Briefing you asked officials to find out about the German proposed reforms. Would it be useful for the Centre for Policy Studies to publish something on reform of health provision in other countries? This could serve not only to underline that we are not alone in seeking reform, but improve the acceptability of certain likely reforms by showing that they work in other countries. For example, the fact that GPs in France conduct minor surgery (eg stitches) or that people pay hotel charges in such and such countries, and pay x% of the cost of medicine.

2. I think this could be helpful once we have a good idea of the shape of the reform package. If you thought this worth pursuing, I could discuss it with David Willetts.

Mc

MARK CALL

ps2/35M

CONFIDENTIAL

FROM: MISS M P WALLACE
DATE: 7 June 1988

MR SATCHWELL

cc PS/Chief Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull Mr Saunders
Mr Parsonage
Mr Griffiths
Mr Call

NHS REVIEW: PREVENTIVE MEDICINE

The Chancellor was grateful for your note of 3 June, and the ... two enclosed reports, which I am returning with this minute.

2. This issue was discussed at yesterday's NHS briefing meeting. The conclusion was that, while some forms of preventive medicine may indeed be highly cost-effective, this is not universally the case, and the area needs watching.

MOIRA WALLACE

SECRET

10 DOWNING STREET

LONDON SW1A 2AA

CH/EXCHEQUER	
REC.	08 JUN1988
ACTION	MR SAUNDERS
COPIES TO	CST FST SIR P. MIDDLETON SIR T. BURNS MR ANSON MR PHILLIPS MR CULPIN MR TURNBULL MR PEIRSON MR PARSONAGE MR CALL PS/IR MR LEWIS MR CORLETT MR KUCZYS

From the Private Secretary

7 June 1988

Dear Geoffrey,

NHS REVIEW

The Prime Minister held a further meeting today to discuss the review of the National Health Service, the seventh in the present series.

I should be grateful if you and copy recipients would ensure that this record of the discussion is shown only to those with an operational need to see it.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Social Services, the Chief Secretary, Treasury, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. O'Sullivan (Policy Unit). The meeting had before it minutes dated 3 June from the Chancellor of the Exchequer, 'NHS Review: Tax Relief', and from the Secretary of State for Social Services, 'A Mixed Economy of Health Care'.

In discussion the following were the main points made:

a. It was essential to achieve substantial growth of the private sector. Otherwise the growing demands for health care meant the costs of the NHS would continue to escalate. The rate of growth in private health care had been relatively slow over the past few years, and this suggested that a major boost was now needed. Action on the supply side, for example on the restrictive practices of the professions, would be important, but by itself was unlikely to be enough. Action to stimulate demand for private care would also be necessary.

b. There was a very strong case for tax relief for private medical insurance premiums paid by the elderly. Although contrary to the general thrust of tax policy in recent years, it stood a good chance of being cost-effective in encouraging more private provision and should not be unduly repercussive. It would also be politically attractive, especially if

SECRET

it were extended, as described in the Chancellor's minute, to premiums paid in respect of the elderly by younger members of their families.

c. The mechanism for tax relief for the elderly described in the Chancellor's minute had many advantages. It would be right for the relief to start at age 60 and a MIRAS-type arrangement would have the attraction of providing the same relief for non-taxpayers as taxpayers, even though relief for non-taxpayers would score as public expenditure. It was doubtful however whether it would be right to restrict the relief to the basic rate. The argument against extension to the higher rate was that it would make the relief much more complicated for the sake of a small minority of taxpayers (a higher proportion of whom were likely already to have private health cover). On the other hand, premiums for the elderly were so substantial that relief at the higher rate might be necessary to provide them with enough incentive to take out private insurance. This aspect of the scheme should therefore be looked at further.

d. It was argued that exemption from tax as a benefit in kind of premiums paid by employers under company schemes raised much more difficult issues of tax policy. The deadweight cost of this relief would be high (about £80 million), and it was unlikely to be good value for money in promoting an expansion of private insurance. It was also likely to be repercussive. On the other hand, it was argued that tax relief going beyond the elderly was required to give the necessary boost to the private sector, and that relief for company schemes would respond to the growing pressure from employees for the introduction of such schemes.

e. The relief for company schemes might be better targeted, and therefore more cost-effective, if it did not apply to premiums paid in respect of people at the highest levels of income, who were the group most likely to have taken out private medical insurance already. A way of achieving this would be to raise from £8,500, for health insurance premiums only, the level of income above which benefits in kind were taxed. This option should be further considered.

f. The option of some form of contracting out should also be considered further. It could be restricted to cold elective surgery and would then make a contribution to cutting queues, which were largely made up of people awaiting treatment of that sort. There would be dead-weight costs, but in assessing the balance of costs and benefits it was important to take account of the behavioural consequences of introducing the scheme.

The Prime Minister, summing up the discussion, said that the group were agreed that a substantial boost to the growth of the private sector was required, through action on demand as well as supply. The group saw considerable attraction in tax relief for health insurance paid by or for the elderly, along the lines set out by the Chancellor of the Exchequer. They saw some objection however to the restriction of the relief to the basic rate. This aspect should be looked at further, and the Chancellor of the Exchequer should arrange for a paper to be circulated to the group accordingly. The main question however was whether tax relief should extend more widely than the elderly. One possibility was the exemption from tax as a benefit in kind of premiums paid by employers under company schemes. The group saw arguments for such a concession, in view of the need to make a big impact on the growth of the private sector. But it also raised difficulties from the point of view of cost and tax policy. Before taking a final decision the group wanted to consider whether there were ways of improving the targeting. One way which had been suggested was that the relief should apply only to those with earnings up to a specified level, which would have to be much higher than the level of £8,500 above which benefits in kind generally were taxable. The Chancellor of the Exchequer should arrange for this option to be considered further, and a paper prepared for the group.

On a separate matter, the Chancellor of the Exchequer had agreed to send her a note on the tax treatment of employees in relation to provision of workplace nurseries.

The Secretary of State for Social Services had suggested that another option was the introduction of a system of contracting out for cold elective surgery. It was unlikely that it would be right to have both contracting out and extensive tax reliefs. But the group agreed that the contracting out option should be considered further and the Secretary of State should prepare a paper on it, in consultation with the Chancellor of the Exchequer.

It had already been agreed that for the next meeting of the group papers should be prepared on a number of practical aspects of change: on financing hospitals, self-governing hospitals and capital allocation, issues to do with the professions, and audits. These papers should be discussed between Departments in the Cabinet Office group before circulation to the Ministerial group. Thereafter the group would need to have a more extensive discussion of the whole package as it was now developing. The further papers which had been commissioned at this meeting on tax relief for the elderly, tax relief for company schemes, and contracting out should be ready for that discussion. In looking at the whole package, the group would need to consider whether it was sufficiently radical. Radical change would be necessary if the growth of public expenditure on health was to be contained. The option of major changes in structure was still open. In particular, the method of financing hospitals would need to be radically changed so that they receive their income under contract; and the future of the health authorities

needed to be reassessed.

I am copying this letter to the Private Secretaries of the Ministers at the meeting, and to the others present.

Yours,
Paul

PAUL GRAY

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

Daily Telegraph Tuesday, June 7, 1988

Minor operations role for GPs

Tax concessions plan to boost private health

By George Jones, Political Correspondent

TAX CONCESSIONS to encourage more private health insurance and new incentives for general practitioners to carry out minor operations in their surgeries are emerging as leading options in the Government's review of the Health Service.

Both the Prime Minister and Mr Lawson, Chancellor of the Exchequer, are ready to drop their long-standing opposition to "tax breaks" on private health insurance premiums in an effort to boost the relatively low level of private contributions to health.

At the same time, ministers are looking at ways of expanding the role of the country's 25,000 GPs to see if they can ease the pressure on overburdened hospitals.

The idea is that family doctors should offer a wider range of services, including carrying out minor surgery requiring a local anaesthetic in their surgeries rather than automatically referring patients to a hospital waiting list for treatment.

The review of the Health Service was initiated by the Prime Minister earlier this year at the height of the political controversy over cash shortages and delayed operations.

Firm conclusions are not expected until after the summer, but it is clear that the review is coming down against the more radical options for re-structuring the Health Service — such as the right to "opt out", promoted by Right-wing advisers in the Downing Street policy unit.

Instead, the review is drawing up "evolutionary changes" building on the basic principles and strengths of the NHS.

The softening of Treasury resistance to tax relief on private medical insurance is a significant victory for Mr Moore, Social Services Secretary, who is fighting back after the mauling he received in the furore over the NHS.

In an interview with The Daily Telegraph in January, Mr Moore identified the extension of private health insurance as one of the main ways of increasing funding for the Health Service, adding:

"I see a need to encourage a much greater private sector contribution."

Initially there was a hostile response to the suggestion from both Downing Street and the Treasury, which were concerned about the £150-£200 million cost of allowing tax relief on private health insurance contributions.

Government sources confirmed last night that both Mr Lawson and the Prime Minister were now ready to consider incentives for encouraging private medical care.

"Some measure of tax break for private health insurance is very much on the cards," said one official closely involved in the review.

The Chancellor signalled his conversion in a speech to doctors on Friday in which he said the 5½ million people with private medical insurance were relieving the burden of demand on the NHS.

He described the growth of about three per cent a year in the number of employer-paid health insurance schemes as a "welcome development", adding:

"But I believe that even more could be achieved by the development of more imaginative health insurance products."

One option under active consideration is tax relief targeted at elderly people.

As Mr Lawson pointed out, increasing numbers of people have private health insurance in schemes paid for by their employers — but this often stops on retirement, at a time when they are likely to begin making demands on the Health Service.

Mr Lawson has also emerged as an influential opponent of more radical proposals for an "internal market" within the NHS — giving health authorities and patients the right to seek the quickest and most effective treatment from NHS or private hospitals anywhere in the country.

The Treasury is worried that such a reform could lead to a big escalation in costs and is fighting a rearguard action to maintain tight controls over NHS funding.

But it is ready to give hospitals more scope to contract out some clinical services to private hospitals where it can be shown this gives better value for money.

The review, chaired by the Prime Minister, has identified doctors as the key to improved efficiency in the Health Service.

An experimental resource management initiative in five hospitals, which involves doctors directly in the comparing the costs and effectiveness of treatments, is to be extented right across the NHS.

Family doctors are regarded as particularly crucial because they deal initially with the vast majority of medical problems and regulate the flow of patients to hospitals.

In off-the-cuff remarks last Friday, Mrs Edwina Currie, the junior Health Minister, said GPs should spend more time treating patients and less time licking stamps.

She said it took nine years to train family doctors, and she chided them for referring patients to hospital without considering whether they could do the work themselves.

Ministers are looking at ways of encouraging GPs to carry out in their surgeries more minor treatments often referred to hospitals.

The Government is already taking powers in the Health and Medicines Bill before Parliament to enable family doctors to take on more staff and to improve their practice premises, and their pay is being more closely related to performance.

● **Peter Pallot**, Health Services Staff, writes: Doctors last night pointed out that giving tax relief on private insurance could be difficult for the very old and very young.

"They still need to be treated, as well as people who develop serious long-term diseases like cancer which have to declared at annual renewal time," said a spokeswoman for the British Medical Association.

But she added that family doctors would welcome the chance to do more minor surgery on their own premises.

"The general practitioner committee of the BMA have been pushing for this for five years because GPs can see that this is a sensible extension of what they can do to relieve the pressure on hospitals."

Private medicine is expanding rapidly, with the proportion of those covered by insurance topping 10 per cent for the first time last year.

Last month BUPA unveiled plans to attract two million more into independent medicine on top of the 5½ million already privately insured.

Mr Roy Clarke, a senior executive, said "Budget BUPA" was the first "package deal" between private and public sectors, with a third of health authorities agreeing to fixed-price deals to mop-up spare pay-bed capacity at weekends.

A spokeswoman for BUPA said: "We are not asking for tax relief on private medical insurance for all our members, but we would welcome it for those who are pensioners."

She said the private insurance industry was worried about the effect withdrawal of tax concessions would have if there was a change of government.

CONT →

4 — CONT

a man aged 40 to 45 to i[illegible] himself and his family costs about £400 a year.

Assuming that current subscribers are in the higher tax bracket, they could expect relief of £160.

But one of the Government's problems in granting relief is the high cost of giving relief to existing subscribers before the benefits of pulling in more patients could be counted.

The private sector has 203 acute hospitals — compared with 2,400 in the NHS — and is calculated to be supplying services worth about £1 billion a year.

TODAY

Keep the NHS alive and well

IT IS said that £1 billion is needed to put the NHS on its feet. Surely this is a small price to pay for the security of knowing that we will be well looked after when we are ill.

The introduction of private health care will be divisive (TODAY, June 3). The private market will be only too happy to cream off profitable hip replacements and such like, but will they undertake dialysis or chemotherapy for the chronically sick? Will insurance schemes cover those whose illnesses may span years, even decades? I think not.

In America, whose system our Government seeks to emulate, there are 30 million people who are not covered in any way by insurance schemes — and the majority are inadequately covered. Patients have been known to die while their insurance cover is checked out before they can be treated.

Preventive medicine is up to the individual and many children are not inoculated against diseases like TB and polio.

Even middle-class families can find themselves in the bankruptcy courts when a member of their family becomes ill.

Susan M Saker,
London SW18

8/2.

PAM25

SECRET

FROM: MOIRA WALLACE
DATE: 7 JUNE 1988

CHANCELLOR

NHS REVIEW: NEXT STEPS

Hayden and his team came round to compare notes after this afternoon's meeting of the Official Group. Unless instructed otherwise, they will now steam ahead to produce:

i. A note "looking again" at the case for relief at the marginal rate for insurance premiums for the elderly;

ii. A note about increasing the PIID limit for health schemes alone to eg average earnings, or the higher rate threshold. (This note would also cover knock-on costs in respect of non-insurance schemes).

iii. A private note, for the Prime Minister only, on benefit-in-kind exemption for workplace creches.

2. Richard Wilson reported various Prime Ministerial remarks supporting the idea that all hospitals should be made self-governing, pretty much instantly, and that they should all have service contracts, with some buying authority. Hayden wonders whether you see this as the "buyer" notion being resuscitated. As for Mr Moore's promised paper on "cold elective" opting out, Hayden thinks we have already seen this at official level (he managed to get it suppresed before, on the grounds that the previous meeting had marginalised it) and he will circulate the earlier draft.

3. The Ministerial Quadrilateral is now fixed for Friday morning, at 11.30. Mr Moore (and for that matter No.10) seem to think that Richard Wilson will be there. We haven't invited him, but do you

want us to? Also, do you want a PS to sit in? Finally, had we perhaps better fix a briefing meeting beforehand, with a smallish group?

MOIRA WALLACE

ph6.7

CONFIDENTIAL

FROM: MISS M P WALLACE
DATE: 8 JUNE 1988

MR CROPPER

cc Chief Secretary
Financial Secretary
Paymaster General
Economic Secretary
Mr Tyrie
Mr Call

NATIONAL HEALTH SERVICE

The Chancellor has seen your minute of 6 June, asking if, in the hope of achieving more public consensus, the Health Review could be conducted in a less secret, more Royal Commission-esque manner. He has commented that he is afraid this isn't on.

MOIRA WALLACE

002/4208

cc:
Chancellor
PMG
Sir Peter Middleton
Sir T Burns
Mr Anson
Mr Phillips
Miss Peirson
Mr Saunders
Mr D P Griffiths
Mr Parsonage
Mr Call

Treasury Chambers, Parliament Street, SW1P

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

8th June 1988

Dear Secretary of State,

GOVERNMENT RESPONSE TO SOCIAL SERVICES COMMITTEE REPORTS ON RESOURCING THE NHS

Thank you for your letter of 23 May.

As you know, both Nigel and I are very doubtful about the wisdom of making public reference to the idea of a health index while it is far from clear that the concept is either feasible or desirable. Nevertheless, if you feel strongly that you do need to deal with the issue in the response to the Committee, I am prepared to make an exception in this case, given the non-committal nature of the reference you propose. However, I must reiterate our firm opposition to any further public mention of the subject until we have reached a conclusion on the merits or otherwise of proceeding with the index.

I am generally content with the terms of the rest of the proposed response. But the footnote to paragraph 10 showing the growth in funding in 1987-88 measured by reference to NHS pay and price increases should be revised to show the percentage increase after revenue released by cost improvement programmes has been taken into account.

Yours sincerely,

Joe "Emma"

for JOHN MAJOR
(Approved by the Chief Secretary
[illegible])

ph6.8

PERSONAL

FROM: MISS M P WALLACE
DATE: 8 JUNE 1988

MR CALL

cc PS/Chief Secretary

HEALTH SERVICE REFORM OVERSEAS

The Chancellor was grateful for your minute of 7 June. He thinks this is a good idea, but it would need to be done "honestly", and not as a propaganda exercise.

MOIRA WALLACE

SIR P. MIDDLETON
BILATERAL

mjd 1/172A

SECRET AND

FROM: A C S ALLAN
DATE: 8 June 1988

SIR P MIDDLETON

A
I have passed this to Terry,
& I gather he had the same
message from Peto via Hayden.
He plans to get Mike
Passmore to do a first
draft. ACSA

BILATERAL WITH THE CHANCELLOR: TUESDAY 7 JUNE

This is to record the main points raised at your bilateral yesterday.

Health

2. The Chancellor said that at the meeting with the Prime Minister that morning, there had been strong pressure for some form of tax relief for private health insurance. You thought it was very important to consider the supply side as well, where it was clear that there were many restictive practices, for example in the fixing of consultants' fees for private operations. It was important to bring out the point that unless we did something to free up supply, higher demand stimulated by tax concessions would simply lead to even higher prices, which would feed through to the public sector. The Chancellor very much agreed; he thought it would be helpful to have a paper spelling this out clearly in time for the meeting on 27 June. You said you would ask Sir T Burns to prepare a paper on these lines.

Bank and DTI

3. You said there were several issues on which the Bank and DTI were at loggerheads, and 1992 in particular was proving a great source of irritation. You would speak to the Deputy Governor and try to identify what the key issues were; it might then be appropriate to have a tri-partite meeting between the Chancellor, the Governor and Lord Young.

Duchy of Cornwall surplus

4. You reported that you had had a meeting with representatives from the Prince of Wales' Office and the Duchy of Cornwall. They had been sympathetic to the idea of "reinvesting the surplus".

Security Service

5. You reported a development to the Chancellor. There would be some small public expenditure implications, which you felt needed to be handled separately from the main discussions in PSIS.

Tax approximation

6. You reported that at EPC the Germans had announced they were not planning to take forward the work on a more market-based approach, commissioned at the last ECOFIN. It was not clear exactly what they were up to - something had possibly been agreed at the Franco-German Summit - and you were investigating further.

Public expenditure

7. You and the Chancellor had a brief word about the Survey prospects. The Chancellor said he saw three main options for our initial strategy: stick to the planning total; aim, as last year, for a declining percentage of GDP; or aim to stick to the planning total with the exception of additional money for health. A more detailed analysis of the bids was now needed.

A C S ALLAN

7.6.6

1. Andrew 2. pmp

FROM: R C M SATCHWELL

DATE: 8 June 1988

PS/CHANCELLOR

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

NHS REVIEW: PROPOSALS FOR CHANGE

I attach an updated note summarising the main proposals for reform of the NHS which have been put forward by outside commentators, for use as a reference document.

R. Satchwell.

R C M SATCHWELL

John Peet: "Healthy Competition" (October 1987)

1. Written by the former Treasury Principal in ST2 Division, now a journalist with the Economist, and published by the Centre for Policy Studies, this paper does not advocate major changes to the present NHS structure. Rather, a greater element of competition should be introduced as a means of "increasing pressure within the health service for greater efficiency". The focus would be on:

a. an extension of competitive tendering, to cover not just support services, but surgery facilities, primary care, hospital building etc.

b. greater competition between hospitals and/or health authorities.

Managers and hospital authorities would have much greater freedom in areas such as finance, pay, and contracts. The system would become less centralised, and there would be room for experimentation in areas such as the internal market.

2. Most of the ideas in the pamphlet are not new, and some are coming in anyway. Mr Peet's views are similar to those in the "NHS Refurbished" model in the Cabinet Office options paper.

Oliver Letwim and John Redwood: "Britain's Biggest Enterprise" (January 1988)

3. Written by two former members of the No. 10 Policy Unit, and again published by the Centre for Policy Studies, this paper offers "ideas for radical reform of the NHS". The authors identify a number of problem areas (waiting lists, excessive bureaucracy, the dehumanisation of patients), and go on to list "a series of options ... which need to be investigated openly". These are

- the establishment of the NHS as an independent trust

- greater use of joint ventures between the NHS and the private sector

- extending the principle of charging

- a system of "health credits"

- a national health insurance scheme

4. The trust idea is really decoupling the service from the DHSS and abolishing RHAs; joint ventures and charging move towards the idea of the internal market; health credits are vouchers under another name. Overall, the thinking is in line with the "Opting Out" option.

Ray Whitney: "National Health Crisis" (January 1988)

5. Much of Mr Whitney's book is taken up with a history of the development of health services in the UK, both before and after the establishment of the NHS. He demonstrates that the current debate is not new, and that some of the problems (notably the concern about the control of costs) have always been present. He also puts his finger on some of the key aspects of the system; the distinction between provision and finance, the need for better and more detailed information about costs and benefits, and the importance of the interfaces between the hospital, GP and community care sectors.

6.His solution is for a massive increase (of about £10bn) in health expenditure, so that the total as a percentage of GDP matches the roughly 9% spent by France and Germany. The additional money would come from the private sector. He also favours the introduction of Health Maintenance Organisations, funded by a voucher system covering a minimum standard of health care. The additional private sector resources would then emerge in due course through patients' topping-up the voucher in order to buy additional benefits.

Michael Goldsmith and David Willetts: "Managed health Care" (February 1988)

7. This Centre for Policy Studies pamphlet argues for the introduction of US-style Managed Health Care Organisations ("MHCOs") providing a comprehensive range of health care services to their subscribers in return for a fixed annual fee. Public sector MHCOs would replace existing DHAs and FPCs, and RHAs would be abolished; funding would be on a variable capitation basis. All MHCOs (public and private) would contract with both public and private sector hospitals and GPs for the provision of services, perhaps using performance-related remuneration. This model is basically the same as "Local Health Funds" in the Review Group paper.

8. Messrs Goldsmith and Willetts also touch on opting out and topping up. But their ideas on these issues (and the problems which come with them) are merely stated as logical extensions of their model and are not developed.

Michael Goldsmith and David Willetts: "A Mixed Economy in Health care" (March 1988)

9. The main issue of the authors' second paper is the extent to which a mixed economy in health care can be encouraged, mainly by greater use of private medicine within the NHS (surprisingly, perhaps. tax relief on private health insurance is specifically ruled out, with the exception of the self-employed). It contains two main ideas. First, that more effort should be put into marketing NHS "extras", such as amenity beds and additional, higher quality, hotel services. This would bring in money, and (crucially) proper commercial management skills, perhaps through NHS hospitals having separately run private wings. But the extension of charges for these services should be linked to distinct improvements in the 'product' (eg weekend consultations/ operations to improve convenience). Secondly, that companies could be seen as another source of finance and another way of pooling the risks of health care coverage. And they would be encouraged to play a bigger role in preventative health care, on the grounds that an unhealthy workforce is both costly and wasteful.

Eamonn Butler and Madsen Pirie: "Health Management Units" (March 1988)

10. The main difference between the Adam Smith Institute's idea of Health Management Units and the MCHOs proposed by the Centre for Policy Studies is that GPs are enrolled with an HMU rather than being free-standing self-employed individuals on contract to one (or more) MCHOs. This means that HMUs would mean less dislocation for patients than MCHOs (for the average patient happy with his GP, there would be no change from the present system); but that more power is concentrated in the hands of the doctor, since the link between the patient and his "health care organiser" is one step removed.

Leon Brittan: "New Deal for Health Care" (February 1988)

11. Mr Brittan warmly embraces many of the ideas on improving value for money through more contracting out, an extension of charging, and the elimination of duplication of services. But his main proposal is for a switch in the financing of the NHS from general taxation to a "health stamp" based on the employee part of national insurance. This would be coupled with either full or partial opting out, plus adjustments to other taxes to combat adverse distributional effects, "likely to be quite complex".

12. Mr Brittan's idea is the "Opting Out" option (though he does also allude briefly to HMOs/MCHOs as a possible future development following the switch). He tends however to play down the problems of such a change which have been flagged up in the Treasury paper to the Review Group on this subject.

The National Association of Health Authorities: "Funding the NHS" (February 1988)

13. NAHA have concentrated on funding (both the overall level and its distribution) rather than provision or organisation, and in particular, funding of the acute care sector. The result is that in spite of purporting to define the parameters for a debate on the future funding of the Health Service, the document is

unbalanced and often strays into the realm of special pleading for more money. To quote the introduction, "the present debate should avoid over-concentration on how to obtain additional funding. It is more important to decide what should be achieved by extra resources and then to investigate which method of funding is most likely to enable health authorities to meet these objectives".

14. After listing the main options for financing health care (tax, national insurance etc) and those for distribution (eg RAWP, direct budgets), NAHA suggest " a way forward within the present system". The idea is to introduce "flexed" clinical or management budgets; that is budgets built up from standard costing (using the Diagnosis Related Groups system developed in the US) which are automatically flexed to take account of changes in activity or throughput. NAHA point out the biggest problem with this sort of resource allocation, namely a spending "free for all" (clinicians who treat lots of patients automatically get lots more money, while clinicians who treat less either can't or won't surrender their underspend) but believe that better planning and controls elsewhere in the system would compensate. This seems naive; in practice all control over expenditure in such a system would be lost.

Kings Fund Institute: "Assessing the Options" (March 1988)

15. Unlike some of the other publications, this does not try to promote a particular model or solution, but rather seeks to provide a dispassionate analysis of the full range of options which will "clarify the nature of the policy of the policy trade-offs in the hope that this will lead to a more informed debate".

16. Although the Institute personally believes that there needs to be a modest injection of new money into the acute sector now, it recognises that money is not, of itself, the solution. "No matter what level or method of funding, there is a pressing need to ensure that maximum value for money is obtained from NHS budget allocations". Doctors and nurses need to become more involved in general management; there should be greater partnership with the private sector; the effectiveness of clinical procedures should be assessed. The Institute also sees the case for an internal market, though only on an experimental basis at this stage.

17. More radical options, such as moving to an insurance-based system, are viewed with scepticism. They are likely to clash with other objectives such as universal and comprehensive coverage. Overall, the watchword is caution; together with a plea for changes to be related in a systematic way to the principles underlying health care policy, rather than simply for change's sake.

NAHA: "The Nation's Health: A Way Forward" (April 1988)

18. NAHA's second effort is a lot better than the earlier document. Although there is still a fair amount of special pleading, much of it is in return for changes within the existing structure. And flexed budgets have been discreetly dropped.

19. NAHA support the existing system of funding and are against HMOs and vouchers. But they would support a regional experiment for an internal market. They are suspicious of an expanded private sector (fears of its leading to a "second class" NHS) and its effects on teaching and research. Most of their recommendations are thus in the "NHS Refurbished" mould; the amalgamation of FPCs and DHAs, more decentralised management and flexibility over pay, and the greater integration of medical staff in the management process. There are also calls for a National health Accreditation Agency to draw up and monitor standards, and a more tightly worded contract between GPs and newly merged FPCs/DHAs.

The Economist: "Set the Hospitals Free" (April 1988)

20. The leader article in the April 30 edition of the Economist was written by John Peet, and extends and develops the ideas put forward in his earlier pamphlet "Healthy Competition". The main idea is to separate finance from provision, and free up hospitals, so that they can compete with each other for both patient referrals and funds. The precise form of independence (trust, company, management buy-out) would be left to the hospital itself; experimentation should be encouraged. Funding on the other hand would remain as now, with revenue coming largely from general taxation. The Economist is against earmarked taxes and insurance, and recognises the problems of opting out and tax relief for private health insurance.

21. The supply structure advocated by the Economist is very similar to that of the "Independent Hospitals" option, though without the intermediate system whereby hospitals are grouped together for management purposes.

Dr David Green: "Everyone a Private Patient" (May 1988)

22. Dr Green is head of the health unit at the Institute of Economic Affairs. He characterises the problems of the NHS as endemic underfunding and insufficient competition. His solution is to offer a two-voucher opting-out system: one voucher for primary care and one for secondary, with the redeemable values of each being weighted according to the age of the recipient. Someone who opted out would have to take out private insurance (including for catastrophic illness), paid for with the vouchers. Such a person could still use NHS facilities but only as a private patient. Intermediary "health purchase unions" would act as brokers, advising consumers on insurance policies and health plans. Insurance companies would be required to charge the same premia to all people in a given age group.

23. Dr Green argues that any consequent increase in administration costs should simply be accepted as the price of greater consumer choice. He ignores the deadweight cost that would be involved in introducing a voucher system. He also skates round the problems of cost control, and of how long-term care for the elderly, the mentally ill, those with learning difficulties, and the chronically sick, would be provided and paid for.

John Redwood: "In Sickness and in Health" (May 1988)

24. Mr Redwood's pamphlet is published by the Centre for Policy Studies. A large part of it is taken up in developing his earlier analysis of the NHS' problems, and advocating a series of "NHS Refurbished" ideas (decentralisation, better management, partnership with the private sector, more imaginative use of property) to improve things. He then goes on to advocate a major change in the method of financing, by switching to a hypothecated

National Health tax with contracting out along the lines of SERPs. The aim would be to increase the share of GDP covered by private sector finance from 0.6% to 2.5%. He also believes the tax would have the advantage of improving the transparency of the costs of health care to the tax-paying population (though not of course to non-taxpayers, of whom the elderly and other major NHS users might constitute a large part).

25. However, media attention has tended to focus on two other aspects of Mr Redwood's pamphlet. One is his almost throw-away remark that real resources should be targeted to grow at 2% per annum, "unless general economic growth falls below such a level". The second is his assertion that administrative costs in reality absorb more than 10% of total expenditure on hospital services rather than the 3-4% normally quoted by Ministers. There is thus a great deal of scope (up to £1bn) for freeing up resources through improved management.

Dr Clive Froggatt (May 1988)

26. Dr Froggatt, a GP, is head of the Conservative Medical Association, and was a participant at the first of the Prime Minister's Chequers Seminars on the NHS. He has submitted two papers, on medical audit and incentives for change in general practice. In the first, he recommends that the Audit Commission be given the responsibility for both clinical and financial audit within the NHS, using the value for money experience gained from its work with local authorities. In the second, he advocates a "carrot and stick" approach towards general practitioners. In return for more money, doctors would have to accept a contract with the NHS which included specific objectives to cooperate on clinical and financial audit, and which forced GPs to engage in continuing medical education.

Royal College of Midwives (May 1988)

27. The RCM is against any move away from the current method of financing the NHS largely from general taxation. But it would accept a limited expansion of private sector provision, provided that there was strict supervision of standards. On maternity matters, it is sceptical about internal markets for maternity

care, on the grounds that it is unreasonable to expect mothers to travel large distances either prior to, or immediately after delivery; maternity should be a "core" activity provided by every health district. Though the College would support measures which eliminated the duplication of midwifery and medical skills, and provided midwives with more of a professional status, thereby reducing unnecessary technical intervention by doctors.

The Institute of Health Services Management (June 1988)

28. The ISHM believes the Review Group should be conservative on finance but radical on provision. It would retain tax-based finance, but allow topping-up for non-clinical services such as a private room and better food. On the supply side, it advocates experiments with "provider" (ie internal) markets, together with increased managerial flexibility, particularly over pay and investment. It would also take central government out of the day-to-day running of the NHS by setting up a completely separate management board, with lines of authority running direct to health service managers rather than to health authorities.

TRAFFORD

CONFIDENTIAL

BF 10/6

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

8 June 1988

CHEQUER
08 JUN 1988
8/6
MR SAUNDERS
EST
SIR P. MIDDLETON
SIR T. BURNS MR PHILLIPS
MR ANSON MR PEIRSON
MR TURNBULL
~~MR LEVENE~~
MR PARSONAGE
MR CALL

Dear Geoffrey,

NHS REVIEW

I enclose, for the information of members of the NHS Review Group, a report submitted to the Prime Minister by Lord Trafford and a number of other doctors who were present at the Chequers seminar in March.

I am copying this letter and enclosure to Alex Allan (H.M. Treasury), Jill Rutter (Chief Secretary's Office), Jenny Harper (Office of the Minister for Health), Sir Roy Griffiths, Sir Robin Butler and to Richard Wilson (Cabinet Office).

Yours,
Paul

PAUL GRAY

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

CONFIDENTIAL

From: The Lord Trafford of Falmer Kt., FRCP.

HOUSE OF LORDS

1st June 1988

The Rt. Hon. Mrs Margaret Thatcher, MP, FRS,
Prime Minister
10 Downing Street
London SW1A 2AA

My dear Prime Minister,

I enclose a report which I have drawn up with other colleagues whom you invited to Chequers in March. We have replied to the questions raised with us in a collective report rather than individually as we thought it might give you a better picture if we consolidated our contributions.

Throughout we have been very conscious that approximately one million voters relate to the NHS on any working day and that there is very strong public interest in your Review. We have tried to introduce elements of competition with financial incentives and penalties at all levels but we have also tried to avoid any further basic reorganisation of structure with the usual consequent disruption.

We have emphasised the absolute necessity of proper Audit and have tried to make sure that there are built-in incentives, not only to encourage excellence but also to ensure the efficient and cost-effective delivery of health care.

If there are any points you would wish to discuss or to have elaborated, or indeed if there is any way in which I can be of service, I should be pleased to do anything you ask.

With best wishes to yourself and Denis.

Yours ever,

Tony.

NATIONAL HEALTH SERVICE REVIEW

May 1988

NATIONAL HEALTH SERVICE REVIEW

Contents:

NATIONAL HEALTH SERVICE REVIEW

The GROUP consists of doctors who were invited to Chequers by the Prime Minister to give opinions on the National Health Service and who, afterwards were asked to enlarge on some of their comments. They felt a coordinated input might give a better picture than individual reports.

Lord Trafford of Falmer

Professor Ian McColl

Professor Cyril Chantler

Dr Clive Froggatt

CONSTRAINTS AND CONSIDERATIONS

1. Seven hundred and fifty thousand to one million voters pass daily through the national health service system and to antagonise a large percentage of these could have a powerful propaganda effect on party fortunes.

2. At present 80 to 90% of consumers, i.e. patients, express varying degrees of satisfaction with health care and 70 to 80% specifically favour the existing NHS.

3. The OECD study on parameters of the outcome of health care systems in a nine nation survey suggested that Britain was not in any way out of line with other similar developed countries, despite the difference in the level of GDP devoted to health care. It is at present therefore relatively efficient and the tight financial control and cash limiting has been effective as a means of cost containment, compared with other systems.

4. Part of the reason for any complaint has been the very success of the health service as operated within the past decade, with increasing numbers of patients treated, operations performed, advances maintained and research carried out. Most complaints in the last nine months have arisen from a small part of the acute sector of the hospital service

only and have been mostly proven to be unjustified.

5. Finally, it is probable that the law of diminishing returns would apply to any increase in money granted to the health service as at present constituted.

REVIEW REQUIREMENTS

Throughout the development of our proposals we have kept in mind certain basic factors of which account must be taken:

1. The proposals must allow:

   (i) An increase in efficiency in the delivery of health care

   (ii) An increase in choice to the consumers of health care, i.e. the patients

   (iii) An increased quality of care with emphasis on medical audit

2. There must be gainers and losers amongst the professionals in the health care field and since the only universal incentive is money, there must be financial incentives and penalties

3. There must be increased competition both in primary care and the hospital care sections

4. There must be an increase in information technology and information systems to enable proper costs to be

evaluated and for value for money to be obtained. Comparative costs and the costs of development would also be available for the first time.

5. The creation of internal markets is essential to increase competition and choice within the framework of the health service.

6. There should be an improvement in the quality of managers and management systems with financial incentives and penalties applied to them also.

PROCEDURE

We have examined and made recommendations on the primary sector, the hospital sector, the management system, the financial system and the private sector.

PRIMARY HEALTH CARE

The gateway to demand in the national health service is largely controlled by the General Practitioners and the primary health care team which deals with approximately 90% of all episodes of illness in the first instance. We would recommend that the present functions of the Family Practitioner Committee are transferred to the District Health Authority (see later) and that the funds for primary care, which should be cash-limited, are channelled through that authority. The General Practitioner would remain an independent contractor but would have a contract as provider of health care with the District Health Authority who would, as buyer of health care, enter into that contract.

General Practitioners would compete for such contracts, laying out for inspection by the Authority and by the public, i.e. the patients, the services that they contract to provide. The provision or otherwise of their contracted services would be used as performance indicators by which to assess the results. Such information must include the rate of referrals to hospitals, the rate of referral to consultants, the rate of domiciliary visiting, the hours of service, the number of sessions available for consultation, the amount of home visiting, prescription rates, the level of screening activity, immunisation rates and the ancillary services at their disposal, e.g. their relationships with health visitors, district nurses, community nurses, psychiatric nurses

and social counsellors. A model contract could be issued by each District Health Authority as appropriate to a particular area to give a guide as to requirements. Patients would have a choice as to which general practice to attend and the payment of General Practitioners by the DHA as buyer would depend upon the results as judged by the performance indicators outlined above. Special audit procedures for quality of care, as described later, would apply to the primary care sector.

The successful primary care team would attract more finance, but failure to achieve the results as judged by the performance indicators on the contract would result in financial penalty.

General Practitioners would be able to refer patients to consultants for opinions or to hospital for admission as at present and would be entirely free to send patients wherever they felt the best service for that patient could be obtained. This would require increased information, for example with regard to the availability of services in the various surrounding districts, the length of waiting lists and the like.

This new, competitive, contractual approach to the delivery of health care with financial incentives and penalties to the provider would increase choice to the consumer; allow control of primary care costs by the buyer of services and improve the quality of service provided by the introduction of compulsory auditing processes.

THE HOSPITAL SERVICE

We believe it is advisable to devolve the responsibility for the running of each Unit as far down the ladder as possible. The District Health Authority would be the buyer of services and would contract for these with individual hospitals which would then, as providers of service, become more self-governing. In some instances, centres of clinical activity could be contractors, especially in areas where most clinical services are concentrated in one centre. In others the scale or nature of the District might dictate that the DHA itself remains the provider of services but it would nonetheless devolve, as far as possible, financial responsibility to individual cost centres.

Within this framework, however, we would strongly recommend that the Griffiths organisation is strengthened and district administration is slimmed (see next section). Each area of medical activity should be defined, brought within one section with a clinical director, and given a specific budget agreed annually with the hospital as contractor to the buyer of services (District Health Authority) or occasionally with the District Health Authority directly. District management would have the added responsibility of implementing the recommendations of an independent audit system.

A detailed survey of how clinical centre budgeting can work has already been presented from Guys Hospital and this system was first introduced there in 1985/6. Its

success is already manifest in the economies effected, the improvement in opportunity for clinicians and, paradoxically, the increased freedom within which they have found they can operate. The management board at Guys with 13 clinical directors and with a Chairman and the DGM, inherited a deficit in 1984/5 of £1.2 million and an inherent overspend in 1985/6 of £300,000 per month. In August 1985 it was apparent that the Unit was heading for an overspend of £5 million, 10% of its budget in that year. The management board tackled this problem and in fact at the end of the year the Unit was overspent by only £1.7 million. By the end of the financial year 1986/7 this deficit had been cleared and the Unit was breaking even. This position was maintained in the year 1987/8 and thus, since the beginning of 1984 the Guys Unit had lost 28% of its beds; its manpower had been reduced by 17% and expenditure by £7.8 million (14%) per annum. Inpatient activity throughout the year is, however, only 6% less than the maximum ever achieved which was in 1982. Insofar as quality control can be applied, it would seem that there has been no deterioration in quality at all.

The above example is a measure of what can be achieved by a determined management in the right context and supported by the right framework.

However, there are certain potential prerequisites:

(a) Professional health service administrators and managers tend to have mixed feelings about the involvement of clinicians in hospital management,

as indeed do clinicians themselves, but it is important to distinguish between professional accountability and management accountability. A clinician is professionally accountable to his patient, audited in various ways, some traditional and some by various professional bodies such as the Royal Colleges, and of course by law. Responsibility and authority must be coterminous and commensurate and if the responsibility to provide a clinical service is to be taken by a group of clinicians with a clinical director, then the authority commensurate with that responsibility must be transferred to this individual.

All this will require a change in the consultant contract and we would now recommend that this should be with the District Health Authority for a period of seven years (renewable) with special recognition for various duties such as those of clinical directors.

(b) The introduction of proper management budgeting throughout the service so that expenditure is under the control of named individuals who can receive their budgets and can check expenditure at regular intervals and take action where necessary, will require a considerable increase in expenditure on information technology and information systems.

(c) Districts and their component hospitals should be seen as being in competition with each other. It is essential to have an internal market operating throughout the hospital system. Thus, referrals from primary care would be to the District or hospital that provides the best service and, according to that service, finance follows. Thus, should Hospital A steadily fail to attract patients and have a low bed occupancy, low utilisation of theatres or long waiting lists, whereas Hospital B has the opposite, the money would flow to Hospital B rather than Hospital A. Since all concerned in Hospital B would then be obtaining more return than Hospital A in financial terms, it would be in the interests of Hospital A and all therein to improve their services, or should they fail to do so, ultimately to be taken out of service altogether.

(d) Financial incentives for successful results are built in both by the flow of money and the change in the consultant contract. Failure to match up to contracts or performance indicators would produce a financial penalty, whereas success would provide a financial incentive.

(e) The position of hospitals of tertiary referral, e.g. special centres for example neurosurgery, cardiac surgery, transplantation, renal dialysis and so forth would also be competitive but in their case the market would be mainly referral from other hospitals. Thus, to take a specific example,

if Guys fail to provide a service to the South East that Kings College Hospital can provide, the patients would tend to flow to Kings College Hospital and once more with them would go the finance. Kings would therefore do better than Guys unless and until Guys changed its habits and became more competitive. It would obviously be of great interest to any referring District as the buyer of health care services to take note of the cost as well as the quality of the service provided at Guys and Kings and one would expect that, in practice, various departments or units at each hospital would develop a particular pre-eminence

(f) The maintenance of requisite local health services in teaching hospitals would remain so that their educational function could continue but as largely pertains at present, finance for the teaching and payment of extra salaries for teaching purposes could come from the SIFT (Special Increment for Teaching).

(g) The position of medical research in the national health service is slightly different and the above system would not allow for research activity. In line with the House of Lords Science and Technology Committee Report on the Medical Research Council, we feel that the setting up of a National Health Service Research Authority, under the aegis of the NHS Management Board for the purposes of funding such research, again on a competitive

basis, would probably best answer this requirement and it would not preclude application to other funding bodies, e.g. Science Research Council or the MRC for further or special project funding. Essentially the National Health Service Research Authority would be concerned with clinical research and applied research, related to the quality of medical care and the delivery of health care.

Joint planning arrangements with the MRC, the charitable trusts and industry should take place to avoid duplication and waste of money or effort.

MANAGEMENT

The buyer of services in the health service should be the District Health Authority. We would see the district health authorities reporting directly to the National Health Service Management Board which would operate more as a holding company operates in a large commercial organisation. (The Department of Environment deals with over 600 councils in England and Wales and it would therefore not seem unreasonable to suggest that the Management Board could deal with less than 200 district health authorities). If devolution of finance along the lines suggested in previous sections of this paper was followed, there would be little necessity for the NHS Management Board to hold for itself large sums of money but it would be responsible for the National Health Research Authority, SIFT and no doubt it would hold a small contingency reserve.

We would see the NHS Management Board with an independent Chairman appointed by the Secretary of State, as the controlling body of the Health Service. We believe it must have the requisite powers and 'bite' but it would of course remain responsible to Ministers and Parliament.

It could decide to keep small Regional offices but we would feel it would be better to have, in its own headquarters, arrangements for a form of Regional advice or action designed to suit its own pattern of management. The NHS Management Board would receive and have to act upon the advice of the independent audit and/or health

inspectorate (see below) and could refer questions to either for examination. The Inspectorate and the Auditors would report to the Board and the Secretary of State who could also refer questions.

The inevitable corollary of the above changes would be a very much smaller Department of Health and a reduction in the existing Regional Health Authority staff numbers.

We would recommend removing from the Department of Health all responsibility for building, maintenance, capital planning and capital allocation. All funds, therefore, apart from the minor ones mentioned above, would be devolved to the District Health Authorities as a block grant which would vary depending upon the amount of services they ought to provide (see example of Hospital A and Hospital B in previous section); there would be no distinction between capital and revenue and for capital purposes the District would have to apply to the market to obtain finance, obtaining only general approval from the NHS Management Board and not the detailed option appraisals, AIP's, Capricode system that now operates and which is so enormously wasteful.

The District Health Authority itself should consist of an appointed Chairman, the Executive Officers (the DGM paralleling the Managing Director of a commercial organisation), a finance officer (Finance Director), Nursing and Personnel, District Medical Officer (responsible for primary care) and five non-executive directors appointed by the Secretary of State, one or two of whom would be from the Community Health Council

to allow for the input of local opinion. Many of the present deficiencies of District Health Authorities would disappear if their management was coordinated in this fashion and their present subjection to political whim, union pressure, local lobbyists and the like would be significantly reduced. Decisions could then be made on their merits, made quickly and put into effect. It would be incumbent on the District Health Authorities to enter into contracts with primary care teams (GP's), hospitals and in some cases clinical budget centres, and to privatise as many services as possible, e.g. hotel services, laundry services, etc. Clearly in all these quality control would be of the essence. There is no intrinsic objection to privatising radiology services, pathology services, nursing services and so forth, but these would probably be better organised as part of an internal market with the clinical services buying from these units whatever service they actually require to carry out their function.

As far as planning services and building and maintenance services are concerned, these should be abolished and private contractors used. All these functions would be subject to quality control but there is no reason why they should not be more efficient and cost-effective than at present.

There would be no specific limitation on precisely how a district health authority carried out the tendering of the above services or whether it operated them by using in-house management. The costs and efficiency

would be reflected as part of their competitive position and would soon become apparent to the authority concerned, relative to other authorities who may use different methods.

Once again, the basic principle is that the District Health Authority would be the buyer of the hospital services, operated through its various general services, e.g. nursing, pathology, portering services, etc. and also through the hospitals and/or clinical directorates and could adjust its allocations of finance accordingly. If its overall cost was much higher than that of an adjoining district, providing exactly the same services, its allocation would be adjusted accordingly by the National Health Service Management Board. It would therefore be in the interests of districts to compete and for all their services to be efficient to enable them so to do. If a district found that its services being provided were not used because of inefficiency or poor quality, and that its primary care contractors were sending their patients to other districts, once again this would become apparent to the authority who could take the appropriate remedial action. It must be recognised that the real virtue of competitive tendering or privatisation is not necessarily the direct assault on high costs but rather an attack on the factors that tend to cause them such as organisational rigidity. It makes managers in the NHS actually define the services they require and would break the local monopoly operated by the present service providers.

Competition between services, between hospitals or between districts probably would save money but certainly would improve efficiency and provide a better service.

To effect these changes it would be necessary to buy out consultant tenure and to change the consultant contract but we see little reason to continue with the concept that a consultant is appointed for life, or for that matter that every doctor should have a job which is the basis of many of the manpower problem that afflict, or are thought to afflict the National Health Service at present. Once the concept is accepted, as indeed it is in Germany, America and elsewhere, that doctors have no more right to a specific job or jobs for life than any other member of the community, manpower problems become easier. There would have to be some changes regarding the responsibility of District Health Authorities and the functions of the National Health Service Board, but essentially, all the above changes would retain the current framework but create an internally competitive and more efficient market.

Other systems have been discussed and each have their advantages and disadvantages, but in many respects it is a question of a choice of which problem one would prefer to tackle. This scheme, for example, removes the question of whether the national health service is a curing or caring service, for the DHA as buyer would make a choice of whether to provide such services

in-house at a certain cost, or to privatise them, or to put them out to tender, perhaps covered in the contract of certain primary care providers.

The financial incentive and disincentive for DHA's lies in their success or failure in buying services that attract custom. Salaried directors or members of the DHA should have a significant part of their salaries performance related so that they have a definite financial interest in the outcome of health care services for which they would be responsible.

THE PRIVATE SECTOR

Much has been made of the possibility of expansion of the private sector to absorb some of the demand on the national health service. If, however, an internally competitive service such as the above is operated, then the national health service would tend to see all patients going to the private sector as potential lost customers. Equally, if the private sector was expanded dramatically, the amount of staff it would tend to draw from the NHS, which is its main source of supply, would severely detract from the capacity of the health service to meet its commitments. The further one extends the competitive market to the health service itself, the less necessity there is, from the point of view of buyers of the service, to look to the private sector.

At the present time, however, the consumer who insures himself buys the provision of a slightly higher standard of hotel care, better manners and increased opportunity to have whatever procedures he requires to be carried out at a time convenient to him. Since this is a private contract between the consultant and the patient, the consultant is frequently content or compelled to operate in unsocial hours and to do more things himself than he would normally do at present in an NHS hospital. Introduction of more competition and the change of the consultant contract in the health service would tend to produce the same effects within

the health service and therefore once again would be more likely to equate the two. There would, however, be no reason why a district health authority should not use the private sector as at present constituted on a contractual basis for a great deal of its elective surgery (which is the main function of the private sector at present) and therefore reduce its own in-house costs. It is probably in these fields that the private sector could be most useful.

It is beyond our remit and our expertise to discuss any tax changes for private insurers and their likely effect but it is probably in the sphere of comparative practices that examination of the private sector is of most value relative to the problems of the health service.

FINANCE

Once again, it is outside our expertise to comment on financial changes that are possible and whether or not the health service should be completely funded solely from the national tax system. Our only major suggestion in this field has been that the present division between capital and revenue allocations cease and that all monies should be devolved to the District Health Authority who will then raise capital from the market to carry out its capital programme. There are many areas in the country which are firmly convinced that a larger capital programme would produce significant revenue saving.(For example SE Thames Region - see appendix 1). If this view were accurate, then clearly they should be allowed to proceed. The only limitation upon this would be that the District Health Authority would have to obtain the approval of the National Health Service Management Board for expenditures over £5 million and they themselves would probably have to obtain permission from the Treasury for anything in excess of £25 million which is roughly the current position.

All the intermediate stages of the concealed cost of planning, the huge mostly under-used departments concerning planning, building, engineering, architecture, etc. in the Department of Health, the Regions and the Districts could all be abolished.

The District Health Authority would be the same as any other customer to the architects and builders and the approval that would be obtained from the National Health Service Management Board would not need to be in the detailed form that is currently required with AIP and Capricode procedures.

We recognise that the devolution of money to Districts, the use of clinical cost centres, privatised tendering, the movement of money with the patient, either in the primary care setting or within the internal hospital setting, would all require an expansion of financial support for information systems. This would probably be necessary in any event in view of the necessity to move the whole national health service from a basis of input statistics to output statistics.

AUDIT AND HEALTH INSPECTORATE

At DHA level there should be an independent audit department that reports publicly on the performance of the DHA as buyers of services and the primary care contractors, and the hospital (and/or clinical service centres) as providers of services. This is an essential ingredient of our scheme as audit of what is performed and how effective it is remains crucial to the maintenance of quality in the service. The pattern of its function could be that of the Audit Commission which already has a proven record of success.

At national level a national audit department could provide the NHS Management Board with vital information to carry out its particular function and could correlate district auditing exercises, thus enabling direct comparisons of efficiency, quality and cost to be made all over the country. (A notional national figure for general or specific costs could then be published as a yardstick and comparisons in any district could be made with the actual charge. This is analogous to the national average and the actual community charge in the proposals relative to Local Government Finance).

Alternatively, or in addition, a health inspectorate along the lines of HM Inspectors of Education could be set up and other functions, also, if desired, such

as consultancy, comparative clinical efficiency, research auditing activity, or even local enquiries or reports, sometimes paralleling the Ombudsman could be carried out. The latter type of role may have advantages and disadvantages to Ministers responding to NHS questions.

CONCLUSION

In reviewing the existing problems in the National Health Service, we have looked at various systems and come to the conclusion that in many respects, as they all have their own virtues and drawbacks, it is largely a question of which type of problem one would wish to tackle. We have produced what we believe to be the least damaging in terms of restructuring or reorganisation and the least likely to require significant legal change. The greatest outcry would probably come from the medical profession and secondly from the unions who have always objected to any form of competitive tendering. However, we believe that a solution along the lines we have outlined by building in at all levels financial incentives and financial penalties would increase efficiency, provide a more cost-effective service, enable quality control to be carefully monitored, improve the requirements of consumer need (and up to a point consumer choice), allow for future medical developments and provide an overall system of health care that does not depart from the fundamental ethos that has served the nation well by and large for 40 years, but at the same time would carry it forward and allow change into the next century. Running through every proposal is our insistence that it is the output statistics that would be emphasised and that quality control (or medical audit) is fundamental to future development.

APPENDIX I

South East Thames Regional Health Authority

Capital for the Acute Sector

There are several major acute schemes which could take place but which are unable to proceed because of lack of capital funds. The rationale behind these schemes is a combination of the following factors:

(1) The need to replace old and obsolete stock which is unsuited to the provision of efficient or effective medical care

(2) The need to eliminate unnecessary duplication of medical and diagnostic services caused by the spread of acute specialties over a number of sites which are within relatively close geographical proximity

(3) The need to rationalise the level of land-holding and to reduce the level of fixed costs associated with state maintenance as well as providing more energy-efficient building stock.

An example of this is the proposed development in the Bromley Health Authority. Their acute services are provided at Farnborough Hospital, Orpington Hospital and Bromley Hospital. The ward sizes are inefficient, resulting in the need for higher nurse/patient ratios than would be necessary in a modern ward design. Diagnostic services

services are replicated on all three sites and the spread of specialties over the sites militates against efficient working relationships. A capital development programme has been worked out at an estimated cost of £86 million, but land sales resulting from rationalising the number of sites should produce approximately £50 million to off-set against this cost. The service benefit is that replacement equipment costs will be reduced; utilisation of equipment will be optimised and a projected increase of 4,000 cases per annum will be achieved as well as producing a revenue saving of approximately £1.2 million per annum which is 4% of current costs.

Similar examples are Camberwell, Dartford, Hastings, Tunbridge Wells, Canterbury and Thanet, and Greenwich.

Capital for Priority Care Services

There are seven major mental illness and mental handicap hospitals in the Region which have land holdings in excess of one hundred acres and a further hospital in Wandsworth of about thirty acres. The Region's problem stems from the difficulty in investing in new services in advance of cleared sites being available for sale. The pace of transition is therefore constrained by the amount of capital available from the general programme. This results in a very slow pace of change and also

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cc Sir P Middleton
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MR WICKS

Review of the National Health Service: Press Articles

There have been four press articles on the Government's Review of the National Health Service in the past three days:

- by George Jones, in the Daily Telegraph, on 7 June;

- by Charles Price, in the Evening Standard, on 7 June;

- by Nicholas Wood, in The Times, on 8 June; and

- by Nicholas Timmins, in The Independent, today.

The first and third of these articles (copies attached) give cause for concern as they contain new information which could only have been obtained, directly or indirectly, from sources with access to the review which Ministers have been carrying out, and perhaps to the meetings of Ministers themselves. There is no evidence of papers having been passed to journalists, and I do not see any purpose in initiating a formal leak inquiry, but I have discussed the articles with senior officials from the Departments concerned in an attempt to discover how they may have come to be written, and what precautions we can take against further articles of this kind.

2. Both of the articles which worry us contain much material that could have been obtained from published sources, and some information that is inaccurate and to some extent incoherent. This points to the conclusion that they are not based on deliberate or inspired leaks. But elements in each do appear to have come from sources with inside knowledge. George Jones'

article includes the sentence "'Some measure of tax break for private health insurance is very much on the cards', said one official closely involved in the review". Mr Jones is not the sort of journalist to invent direct quotations, and the substance of it is accurate. He also says 'One option under active consideration is the relief targeted at elderly people', information which is both true and up-to-date.

3. Mr Wood's reference to restricting tax relief on private insurance to people prepared to cover themselves for elective surgery such as hip replacements is also close to one aspect of Ministers' discussions.

4. Another important feature of these articles is their timing: both appeared within 24 hours or so of the meeting of Ministers on Tuesday, and it would be surprising if the coincidence were accidental. They also address the subjects discussed at the meeting.

5. The mixture of inaccurate and authoritative information in these articles, and the absence of any obvious motive in the disclosures leads me and my colleagues to conclude that the authors assembled these pieces from a variety of sources. We know, for example, that on Monday Mr Jones telephoned a Special Adviser at the DHSS (who immediately referred him to the Press Office). There were no doubt other telephone calls. One of these may well have led him to more information than he should have had.

6. Although it is unrealistic to expect to locate the source of the inside information which appears in these articles, we must do what we can to avoid a repetition - not least as the review moves into an even more sensitive phase in which Ministers will be invited to take specific decisions on the future of the Health Service. First, I think that we need to ask Departments to keep confidential the timing of future meetings of Ministers,

as it seems that the knowledge of imminence of such meetings stimulates this sort of 'fishing expedition' by journalists. Secondly, I suggest that all officials and Special Advisers engaged in the review need to be warned of the dangers of any sustained conversations with journalists on matters relating to the review. Any discussion, however guarded, beyond a clear refusal to discuss the subject, is liable, inadvertently, to lead the journalist to try out, and perhaps confirm, conjectures.

7. If the Prime Minister agrees, I shall ask Departments to make arrangements to implement these two recommendations.

8. I am copying this minute to the Private Secretaries to the Chancellor of the Exchequer and the Secretary of State for Social Services.

R.B.

ROBIN BUTLER

9 June 1988

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Split over tax incentives to boost private health cover

By Nicholas Wood, Political Correspondent

The Government's review of health policy developed yesterday into a struggle between the Treasury and the Department of Health and Social Security.

Mr Nigel Lawson, the Chancellor of the Exchequer, has declared his opposition to proposals from Mr John Moore, the Secretary of State for Social Services, to give everyone a cash incentive to take out private health insurance.

Mr Lawson's rejection of a health tax break is set out in a Treasury memorandum submitted to the group of ministers chaired by Mrs Margaret Thatcher, which is conducting the review.

Nevertheless, Mr Lawson has left the door open to some limited form of sweetener to those considering switching to the private sector.

And Mr Moore is seeking to capitalize on this by advocating a less ambitious shake-up of the existing system.

He is understood to be arguing for a limited scheme under which tax relief, for instance, would be restricted to elderly people insuring themselves privately or people prepared to cover themselves for such surgery as hip replacements.

As *The Times* reported last month, Mr Moore originally recommended that people should be able to opt out of the NHS and pay a lower health stamp or tax if they took out private health insurance.

Mr Lawson's initial reaction left health ministers believing that thay had overcome the traditional Treasury opposition to such special arrangements, but it has since become clear that the Chancellor is sceptical of this approach.

In his memorandum, submitted within the past fortnight, he cautions against such a change on three grounds:

- The cost to the Exchequer of extending tax relief on private health insurance to the 5½ million people covered by such schemes – likely to run into hundreds of millions of pounds without relieving pressure on the national health service.
- The danger that once the principle of tax breaks for health insurance was established, pressure would grow for similar concessions for other forms of expenditure such as education.
- The fact that such a change would conflict with the Government's underlying principle of neutrality in taxation.

Mrs Thatcher, while attracted to the radical nature of Mr Moore's proposals, remains unconvinced about their political wisdom.

She and senior ministers are aware that to boost the private sector will leave them open to the charge of introducing a two-tier service.

The new ideas seem certain also to include managerial changes to cut red tape and strengthen the consumer voice in the NHS by giving greater powers to health authority managers and introducing an internal market to reduce waiting lists.

Ministers hope that they will complete the review in time for the Conservative Party conference in October.

The Government is setting up a committee to review ethical guidelines on the medical use of foetuses.

It follows recent cases when foetal brain tissue was transplanted into patients with Parkinson's disease. Professor Edward Hitchcock, of the Midland Centre of Neurosurgery and Neurology, Birmingham, has carried out three operations using foetal tissue.

The committee, chaired by the Rev Dr John Polkinghorne, Dean of Trinity Hall, Cambridge, will include Sir Raymond Hoffenberg, president of the Royal College of Physicians, Professor Ian Kennedy, Professor of Medical Law and Ethics, King's College London, and Dr Sally McIntyre, Director MRC Sociology Unit, Glasgow University.

Sympathy for t

The Queen Mother at Enniskillen yesterday with Mrs Joan Wils

By Paul Vallely

Outwardly there was little to distinguish the bomb victims from the rest of the crowd who gathered yesterday to watch the Queen Mother fly into Enniskillen to open a newly restored National Trust mansion only a mile away from the spot where last November a bomb ripped through a Remembrance Day crowd.

They stood among a crowd of guests at Castle Coole which the National Trust boasts is perhaps the finest neo-classical house in the country. But they offered none of the nervous smiles or neat curtseys which distinquished the local dignatories and the craftsmen who have worked on the restoration.

For the survivors of the IRA bomb and the bereaved, the ceremony was a painful reminder of the day last November when 11 people died and more than 16 were injured by the blast.

The Queen Mother said: "On this visit to Co Fermanagh my thoughts must inevitably turn to the events at Enniskillen on Remembrance Day last year only a mile or so from here.

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Satellite television

'Low cost' deal anno

By Richard Evans, Media Editor

Satellite television channels controlled by Maxwell Communications, W H Smith and British Telecom are to be marketed jointly to individual homes in a "single low cost package", it was disclosed last night.

The companies control or are significant shareholders in the Premiere film channel, the Home Video Channel, Screensport, Lifestyle, MTV and the Children's Channel. The trio, which will jointly fund a new company to market their product to British viewers buying satellite dishes, plan to place their channels on the same medium-powered satellite and are inviting bids from SES, the Luxembourg-based financial consortium, which is launching the Astra satellite this November, and Eutelsat, whose satellite launch is planned for 1989.

The announcement came on the eve of today's press conference being given by Mr Rupert Murdoch where he will unveil News International's satellite television plans. Mr Murdoch is expected to disclose he will be leasing up to four channels on Astra and use PAL, the transmission signal currently used

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continue to pay for their bed and breakfast hotels.

The families, including 46 children, will live in the church hall off Bethnal Green Road until other accommodation is found.

The council found that the families were intentionally homeless because they had left accommodation in Bangladesh.

Yesterday the Bishop of Stepney, the Rt Rev James Thompson, appealed to the council to reconsider its decision.

"This is of great concern to us as Christians. We hope that other authorities will take note of the people," he said.

The council was ordered by the Court of Appeal in April to examine afresh the cases of 12 Bengali families.

Tower Hamlets said yesterday that it had done so and decided another 30 families would be similarly treated later this month.

It said that the heads of the families had lived and worked in Britain for many years and had exercised their rights to bring their families to join them.

Tax concessions plan for private health

Continued from P1

and their pay is being more closely related to performance.

● **Peter Pallot**, Health Services Staff, writes: Doctors last night pointed out that giving tax relief on private insurance could be difficult for the very old and very young.

"They still need to be treated, as well as people who develop serious long-term diseases like cancer which have to declared at annual renewal time," said a spokeswoman for the British Medical Association.

But she added that family doctors would welcome the chance to do more minor surgery on their own premises.

"The general practitioner committee of the BMA have been pushing for this for five years because GPs can see that this is a sensible extension of what they can do to relieve the pressure on hospitals."

Private medicine is expanding rapidly, with the proportion of those covered by insurance topping 10 per cent for the first time last year.

Last month BUPA unveiled plans to attract two million more into independent medicine on top of the 5½ million already privately insured.

Mr Roy Clarke, a senior executive, said "Budget BUPA" was the first "package deal" between private and public sectors, with a third of health authorities agreeing to fixed-price deals to mop-up spare pay-bed capacity at weekends.

A spokeswoman for BUPA said: "We are not asking for tax relief on private medical insurance for all our members, but we would welcome it for those who are pensioners."

She said the private insurance industry was worried about the effect withdrawal of tax concessions would have if there was a change of government.

For a man aged 40 to 45 to insure himself and his family costs about £400 a year.

Assuming that current subscribers are in the higher tax bracket, they could expect relief of £160.

But one of the Government's problems in granting relief is the high cost of giving relief to existing subscribers before the benefits of pulling in more patients could be counted.

The private sector has 203 acute hospitals — compared with 2,400 in the NHS — and is calculated to be supplying services worth about £1 billion a year.

trimaire arguments, Lord Bruce-Gardyne came back *con feroce* to hammer the point home.

It would be helpful, he said, "if Her Majesty's Government bears in mind that we were told persistently in the case of Concorde that it was always better to put in further money rather than to lose our investment. That wasn't true."

"I hope my noble friend is aware that we are under new management," the Secretary of State said, succeeding in silencing Lord Bruce-Gardyne.

The main business was the committee stage of the Local Government Finance Bill.

Having failed to link the community charge to ability to pay, the Lords have decided not to give up on the fine print, but to torture Lord Caithness, the Minister, on every clause.

Certain wraith-like figures of internal opposition, such as Lord Pym, sat minatorily behind Lord Caithness, radiating gloom.

Lord McIntosh of Haringey, as befits a man who has chosen a dog-track as his territorial designation, hounded the Minister on

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PASSPORT CONTROL

Today's prize: A peaceful and relaxing holiday on the island of Menorca staying in a serviced apartment near the bustling village of San Jaime, with the free use of a hire car

VillaSeekers

plus £1,000 holiday spending money or
£1,800 in Thomas Cook Travel Bonds (designated prize value)
How to enter: Tel. 01-541 4040 for your Passport and competition guide.

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WEATHER

GENERAL SITUATION: Weak high-pressure ridge over central areas.

LONDON, SE & E ENGLAND, E ANGLIA: Some sun; rain in places before evening. Winds N light to moderate. Max 63F (17C).

CEN S, NW & CEN N ENGLAND, E & W MIDLANDS: Mostly dry with spells of sunshine. Winds N to NE light. Max 66F (19C).

SW ENGLAND, WALES, LAKE DIST, IoM: Rather cloudy start with some rain; brighter and drier later. Winds E light. Max 64F (18C).

NE ENGLAND, BORDERS: Dry with some sunshine. Winds E light. Max 63F (17C) but cooler on exposed coasts.

S NORTH SEA: Winds N force 4 or 5. Sea moderate.

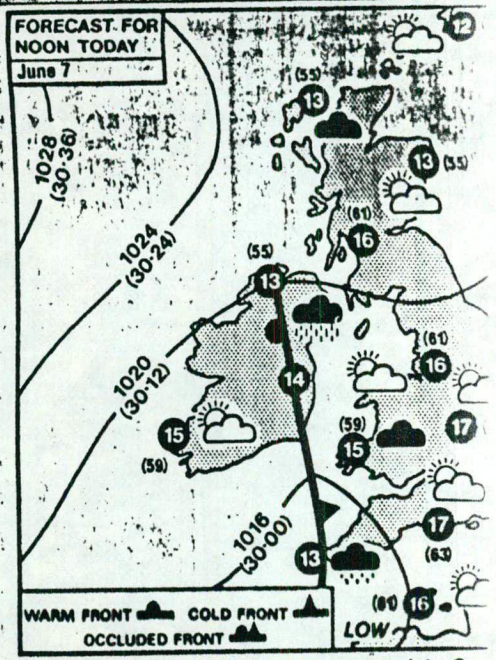
DOVER STRAITS: Winds N 4. Sea slight.

ENG CHAN (E): Winds variable 1 to 3. Sea slight.

St GEORGE'S CHAN, IRISH SEA: Winds SE 1 to 3, later NE 4. Sea slight.

OUTLOOK: Rather unsettled; becoming warmer over England and Wales.

Lighting up 9.44 p.m. to 4.16 a.m. (Manchester 10.03 p.m. to 4.12 a.m.). Sun rises 4.45 a.m. sets 9.14 p.m. Moon rises 1.34 a.m. sets 12.58 p.m. High water at London Bridge 7.55 a.m. (6.6m),



Black circles show temperatures expected in Cen
brackets). Arrows indicate wind direction and spe

Minor operations role for GPs

Tax concessions plan to boost private health

By George Jones, Political Correspondent

TAX CONCESSIONS to encourage more private health insurance and new incentives for general practitioners to carry out minor operations in their surgeries are emerging as leading options in the Government's review of the Health Service.

Both the Prime Minister and Mr Lawson, Chancellor of the Exchequer, are ready to drop their long-standing opposition to "tax breaks" on private health insurance premiums in an effort to boost the relatively low level of private contributions to health.

At the same time, ministers are looking at ways of expanding the role of the country's 25,000 GPs to see if they can ease the pressure on overburdened hospitals.

The idea is that family doctors should offer a wider range of services, including carrying out minor surgery requiring a local anaesthetic in their surgeries rather than automatically referring patients to a hospital waiting list for treatment.

The review of the Health Service was initiated by the Prime Minister earlier this year at the height of the political controversy over cash shortages and delayed operations.

Firm conclusions are not expected until after the summer, but it is clear that the review is coming down against the more radical options for re-structuring the Health Service — such as the right to "opt out", promoted by Right-wing advisers in the Downing Street policy unit.

Instead, the review is drawing up "evolutionary changes" building on the basic principles and strengths of the NHS.

The softening of Treasury resistance to tax relief on private medical insurance is a significant victory for Mr Moore, Social Services Secretary, who is fighting back after the mauling he received in the furore over the NHS.

In an interview with The Daily Telegraph in January, Mr Moore identified the extension of private health insurance as one of the main ways of increasing funding for the Health Service, adding:

"I see a need to encourage a much greater private sector contribution."

Initially there was a hostile response to the suggestion from both Downing Street and the Treasury, which were concerned about the £150-£200 million cost of allowing tax relief on private health insurance contributions.

Government sources confirmed last night that both Mr Lawson and the Prime Minister were now ready to consider incentives for encouraging private medical care.

"Some measure of tax break for private health insurance is very much on the cards," said one official closely involved in the review.

The Chancellor signalled his conversion in a speech to doctors on Friday in which he said the 5½ million people with private medical insurance were relieving the burden of demand on the NHS.

He described the growth of about three per cent a year in the number of employer-paid health insurance schemes as a "welcome development", adding:

"But I believe that even more could be achieved by the development of more imaginative health insurance products."

One option under active consideration is tax relief targeted at elderly people.

As Mr Lawson pointed out, increasing mumbers of people have private health insurance in schemes paid for by their employers — but this often stops on retirement, at a time when they are likely to begin making demands on the Health Service.

Mr Lawson has also emerged as an influential opponent of more radical proposals for an "internal market" within the NHS — giving health authorities and patients the right to seek the quickest and most effective treatment from NHS or private hospitals anywhere in the country.

The Treasury is worried that such a reform could lead to a big escalation in costs and is fighting a rearguard action to maintain tight controls over NHS funding.

But it is ready to give hospitals more scope to contract out some clinical services to private hospitals where it can be shown this gives better value for money.

The review, chaired by the Prime Minister, has identified doctors as the key to improved efficiency in the Health Service.

An experimental resource management initiative in five hospitals, which involves doctors directly in the comparing the costs and effectiveness of treatments, is to be extented right across the NHS.

Family doctors are regarded as particularly crucial because they deal initially with the vast majority of medical problems and regulate the flow of patients to hospitals.

In off-the-cuff remarks last Friday, Mrs Edwina Currie, the junior Health Minister, said GPs should spend more time treating patients and less time licking stamps.

She said it took nine years to train family doctors, and she chided them for referring patients to hospital without considering whether they could do the work themselves.

Ministers are looking at ways of encouraging GPs to carry out in their surgeries more minor treatments often referred to hospitals.

The Government is already taking powers in the Health and Medicines Bill before Parliament to enable family doctors to take on more staff and to improve their practice premises,

Continued on Back Page

INSIDE TODAY

Happy triplets — but multiple births can also mean multiple problems
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A campaign is growing to stop South Korea's slaughter of dogs for food
PAGE 19

George Walden MP believes it is time to abolish mortgage relief
PAGE 18

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WEATHER

Mainly dry; some sun. Details Back Page

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CONTRACTING OUT

9.6.2

SECRET

CHANCELLOR

FROM: R B SAUNDERS

DATE: 9 June 1988

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

NHS REVIEW: CONTRACTING OUT

I attach for information the draft DHSS paper which we were shown at official level before the last meeting but which Mr Moore was persuaded not to circulate. Presumably he will circulate something similar for the next meeting, although we do not yet know how much it is likely to change.

2. He proposes to:

- juggle with NICs and the NI Fund as proposed in your earlier paper

- allow contracting out of cold elective surgery

- pay an age-related rebate (ranging from some £15 for children up to £54 for those aged 55-64).

3. In our view these are very little different from the proposals set out in your paper and which were rejected at that time. We suggested that contracting out would cover effectively whatever the insurance contract covered. In practice, the bread and butter of insured treatment is elective rather than emergency. The DHSS proposal would appear to omit medical rather than surgical treatment, but that does not seem greatly to affect the

SECRET

principle one way or the other. The proposed rebate is age-related rather than flat rate. But these are variations around quite small numbers (an annual rebate of £21 at age 16 rising to £37 by age 54) and again do not seem to me to imply significantly different behavioural effects from those described in your paper.

R B SAUNDERS

SECRET HC ( )

DRAFT

CONTRACTING OUT

Note by Secretary of State for Social Services

At our next meeting, we are to resume our discussion on how best to encourage the growth in the private health sector.

2. The two particular options we identified in our earlier discusion were tax relief for private health insurance premiums paid by the elderly and exempting health insurance premiums paid by employers under a company scheme for tax as a benefit in kind.

3. When we look at these options in the light of the Chancellor's further paper, I thought it would be helpful to colleagues if at the same time we looked at the way in which those options might be complemented by a limited system of contracting-out.

4. I therefore asked my officials to prepare the attached note which sets out how such a system might work.

5. Basically, the proposal is that those paying National Insurance contributions would be able to contract out of NHS funded provision of cold elective surgery in return for an age related contribution rebate. It would be a condition of contracting-out that the employee concerned was covered by an appropriate health insurance policy with an approved insurer. The policy would be taken out individually, or by a company. So the model would be broadly similar to contracting-out of the additional component of the state earnings related pension scheme. The cost to the National Insurance Fund of the rebates would be matched by an equivalent increase in the Treasury Supplement, on the lines mentioned in the earlier paper circulated by the Chancellor, so that contribution rates would not be affected,

6. I accept that - taken by itself any system of contracting-out has deadweight costs: the same applied to contracting-out of the state pension scheme. I also accept there will be extra administration costs, though we can minimise these by making good use of our pension machinery, including that developed for personal pensions.

7. But these drawbacks could be substantially outweighed by the value of an effective stimulus to the development of a mixed economy of public and provide health care, with more competition and choice. If we were to implement all three options, it would provide such a stimulus, which should pay for itself in the longer if not shorter term. What is more they would be a stimulus which would complement provision under the health service rather than provide an alternative to it. It would enhance freedom of choice but not at the price of our appearing to open the door to a second class service in the NHS. It would also have the advantage of making a major impact on one of our weak spots - waiting times for cold elective surgery.

SECRET

CONTRACTING OUT

Draft 2.6.88

1. This note describes a limited scheme for contracting out incorporating two key features:

- adoption of the proposal contained in the Chancellor's paper. "A scheme for contracting out of the NHS" to increase the NHS element of NICs, with an increased Treasury Supplement.

- the facility for NIC payers to "contract out" of NHS funded provision of elective surgery in return for an age related contribution rebate. This rebate would contribute to the cost of an appropriate health insurance policy with an approved insurer.

2. The way in which a scheme of this sort might operate is discussed below. A number of more technical questions are covered in the Annexes. However, the major operational consequences of the scheme would be:

- Tax and NI rates could remain unchanged. This would avoid the disadvantagous distributional effects of a wholesale transfer to NI funding, although losing the important advantage of transparency of expenditure explicit in complete hypothecation.

- There would be no question of NI contributions establishing entitlements to treatment. All who wished to do so would remain entitled to the full range of state funded NHS treatment. Only those who voluntarily chose to contract out would lose entitlements to state funded elective surgery.

- Although people would remain at liberty to insure privately against as wide a range of medical contingencies as they wished, the major stimulus of the rebate scheme would be to the new low cost policies covering elective surgery increasingly offered by the major private insurers.

Operation of the scheme

3. Finance

- The value of tax and NI revenues for the NHS and social security implied by the Treasury's contributions scheme are shown in the table in Annex 1.

4. Collection of contributions

- Employers would continue to collect health and appropriate NI contributions from employees.

- As the NHS would be only partially financed from NICs employers are not required to identify their employee's monthly health contributions separately on pay slips.

5. Contracting out

- Contributors may contract out of state funding for elective surgery on behalf of themselves and their immediate dependants.

- As a condition of the rebate individuals must arrange, at least, a minimum approved insurance cover, either through their employers or on a personal basis. The required minimum insurance would cover a defined list of the main elective surgical procedures. A number of policies covering precisely these procedures are already on the market, for example the "Budget BUPA" plan (see Annex 2).

The contracted out patient's route to treatment

6. Non-emergency admissions:

- Following consultation with a GP, a contracted out patient would be referred to either a private health care provider or for admission to an NHS pay bed.

- Both public and private health care providers would ascertain the willingness of insurers to pay for private treatment before admitting a patient.

7. Emergency admissions:

- In the case of emergency admission to an NHS hospital, the health authority concerned would be empowered to seek any payment due from private insurers. As all patients must be either privately insured or fully "contracted in" to the NHS, there could be no question of patients being denied treatment which they urgently required.

8. Pre-existing conditions:

- These will not generally be covered by private insurers.

- Patients' GPs, being aware of the existence of these conditions and any exclusions from private health cover that they involve, could make references for state funded treatment as appropriate.

- Patients in these circumstances will have a guaranteed entitlement to state funded treatment for those conditions not covered by their private policies.

9. **Exclusion from state funded treatment of those contracting out**

In practice, exclusion would be self policed, as non urgent treatments are those for which waiting times apply in the NHS but immediate access and treatment is available in the private sector.

10. **Rejoining the state scheme**

Contracted out patients could rejoin the state scheme at the end of their private insurance contract periods. Private insurers would be responsible for informing DHSS that a policy with a particular subscriber has lapsed. However insurers should be prevented from encouraging patients to return to the state scheme in the case of mid contract episodes of ill health. For this reason it may be necessary to make insurance policies offering excesses, co-insurance and no claims bonuses ineligible for the rebate.

11. **The value of the contracted out rebate**

- could be based on the average costs incurred by the NHS in providing elective surgery to those contracting out.

- in order to avoid the tendency for low risk individuals to contract out while high risk ones remain in the state scheme rebates would be related to both age and family size (further details are given in the annex.)

12. **Payment of rebates**

- Rebates would be paid annually, in arrears, direct to the insurer by DHSS. This follows the procedure for the payment of contracted out rebates in the personal pensions scheme and avoids additional burdens on employers.

- Private insurers would claim rebates by submitting a list of policy holders (with their NI numbers) and dependants covered by medical insurance direct to DHSS, guaranteeing that all those contracting out were covered by an appropriate policy.

13. **Implications for health authorities**

- Revenue allocations to health authorities would be adjusted to take account of the extent of contracting out in their areas.

- This strengthens the incentive of NHS hospitals to compete and win contracts from private insurers to treat those who have contracted out.

- Failure to win contracts to sell services to private insurers would make it increasingly difficult for NHS hospitals to remain at their current capacity levels.

14. **Growth of the private sector**

The growth in private insurance cover following the introduction of a contracting out scheme would depend on:

- the proportion of annual premiums represented by the rebate

- the responsiveness (or elasticity) of the demand for health insurance to reductions in its price.

Annex 2 examines the first of these points for a representative set of household groups and makes an estimate of the resulting increased coverage of private health insurance. The available elasticity estimates are, however, tentative and subject to wide margins. The overall effect would largely depend on the response of the private insurance industry.

Annex 1

THE NATIONAL INSURANCE FUND AND NI FINANCING 1988-89

The Chancellor's scheme to increase the NHS allocation from the NI fund proposed raising employee's NHS contributions from 0.95% to 2.4%, with additional increases in contribution rates for both the self employed and employers. The sources of NHS income which would result from this arrangement are shown in the table.

	£bn
Employees contributions	4.3
Employers contributions	2.2
Self employed contributions	0.2
General taxation	14.4
	21.1

The value of employee's contributions in this scheme would be more than sufficient to underpin a contracting out arrangement of the sort described in this paper. Total expenditure on NHS surgical acute specialties, that is, those for which contracting out is envisaged, is in the region of £2bn for 1988/89.

It should be noted that a possible feature of the scheme is that some low earners may be entitled to rebates which are in excess of their annual NHS contributions. Excess rebates this sort would score as public expenditure. In practice, however, this is unlikely to be a serious problem. A married couple in their mid 50s with two children would have earnings of less than £100 per week before being faced with rebates in excess of their health contributions.

Annex 2

THE VALUE OF REBATES AND THE EXPANSION OF PRIVATE SECTOR

Unless rebates reflect, in some way, the risks represented by groups in the population, the consequence of a contracting out scheme will inevitably be that low risk cases leave the state scheme while high risk ones remain.

Age is an important determinant of the risk of requiring elective surgery. The table below shows the value of NHS expenditure per head on surgical acute specialties.

Age Band	Expenditure per head (1988/89 prices)
All ages	41
0-4	13
5-14	16
15-24	21
25-34	24
35-44	29
45-54	37
55-64	54
65-74	88
75+	154

Eight of these specialties account for in excess of 90% of cases from the waiting list, and cover procedures typically offered by most private health insurance policies. These average cost figures would therefore form the best basis of a contributions rebate for contracting out of elective surgery.

Insurance premiums

An indication of the contribution of these rebates to the cost of private health insurance is given below. The table expresses the value of rebates as a percentage of premium costs for a variety of family types. The family rebate consists of the sum of the age specific rebates (calculated on the

basis of expenditure on people in five year age bands applicable to each family member. The costs of premiums are those applicable to BUPA's recently launched "Budget BUPA" plan. This covers 85 in-patient and 30 day care elective surgical procedures which represent the majority of operations on NHS waiting lists.

Family type	Rebate as % of undiscounted Budget BUPA premium
Single person age 20	23.5
Couple mid 20s	23.7
with 2 children	27.5
Couple mid 30s	23.2
with 2 children	26.7
Couple mid 50s	26.9
with 2 children	28.3
Couple mid 60s	29.9

Expansion of private health insurance

US experience, which has to be applied cautiously to the UK, suggests that the demand for private health care insurance rises by about ½% for every 1% fall in the cost of premiums. On this basis the number of private insurance subscribers might be expected to increase by between 12 and 15% as a result of a rebate scheme of this sort. Using estimates produced by the Institute of Health Services Management of the number of people with private health insurance in 1987 as a base, the contracting out scheme could:

- increase the coverage of private health insurance from 6 million to around 7 million people

- boost the annual value of premiums paid to between £850 and £875 million, an increase of in excess of £100 million.

I agree. In many ways, it would be easier if DHSS wanted money from us now, since we have lots of good reasons to say no. They are being more subtle, however, and trying to get the blame pinned on us if things go wrong. RPG 9/6

CONFIDENTIAL

FROM: D P GRIFFITHS
DATE: 9 JUNE 1988

1 MR SAUNDERS

2. CHIEF SECRETARY

cc Chancellor
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull

MEETING WITH MR NEWTON: 13 JUNE

We have heard from DHSS that when Mr Newton calls on you on Monday to discuss the in-year funding difficulties faced by health authorities he may take the opportunity to raise again the question of the retention of the receipts from the Great Ormond Street settlement (my submission of 2 June gives the background). He is likely to argue that, given the very high public profile of Great Ormond Street, there could be political problems in monies associated with the hospital coming into the maw of the Treasury. This is a spurious argument for two reasons:

(i) DHSS have no intention of spending the receipts on Great Ormond Street: they would spend the money on AIDS and drug misuse programmes;

(ii) Great Ormond Street itself has suffered no financial loss. Funding was provided from the HCHS Capital vote to rebuild the hospital's cardiac wing.

2. As regards the in-year resource problems, Mr Newton may press you as to what message health authorities should be given. DHSS believe that a policy of nods and winks - encouraging authorities not to proceed with service cuts in the expectation of that something will turn up - would simply store up problems for the future. We fully agree with this. We do not want authorities to think that we will step in to bail out overspends at the first hint of cuts. However, we would want to minimise the risks of DHSS's throwing the responsibility on us for a hard-line approach

as they are obviously seeking to do. We therefore recommend that you try to avoid being pinned down on the question but tell Mr Newton that what is said to health authorities is a matter for DHSS. If pressed, however, we see no alternative to a robust line : health authorities have been given their allocations and must stay within them while bearing in mind their duty to their population and so doing all they can to minimise service cuts.

3. It would be helpful to discuss this with you before the meeting.

D P GRIFFITHS

week.1.6/m.9

SECRET

FROM: H PHILLIPS
DATE: 9 June 1988

CHANCELLOR

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

Mr Corlett } IR
Mr Kuczys }

NHS REVIEW: TAX RELIEF AND CONTRACTING OUT

You will have seen the article by Mr Timmins in today's Independent about the dangers and costs involved in giving tax relief for private health insurance premiums, or in enabling contracting out. In view of earlier press stories about the work of the review, and the fact that this article will no doubt be seen as a 'Treasury story' you should know that we did give to Mr Timmins confirmation that the sort of expenditure figures he uses were of the right magnitude. Mr Saunders did this with my approval. The idea of the piece, its argumentation, and its views were Mr Timmins own and planned before his contact with us.

HP.

HAYDEN PHILLIPS

The acid test of the Government's plans for the health service

Nicholas Timmins warns of the dangers behind the bland words 'opting out'

If you want to change the world, first steal the language. Margaret Thatcher understands this well. Go back to 1979. Before then anyone radical was from the left. Anyone reforming was from the 1960s liberal tradition that this Government so deeply loathes. Use either word now and the image that springs to mind is of the right-wing think-tanks, refurbishing Adam Smith to "reform" the Welfare State. The words have been redefined.

So it is worth asking just what ministers mean by the little they say in public about the oh-so-secretive, but oh-so-selectively leaked NHS review.

"Access to care regardless of the ability to pay is absolutely crucial" — John Moore, Secretary of State for Social Services. That sounds plain enough. So does Edwina Currie in similar vein: the NHS, she says, "was intended to give a fully comprehensive service based on medical need and not ability to pay. We have no intention of making changes which would destroy those basic principles."

But in other parts of the same speeches, both ministers state bluntly that we need more private health spending. "We do seem," said Mrs Currie, "to have a hang-up that somehow it is wrong to pay for aspects of health care. We don't think that way about food, or clothing, or housing, or pensions, all of which are equal necessities."

Treatment regardless of ability to pay has thus been, if not redefined, at least very tightly defined to exclude its traditional corollary — that it implies treatment for all free at the point of use.

With higher disposable incomes, the argument goes, more people can (and thus should) pay for their own care either in NHS pay beds or private hospitals. Provided that is a real choice (not one forced on people by a third-rate health service), that is fine. In a free society, those who choose to spend money on private care are entitled to do so.

But the review is going well beyond that. It is looking at a whole series of options to boost private health spending directly. These include tax reliefs on private health insurance; or a switch to an earmarked NHS tax where contributions would be reduced if people opted out of the NHS; or just a simple rebate, in effect a voucher of say £100 or £50 towards private cover for those who agreed to opt out of all or part of the NHS for a year.

The Government should firmly resist these temptations. It should do so on grounds of ideology, practicality, fiscal policy, equity — and in the long-term interests of good care for all.

Take tax relief. Approaching six million people have private health insurance. Offer them basic rate relief and the "deadweight cost" — the cost of giving it to those already covered before anyone else is induced to join — would be around £200m. For the elderly only, the cost would be nearer £20m. Either would be a direct private sector subsidy from a Government that a) does not believe in subsidising the private sector, and b) is busy abolishing similar reliefs (on life assurance, home improvement loans, etc.) with the laudable aim of simplifying the tax system. Initially it would do nothing to reduce the burden on the NHS. The subsidy would go chiefly to healthier and wealthier individuals whose disposable income is already rising, at a time when the numbers covered by insurance is in any case on the increase. In addition, tax relief is regressive — it is worth more to the better off than the worse off. It would thus give the better off still better chances than their higher income already offers of avoiding NHS queues — which sits ill with the claim that treatment will continue to be offered regardless of ability to pay.

Opting out is even worse. Leave aside for a moment the right to opt out of the NHS completely. Just take the offer of, say, a £50 rebate for those who agree not to use the NHS for waiting-list type treatment for a year. Ignore the considerable difficulties of defining precisely what that would mean. With approaching six million people insured, the cost would be about £300m. With the average cost of insurance per head in the region of £150 a year, just to get that £300m back would require the numbers covered to rise to nine million — a 50 per cent increase on the present figure. For the subsidy to show any real "profit" — a net increase in private spending after the taxpayer's subsidy — the numbers covered would have to come close to doubling. Increases on such a scale are unlikely to happen overnight. Yet the £300m subsidy — let alone the £600m it could become — is three times the amount for lack of which well over 3,000 NHS beds closed last autumn. It looks as though there are many better buys for the money.

Second, once people have opted out, those still in the NHS will be required to prove their entitlement — some form of NHS identity card would probably be needed: bureaucratic that, and politically unpopular.

Third, even if you weight the rebate to give less to younger healthier people who are least likely to use NHS hospital services and more to the elderly, there will still be a "healthy-wealthy" effect. The younger and/or fitter who can obtain insurance relatively cheaply will tend to take their rebate and opt out — leaving the Government with less money coming in, but the most difficult and expensive cases to deal with. This is not just some theoretical risk. It happened in Holland with a scheme where the self-employed were allowed to opt out of the state insurance plan leaving it with the worst cases and rising premiums.

Fourth, however slowly it happened, opting out would accelerate the move away from the NHS by the better off and articulate who are already quitting the service for their routine hospital care, while still leaving them dependent on the NHS for major catastrophes and longer-term illness. Health care would become increasingly two-tier. The NHS would be left with the poor, the old, the chronically ill and less cash, while the very consumer voices which the Government values so highly would increasingly be outside the service when able to shout loudest for its improvement, but inside it when they were most ill and least able to fight.

Opting out is thus not about improving the health service, or lifting a burden from it, but about destroying it. There would be a steady erosion of the communal commitment to care for those least able to care for themselves among those temporarily able to afford to opt out.

If the Government goes down this road, no clever language about "lifting a burden from the NHS", "improving consumer choice", or claiming still to provide care "regardless of the ability to pay," will make it possible to believe other than that the ultimate aim is to destroy the health service, rather than improve it. It is one acid test of the Government's intentions.

I agree. Cleared with GSP and FM
RBS
10/6

1.MR SAUNDERS
2.CHIEF SECRETARY
(via MCM)

From: J M SUSSEX
Date: 10 June 1988

cc Chancellor 14/2
Mr Anson
Mr Phillips
Miss Peirson
Mr Parsonage
Mr Richardson
Mr Welsh
Mr Wellard

LETTER FROM G ALLEN MP - NHS EQUIPMENT RENTING

Mr G Allen MP (Lab) has written requesting further consideration of a PQ he asked on 3 May and which was answered by Mr Newton.

2. Mr Allen's letter concerns the ability of the NHS to rent telephones and medical equipment rather than purchase them outright. In particular, he suggests that renting such equipment is preferable to outright purchase because renting provides a way of bringing home to NHS managers the costs of using such assets. I enclose a suggested, self-explanatory, reply.

J M Sussex

229/6

GRAHAM ALLEN ESQ MP
HOUSE OF COMMONS

Thank you for your letter of 27 May to the Chancellor of the Exchequer.

I share your desire to ensure that those who use publicly purchased or rented equipment, in the NHS as elsewhere, should take full account of the costs associated with that use. However, it is not necessary to rent equipment in order to achieve this end. The decision whether to purchase or rent should be based solely on the criterion of maximising value for money, as Tony Newton said in his reply to your 3 May PQ. As you will be aware, major purchases are made from the capital programme which is allocated to Health Authorities quite separately from current resources. In this respect, a Health Authority is different from a family considering the purchase of a new car.

As you say, however, the cost of using capital equipment needs to be brought home to NHS managers. This is currently being addressed in pilot projects in three Regional Health Authorities for introducing capital and asset accounting methods into the NHS. Evaluation of these projects will begin in the autumn. The introduction of such systems will provide financial and management discipline by its demonstration of the costs of using capital equipment.

CHIEF SECRETARY

FROM:- **GRAHAM ALLEN, Labour MP for Nottingham North**

HOUSE OF COMMONS

LONDON SW1A 0AA

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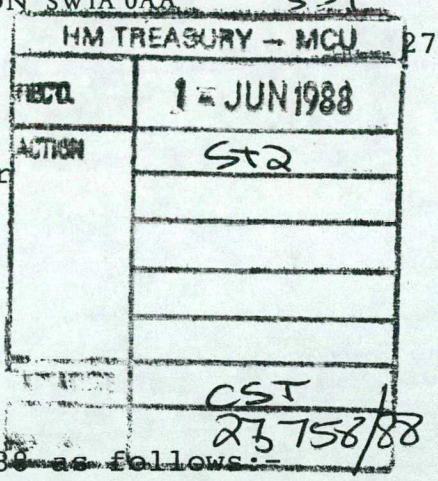


27 May 1988

The Rt Hon Nigel Lawson MP
Chancellor of the Exchequer
The Treasury
Parliament Street
LONDON SW1P 3AG

Dear Chancellor

I asked a PQ on May 3rd 1988 as follows:-

"....To ask the Secretary of State for Social Services, what is his policy towards district health authorities renting medical equipment or telephone systems or creating a capital fund; and if he will make a statement.

MR TONY NEWTON

The NHS may employ renting for such items but only where it represents best overall value for money to the Exchequer as a whole. The full costs of renting must be shown to be lower than outright purchase and the Department's and, in most cases, Treasury's approval is required. Health authorities derive capital funding from the Exchequer (and the sale of surplus property) on an annual basis."

I would like to press you on this matter and request your further consideration.

I accept that the renting of equipment is viewed by the Treasury with great concern because they are worried that abuse might take place and that substantial debts could be incurred which, in the Treasurers' view may not be as adequately monitored as capital spend could and should be.

I actually do not accept that argument because I believe that adequate controls could be put in place to cover the monitoring of renting.

Continued.....

HOUSE OF COMMONS
LONDON SW1A 0AA

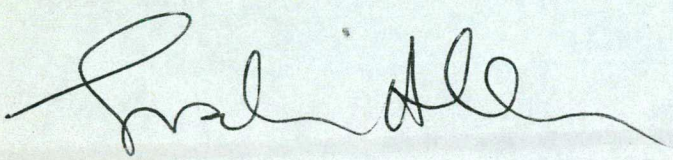
I believe it could be desirable to enable Health Authorities, and possibly other Government organisations, to use the renting system of acquiring equipment where it is the right financial decision to do so. It may under some circumstances be more expensive in the short term but one has to consider the overall position.

For example, if equipment is rented and the rent charged is included in the monthly cost statements of a business unit, then it is brought home each month the cost of the original decision. It may also encourage those who are renting equipment to be more mindful of the eventual replacement costs.

I could probably equally well illustrate what I have in mind by referring to the normal family trauma that occurs when one has to replace the family car. Invariably no depreciation will have been set aside for such an event to take place and it becomes a traumatic moment when one has to acknowledge that the car is in pieces and that the cost of a replacement through the normal inflationary process has become outrageously expensive. It is under these circumstances when hospitals and health authorities are faced with replacing major items of medical equipment. Medical science is advancing at such an enormous rate that it is almost guaranteed that the day hospitals start using a new piece of equipment it is very nearly obsolete.

Could I ask that you have a further look at this question and let me have your views.

Yours sincerely



GRAHAM ALLEN

MC5.92

MANAGEMENT IN CONFIDENCE

FROM: MARK CALL
DATE: 10 JUNE 1988

PAYMASTER GENERAL

cc Chancellor
Chief Secretary
Financial Secretary
Economic Secretary
Mr Cropper
Mr Tyrie

NHS MANAGEMENT BOARD - NEW CHAIRMAN

I'm not entirely sure how we take this forward. Are we really intending to brief a search firm?

2. My own view is that we should not rule out the possibility of someone with public service experience, perhaps even NHS experience. Margaret Peirson has tentatively suggested Chris West, the Portsmouth District General Manager. He has apparently achieved marvels in converting doctors and nurses to cost consciousness, and has a reputation for getting things done. He was at the Chequers seminar. He is known to Hayden Phillips, Richard Wilson, John O'Sullivan, and Graham Hart (Deputy Secretary, DHSS). Ian Mills of the NHS Management Board thinks he's good. Because of his relative youth (around 40) and the fact that he is now at District level, the DHSS can be expected to be lukewarm. Obviously his background and track record would need to be examined, but there would be some advantages to such an appointment. It would strengthen the morale and credibility of managers within the NHS. A 'folklore' reputation for turning attitudes around and getting things done would be of great value to a Chairman. Finally, he would know what he's up against (a businessman coming into the job may or may not). On the other hand, I recognise that he would not be seen as a 'new broom' and this may not send the right signals both outside and inside the NHS. [Ian Vallance/BT?]

3. I pass this on only as an illustration of the benefit of keeping an open mind on where we look for candidates for the job.

MC

MARK CALL

PERSONAL AND CONFIDENTIAL

cc CST
SIR P. MIDDLETON
MR H. PHILLIPS

10 DOWNING STREET

From the Principal Private Secretary

SIR ROBIN BUTLER

REVIEW OF THE NATIONAL HEALTH SERVICE

I have shown the Prime Minister your minute of 9 June about the four press articles on the Government's review of the National Health Service which appeared last week.

The Prime Minister agrees, very strongly, that you should ask Departments to make arrangements to implement the two recommendations described in paragraph 6 of your minute. She has said that she was horrified when she read these articles, which could only have been prepared with the help of someone who had inside knowledge.

I am sending a copy of this minute to the Private Secretaries to the Chancellor of the Exchequer and the Secretary of State for Social Services.

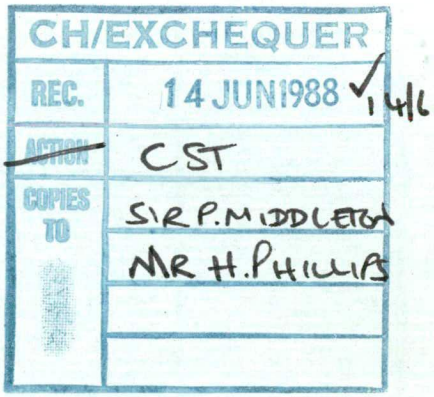
N.L.W.

(N. L. WICKS)
13 June 1988

PERSONAL AND CONFIDENTIAL

1. MRS THORPE
2. PLP

CONFIDENTIAL



CABINET OFFICE

70 Whitehall London SW1A 2AS
01-270 0101

From the Secretary of the Cabinet and Head of the Home Civil Service
Sir Robin Butler KCB CVO

Ref. A088/1806

13 June 1988

Dear Alex,

Review of the National Health Service: Press Articles

You will have seen Sir Robin Butler's submission of 9 June to Mr Wicks and Mr Wicks's reply of 13 June about the press articles last week on the Government's Review of the National Health Service.

In accordance with the Prime Minister's instructions, could you please make arrangements to ensure that the dates of future meetings on this subject are not made available to the press and are notified only to those within Departments who need to know them. Second, please will you and other recipients warn all officials and special advisers engaged in the Review, and press officers, of the dangers of involving themselves in any sustained conversations with journalists on matters related to the Review, since they may inadvertently enable journalists to try out propositions in order to gauge reactions. It could be pointed out that these instructions are particularly important as the Review enters its later, and most sensitive, stages.

I am copying this letter with a similar request to Geoffrey Podger and Nigel Wicks.

Yours ever,

Trevor Woolley

(T A Woolley)
Private Secretary

A C S Allan Esq
PS/Chancellor of the Exchequer

CONFIDENTIAL

APPOINTMENTS IN CONFIDENCE

FROM: S P JUDGE
DATE: 13 June 1988

MR CALL

cc PS/Chancellor
PS/Chief Secretary
PS/Financial Secreatry
PS/Economic Secretary
Mr Cropper
Mr Tyrie

NHS MANAGEMENT BOARD - NEW CHAIRMAN

The Paymaster General was grateful for your note of 10 June.

2. If there is a good enough candidate inside, the Paymaster is quite content not to look further. He had earlier had the impression that we were going to need to look outside.

S P JUDGE
Private Secretary

PAM31

SECRET

FROM: MOIRA WALLACE
DATE: 14 JUNE 1988

CHANCELLOR

cc Chief Secretary
Financial Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Mr Parsonage
Mr Saunders

NHS REVIEW: THE NEXT THREE WEEKS

Following your meeting with Mr Moore and Mr Newton on Friday, we now need to fix up further "quadrilaterals" to prepare for the forthcoming No.10 meetings. Before we approach DHSS can we just check that you and the Chief Secretary are content with the details of what we propose?

2. First, is the cast list now agreed - the four Ministers plus Strachan Heppell from DHSS, Richard Wilson and Hayden Phillips - but no-one from the Policy Unit? Would you prefer us to delay inviting Richard Wilson until you have mentioned this to the PM?

3. Timetable and agenda are more complicated. We have only tried to plan the run-up to the next two No.10 meetings (30 June and 8 July) but already this looks pretty nightmarish. We have assumed that the quadrilaterals ought to be scheduled so that we have a couple of working days in which papers can be revised, if need be, before circulation to the full group. We have also assumed that you would wish to have an opportunity to approve at least the broad outline of any Treasury papers before drafts are discussed at a quadrilateral. This makes things very tight, especially for the first meeting. There are a total of seven papers on the agenda:

Treasury

- Tax relief (the elderly, and company schemes)
- "Top-slicing"
- VFM audit (already written, CST to discuss with Mr Newton tomorrow)

DHSS

- Contracting-out
- Self-governing hospitals
- Capital
- Consultants' contracts (looks good)

Papers for the No.10 meeting on 30 June will have to be circulated on Tuesday 28th, so the latest we could reasonably have a quadrilateral would be Friday, 24th. The papers would have to be sent across to DHSS some time in the afternoon of Thursday, 23rd, at the very latest. This means that we will be looking for you to say whether you are content with the general line of the drafts pretty much as soon as you get back from Toronto on Wednesday.

4. We assume you would want to keep the paper on the economics of health care out of the quadrilateral discussions, but that you would want to circulate it on Tuesday, 28th or Wednesday, 29th, immediately before the No.10 meeting. We could, if you wish, pencil in an internal meeting to discuss the economics paper.

5. Unfortunately, we then have little more than a week to recover from the first No.10 meeting and prepare for the half-day session on Friday, 8th. Here again, we have a long list of papers:

- restrictive practices
- training
- manpower
- private sector action plan
- resource management initiative
- competitive tendering
- the overall strategy paper.

DHSS are in the lead on all except the last of these, which is to be a joint effort. Hayden thinks that he should be able to show us an early outline of the package paper in the week beginning 27 June, but clearly it will not make sense to begin substantive discussions about it until after the No.10 meeting on Thursday, 30 June. If we could have a first internal discussion of this after your No.10 meeting, combining it with a debrief, then officials could perhaps make some progress in refining it before a Ministerial quadrilateral on Monday, 4 July. The paper will have to be circulated to the full group on 6 July.

6. The full horror of this timetable is set out in calendar form in the annex. If you and the Chief Secretary think this is manageable, we will put the plan to DHSS and set up the meetings. We should also, I assume, set up short internal briefing meetings before the quadrilaterals with Messrs Moore and Newton - perhaps just half an hour.

MOIRA WALLACE

WED 22/6	Chancellor returns from Toronto (a.m.). HMT papers on tax relief, top-slicing (+vfm audit, if necessary) put to C/Ex and CST for provisional approval
THURS 23	HMT & DHSS draft papers circulated to quadrilateral group
FRIDAY 24	Quadrilateral [plus internal pre-meeting?]
MONDAY 27	[if needed, internal meeting to discuss 'economics' paper]
TUESDAY 28	Final DHSS and HMT papers circulated [outline of "package" paper from official group available]
WED 29	Internal briefing meeting [do we need this?]
THURS 30	No 10 meeting plus internal meeting to debrief and discuss "package" paper for next No 10 session
FRIDAY 1/7	[DHSS to circulate other draft papers for quadrilateral e.g. restrictive practices, private sector action plan?]
MONDAY 4	Quadrilateral [plus internal pre-meeting?]
WEDNESDAY 6	Final "package" paper and others circulated
THURSDAY 7	[internal briefing meeting, if needed]
FRIDAY 8	No 10 all morning session

CHANCELLOR OF THE EXCHEQUER

Treasury Chambers, Parliament Street, SW1P 3AG
01-270 3000

MP

14/6/88.

Ch/

You might like an update on Health review front. And some decisions required too, I'm afraid, as soon as possible.

1. "Quadrilateral" now fixed for Friday a.m. Mr Newton can't come, it now transpires, & Mr Moore wants to bring Sir Roy G. Are you happy with this? (Hayden isn't – the more people we invite the more obvious it becomes that only PM & Policy Unit excluded. No view from CST yet.) Content if CST is, but with Moore.

2. Are you happy for draft of tax relief paper (behind) to be sent to quadrilateral members tomorrow p.m? Any changes required? Done

3. And are you content for CST's top-slicing paper (in your car-box this a.m.) to go round to same group tomorrow? Done

4. Final issue for decision now – content for Hayden to discuss his draft of package paper, flagged behind, with R Wilson + Heppell of DHSS? (Hayden emphasises this v. much a first shot – but just wants to be sure you see no great tactical difficulties.)

5. Finally, to note: (i) a first draft of the Health Economics minute is behind. You could look at this over the weekend.

(ii) we have a draft paper on workplace nurseries (not in this folder). Again, defer until weekend box, when likely tone of No 10 meeting may be clearer following quadrilateral? Right

(iii) CST has written re agenda (behind) Noted – nothing.

CONFIDENTIAL

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

14 June 1988

Dear David,

NHS REVIEW

The Prime Minister has been considering further the arrangements for the conduct of the NHS Review. She would be grateful if your Secretary of State, together with the Secretaries of State for Wales and Northern Ireland, could join the Ministerial group for its meetings from the beginning of July onwards. A meeting is currently scheduled for Friday 8 July and Tessa Gaisman here will be in touch with your offices to settle the precise arrangements.

The Prime Minister would also be grateful if your Secretary of State, together with the Secretaries of State for Wales and Northern Ireland, could each nominate one person to join the group of officials chaired by Richard Wilson in the Cabinet Office.

I am sending a copy of this letter to Jon Shortridge (Welsh Office), David Watkins (Northern Ireland Office), Alex Allan (H M Treasury), Jill Rutter (Chief Secretary's Office), Geoffrey Podger (Department of Health and Social Security), Miss Jenny Harper (Minister for Health, DHSS), Trevor Woolley and Richard Wilson (Cabinet Office).

Yours,
Paul

PAUL GRAY

David Crawley, Esq.,
Scottish Office

CONFIDENTIAL

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SECRET COPY NO 2 OF 11 COPIES

FROM: JILL RUTTER
DATE: 14 June 1988

MR H PHILLIPS

cc:
PS/Chancellor (Ms Wallace)
Sir Peter Middleton
Sir Terence Burns
Mr Anson
Miss Peirson
Mr Saunders
Mr Turnbull
Mr Parsonage
Mr Call

NHS REVIEW

The Chief Secretary de-briefed you, Mr Saunders, Mr Call and Ms Wallace about the meeting he and the Chancellor had with the Secretary of State for Social Services and the Minister for Health on Friday.

2 The Chief Secretary said that there was a lot of agreement on the key headline points though less on detail. The Chancellor said that three objectives of the review were:

(a) to make the NHS more cost effective;

(b) to boost the private sector and

(c) to meet the pressure points that were being revealed.

3 It was agreed that the areas set out in indent (e) of Paul Gray's note of the meeting of 25 May were the key areas that needed to be addressed. It was agreed that it was unwise to start thinking of significant structural changes. The Chancellor offered Mr Moore a paper on the economics of health care which Mr Moore welcomed.

NOTE OF MEETING QUADRILATERAL 10/6

4 The Ministers then went through the individual items in indent (e):

- on independent hospitals, it was agreed that there should be pilot schemes based on teaching hospitals. The DHSS would offer a paper on London Teaching Hospitals;

- acceleration of the resource management initiative was agreed;

- on VMF audit the Chancellor expressed the clear view that the Audit Commission should take on this role. Mr Moore had been less enthusiastic. The Chief Secretary noted that since we had Prime Ministerial support on this item he did not intend to give an inch at his meeting on Wednesday with Mr Moore;

- on extension of competitive tendering, it was clear that DHSS envisaged only non-clinical areas whereas the Treasury envisaged extension into medical areas.

- DHSS would offer a paper on reform for professional practice.

5 There was some discussion of ways of encouraging the private sector. The principle was not disputed. The Chancellor made clear his strong opposition to opting out but that he was prepared to offer tax relief for the elderly and remove health from the P11D limit. Mr Moore saw the P11D point as a substantial break through. The Chief Secretary thought that Mr Moore would be prepared to drop the opting out proposal if the Treasury agreed to act on the P11D.

6 The Chief Secretary said a package based on the ideas set out above was now emerging with the possibility of a Green Paper on longer-term issues if necessary. Mr Moore had handed

him and the Chancellor a list of the papers that were likely to be needed. He would be grateful if you and Mr Saunders could consider that list and consider whether any additions were needed.

7 It was agreed that the next stage was a series of bilateral meetings with Mr Moore and Mr Newton and Treasury Ministers to be set up.

Jill Rutter

JILL RUTTER
Private Secretary

14/6/88 -

CH/ Sorry to trouble you with something fairly tedious. Behind is my note of Friday's meeting, which I have shown to Richard Wilson. He agrees with the substance, but questions wisdom of circulating something so sensitive. I have to say I share his doubts. The options are

(i) send only note of action points
(ii) send this version, but only to Ministers attending, and classify C.M.O.
(iii) send this version, numbered copies to those attending, and add 2nd para as in all No 10 notes of meetings - ie share only to those with strict need to know, no copies to be taken.

What do you think?

MPW

st.ts/docs/1.14.6

CONFIDENTIAL

FROM: MISS M PEIRSON
DATE: 14 JUNE 1988

CHIEF SECRETARY

cc Chancellor
Sir Peter Middleton
Mr Anson
Sir A Wilson
Mr Phillips
Mr Beastall
Mrs Case
Mr Turnbull
Miss Parsonage
Mr Potter
Mr Saunders
Mr Call

NHS REVIEW: AUDIT

1. You are to discuss with DHSS Ministers tomorrow afternoon the paper by officials which you sent to Mr Moore on 28 April. For briefing, you may like to have another look at your minute of 26 February to the Chancellor. In addition, I suggest the following positive and defensive points to make. The defensive material attempts to answer the points which have been raised recently by DHSS officials, and which Mr Moore can be expected to make tomorrow.

Positive Points

2. There is no disagreement that (paragraph 15 of paper of 28 April) the objective is better value for money audit covering a broader range of NHS activities; nor that the value for money audit reports need to be demonstrably independent of health authorities, and published regularly and widely in order to enable comparisons to be made and to stimulate public discussion.

3. There is no disagreement either that, to achieve these objectives, the present DHSS statutory audit needs to be beefed up.

4. To achieve real change, we need energetic management which knows what it is trying to do, and more expertise. By far the best and quickest way of getting it (despite the need for primary legislation) is to seize the opportunity of an existing organisation (the Audit Commission) which has a good track record in exactly the same sort of field, the experience of working with professionals, and the enthusiasm to take on the NHS whilst maintaining its reputation for solid achievement.

5. The Audit Commission already carry out, for local authorities, the work of publishing statistics of comparative performance and central value for money studies, which is just what is needed for the NHS. There are similarities between local authority work and NHS work, and the Commission's experience of working with local authorities ought to be helpful, as would its experience of working with professionals such as the police.

Defensive Points

6. There would be constitutional and political difficulties in using the Audit Commission (the Secretary of State would be in difficulties if the AC published a critical report of the health authorities)?

We should need to decide on the exact relationship between the Audit Commission and the NHS Management Board and the Secretary of State. But the Audit Commission would report to the Secretary of State, and critical reports by the Commission concerning the performance of individual health authorities would provide the Secretary of State with the information on which to base any necessary action.

7. There would be problems with the PAC and NAO?

The role of the PAC and NAO would continue unchanged, as paragraph 20 of the joint paper explains. Indeed, the PAC ought to welcome a move to improve the second tier of audit of the NHS (particularly as they have recently

criticised the third tier, the internal audit within the NHS). We should need to handle the change carefully with the PAC and NAO, but the Audit Commission themselves are well aware of the need for tactful relations between themselves and the NAO.

8. The doctors would not like the Audit Commission, and we should not do too many things to offend them (Sir Donald Acheson suggests that value for money audit and medical audit are the same thing, and that they require a medical and nursing input)?

It will probably be better to introduce all the changes affecting doctors directly in one package, rather than having an annual series of initiatives which they might object to; we want them to face up to greater involvement in resource management, and value for money audit is the other side of that coin. Medical audit is different from value for money audit, though related to it. We would certainly agree, though, that the Audit Commission teams should include medical expertise: their teams dealing with local authority subjects already adopt the principle of including professional expertise, eg in dealing with police subjects.

9. The question of audit should be decided after decisions on the health review have been reached, ie after we have decided what we wish to create and what therefore is to be audited?

We need better value for money audit as soon as possible, and the question of who is to do it should not be delayed until after the decisions on the structure of the Health Service etc. Primary legislation will be required anyway to bring in the Audit Commission (or to establish a new independent body, or to enable the Audit Commission to assist with the existing DHSS audit), so we need to get going as soon as possible. We would hope to reach agreement now, but if that is not possible the next move must be to put it back to the Prime Minister's group for decision alongside the other Health Review decisions.

10. Why the Audit Commission?

If it were possible to find another organisation with equally good experience and expertise in a similar field, and as good a track record, of course that would do equally well. Failing that, we face unwarranted delay and are not nearly so likely to achieve what we want.

MISS M PEIRSON