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PART C

Part C.

SECRET

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Begins: 18/1/88
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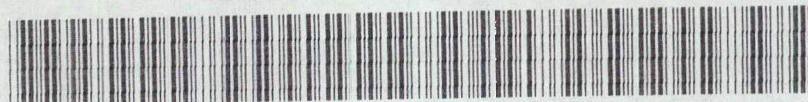
PO -CH /NL/0410

PART C

PO -CH /NL/0410
PART C

Chancellor's (Lawson) Papers:

REVIEW OF WELFARE PROVISION AND THE NATIONAL HEALTH SERVICE

DD's: 25 Years

[signature]

11/1/96.

CONFIDENTIAL

I agree. This is outrageous behaviour by DHSS and a sharp reply is justified RBS 13/1

PMP

FROM: MRS E M WISEMAN
18 JANUARY 1988

1. MR SAUNDERS
2. CHIEF SECRETARY

CST already written - not minuted

cc Chancellor
Mr Anson
Mr Kemp
Miss Peirson
Mr Turnbull
Mr Gieve
Mr McIntyre
Mr Gibson
Mr Call

WELFARE FOOD

Mr Newton's letter of 8 January informs you that DHSS Ministers announced in December that welfare milk will continue to be available to children attending day nurseries, childminders and playgroups. This reverses a 1987 Survey decision to withdraw this benefit, which would save about £4.6m in 1988-89. He goes on to propose extending welfare food to a further category of recipients.

2. It is unacceptable for DHSS to announce the retention of the status quo, without first consulting you and without guaranteeing the offsetting saving. Furthermore we are doubtful about the merits of the decision. We recommend that you ask DHSS to urgently re-consider their position.

Background

3. As part of the welfare food scheme children attending nurseries etc get free milk. If the children are in low income families they get a further 7 pints of milk a week at home. If they are not their parents can afford to buy it for them. During the Survey the Secretary of State for Social Services recognised that this particular area of the Welfare Food scheme was anomalous and duplicated provision and agreed to withdraw it.

4. The Social Security Bill included a provision for making changes to the Welfare Food Scheme. When the subject was raised in

Committee in December DHSS Ministers confirmed that the provision for nurseries etc would be continued. DHSS did not consult us about the possibility of a reversal of the Survey decision before the debate, nor even drew our attention to it afterwards. We picked it up ourselves from reading the notes on clauses after Mr Scott had made his announcement. We immediately raised the matter with DHSS officials. We insisted that the matter be put to you.

Discussion

5. The main DHSS concern was the criticism that withdrawal would attract at a time when the level of NHS resources was under fire. This is a political judgement but in our view DHSS exaggerate the potential criticism. There is a good case for the removal of this particular concession. No child's health is likely to be affected by its abolition.

6. DHSS's handling of this volte face is reprehensible. It was announced without consultation, and without considering first how it would be financed.

7. Mr Newton now suggests that the cost will be offset by savings from negotiations with the milk suppliers on a discount for welfare milk. We welcome such negotiations - we have been urging DHSS to press the Dairy Trades Federation for a discount for some time. Irrespective of the playgroups etc issue we want DHSS to pursue these negotiations and look for savings to offset other increases in this demand led expenditure.

8. However in the 1987 Survey the Secretary of State suggested that such discounts were unobtainable - with the milk suppliers arguing that the costs of doorstep delivery of welfare milk were just the same as paid milk. DHSS were unwilling to see any changes to the form of the scheme (eg cash vouchers) to give an incentives to beneficiaries to buy their milk at supermarkets, where milk can be cheaper.

9. The negotiations with the Federation are not yet complete and, going by past negotiations, we do not share Mr Newton's confidence in their success. If the outcome of these negotiations is unsuccessful DHSS will need to find offsetting savings elsewhere, either from the NHS or Centrally Financed Services programme.

10. If DHSS are to revise their position so as to make it plain in the context of the Social Security Bill (now in the House of Lords) they will need to re-consider their decision very quickly.

10. Mr Newton also proposes a new milk benefit. From 1 April 1988 mothers receiving Family Credit will be ineligible for free milk. Family Credit was increased by £2.55 to reflect this. This was a generous exchange, with £2.55 more than meeting the cost of 7 pints of milk. However DHSS now propose that FC recipients with children up to 1 years of age should still be entitled to **dried** milk at a subsidy of 45p a week - the extent to which the cost of dried milk exceeds the £2.55 addition to FC.

11. The cost is estimated at about £0.63m. Although this is small our aim is to abolish welfare milk altogether, and we are intending to raise this again in the 1988 Survey. It therefore seems unhelpful to add a further group to those receiving this benefit in kind, particularly when the FC settlement was generous overall. I therefore recommend that we resist this proposal.

12. I attach a draft letter to Mr Newton.

EMWiseman

MRS E M WISEMAN

CONFIDENTIAL

The Rt Hon Tony Newton Esq MP
Minister for Health
DHSS

WELFARE FOODS

Thank you for your letter of 8 January. I am disappointed that you should go back on the agreement we reached during the 1987 Survey. I am most disturbed that you should announce this without even consulting the Treasury.

2. You proposed that the cost should be met from savings from a discount on welfare milk. Why then, when the Treasury suggested this, did John Moore tell me during the 1987 Survey discussions that this would be difficult to achieve? Any savings in this area would naturally be most welcome. But I do not see them as a reasonable quid pro quo for the continuation of welfare milk for children attending nurseries, play groups and child minders. Welfare milk in these cases is not justified on merits. No child in a low income group would lose milk, since they already receive it through Family Credit or as part of the main welfare food scheme. The parents of others can be expected to take responsibility for their children's nutritional needs.

3. On your other proposal, having decided more than a year ago to exclude FC recipients from the welfare food scheme, I do not understand why they need to be brought back in again, even in this limited form. As you know, we question the value of the welfare food scheme and I should be reluctant to see the range of beneficiaries extended.

4. I hope therefore that you will feel able to reconsider both proposals. If not, and the negotiations with the milk suppliers are unsuccessful, I should make it quite clear that there will be no question of extra PES provisions. The savings would have to be found elsewhere.

5. Finally, I should register my concern at the way in which the first issue was handled. It is quite unacceptable that agreed Survey decisions should be overturned in this cavalier fashion without even informing the Treasury in advance. The Treasury found out about it only by reading the committee stage briefing - which was not received in here until after Nick Scott had made his statement. Since your officials had time to prepare briefing announcing the decision, there was clearly time to consult the Treasury. I hope I may have your assurance that this will not happen again.

I agree

RB

FROM:MRS E M WISEMAN
18 JANUARY 1988

1. MR SAUNDERS
2. CHIEF SECRETARY

cc Chancellor
FST
PMG
EST
Sir P Middleton
Mr Anson
Mr Kemp
Miss Peirson
Mr Hawtin
Mr Potter
Mr McIntyre
Mr Fellgett
Mr Gibson
Mr Call

WISEMAN TO CST 18 JAN

REVIEW OF COMMUNITY CARE: GRIFFITHS' REPORT

Sir Roy Griffiths is aiming to present his report on community care to the Secretary of State for Social Services on 29 January. This brief sets out his likely conclusions and the issues on publication. No action is proposed at this stage.

Likely Conclusions

2. The terms of reference of the review are attached. The report has not yet been finalised, but we believe the main features of the report will be

(a) clarification of the roles of the various players (mainly local authorities and DHSS/health authorities), with local authorities cast as the community care authority, with responsibility for ensuring that care is provided within the resources available, and a more strategic role for DHSS;

(b) the provision of community care services to maximise consumer choice and be open to competition;

(c) on financing - a LA community care budget for community care comprising

- LAs own spending on relevant services
- a transfer from the social security budget for the "care" element of existing supplementary benefits

- targetted specific grants, eg for pump priming, instead of the existing joint finance arrangements;
- a transfer from the Social Fund for the community care element of that fund.

(d) local authorities to be responsible for assessing the need for entry into residential care (including the care element of NHS run nursing homes), and for financing the care element of residential care;

(e) for the central government funding to take the form of a specific grant.

3. There will be no proposals on the future level of resources - it is seen as a "systems" report, setting a framework through which decisions can be taken about what can be achieved within a given level of resources. But changes to systems can themselves cost money, if they imply a more expensive service.

4. These are still guesses, albeit informed ones, of the report's conclusions. We have not yet seen the report, even in draft form. We have not been involved in the development of Sir Roy's thinking, which he has kept largely to a small team in DHSS. No attempt has yet ben made to cost the recommendations.

5. On the basis of what we have been told, Sir Roy's conclusions make useful progress in tackling the difficult questions on rationalising the assessment and provision of care in the community. Local authorities look the logical people to take charge of community care. However it is worrying that DHSS have been unable to put a figure on the likely costs implied by the report's conclusions.

6. The Treasury's main interest will centre on the financing arrangements proposed, in particular the proposed use of specific grants, and the expectations that the Griffiths report might raise in terms of improving the output of community care policies.

7. On the level of resources the Secretary of State referred to the need for additional resources arising from Griffiths in the context of the 1987 Survey - we did not accept this as the inevitable outcome of Griffiths. Recent press speculation about the Griffiths report has also focussed on resources.

Publication

8. DHSS Ministers have not yet decided on whether to publish the Griffiths Report. There has been no previous commitment about publication, but it is widely known when the review is likely to be completed and the pressures for publication will build up and are likely to be irresistible.

9. If publication is proposed care would be needed in the terms of any accompanying Government statement. We would want to see a neutral statement to the effect that the report made a welcome contribution to the development of effective community care policies and would be given careful consideration. This is especially important given the handling of the consultative process by Sir Roy. Any warmer response would fuel expectations about the future level of resources for community care.

EMWiseman

MRS E M WISEMAN

Ms Wiseman for file

Department of Health
and Social Security

PRESS RELEASE

Alexander Fleming House
Elephant and Castle
London SE1 6BY

Telephone 01-407 5522

16 December 1986

86/410

SIR ROY GRIFFITHS TO REVIEW COMMUNITY CARE

Norman Fowler, Secretary of State for Social Services today announced that he had asked Sir Roy Griffiths, the Government's adviser on the health service, to undertake an overview of community care and to advise him on options for action that would contribute to more effective community care.

In response to a Parliamentary Question from Robert Hayward MP (Kingswood), Mr Fowler said: "I am concerned that our community care policy should be as effectively delivered and efficiently managed as possible. It is a key element in our strategy for the health service, for the personal social services and for social security. And we devote substantial public funds to it. So we need to be sure that we are doing all we can to get it right.

"I have therefore asked Sir Roy Griffiths, the Government's adviser on the health service, to undertake an overview of community care policy. The review will be geared towards advice on action, as was Sir Roy's review of management in the health service. The review will be completed within 12 months.

"The terms of reference of his remit are:

'To review the way in which public funds are used to support community care policy and to advise me on the options that would improve the use of these funds as a contribution to more effective community care.'

"We have in hand detailed studies of certain aspects of community care, particularly residential care. But we need to complement these studies by Sir Roy's overview for three main reasons.

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"First, the present structure of social security benefits may encourage people to go into residential or nursing care, whe[illegible] they might actually be better off in their own home and pre[illegible] to remain there. It is important that the social security system is sensitive to individual requirements. But it is equally important that the system should operate neutrally and not distort individual choice. Given the sharp rise in expenditure on residential and nursing care in recent years, we need to see whether the system is operating sensibly and fairly. One of the main focusses of Sir Roy's work will therefore be to examine the financing of nursing homes, residential care homes and other group accommodation in which social care facilities are provided on a communal basis and compare it to the financing of domiciliary care.

"Second, substantial public funds go, quite rightly, into supporting our community care policies. They are provided through social security, through the personal social services run by local authorities and through the health service. Given the scale of funds involved, we need to look at whether they are being used to give best value for money, whether they are properly targetted and whether people who have help are given the help most appropriate to their needs.

"Third, there is considerable variation in the way that community care funds are managed in different parts of the country. And indeed it is sensible that the arrangements should be capable of adaption to suit local circumstances. But this does not mean that there is no scope for better budgetary and other financial management arrangements, which would help to improve the use of resources. This, too, is an area which would benefit from an expert outside scrutiny."

NOTES FOR EDITORS

1. There are two committees already doing work in this field, which Sir Roy will take into account: one is reviewing the arrangements for the financial support of residents in residential care homes, the other the role of residential care and the range of services given in residential establishments. Sir Roy will also have regard to the forthcoming report of the Audit Commission.

2. The two committees are:

a) Joint Working Party on Supplementary Benefit and Residential Care. Membership: representatives of central and local government. Chair: Mrs Joan Firth PhD (DHSS). Report due Easter 1987.

b) Review of Residential Care. Membership: individuals who can speak with authority on widely different forms of care. Chair: Lady Wagner PhD OBE. The group is supported by a resource team from the National Institute of Social Work.

3. Sir Roy will be supported by a Departmental team.

RA7.15 UNCLASSIFIED

BF 22/3

DRAFT

FROM: A C S ALLAN

DATE: 19 January 1988

MR BYATT

cc Sir P Middleton
Sir T Burns
Mr Scholar
Mr Culpin
Miss Peirson
Mr Spackman
Mr R I G Allen
Mr Parsonage
Mr C Riley
Mrs Holmans

TAX AND SOCIAL SECURITY IN SELECTED COUNTRIES

The Chancellor has seen Mr RIG Allen's minute to you of 8 January. He agrees with Mr Allen's view that it would not now be appropriate to publish the report in the run up to the Budget. He would, as Mr Allen suggests, be content for a limited number of copies to be made available to those who have specifically put in requests, and would be ~~glad~~ ready to reconsider formal publication after the Budget.

A C S ALLAN

Ch

OK for me to minute as above?

AA

SECRET

1 Jopath
2 pmp

A J G Isaac CB
Deputy Chairman

THE BOARD ROOM
INLAND REVENUE
SOMERSET HOUSE
LONDON WC2R 1LB

Telephone 01- 438 6604

19 January 1988

PERSONAL - Mr. Allan

M C Scholar Esq
HM Treasury

cc Mr McIntyre
Mr Battishill
Mr Lewis
Mr Mace

Dear Michael,

Brian Mace has shown me a copy of this letter of 15 January from Birch in the DHSS to Paul McIntyre about Family Benefit Options.

I had a brief word about this with Paul McIntyre in the margins of Friday's meeting. Following our exchange of minutes with the Chancellor, I have told Brian Mace that he must indeed give overriding priority to the work for the Budget and Finance Bill. My clear judgment - and I have confirmed this with him - is that there is absolutely no way in which he could make any serious contribution to this DHSS exercise without prejudicing essential work for the Budget and Finance Bill. And the same (for obvious reasons) holds for the people on his staff and the quite large number of people on the operational side here who would be involved in the DHSS proposal and who are themselves heavily occupied with Budget work.

I am sorry to have to give this negative response. However, people are already working late at night and through the weekend to try to catch up with the unusually heavy flow of income tax work for this year's Budget. There is simply no more time and there are no more resources left.

I wouldn't want at this stage to forecast any kind of precise time period for the present pressures. Obviously we are talking not just about the period up to 15 March, but also about the Finance Bill period. Clearly, we shall need to reassess priorities, when the main burden of Finance Bill work is under our belt. But I see no merit in trying to judge precisely how and when these pressures will develop over the coming months.

When I mentioned this to Paul McIntyre, he replied that there were plenty of matters alive on the Treasury side, on which he could keep discussions going with DHSS. I hope we can leave the thing on that basis for the time being.

I am sending a copy of this letter to Paul McIntyre.

yours ever,

Clive

A J G ISAAC

copy no. 2 : Mr Mace

DEPARTMENT OF HEALTH & SOCIAL SECURITY

New Court, Carey Street, London WC2A 2LS

Telephone 01-831 6111

SECRET

J P McIntyre Esq
H M Treasury
Parliament Street
LONDON SW1P 3AG

15 January 1988

Dear Paul.

FAMILY BENEFIT OPTIONS

1. Now that the APA paper has been submitted to Ministers, we need to turn our attention to the primary objective of this exercise, the paper on options for the future of Child Benefit.

2. As you know, a certain amount of work was carried out last autumn in this area. We circulated, just before Christmas, the paper prepared during the last PES round. This detailed most of the options available on Child Benefit. Subsequent developments and discussions indicate the need for some modification of the list, which I now see as containing the following options:

a) means testing (including "tapered" and "stepped" withdrawal variants);

b) reduction in rate (variants might be an across the board reduction; the introduction of different rates for first or second child etc; or the freezing Child Benefit in cash terms);

c) restriction of payment according to the number of children in the family, e.g. no payment for the first child or payment for only the first 2 children;

d) payment of different rates for children of different ages;

e) taxation of the benefit through the normal PAYE procedures;

f) universal taxation at source by DHSS, with PAYE adjustments for higher rate taxpayers.

3. I would welcome your comments, and Brian Mace's, on the above list. However, I assume that we have largely identified all the options open to us for the present exercise. To make further progress we now need more detail on the administrative and operational implications of these options. We also need to review the costs and benefits of the options including their implications for incentives, dependency and family income; also the consequences for other benefits.

E.R.

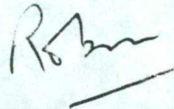
4. It is clearly for DHSS to investigate the means testing options. Options (b), (c) and (d) are also for us. Option (e) is for Inland Revenue: judging by earlier papers it is clear that they have already made some preliminary assessment of the implications - can I now ask Brian Mace to take this further? Option (f) is largely for us but we shall have to consult with Inland Revenue on how to deal with higher rate taxpayers. (If these are not dealt with (f) simply becomes a variant of the across-the-board version of (b)).

5. Given our deadline of the end of February for submitting to Ministers, we should be aiming for a first draft by around the end of this month. I would therefore be grateful for early comments and contributions. The original draft timetable suggested a meeting this week! Obviously that is not now on but subject to your views I think we could postpone this until we have some new material to consider, preferably a first draft of the paper. But I would of course be quite happy to arrange a meeting, if you felt that it would be helpful.

6. No doubt you, like us, will be reading carefully the interesting proceedings in the Commons on this subject on 12 January. The Parliamentary arithmetic is instructive!

7. I am copying this to Brian Mace.

Yours sincerely



R A BIRCH

3977/40

FROM: P J CROPPER
DATE: 19 January 1988

CHANCELLOR
CHIEF SECRETARY
FINANCIAL SECRETARY
PAYMASTER GENERAL
ECONOMIC SECRETARY
MR TYRIE
MR CALL

OPINION RESEARCH: TAX AND THE NHS

Please see the attached letter from Robin Harris. For Prayers 20 January.

P J CROPPER

Conservative Research Department

32 Smith Square Westminster SW1P 3HH   Telephone 01-222 9511

Director: ROBIN HARRIS CBE

RH/CR

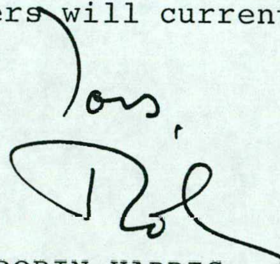
18th January 1988

Dear Peter,

OPINION RESEARCH: TAX AND THE NHS

I thought that you and perhaps Treasury Ministers might just like to see the attached opinion research finding, summarised in a note prepared by Keith Britto for another purpose. The interesting point is, of course, that while people would like - or think that they would like - money available for tax cuts to be spent on the Health Service they do not want taxes to be increased to spend on Health. In other words, once taxes have come down a Party which promises to put them up again in order to provide extra for Health is on to a sticky wicket. This seems to me to have quite important implications for issues that you and others will currently be considering!

Yours,



ROBIN HARRIS

Peter Cropper Esq CBE
Special Adviser
H M Treasury
Parliament Street
LONDON SW1

b) Welfare without the State: A Quarter Century of Suppressed Public Choice by Ralph Harris and Arthur Seldon (Institute of Economic Affairs) based on a survey conducted by Peagus in March 1987.

a) GALLUP - PUBLIC FINANCE FOUNDATION SURVEY

Gallup conducted this study from 8th to 13th July 1987 and as part of the interview included a lengthy statement on the current costs of the health service. They told respondents:

'I am going to ask you a few questions on the National Health Service which includes hospital services, family doctors and dentists and community health services such as district nurses and ambulances.

The total cost works out on average of about £6.50 per week for every person in the country, that is what on average we pay through taxes, national insurance contributions and charges. The better off pay more than average, the less well off pay less'.

Gallup then asked respondents whether they agreed or disagreed with the statement that more money should be spent on the NHS to give a better service to patients. 88% of respondents agreed, 8% disagreed and 4% had no view. When Gallup asked the same question but without the preamble, they found 89% agreeing with the statement that more money should be spent on the NHS to give a better service to patients.

Gallup put to respondents a number of possibilities of raising more money to spend on the health service and they asked whether they thought each possibility was reasonable or unreasonable. They found:-

	Reasonable	Unreasonable	Not Sure
Spend money which would otherwise go into tax reductions i.e make smaller tax reductions than would otherwise be possible (%)	69	17	14
Increase taxes e.g. income tax for the weekly national insurance constributions and the tax on cigarettes (%)	38	47	15
People who can afford to to do so should contribute more to the cost of the service at the time that they use it e.g for specialist consultations or for admission to hospital or for consulting the doctor (%)	54	35	11

3:2

b) PEAGUS - INSTITUTE OF ECONOMIC AFFAIRS SURVEY

The IEA study conducted in March 1987 included a number of questions on attitudes to the provision of health services. Some of the key findings are summarised below.

CONFIDENTIAL

PEIRSON TO CST 19 JAN

FROM: MISS M E PEIRSON

DATE: 19 JANUARY 1988

CHIEF SECRETARY

cc Chancellor
FST
PMG
EST
Sir P Middleton
Mr Anson
Mr Kemp
Mr Hawtin
Mr Potter
Mr McIntyre
Mr Saunders
Mr Fellgett
Mr Gibson
Mrs Wiseman
Mr Call

REVIEW OF COMMUNITY CARE: GRIFFITHS' REPORT

I should just like to add 2 points to Mrs Wiseman's submission of 18 January.

2. First, as she says, the report is likely to recommend that the local authorities be given the responsibility for community care. That is sensible, but it will create a financial incentive to the local authorities to find loopholes for avoiding the burgeoning cost of care. There is a major potential loophole which the Treasury were unable to persuade the pre-Griffiths' working party to address, and which does not appear likely to be addressed by Sir Roy. That is, care of the elderly (particularly) in NHS hospitals. The local authorities need merely refuse to take the elderly back from hospitals, after they have gone in for some treatment, on the grounds that there is nowhere to put them, and they (the local authorities) will then be spared all expense. The NHS will bear the cost. DHSS say they do not think that happens much at the present; but there is no very great incentive at present, and that will change. The DHSS ought to take some interest in the problem, because the cost will fall on their NHS budget, but they are doing nothing at present about thinking of a

solution. (A solution might be on the lines of giving the hospitals power to charge the local authorities a hotel plus care charge - at least equal to the charges of an NHS nursing home - from the date at which the hospitals would otherwise have discharged their patients .)

3. It will be necessary therefore for the Treasury to inject this idea, when the Secretary of State consults about the Griffiths report.

4. My second point concerns the line to take, not only if publication is proposed but in response to press enquiries as knowledge of the existence of the report gets around (possibly on 29 January). As Mrs Wiseman says, we want a careful statement, which does not encourage the idea that additional resources will be made available. Mr Saunders will be in touch with DHSS about this, but your office might like to get in touch with the Secretary of State's, given what happened with the press statement following his meeting with the 3 medical Presidents.

MEP

MISS M E PEIRSON

CONFIDENTIAL

FROM: E P KEMP
20 January 1988

MISS PEIRSON

cc Principal Private Secretary
PS/Chief Secretary
PS/Financial Secretary
PS/Paymaster General
PS/Economic Secretary
Sir Peter Middleton
Mr Anson
Mr Hawtin
Mr Potter
Mr McIntyre
Mr Saunders
Mr Fellgett
Mr Gibson
Mrs Wiseman
Mr Call

REVIEW OF COMMUNITY CARE - GRIFFITHS REPORT

I am sure you are right - paragraph 4 of your note of 19 January - to advise the Chief Secretary that we need to make sure that when the Griffiths Report on Community Care is published DHSS handle Press enquiries etc carefully, and on a basis agreed with us. Both presentationally and in reality it is of course inextricably tied up with the present lively interest in the NHS more generally, and I would guess that it will turn out to be very difficult, as well as in fact wrong, for the Government to try to deal with it separately from the present Health debate and anything that may emerge from that.

2. The other point you make in your minute very much sharpens this view; this is the question of the practical interface between the NHS and community care and the need to get the financial disciplines and regime set up in such a way that the various interfacing authorities are encouraged to treat patients in the most cost-effective place and most cost-effective manner at any given time; rather than creating a financial regime which gives perverse incentives. Clearly anything which might encourage local authorities to leave people in NHS beds which might be used for other

patients when those people ought to be out in community care could be just such a perversity. As you point out, one solution might be on the lines of giving hospitals power to charge local authorities for people looked after for them. But this is just a specific example of the need to look again at NHS charging policy in the widest context, and a further good reason for so doing.

E P KEMP

BUDGET CONFIDENTIAL

FROM: E P KEMP
21 January 1988

CHANCELLOR OF THE EXCHEQUER

cc Chief Secretary
Financial Secretary
Paymaster General
Economic Secretary
Sir Peter Middleton
Sir T Burns
Sir G Littler
Mr Anson
Sir A Wilson
Mr Scholar
Mr Culpin
Mr Sedgwick
Mr Odling-Smee
Miss Evans
Mr Cropper
Mr Tyrie
Mr Call
Miss Peirson
Mr Saunders
Mr Sturges
Mr Hudson AH 21.1.
Mr Battishill - IR
Mr Isaac - IR
Mr Painter - IR
Mr Unwin - C&E
Mr Knox - C&E

TAX RELIEF FOR HEALTH INSURANCE - MONDAY'S OVERVIEW: ITEM (v)

Mr Allan's note of 15 January asked for a note setting out the arguments for and against giving tax relief for private medical insurance, and discussing the practicalities and cost. I attach such a note, which has been prepared by ST in consultation with FP and the Inland Revenue.

2. As you will see, the note turns up nothing very new. There is an immediate deadweight cost of around £150 million in respect of people already insured, and of course further cost over time, some deadweight, some additional, as the market develops. There should be a net addition to health care expenditure in the country, but while helpful in terms of additional provision it seems unlikely that this would in reality reduce the pressures to spend more on the National Health Service at all in the

short term. While administratively practicable at relatively low cost provided a "deduction at source" scheme is adopted, FP have pointed out that taken in isolation it goes in the opposite direction to the way you have been taking the tax regime generally, and may not sit well with certain ideas under consideration in the Budget more specifically, which are of course not discussed in the note. And the possible repercussions into demands for tax relief for other private purposes, such as in particular private education, need close watching.

3. The note essentially considers tax relief on insurance premiums for private health care howsoever paid. As it brings out, however, there are two variants on this.

> First, theoretically one could think about giving tax relief not just on insurance premiums paid, but (as an alternative for individuals not insured) the actual costs to them of payment for health treatment. This would of course have a much bigger deadweight cost - the figure of £150 million referred to above only refers to insurance premiums paid not to the total amount paid for private health care. By the same token it might give more encouragement to the provision of private health care and could facilitate the introduction of wider charging in the NHS proper (see paragraph 5 below). But it is a rather different approach and would need a separate examination.

> Second, as Mr Moore seems to have hinted recently it would be possible to distinguish for tax relief purposes between insurance premiums paid (or the actual costs of medical treatment received) by individuals on the one hand as opposed to employers on behalf of their employees and indeed their employer dependents, on the other. Restricting relief only to schemes for individuals would greatly reduce the deadweight cost, but also, probably, the encouragement to the private health industry.

In any case if employer schemes are included further consideration would have to be given, as the note indicates, to the method of giving relief

to the employee (the employer can already deduct the premiums for corporation tax purposes) which impinges on matters elsewhere under discussion. (I should add that this in turn has some links with the point raised by "MEDISURE" - Mutual Trusts as a Method of Providing Employee Health Care Cover - on which the Revenue have submitted a separate note to the Financial Secretary; but I understand that this is being separately resolved and relates not to giving such schemes some kind of advantage over present employer schemes, but simply bringing them up the same starting line.)

4. However none of these courses is at all attractive seen in isolation, and it seems to me that the best, if not the only, reason (politics and presentation apart) for going down any of these paths would be if it could be seen in the context of the present lively debate over health, and as part of a wider based and more thought out strategy in relation to the provision of health care and the encouragement of new thinking here, and as may be traded for ideas which we do want, and which eg DHSS are slow on.

5. There are possible ideas on the wider front which could sit fairly well with one or other of these courses. Giving tax relief one way or another for health care privately provided (give or take pay beds in the NHS) would as I say increase the total of health care overall and could eventually reduce pressures on the NHS, but only slowly and with considerable deadweight and a likely considerable net PSBR cost. But it would be very different if tax relief could be used as a lever to introduce more substantial charging for NHS services. Such charging is any way desirable from a number of points of view, including PSBR reduction, encouragement of private provision, further reduction of the "cliff edge", establishment of a basis for the internal market (and the quasi internal market such as transactions with local authorities), and the general stiffening of NHS costing and management. But so far this has proved elusive. One would have to move slowly, and clearly there would be many variations as to how to proceed. But if this was a strategy, or one of the strategies, to be pursued tax relief on some basis could

be both actually and presentationally helpful.

6. All this is looking a long way ahead, perhaps. But if you felt that this was the sort of direction Ministers might eventually want to go, then the case for doing something by way of tax relief for private medical insurance or private health costs more directly met, whether for all or just for people not in employer schemes, none of which seen in isolation is very clearly justified, has something to be said for it. But as ever would depend on cost and repercussions (cf education) and tax policy desiderata, as well as possible health policy developments.

E P KEMP

TAX RELIEF ON PRIVATE HEALTH INSURANCE

This paper, as requested, summarises key points concerning the possibility of allowing tax relief to individuals on private health insurance. There are possible variants which could be explored notably allowing such tax relief for either individual subscribers or company schemes but not both; and extending the tax relief to these paying directly for private health (not via insurance). Aspects of these variants are touched on below.

2. Summary of likely effects. If tax relief was made generally available for private health insurance it seems likely that:-

(i) there would be an increase in the number of people covered by private insurance (para 6);

(ii) (assuming constant NHS expenditure) the total provision of health care, public and private, would increase. An expansion of the private health sector might help to counter some of the perceived pressures in the NHS - because although waiting lists might fill up again with further cases, waiting times might reduce - but seems unlikely to result in lower public expenditure and could increase it (see paragraph 11);

(iii) an immediate deadweight cost (about £150 million pa assuming relief at marginal rates - though the cost of relief for individuals only, not company schemes, would be significantly less) would be incurred for those currently insured and the revenue foregone would continue to increase (see para 6 below);

(iv) individual taxpayers would still have to "pay twice" for the NHS (via general taxation and national insurance contributions) and private insurance (albeit at a lower net cost than now). See also paragraph 10;

?

(v) champions of the NHS would probably characterise the change as irrelevant to the current perceived problems of the NHS. Some may consider it positively provocative and ask why the money was not being given to the NHS;

(vi) such a change might be thought inconsistent with both the main reforming thrust of the Budget and the Government's approach to taxation generally (broadening the base, reducing the rate). See paragraphs 13-14 below.

3. Private expenditure on health. About £600m of the £1 billion expenditure on private health services is covered by private health insurance; the rest is paid direct by the patient. (These figures do not include payment of NHS charges and purchase of medical goods without an NHS prescription eg aspirins). There are about 200 private hospitals and some 10,000 beds. In addition there are, of course, pay beds in NHS hospitals.

Private health insurance

4. In 1986:-

a. about 5 million people, including dependants, were covered by private health insurance under policies held by:-

- individuals 586,000;
- employee purchases (employee pays) 391,000;
- company purchases (company pays) 1,160,000;

b. total outlays on private health insurance premiums were £613m. The average premium per subscriber was £200-250 (company) and £500 (individual), but because most subscribers obtain insurance cover for their families this produces a lower average premium per person insured. (We do not know the reason for the disparity between company and individual rates but it might be age related);

c. 86% of subscribers were with three large insurance companies British United Provident Association (BUPA), Western Provident Association (WPA) and Private Patients Plan (PPP);

5. Numbers covered grew dramatically between 1978 (only 2½ million people covered) and 1981 and have grown by about 4% pa since then. The main insurers are forecasting growth in new subscriptions of about 5% in 1988 - with subscriptions by smaller companies providing particularly fast growth.

6. Cost of tax relief. If tax relief were given at marginal rates (see also para 8 below) then there would be an immediate deadweight cost for those already insured of around £150m pa, rising rapidly as both numbers (assuming 4-5% growth would have continued without relief) and costs rose. Tax relief could prove attractive to both those who find the current cost of health insurance slightly too high to contemplate and uninsured patients who currently pay private treatment costs directly. The increase in cost could be particularly marked if many new individual subscribers were recruited: their subscriptions are much higher than present subscribers' who are mostly in group schemes. If relief increased coverage that would increase the total cost correspondingly.

7. Current Tax Treatment. In common with almost all private expenditure, medical insurance premiums do not attract tax relief. The tax treatment of private medical insurance premiums paid on behalf of an employee by an employer is consistent with that of other benefits in kind. The employer obtains corporation tax

relief for the premiums paid (as he does for other "wage" costs). The employee pays income tax on the value of the premium paid by the employer on his behalf if he is a director, or an employee with earnings of £8,500 or more. If an employee earns less than £8,500 the benefit is not taxed. Employer organised group insurance schemes can be of additional benefit if group discounts can be negotiated with the insurer.

8. Possible Mechanisms. Relief could be given to individuals for private medical insurance by allowing the cost of premiums to be set off against taxable income either at the individual's marginal rate or at some flat rate - life assurance relief, for example, is given at a flat rate of 15% (for pre-1984 policies). This relief could be given either through the employee's tax code, or, it could be given at source by the insurer and reflected in lower premiums. The administrative cost to Inland Revenue of the former would be far greater (perhaps of the order of 100 staff per 150,000 taxpayers affected) than of the latter. One danger of either would be that the availability of tax relief could be reflected in increased charges by the suppliers of private health care eg private hospitals which would result in enhanced premiums so splitting the benefit of the relief between the individual, the supplier and the insurer. If relief were to be given at source then there would be a public expenditure cost in respect of any non-taxpayers who might benefit from the relief.

9. If the relief were also to be given to company schemes several different arrangements could be considered. The simplest way might be to exempt the premiums from the benefits-in kind legislation, ie ignore them for tax purposes. But if that seemed inconsistent with the thrust of policy on benefits-in-kind it might be possible to leave the general benefits-in-kind arrangements to apply equally to health insurance premiums as to any other fringe benefit but to apply the tax relief for all - individuals and companies - through a MIRAS-type arrangement with the health insurance providers. Whether or not this latter arrangement would be worth pursuing would depend on the discounts achieved by company schemes, the benefits-in-kind arrangements in force and the rate of tax relief which applied.

10. Public sector/private sector interface. Individuals at present confront a "cliff edge" when choosing between treatment wholly on the NHS or on a completely private basis. Tax relief on private health insurance would reduce the height of the cliff but even so it would remain high unless also reduced by an increase in NHS charges.

11. Repercussions on NHS. Allowing tax relief would probably lead to some diversion of demand for health care to the private sector, thus relieving pressures on the NHS. However the extent to which NHS pressures would reduce is necessarily limited because:-

a. those insured are unrepresentative of the population at large, being generally younger, better off and healthier;

b. coverage of private insurance is limited eg it generally excludes cover for pre-existing conditions, long-stay care, psychiatry, maternity, emergency treatment, GP and dental services. There is also usually a limit on the benefit that can be paid in any one period;

c. those insured remain entitled to use the NHS.

It is possible that the NHS might derive more income from pay beds - but only if the supply of pay beds can be increased to meet extra demand. The expansion of the private health sector and thus of total health care provision could exacerbate existing problems for the NHS in recruiting and retaining skilled staff, and could put pressure on costs. Thus if demand on the NHS did not reduce and costs rose the result might be pressure for greater public expenditure not less.

12. Wider repercussions. There is already substantial tax relief for home ownership. Now there is pressure for tax relief on private health. The next step could well be pressure for tax relief on private education. Also within the field of private

health if tax relief were allowed on insurance it might need to be extended to direct payments for health (40% of total private health expenditure) which would increase the deadweight cost, and carry increased risk of price inflation.

Tax Policy and Budget Considerations

13. The Government's tax policy objectives are to maintain a broad tax base and avoid tax driven distortions. Removal of life assurance premium relief in 1984 reflected this objective. More recently the Prime Minister summed up the Government's policy on special tax reliefs: when asked whether the time had come to introduce tax relief for individuals who take out health care insurance, the Prime Minister replied "no, it is more important to leave people to make their own decisions about what they do with their money rather than increasing reliefs for a particular sort of expenditure" (O.R. Col 579, 10 December 1987).

14. In the context of those publicly stated objectives, the impact of any special relief for private medical insurance on the Budget as a whole would have to be carefully assessed. Tax reform has come to mean reductions in tax breaks and cuts in the rates of tax. The introduction of a new relief would be a move in the opposite direction. Many commentators have already pointed to the narrowing of the tax base by the proliferation of benefits in kind. The exemption of premiums paid by employers from the benefits in kind legislation would be seen as a step in the wrong direction. Finally, the impact of the introduction of such a relief on the distributional consequences of the Budget would have to be assessed. We do not have very much data on the distribution of those subscribing to, or likely to subscribe to, private medical insurance but we are looking into this urgently.

15. Conclusion. Within current arrangements for health care provision tax relief on private health insurance would produce an expansion of private health care and total health care. However public expenditure on the NHS is unlikely to be reduced and might well be increased by the resulting pressure on costs. The new tax relief would involve a deadweight revenue cost of around £150m and growing. The cliff edge would still be there but reduced. The change would further restrict rather than extend the tax base.

ST 21 January 1988

GALLUP ON CHARGES

ps2/34M CONFIDENTIAL

FROM: MISS M P WALLACE
DATE: 21 January 1988

MR CROPPER

cc PS/Chief Secretary
PS/Financial Secretary
PS/Paymaster General
PS/Economic Secretary
Mr Tyrie
Mr Call
Mr Saunders (with copy of Mr Cropper's minute)

OPINION RESEARCH: TAX AND THE NHS

The Chancellor was grateful for your minute of 19 January, attaching a letter from Robin Harris. He was interested to note that 54 per cent of those questioned by Gallup thought it reasonable for people to contribute more to the cost of treatment, if they could afford it. This should be kept in mind for the next NHS meeting.

MW → CROPPER 21/1

MPW

MOIRA WALLACE

Carlton Club Political Committee

in association with The Conservative Medical Society
69 St. James's Street, London SW1

RESTRICTED CIRCULATION

STRICTLY PRIVATE & CONFIDENTIAL

THE NHS & THE PRIVATE SECTOR

Findings & Conclusions from an Investigative Seminar
Monday 30 November 1987

Date of Issue:- 25 January 1988

Note:-

1. Nothing written here should be taken as representing the view of the Carlton Club, Carlton Club Political Committee or The Conservative Medical Society.

2. All enquiries concerning this report should be addressed to Michael A Silverman : Hon Librarian Carlton Club Political Committee C/o Merton House 70 Grafton Way London W1P 5LE (01 388 2051) or Sir Arnold Elton CBE MS FRCS : Chairman Conservative Medical Society The Consulting Rooms Wellington Hospital London NW8 9LR

CONTENTS

		PAGE NO.
I	PURPOSE OF STUDY	1
II	BACKGROUND	1
III	CONCLUSIONS & ADVISORY POINTS FOR CONSIDERATION	2
IV	CONTRIBUTORS	6
V	DEFINITION OF PRINCIPAL NHS PROBLEM AREAS	7
VI	PROPOSALS MADE BY SPEAKERS WORTHY OF MINISTERIAL CONSIDERATION	8
	1. A Need to Improve Resource Management	
	2. Development & Benefits of Cooperative Ventures	
	3. How to Improve Training & Utilisation of Staff	
	4. Planning for Change	
	5. Improve Resource Management	
VII	SYNOPSIS OF EACH SPEAKER'S MAIN POINTS	11
	1. Dr Kenneth Grant	
	2. Professor Ian McColl	
	3. Mr Roy Forman	
	4. Dr Marvin Goldberg	
	5. Lord Skelmersdale	
VIII	APPENDIX	15

Carlton Club Political Committee

in association with The Conservative Medical Society
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'THE NHS & THE PRIVATE SECTOR

Findings & Conclusions from an Investigative Seminar
Monday 30 November 1987

I PURPOSE OF STUDY

The Conservative Government's record of success in managing the NHS, since 1979, is under intense scrutiny. Can it be put right with a stiff dose of efficiency? Will more money quench the thirst of increasing demands? Or does it need a radical change in approach? 90% of problems relate to meeting the increasing resource requirement of Britain's hospitals. The Ministerial Team and Government Policy makers have encouraged authoritative opinion to be sought.

The Seminar concentrated upon ascertaining the extent of problems and how Partnership between the Private Sector and the NHS could work more effectively to improve patient service and reduce costs to the Public Sector. The wider issues were also addressed, mindful of the new shift in mood emerging in Government circles and the unprecedented opportunity existing to effect real change for the better at this moment in time.

II BACKGROUND

The National Health Service is the biggest enterprise in the UK:-

- It absorbs c£21 billion a year - nearly £500 from every adult
- It treats c100,000 patients per day
- It is the largest employer in Western Europe (just under 1m employees - almost 200% more than in the entire Civil Service).

Apparent under-funding and a tendency to drift, taking short-term action rather than tackle the Service's fundamental problems, leaves the NHS in need of a drastic overhaul; such was the concensus of opinion of all Speakers, the Panel and Audience.

Against a background of inadequate Central Government Funding, the Health Authorities throughout Britain are technically bankrupt with aggregate debts approaching £1,000m. In commercially realistic terms, no Industry or Service can exist without investment. Attention was, therefore, focused upon the dichotomy caused by the Government's philosophy which is opposed to excessive State spending and its willingness to actively encourage the expansion of Private Sector medicine.

The question was raised 'Can we afford a National Health Care Service entirely funded by the State and what shape of Health Service should we be aiming for?' - Those attending the Seminar were unclear as to the optimum solution to adopt and felt that there was an urgent need for a radical re-think on the whole NHS structure of activities and means of funding such.

All participants were pre-briefed to express opinion and to provide additional facts to prove how the Private Sector might play a greater role in alleviating the pressures on Finance and Resources within the NHS. This Paper, therefore, seeks to formally present the opinions generated and to record the results of subsequent discussions held with interested parties.

III CONCLUSIONS & ADVISORY POINTS FOR CONSIDERATION

1. Need for radical change is widely accepted : among alternatives which emerged were:-

1.1 Moving the NHS away from Pensions and other areas of social services.

Re-titling the NHS to show that its first 40 years was the 'end of the beginning' and that, from 1988 onwards, a whole new concept of **funding** and **services** (with a major accent on fitness) will take us into 2000 AD.

1.2 Establishment of the NHS as an independent statutory body - with financial accountability : Move from a centralised to a devolved service.

1.3 Increase the use of joint ventures between the NHS and the Private Sector creating an integrated and inter-related market.

1.4 Extend the principles of charging and create a costed service.

1.5 Create, in party with the Private Sector, a National Health Insurance Scheme, capitalising upon 1.2 above providing a health care plan for the nation.

1.6 Devolve all Health Care responsibility to directly funded District Health Authorities (statutory body), thereby dismantling Regions and concentrating all Funding and Administration at DHA level. (In this context individual hospitals could 'opt out', thereby instilling into the system a competitive element.)

1.7 Dismantle the appallingly involved Employment packages/salaries and wages structure currently dictated by an out-of-date Whitley Council.

Introduce one new streamlined package comparable for the Public and Private sectors.

2. **Create a Career Structure for medically qualified staff throughout the NHS and the Private Sector -harmonising so far as is practical, to avoid a conflict of systems, one to the other.**

Specific ideas put forward included:-

2.1 Re-think the **process** - especially its length - of doctor and nurse training and their contractual terms of employment.

2.2 Create a Ward and Special Unit Career Structure for nurses with **different** salaries recognising the special skills and qualifications of personnel working in, e.g.

- Theatre
- Paediatrics
- I.C.U.
- Ward Management

Remuneration to vary by UK Region in line with ±% National Differentials prevailing in the Non-Medical/Private Sector.

2.3 Raise the salary of the Clinical Nurse and give more accountable authority for decision making. Stop incentivising the nurse to move to administration as the primary means of gaining more money.

2.4 Study the Doctors Career Progressional problems causing bottlenecking at Senior Registrar level, resulting in poor morale, etc.

3. **Improve Training, Utilisation of Staff & Equipment**

Clinical autonomy confuses management ability to direct, improve and effect changes, in the way that clinical staff are used to. Create an opportunity for the Private Sector to contract for the provision of:-

(i) Intensive Care Units
(ii) Pathology
(iii) Ambulance Service
(iv) Secretariat
(v) Housekeeping
(vi) Building Project Management
(vii) Joint Sharing of Major Capital/Revenue Using Equipment

4. **Create the basis for a Nationally Costed Service - Implement Monitoring of Hospital Performance and Standards of Care and equate such to a cost/benefit analysis which is published for all to see.**

There is an urgent need to develop information, standards and criteria and outputs in order to identify and reward efficiency. Conversely, the patient needs to know the cost of services received if they are to appreciate the service.

5. **Union entrenchment must be addressed for such represents much of the cause for slowness to adapt to newly created opportunities of delivering an improved, more cost efficient health care service product, to the benefit of the patients and staff.**

Government should encourage disbanding of old fashioned Trade Unions (COHSE, NUPE, ASTMS, etc etc) and the creation of one body with specialist sections.

6. **<u>Tax Relief on Healthcare Insurance Premiums should be implemented in the next Budget so as to encourage further growth of the Sector and generate more funds for healthcare.</u>**

   The Healthcare Insurance market only covers 6m (c11%) of the population. In the early 80's it was hoped it would grow to 12m (c22%).

7. **<u>Increase expenditure on Health by provision of extra short-term Central Government Funding and encourage the Private Sector to become an increasingly contributory resource by taxation and other incentives so that the UK is in line with other Nations in the Western world.</u>**

   An analysis of % GNP and £ per capita expenditure of the UK reveals **the UK to be spending less** per capita than all other major nations, except for Ireland and Italy. The trend is that all nations are spending more than the UK and the gap seems to be widening between the UK and other industrial nations.

Expenditure on Health : % GDP vs £ per capita
Nations spending more than the UK & the significance of the Private Sector
Calendar Year : 1985

	% GDP Contribution			Funding per Capita : (£)		
Nation	**Govt**	**Private**	**Total**	**Govt**	**Private**	**Total**
UK	**5.5**	**0.7**	**6.2**	**324**	**41**	**365**
Belgium	6.0	0.5	6.5	381	32	413
Norway	6.2	0.7	6.9	604	68	672
Austria	4.6	2.7	7.3	284	167	451
Finland	5.2	1.4	6.6	442	119	561
Italy	6.2	1.2	7.4	278	54	332
Denmark	5.6	1.0	6.6	490	87	577
Switzerland * 1980 Figs	4.7	2.5	7.2	550	293	843
Ireland * 1982 Figs	7.7	0.5	8.2	255	17	272
Netherlands	6.9	1.9	8.8	442	122	564
France	6.6	2.7	9.3	437	179	616
Sweden	8.8	0.8	9.6	730	66	796
W Germany * 1982 Figs	6.6	1.6	8.2	581	141	722
USA	4.5	6.3	10.8	578	810	1,388
Japan	5.0	1.7	6.7	314	107	421

<u>Source</u> : Measuring Healthcare - Expenditure Costs & Performance : OECD : 1985
<u>Note</u> : £ per capita figures for 1985 are estimates created by applying 1983 % factors of GNP 'split' to real 1985 figures.

<u>The fact that the UK is spending less per capita currently on Healthcare than other nations is sufficient evidence that Government action is needed urgently to release additional monies.</u>

8. **Consider Creating 3 types of service for Medical Healthcare viz:-**

8.1 An acute major sector

8.2 Less acute centres (e.g. elective surgery)

8.3 Home medical care services

Selectively follow some of the practices adopted in the USA (reference : The Shepherd Institute) and involve the Private Sector heavily in absorbing the capital cost of buildings and medical equipment, thereby deriving a 'fixed price' for each procedure. Such would substantially lessen the financial burden facing the NHS.

9. **Evaluate the benefits offered by the 'Education Bill' and ascertain how they might be deployed within a restructured NHS.**

In particular, consideration should be given to:-

9.1 Creating an improved freedom of choice

9.2 Permitting patients and/or their GP's to select:-

- A Consultant
- Hospital
- Specialist Unit

9.3 Publishing regularly by District the UK statistics on, e.g.

- Patient Waiting Lists
- Treatment Success Rates
- Costs for Procedures
- Patient Complaints

9.4 Evolving a financially worthwhile scheme whereby a patient can 'opt out for life' from the NHS and commit fully to a 'Private Scheme'.

10. **Devolve responsibility for • Design • Construction • Fitting out of all Hospitals and Medical Centres to the Private Sector and either pay a 'Project Management Fee' or 'Lease Back' the facility for, say, a 25-year term on a commercially based rental calculation.**

This radical change would offer the significant benefits of:-

10.1 Enabling the NHS to provide new facilities as quickly at the Private Sector has already demonstrated

10.2 Reducing a major central overhead

10.3 Remove the responsibility for maintenance and quality control of building structures

10.3 Delete the cost of capital spending from the NHS Budget, offsetting costs to accrued expenditure

There is clearly a strong case for Government to commission a fundamental review of the NHS and its inter-relationship with the DHSS. Such a review should build on Clause 4 of the Health and Medicine Bill. It should cover each of the suggested areas of change detailed above, for the Private Sector is evidently anxious to work closely with Government in ensuring the delivery of the Manifesto promise • 'Every patient shall have prompt professional care' and 'To make very NHS £ work harder'.

IV CONTRIBUTORS

1. Speakers

Lord Skelmersdale	Parliamentary Under-Secretary of State for the Department of Health & Social Services
Dr Marvin Goldberg	Chief Executive : AMI Healthcare Ltd
Mr Roy Forman	Managing Director : Private Patients Plan
Dr Kenneth Grant	District General Manager : City & Hackney Health Authority

2. Panel

Mr Christopher West	Manager : District Health Authority : Portsmouth & SE Hampshire
Professor Ian McColl	Professor of Surgery : Guy's Hospital

3. Advisors

Dr Sir Gerard Vaughan MP*	President of the Conservative Medical Society
Sir Arnold Elton*	Chairman of the Conservative Medical Society
Mr Barry Caulfield	BUPA
Mr Oliver Rowell	General Manager : Nuffield Hospitals
Mr Michael Silverman*	Hon Librarian : Carlton Club & Member of the Conservative Medical Society
Mr John Gelling*	Director : Merton Associates, Member of the Carlton Club & Member of the Conservative Medical Society
Dr Maurice Dunstan*	London Business School

* (Authors of the Report)

4. Delegate & Participants Attending Seminar

(See Appendix A)

V DEFINITION OF PRINCIPAL NHS PROBLEM AREAS

The Speakers, Panel and Delegates focussed particular attention upon the following problem areas. Strong demand appeared to be building for positive Government action **to save the service from further decay.**

1. Management

1.1 **Too much bureaucracy** : Need for fewer better qualified and more innovative management rather than administrators.

1.2 **Cost containment in the NHS** : Directly 'hits' the patient. It results in:-

- ward closures
- decreased nurse recruitment
- lowering of morale amongst Healthcare workers

1.3 **Lack of cost information** : There is no reliable data against which to cross-compare the Private Sector offering.

1.4 **Methods of Accounting are questionable** : Health Authorities are penalised for savings made, i.e. **Budgets cut the next year.** No account of capital costs is made in costing services. No O & M is conducted into working practices and their related direct costs, which is published.

2. Funding

2.1 **Lack of funds** : This appears to be national and a comparative with other Western economies suggests a need for a higher spend **(See pp 4).**

3. Hospitals

3.1 **Many Hospitals need updating** : to bring them in line with sanitary and safety codes.

3.2 **Many Hospitals are technologically behind** : patient care is, accordingly, suffering.

4. The Service

Hospital Waiting Lists are rising : currently estimated at 680,000 p.a., 47,000 (6.9%) of these are urgent cases and the number will rise as medical technology gains further entrenchment.

Against this scenario, it is to be noted that:-

(i) Insufficient preventative medicine is being carried out

(ii) Empty wards are an increasing feature due to staff cuts

(iii) Under-utilised operating theatres result in a waste of expensive resources

(iv) Inflexibility of ancillary services results in high fixed overheads

THE NHS & THE PRIVATE SECTOR

EXAMPLES OF COOPERATIVE SCHEMES : COST SAVING PROGRAMMES & IMPROVEMENTS IN PATIENT CARE

Location	Private Sector Facility	Application	Benefit	Value of Contract
Southend HA	HCA Wellesley Hospital	Use of spare theatre capacity	240 gynaecological operations to minimise waiting lists	£96,000
Tunbridge Wells HA	Ticehurst House Hospital	Provision of beds & facilities whilst local HA waiting list closed down	To assist with special needs	Not quantified
London W1	Princess Grace Hospital	Use of spare theatre capacity to take off waiting list from St Bartholomews Hospital	130 tonsil operations to minimise waiting list	Not quantified
Local HA (Cheadle : NE)	AMI Hospital in Cheadle	Use of spare theatre capacity	40 prostate operations to minimise waiting list	Not quantified
Local HA (Huddersfield)	Huddersfield/ Nuffield Hospital	Use of spare theatre capacity (15 month contract)	Breast cancer surgery - minimise waiting list & use of specialist unit	Not quantified
Leeds HA	Methley Park Hospital	Use of spare bed/theatre capacity	Gynaecology/ENT/Orthapaedics : 500 minor operations p.a.	Over £50,000
London : East	London Bridge Hospital	Specialist facility clinic	Available to NHS Patients by agreement/referral of DHA	-
London : W1	AMI Portland Hospital	Provision of specialist tube baby team for next 2 years by St Bartholomew Hospital (Training Prog.)	Salaries paid for by AMI	-
South Lincs HA	AMI Park Hospital	Use of spare bed/theatre capacity & joint venture with DHA	Orthopaedic surgical cases treatment centre set up	£100,000
London	BUPA Hospitals	Training bursary for new specialists	Work as RMOs at BUPA Hospitals for 6 months Work at Guy's & St Thomas' Medical Schools for 6 months in Anatomy Department	£120,000
London	St Thomas' Hospital BUPA sponsored	To pay capital cost of lithotripter equipment	Both NHS & private patient applications	-
London	Humana Wellington AMI Hospitals	Sponsoring a training scheme for cardiac profusionists (first ever!)	Assisting NHS in training of personnel - at no cost!	-
London	• Humana Wellington • Nuffield Hospitals • Cromwell Hospitals • AMI Hospitals	Sponsoring various training schemes • Joint Operating Theatre Course with Brompton Hospital/Cromwell Hospital (now in 4th year)	Assisting NHS in training of personnel - at no cost!	-

VI PROPOSALS MADE BY SPEAKERS WORTHY OF MINISTERIAL CONSIDERATION

1. A Need to Improve Resource Management

The provision and control of resources is fundamental to efficient and effective operation in both Public and Private Sectors and there are signficant differences in accounting practice and accountability.

Improvements in cost effectiveness would flow from greater attention to a number of points. These include:

1.1 Better management/cost accounting including improved Management Information Systems.

1.2 Longer term budgets in the NHS.

1.3 Promotion of private health insurance

1.4 Competitive tendering for capital expenditure

1.5 Independent Sector to design-build and manage contracts

1.6 Marketing of pay beds within private wings of NHS

1.7 Opening up of pathology laboratories to Independent Sector management

1.8 Increasing cost awareness of healthcare treatment amongst staff and public

2. Development & Benefits of Cooperative Ventures

There are numerous examples of ways in which Public and Private Healthcare services are already cooperating (See Charts Opposite & Overleaf) and there is potential for further collaborative ventures. Among specific suggestions made were the following:-

2.1 **Better utilisation of NHS facilities**, e.g. delayed and cancelled operating lists and **patients failing to keep appointments** cause much dislocation.

2.2 **Increase percentage of day case surgery.** A good example of collaboration is the treatment of NHS patients at the privately run Bioplan Day Surgery Centres and the other parts of the country where post operative NHS cases are moved to the Private Sector at a cost of c£25 per day.

2.3 **A need to reduce length of stay in NHS beds.** Agreed lengths of stay for different procedures need to be formulated and with a degree of flexibility adhered to.

THE NHS & THE PRIVATE SECTOR

EXAMPLES OF COOPERATIVE SCHEMES : COST SAVING PROGRAMMES & IMPROVEMENTS IN PATIENT CARE (SCHEDULE II - REFERENCE PP8)

Location	Private Sector Facility	Application	Benefit	Value of Contract
Leicester	The Leicester Clinic	Use of spare theatre capacity	320 ENT patients treated when NHS facility late in opening	-
Hull (Scunthorpe HA)	Hull Nuffield Hospital	Use of spare theatre capacity	63 ENT patients treated	£29,925 (incl. cost £475 pp)
Northallerton HA	Cleveland Nuffield Hospital	Use of spare theatre capacity	50 ENT patients treated (incl. cost £475 pp)	£23,750 (incl. cost £475 pp)
Northumberland HA	Newcastle Nuffield Hospital	Use of spare theatre capacity	20 Hip Replacement Patients treated	£30,000 (incl. cost £1,500 pp)
Winchester HA	Wessex Nuffield Hospital	Use of specialist facility	Vasectomies : 70 cases p.a.	N/A
S Derbyshire HA	East Midlands Nuffield Hospital	Use of specialist facility	Laproscopy Sterilisation : 60 day care patients so far in year for Derby City Hospital	(Incl. cost £225 pp)
Huddersfield HA	Huddersfield Nuffield Hospital	Use of specialist facility (15 month trial scheme)	Breast surgery : 300 patients est'd 1987/88 (Av = 5 per wk for past 6 wks)	£90,000 (incl. cost £330 pp)
Huddersfield HA	Huddersfield Nuffield Hospital	Use of specialist facility (15 month trial scheme)	Gynaecological Procedures 25 patients treated	Incl price £234 to £740 per patient dependant upon procedure
Nationally	Nuffield Nurse Training Programme	'Back to Nursing' Campaign	Courses being run in Bristol, Oxford, Wolverhampton, Woking & Huddersfield	-

2.4 **Promotion of increased specialisation of hospitals to improve efficiency should be encouraged, thereby creating specialist centres of excellence for specific procedures.**

2.5 **Contracting out work to the Private Sector in order to ease NHS waiting lists is both cost effective and practical.** This is done on a marginal costing basis and helps both parties, but cannot be relied upon long-term since Private Sector business is more profitable unless the Minister was to make a long-term recommendation to such a practice.

3. **How to Improve Training and Utilisation of Staff** - Among the suggestions made were the following:-

3.1 Measure improvements in efficiency and reflect in rewards to staff

3.2 Closer monitoring of consultants, NHS commitments and expansion in the number of consultant posts as Private Sector commitments increase

3.3 Consideration should be given to rotating Doctors between the NHS and the Private Sector with recognition by the Royal Colleges of the experience gained in both Sectors.

3.4 Crash training schemes for nurses and theatre technicians to meet shortages. This may require joint collaboration between the two sectors

3.5 Greater flexibility of nursing rotas and trained nurses to engage in **less** administrative and non-technical ward work

3.6 Need for cooperation between clinicians and managers

3.7 Reduce tension between Public and Private Sectors by mutual education of staff on both sides

4. **Planning for Change**

Among the suggestions made were the following:-

4.1 Introduce joint strategic planning at district and regional level

4.2 There is a requirement for the setting of standards for **Hospital Services** in line with the White Paper on 'Promoting Better Health'

4.3 A system should be instituted to monitor hospital performance and standard of care and communication of these to the consumers

4.4 A formula should be set for the planned provision of expensive high technology equipment. Knowledge of population it is likely to serve and proximity of similar equipment should be taken into consideration prior to purchasing such items

4.5 Accurate and up to date records of joint ventures between the Public and Private Sectors are needed

5. Improve Resource Management

5.1 Accountability

There is a need for clear cost effective accountability, to facilitate comparison of relative effectiveness of the Public and Private Sectors, e.g. costing of individual procedures.

5.2 Budgeting

Longer term budgets, NHS health authorities at present operate on yearly budgets. 3-5 year planning periods, at a minimum, need to be committed to.

5.3 Private Health Insurance

The promotion of private health insurance to relieve the burden on the NHS is essential. Tax relief on private health insurance schemes should be given.

5.4 Hospital Construction

The use of private industrial firms to finance construction of new hospitals and to lease facilities to the NHS on long term contracts should be adopted.

5.5 Marketing of Pay Beds

Those integrated within NHS wards cause resentment amongst staff, are under-utilised and are often loss-making. Separate private wings are better but require more effective management than at present. They should be subcontracted to the Private Sector for management.

5.6 Laboratory Facilities

Opening up of NHS Pathology/Immunology/Mammography/Cervical screening to the Private Sector would release a substantial burden on the NHS. Either 'in-house' under Private Sector management or competitive tendering to external firms are the considered options.

VII SYNOPSIS OF EACH SPEAKER'S MAIN POINTS

The content of each Speaker's main points is briefly summarised in this section of the report in order that interested readers of this report may better appreciate the source and quality of opinion.

1. Dr Kenneth Grant : District General Manager : City & Hackney Health Authority

1.1. The 'NHS Crisis'

- Over-capacity in London, too little money and too many patients
- The rewards of success in the NHS are punishment
- Nursing recruitment poor and numbers leaving are high
- Empty beds and Christmas ward closures

1.2 The NHS Needs:-

- Money
- Competition - as a way of releasing money
- Collaboration

1.3 Marketing of Ancillary Services Needed

1.4 Examples of Successful Collaboration, e.g. In-vitro fertilisation scheme between AMI and St Bartholomews Hospital

1.5 Need to Remove Central Constraints in Administration and improve freedom in selecting staff and remuneration

1.6 Easier to experiment in the independent sector with regards cost and quality, specialised units can do more work for less money

1.7 Market pay beds

1.8 Need to reduce bureaucracy

2. Professor Ian McColl : Professor of Surgery : Guy's Hospital

2.1 Main advantages of private sector include courtesy, punctuality and good food

2.2 Need to improve service side of the NHS. At present there is poor management of cleaning, portering and catering. Privatise these re Servicemaster, USA

2.3 Need to reduce bureaucracy re at Guy's Hospital, staff reduced from 200 to 110

2.4 Reassessment of doctor's career structures. Lengthy and wasteful at present

2.5 Training of doctors in both the NHS and private sectors is needed

2.6 Should aim for:-

- Good output
- Good outcome
- Good quality of care

3. **Mr Roy Forman : Managing Director : Private Patients Plan**

3.1 The rising costs of healthcare with an ageing population and increasing technology

3.2 Need to greatly improve staff and public's awareness of the cost of treatments

3.3 Consumer to meet a part of the costs

3.4 Need for comparative measures of costing between the 2 sectors to facilitate better allocation and utilisation of resources

3.5 Consideration of costing procedures according to diagnostically related groups

3.6 Reward efficient hospitals and provide incentives to less efficient

3.7 Communication of quality of care to the consumer

4. **Dr Marvin Goldberg : Chief Executive Officer : AMI Health Care Ltd**

4.1 The 'NHS Crisis':-

- Excess demand and inability to meet it
- The large waiting lists
- Over 65's not getting on waiting lists
- No real preventative medicine being carried out

- **Many hospitals technologically behind**
- **Professionals are the lowest paid in the western world**

4.2 The private sector's role

4.3 The need to increase percentage of GNP spent on healthcare

4.4 Increase day case surgery

4.5 Need to depoliticise whole debate and treat problem as a national crisis - create a nationally insured scheme!

4.6 40 year anniversary is an appropriate time to re-examine mission and consider radical alteration of funding system

4.7 Need to reduce mutual suspicion between the two sectors for successful future collaboration ventures

4.8 Education of staff and public concerning private sector role and contribution

4.9 Recognition of staff training in the private sector

4.10 Introduce private design-build and lease programmes to reduce NHS capital expenditure

4.11 Need to improve NHS efficiency

5. **Lord Skelmersdale : Parliamentary Under-Secretary of State Department of Health & Social Service**

5.1 Reaffirmation of this Government's intention to improve patient care and to increase efficient use of healthcare resources

5.2 A potted history of the NHS, pointing out that the NHS has never been a full, comprehensive and entirely publically funded system:-

(i) Private practice concessions to consultants at NHS inception

(ii) Prescription charges

(iii) GP's as independent contractors

(iv) Independence of Teaching Hospitals

(v) Pay beds

5.3 The need to allocate resources which could involve establishing priorities so that elective procedures were either paid for by the patient or only took place when more urgent needs had been satisfied (e.g. Cosmetic Surgery)

5.4 The success of competitive tendering of ancillary services

5.5 Examples of successful joint ventures

5.6 Lessons to be learned from the private sector

5.7 The waiting list initiative

5.8 A summary of income generation schemes for the NHS as outlined in the Health and Medicines Bill

22.1.1988
Michael A Silverman

NB Further copies of this report may be obtain from The Carlton Club or the Conservative Medical Society at a cost of £10.00 - Cheques to be made payable to **'Carlton Club Political Committee'**

APPENDIX A

CARLTON CLUB POLITICAL COMMITTEE

From the Hon. Librarian
Michael Silverman

Please reply to:
Merton House,
70 Grafton Way,
London, W1P 5LE.
Tel: 01-388 2051

INVESTIGATIVE SEMINAR : MONDAY 30 NOVEMBER 1987

THE NHS AND THE PRIVATE SECTOR

GUEST LIST

E	ADEY John	Managing Director	Travenol Laboratories Ltd
E	ALDERSON C G P	Chairman Executive	East Sussex HA Conservative Medical Society
A	ANDREWS D R	Director Member	Mutual of Omaha International Conservative Medical Society
A	ARMSTRONG W L	Director	Mutual of Omaha International
B	BIDDLE Donald	Member	Carlton Club Political Committee
B	BLACK Susan	Medical Journalist	London Health Care Information Centre
B	BLACKWELL Norman		No 10 Policy Unit
A	BRICKNELL B R	Director	BUPA
E	BROOK Sir Robin	Chairman	Special Trustees for St Bartholomews & St Marks Hospital
C	BUTLER Dr Eamonn	Director	Adam Smith Institute
D	BURGESS K	Chief Executive	Shanning Group
A	BUGLASS Fay	Secretary	The Wellington Foundation
B	BURN Mr Ian FRCS	Consultant Surgeon Chairman Member	 Advisory C'ttee in Surgical Specialties : North West Thames RHA Conservative Medical Society
B	BYRNE A J	Chief Executive	Independent Hospitals Association
B	BYRNE A J	Chief Executive	Independent Hospital Association
E	CAULFIELD Barry	National Provider Liaison Manager	BUPA
D	CHADWICK A J	Member	Carlton Club

C	CHAPLIN Judith	Head of Policy Unit	Institute of Directors
D	CLARKE Ian	Member	Carlton Club Political Committee Conservative Medical Society
B	CLARKE Roy	Chief Executive	BUPA
D	COLLIER James CBE	Member	Carlton Club
C	COOMBS Simon MP		Member of Parliament
E	DOUGHTY William	Chairman	North West Thames RHA
A	DOWNES Mary		Theatre Superintendent
E	DUNSTAN Dr M	Business School Grad	London Business School
D	ESTALL James	Company Secretary	Nuffield Hospitals
D	ELWELL Hugh	Member Adviser	Conservative Medical Society Medical Insurance
TT	ELTON Sir Arnold	Chairman	Conservative Medical Society
C	FAVELL Tony MP		Member of Parliament
C	FELDMAN Sir Basil		
E	FITZHUGH Bill	Consultant	Healthcare Sector
TT	FORMAN Roy	Managing Director	Private Patients Plan
B	FROGGATT Dr Clive	Research Executive	Conservative Medical Society
D	FYFE W S OBE	Chairman	Ayrshire & Arran Health Board
A	GARDNER Paul	Research Executive	Research Dept Central Office
C	GELLING John	Member Member	Carlton Club Conservative Medical Society
A	GODDEN Mary	Nursing Officer	Out-Patient Superintendent
TT	GOLDBERG Dr M	Chief Executive	A.M.I. Healthcare Ltd
B	GOLDSMITH Dr M J	Director Member	Medisure Marketing & Management Ltd Conservative Medical Society
C	GOODSON WICKES Dr C	 Member	Member of Parliament Conservative Medical Society
C	GREEN Dr David	Physician Member	 Conservative Medical Society
TT	GRANT Dr Kenneth	District Gen. Mgr.	City & Hackney HA
A	HANCOCK Christine	General Manager	Waltham Forest Health Authority
D	HANHAM Dr I W F	Vice-Chairman	Conservative Medical Society
D	HANHAM Mrs J B	Member	Conservative Medical Society
TT	HAVARD John	Secretary	British Medical Association
A	JANMAN Tim MP		Member of Parliament
B	KELSEY FRY Dr I	Consultant	St Bartholomews Hospital
E	KOOPS Eric	Chairman	Carlton Club Political Committee
A	LETTIN Dr Alan	Consultant	St Bartholomews Hospital
B	LEVIN Dr Arthur	Chairman Member	Wellington Foundation Conservative Medical Society
B	MAYALL Dr Mark	Member	Conservative Medical Society

D	MAYNARD Prof Alan	Health Economist	University of York
TT	McCOLL Prof Ian	Prof of Surgery Member	Guy's Hospital Conservative Medical Society
D	McCRINDLE Robert A		Member of Parliament
E	McDONAGH Nora	Sec to Committee	Carlton Club Political Committee
C	McLEOD Sir Ian	Vice-Chairman	National Union
B	MEISNER Dr Peter	Consultant Phys Member	St Thomas's Hospital Conservative Medical Society
D	MILLINGTON Geoffrey	Planning Officer	National Hosps for Nervous Diseases
A	MOCKLER Chris	Administrator	Conservative Medical Society
C	ODELL Sir Stanley	Vice Chairman	National Union
C	PRICHARD Prof B M C	Treasurer Consultant Phys	Conservative Medical Society University College Hospital
B	PHILLIPS Bill	Managing Director	Westminster City Council
B	ROBSON Prof J		
TT	ROWELL Oliver J	General Manager Member	Nuffield Hospitals Conservative Medical Society
C	SECCOMBE Dame Joan	Chairman	National Union
B	SELLARS John	Managing Director	Medisure Marketing & Management Ltd
B	SHANKS Dr Jean	Chairman Member	J S Pathology Conservative Medical Society
TT	SILVERMAN Michael	Hon Librarian	Carlton Club Political Committee
D	SIMS Roger		Member of Parliament
D	SIMMONDS Dr Norman	Consultant Pathologist	Guy's Hospital
A	SIMMONS Richard	Partner	Arthur Andersen
C	SINCLAIR Dr Leonard	Consultant	Westminster Hospital
TT	SKELMERSDALE Lord	Parliamentary Under- Secretary of State	DHSS
D	SKIDMORE Mr David OBE	Member	Conservative Medical Society
A	SLACK Prof William	Dean	Middlesex Hospital
A	STEVENSON A D	Chief Executive	Independent British Hospitals
D	STEWART MUNROE C	Managing Director	CSM Parliamentary Consultants
E	STONE Evan	Chairman	City & Hackney RHA
C	TOD Dr David	Vice Chairman	Conservative Medical Society
D	TRUE Nicholas	Former Spec Adviser Member	DHSS Conservative Medical Society

A	TUCKER Dr Audrey	Consultant Radiologist Member	St Bartholomews Hospital Conservative Medical Society
D	TURNER Andrew	Special Adviser	DHSS
TT	VAUGHAN Dr Sir Gerard	President Consultant Physician	Conservative Medical Society
C	VAWSER Eric	Director	Mersey Healthcare Ltd
A	WALKER C J S	Chairman	East Anglia AHA
A	WALLER Sarah	Member	Conservative Medical Society
C	WALSH-WARING G FRCS	ENT Surgeon	St Mary's Hospital Paddington
TT	WEST Christopher	Manager	Portsmouth & SE Hampshire DHA
A	WHEELER Carol	Nurse Administrator	Portsmouth & SE Hampshire DHA
B	WHITE Dr Anthony	Consultant Physician Hon Secretary	Royal Free Hospital Conservative Medical Society
B	WHITEHOUSE N H	Dental Surgeon/ Spokesman	British Dental Association
C	WILLETTS David	Director	Centre for Policy Studies

NOTE OF MEETING
26 JAN

mjd 3/62m

SECRET

pmp

FROM: MOIRA WALLACE
DATE: 26 January 1988

NOTE OF A MEETING HELD AT NO.11 AT 11.15 AM
ON TUESDAY, 26 JANUARY 1988

Present: Chancellor
Chief Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Mr Kemp
Miss Peirson
Mr Parsonage
Mr Saunders
Mr Call

THE NHS

The Chancellor said that he had had a brief word with the Prime Minister at the weekend: it appeared that she was now keen to produce, within the next six months, a package of what would be seen as fairly radical changes to the financing and organisation of health care. In particular, the Prime Minister had welcomed the idea that Audit Commission-type reports should be published on the health service, and she also had a preference for a scheme where, by analogy with the education reforms, the money would follow the patient.

2. The Chancellor said that he thought the Treasury had done well to resist pressure for extra health spending in the Budget: Ministers should now take the position that extra money would only be provided in exchange for reforms. The Chancellor said that there were a number of points in Mr Moore's paper with which it would be important to take issue. First, it was misleading to

argue, as the DHSS did in paragraph 3, that the pay bill had increased so much that the additions to 'purchasing power' were derisory - this confused inputs and outputs, and failed to take account of increased productivity in public services. Secondly, the DHSS analysis of 'the problem' focused almost entirely on the elderly, and neglected to mention children, on whom media attention had been concentrated. On manpower, Mr Moore's paper made no mention of the possibities for greater delegation from doctors to nurses, and nurses to auxiliaries. DHSS opposition to charges was clear from the paper - it was interesting that they had not addressed the question of how far charging would deter frivolous visits to GPs. The DHSS description of the "real health issue" as one of "public health, not day to day issues of health care delivery" was also troubling: this was not the main focus of public concern, and to set objectives of this kind would have considerable expenditure implications. Mr Anson pointed out that it would be a move in the wrong direction for the state to take over what was currently a private responsibility-but the private sector could have a role in providing information.

3. The Chancellor then worked through the main points made in his minute to the Prime Minister, and which he would want to expand upon at the meeting. On the question of charges, it was obviously important to press for reduced exemptions from prescription charges: a two-tier system of charges would have to be one of the options considered, and the Chancellor would also want to argue for prescription charges to be related to the cost of the drugs. Charging for visits to GPs was obviously the most promising option for introducing charging for treatment, but it was agreed that the suggested figure of £5 per visit might be too high. The Chancellor agreed that the DHSS reference to a forthcoming review of consultants' contracts should be welcomed - but it would be important for the Treasury to be clear what precisely it would be looking for from such a review.

4. The Chief Secretary said that he was very concerned about the DHSS proposals to finance health spending from NICs - to narrow the

tax base for health in this way was a move in the wrong direction at a time when the numbers of fairly well-off elderly people were increasing so fast. However, he had more sympathy with DHSS pleas for resources to be allocated on the basis of throughput and efficiency, rather than population. He said that he felt it would be necessary to look at the question of local health lotteries as one way of generating income, but it was agreed that the Treasury should not reveal its hand on this at the No.10 meeting, but let others make the running. The Chief Secretary said he was considering whether a change in the timing of pay review body reports would make for a better interaction with PES - but again this was an idea that Treasury Ministers would not want to float with other Departments at the moment.

5. Sir Peter Middleton said that he saw three crucial issues in the debate. First, this was the Treasury's opportunity to push for progress towards an internal market - not just within the NHS, but also between it and the private sector, and local authorities. Secondly, in the longer term, the Treasury would have to consider what would be the right balance in any package of charges, insurance, and tax measures. Sir T Burns agreed that in the longer term some way would have to be found to encourage private finance, or the current problems would resurface in a few years. Thirdly, the Treasury had an interest in ending the current situation where health service pay was partly determined by review bodies, and partly by negotiations. The Chancellor commented that dropping the review body system was not a feasible option, so effort should be concentrated on reducing the scope for collective bargaining.

6. The Chancellor said that it would be helpful if he and the Chief Secretary could have a short note for use at the No.10 meeting, setting out the problems, the objectives, and the various ways forward.

MPW.

MOIRA WALLACE

Circulation: those present

MC27

SECRET

pmp

FROM: MARK CALL
DATE: 26 JANUARY 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Mr Kemp
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Saunders

NHS

Further to our conversation this morning, a few thoughts on the internal market and other aspects of the NHS debate.

THE INTERNAL MARKET

2. The concept of the internal market seems to be a very promising vehicle for reform of the financing of the health service. Through it changes could be achieved which are important in principle (and the first steps of longer-term reform), while politically manageable. A system in which the money followed the patient would provide a mechanism whereby resources get to where they're needed, improving on the demonstrably poor centralised planning used currently.

3. Another benefit would be the impetus it would give to the development of good cost information. This is vital if we are to shift the debate away from inputs into the black box of the NHS, towards outputs and relative performance.

4. Whereas the internal market might start with hospitals being paid via the region or district for work undertaken from outside their area, the way would be open for a system of patient vouchers in the future.

CALL 26/1

5. A further benefit would be that it would lower the barriers between the state and private provision of health services. As these barriers come down, and there is greater interchange between the state and private provision, I believe we should push for asymmetry, ie encouraging NHS use of private facilities, rather than privately financed use of NHS facilities. This is because the problems we are facing are not only of funding, but also of poor productivity, management, and service delivery, as well as weak incentives to control costs. Private facilities would have the incentive to control costs and, since they experience competition, for improved customer service. This would be a motor for greater efficiency in health provision.

6. Once patients, as customers, perceive that private provision not only works but delivers a high quality of service, we will have started to challenge the sacred cow of monopoly provision, and reinforced the perception that the NHS is part of a service to treat illness, as opposed to the nebulous concept of the "national health". It is vital, however, that this be presented as a symbiotic relationship of mutual benefit to the NHS and the private sector. Any sense that NHS hospitals are being encouraged to "make a profit", or that private facilities would be competing with NHS facilities would be fatal. A BUPA spokesman on the television on Monday night was careful to stress the aspects of partnership, rather than competition.

CHARGING

7. I am in favour of introducing limited charging. The recent debate may have demystified the NHS/GPs/nurses enough to undertake this. Even though charges would not be full cost, there is great advantage to making the prices "transparent", that is having a scale of charges which reflected as closely as possible the full cost of the activity from which discounts and exemptions would be calculated. This can only be done with much improved cost information.

PRIVATE HEALTH INSURANCE

8. Unless we believe there is a high price elasticity of demand, there could be a political pitfall in this. Although I have not seen any figures, there must be a good corelation of the incidence of private health insurance with income. As a result, tax deductability of premia would be seen as a further reward for the better off, in or following a Budget package which already gave them massive gains.

LOTTERIES

9. On the general question of lotteries, I favour deregulation to allow the development of local lotteries rather than the creation of a National Lottery. However, I have reservations about lotteries as a policy response to the current debate on NHS funding. I believe this could be misrepresented as gambling with people's health.

MC

MARK CALL

26.1.5

SECRET

pmp

FROM: R B SAUNDERS
DATE: 26 JANUARY 1988

CHANCELLOR

Ch/ X is surely a bit of an own goal!

cc Chief Secretary
Paymaster General
Sir Peter Middleton
Mr Anson
Mr Kemp
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Call

THE NATIONAL HEALTH SERVICE

mpw 26/1

I attach the aide-memoire you asked for at the end of this morning's meeting.

2. I would just add a couple of further points. First, there will be a critical decision as to who should run this work at official level. Some kind of working group would be needed. DHSS are proposing Michael Partridge, the Second Permanent Secretary responsible for health policy. We have serious doubts as to whether a DHSS-run operation would yield the sort of proposals which you and the Prime Minister want to see. Nor are we sure that a Cabinet Office operation is called for. We think the best solution would be for the Treasury to take charge, perhaps with Mr Kemp in the Chair. This will obviously need delicate handling at the meeting, and you might like to consider if you will have an opportunity to make the point to the Prime Minister beforehand.

2. Secondly, I understand that there is concern that the Budget may not go down well if there is nothing at all in it about health - notwithstanding the Chief Secretary's remarks at the PEWP press conference. One possibility would be to announce increases for next year in the light of pay review body awards. There must however be considerable doubt about the ability of the Nurses Review Body to report by the time of the Budget - particularly after the Government was 2 months late getting its evidence in. You might nevertheless try it on Sir James Cleminson when you see him on Friday, and bear the thought in mind for tomorrow's meeting.

X

RBS

R B SAUNDERS

SECRET

THE NATIONAL HEALTH SERVICE

What is wrong

1. No mechanism to relate demand to cost. Only constraint on cost is global. So continued pressure from users and suppliers to expand services without reference to ~~expenditure~~ cost consequences. The only incentives to use resources economically and efficiently are bureaucratic exhortation rather than supply and demand or competition.

2. Health care very largely financed publicly. Gulf between public and private sector provision far too wide.

Objectives

1. Get closer links between use of the service and its financing, and between supply and efficiency.

2. Get a better balance between public and private sector provision: more private funding, more private provision and more cross-pollination.

How to get there

1. Develop a workable internal market model, possibly including both FPS and HCHS. Develop more flexible arrangements (including costing of marginal capacity) for charging between public and private sectors. Gear RAWP to levels of activity and efficiency, rather than just population.

2. Medical manpower:

- give doctors responsibility for sticking to budgets and for the use of resources under their control;

- review present arrangement whereby doctors employed by regions but resources managed by districts;

?

- delegation from doctors to nurses and from nurses to auxiliaries.

- review present arrangement whereby nurses have both RB and Whitley negotiation.

3. Charges:

- narrow the exemptions (possibly a two-tier system)

- relate prescription charges to costs

- charge for visits to GPs

- (longer term) hotel charges

- work towards full <u>costing</u> of all activities, even if initially not charged.

4. Publish more and better information about performance - vital if market mechanisms to work. Beef up audit. Equiv to Audit Commission - JORG

5. <u>If pressed</u>. Tax breaks (or vouchers) for private health insurance not ruled out. But for this exercise, not Budget.

<u>Procedure</u>

1. Some form of working group of officials (Treasury, DHSS, No 10, territorial departments, possibly Revenue) inevitable, if only to work up internal market proposal. Need to settle arrangements, including chairmanship.

2. Prime Minister did not commit us to a Green Paper on Panorama last night - only "consultation". If speedy progress is to be made, elaborate consultation (eg a Green Paper) is to be avoided at all costs.

COMMUNITY CARE

RC2/46

CONFIDENTIAL

FROM: MOIRA WALLACE
DATE: 26 January 1988

PS/CHIEF SECRETARY

cc PS/Financial Secretary
PS/Paymaster General
PS/Economic Secretary
Sir P Middleton
Mr Anson
Mr Kemp
Miss Peirson
Mr Hawtin
Mr Potter
Mr McIntyre
Mr Saunders
Mr Fellgett
Mr Gibson
Mrs Wiseman
Mr Call

REVIEW OF COMMUNITY CARE - GRIFFITHS REPORT

The Chancellor has seen Mrs Wiseman's minute of 18 January, Miss Peirson's minute of 19 January, and Mr Kemp's minute of 20 January. He has commented that the points made by Miss Peirson and Mr Kemp about the interface between the NHS and community care are worth raising with Mr Moore orally.

MPW

MOIRA WALLACE

mjd 3/82m

SECRET

FROM: MOIRA WALLACE
DATE: 26 January 1988

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Miss Peirson
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3. The Chancellor then worked through the main points made in his minute to the Prime Minister, and which he would want to expand upon at the meeting. On the question of charges, it was obviously important to press for reduced exemptions from prescription charges: a two-tier system of charges would have to be one of the options considered, and the Chancellor would also want to argue for prescription charges to be related to the cost of the drugs. Charging for visits to GPs was obviously the most promising option for introducing charging for treatment, but it was agreed that the suggested figure of £5 per visit might be too high. The Chancellor agreed that the DHSS reference to a forthcoming review of consultants' contracts should be welcomed - but it would be important for the Treasury to be clear what precisely it would be looking for from such a review.

4. The Chief Secretary said that he was very concerned about the DHSS proposals to finance health spending from NICs - to narrow the

tax base for health in this way was a move in the wrong direction at a time when the numbers of fairly well-off elderly people were increasing so fast. However, he had more sympathy with DHSS pleas for resources to be allocated on the basis of throughput and efficiency, rather than population. He said that he felt it would be necessary to look at the question of local health lotteries as one way of generating income, but it was agreed that the Treasury should not reveal its hand on this at the No.10 meeting, but let others make the running. The Chief Secretary said he was considering whether a change in the timing of pay review body reports would make for a better interaction with PES - but again this was an idea that Treasury Ministers would not want to float with other Departments at the moment.

5. Sir Peter Middleton said that he saw three crucial issues in the debate. First, this was the Treasury's opportunity to push for progress towards an internal market - not just within the NHS, but also between it and the private sector, and local authorities. Secondly, in the longer term, the Treasury would have to consider what would be the right balance in any package of charges, insurance, and tax measures. Sir T Burns agreed that in the longer term some way would have to be found to encourage private finance, or the current problems would resurface in a few years. Thirdly, the Treasury had an interest in ending the current situation where health service pay was partly determined by review bodies, and partly by negotiations. The Chancellor commented that dropping the review body system was not a feasible option, so effort should be concentrated on reducing the scope for collective bargaining.

6. The Chancellor said that it would be helpful if he and the Chief Secretary could have a short note for use at the No.10 meeting, setting out the problems, the objectives, and the various ways forward.

MPW.

MOIRA WALLACE

Circulation: those present

ph/23

FROM: A C S ALLAN
DATE: 28 January 1988

CHANCELLOR

cc Chief Secretary

NHS: PRIME MINISTER'S SUMMING UP

Richard Wilson has not yet written the summing up. The main points will be:

i. Same Ministerial team.

ii A single paper for next meeting, about how to proceed - not just a list of further papers, but a think-piece on how to tackle the tricky issues.

iii. Work to focus on structure and costs first, not financing or more resources - and certainly not more finance for pay.

iv. No publicity.

2. Discussions are still going on about who should chair the official group. There ~~were~~ are worries about it being under Treasury chairmanship, and the most likely outcome seems to be that Richard Wilson himself would take the chair, providing others agreed.

3. A very rough flavour of the summing up would be:

The present Ministerial group, supported as necessary by officials [this is code to hide fact that DHSS representation is unclear], should carry out a fundamental review of the National Health Service with special emphasis on the hospital service and prescriptions. The next meeting would need to consider how to proceed and a paper for that meeting should be prepared by [a group under Cabinet Office chairmanship]. It was clear that the issues which needed to be examined first

would relate to the existing structure of the service and its costs. Deriving a structure with incentives to drive down these costs was the first priority. [It would make no sense to set out to derive a system which simply financed these swollen costs]. There would be no statement in Parliament about the exercise. All that needed to be said was that an internal review was being carried out with special reference to the hospital service, and that any member of the public who wished to offer their views would be very welcome to do so."

A C S ALLAN

PMG COMMENTS

SECRET

FROM: S P JUDGE
DATE: 28 January 1988

APS/CHANCELLOR OF THE EXCHEQUER

cc PS/Chief Secretary
Sir Peter Middleton
Mr Anson
Mr Kemp
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Saunders
Mr Call

THE NATIONAL HEALTH SERVICE

The Paymaster General has seen Mr Call's minute of 26 January, and awaits the record of the Prime Minister's meeting yesterday with interest.

The Paymaster can recall advancing thoughts on the internal market similar to those of Mr Call (who puts the point more eloquently and effectively) during a Consolidated Fund debate at 4.00am in 1978-79 - including a very contemporary horror story about a potential amputee who had died during a six week wait for an operation.

PS/PMG 28/1

He adds that it is not just that (at present, as then) the pricing is based on such average figures that in a centre of excellence an extra-district operation is likely to involve a subsidy from the centre's district, but also that the consequential accounting is so slow (the Paymaster's recollection is that it takes up to two years) that it becomes simply ponderous - with a sluggish and often adverse cash flow - instead of the fast-moving stream which would excite action.

S P JUDGE
Private Secretary

pup

BF LM 1/2

SECRET

CH/EXCHEQUER
REC. 29 JAN1988
ACTION CST
COPIES TO

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

28 January 1988

Dear Geoffrey,

NATIONAL HEALTH SERVICE

The Prime Minister chaired a meeting yesterday to discuss the review of the National Health Service (NHS). There were present the Chancellor of the Exchequer, your Secretary of State, the Chief Secretary, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler and Mr. Wilson (Cabinet Office), and Mr. John O'Sullivan (No. 10 Policy Unit). The meeting had before it minutes from your Secretary of State and the Chancellor of the Exchequer, both dated 15 January.

Your Secretary of State said that the present public debate about the NHS provided an opportunity to tackle its problems more fundamentally than ever before. There were three related problems: the public equated the NHS with the acute care sector; the NHS was seen as costless; and the structure was monolithic and producer-dominated. The answers would have to be both financial and structural; the structural changes would be politically difficult unless total resources for health care could be increased and diversified. Key issues to address were the absence of consumer choice in the present system and the lack of public understanding of costs. This pointed to considering such options as higher charging (although this would not deal with all the fundamental problems) and switching from a system which was tax-financed to funding health care on a National Insurance model. Structural changes which could be considered within the present system included developing an internal market, reviewing consultants' contracts, greater use of contracting out and changing the private/public mix. In procedural terms there were seven key aspects of the NHS which he suggested that the Group might wish to consider, and his Department stood ready to prepare papers on them.

In discussion it was pointed out that the lack of information about costs was a crucial weakness in the NHS at present. It would be wrong to make changes in financing unless there was confidence that there was a system and structure which would drive costs down and operate cost-effectively. The Group ought to look at what could be learned from how BUPA operated; from the experience of, say, the ten best hospitals in this country; and from overseas experience (e.g. New Zealand). It was crucial that those who took the decisions about medical treatment - both the public

and the medical profession - should be given greater information about costs. And there was a need to consider some form of medical audit, perhaps on the model of the National Audit Commission. None of this meant producing a massive amount of management information which no one could use. Nor should it take too long to produce; the present timescale for the full implementation of the Resource Management Initiative was not acceptable.

In further discussion it was argued that the present structure of the NHS was an important part of the problem. There had to be proper incentives to those who worked in the service to bring costs down, as well as clarity about who was in charge and could take decisions. There also had to be a more dynamic market, including greater interchange between the private and public health sectors, which made the best use of resources and allowed patients and doctors greater choice. It ought to be possible to make information readily available about the relative length of waiting lists and the availability of beds in different areas and hospitals.

A further important area for consideration was the terms of employment of the medical profession. Notwithstanding the sensitivities, the Group would need to look carefully at the issues of consultants' contracts and tenure with a view to early changes.

Summing up the discussion, the Prime Minister said it was agreed there should be a small Ministerial Group, based on those present, to take a fundamental look at the National Health Service and health care. Nothing would be said publicly about the work of the Group, or the timescale in which it expected to reach conclusions or about publishing a White or Green Paper, beyond a brief indication that there was an internal review of the NHS with special emphasis on the hospital service and that anyone who wished to put in representations to the Secretary of State for Social Services would be very welcome to do so. On the substance, it was clear that the issues which needed to be considered first were those which related to costs, structure and the medical profession. Increases in financing could not be considered before there was confidence that the system was cost-effective. The next meeting would wish to consider a paper proposing how the Group should proceed in tackling the issues, and work on this should be put in hand co-ordinated by the Cabinet Office. Finally, it was essential that there should be no leaks about the Group's work: Departments should ensure that the papers were only seen on a strict need-to-know basis.

I am sending a copy of this letter to the Private Secretaries of Ministers present at the meeting, to Sir Roy Griffiths, to Sir Robin Butler and Mr. Wilson (Cabinet Office) and to Mr. O'Sullivan (No.10 Policy Unit).

Yours, Paul.

(PAUL GRAY)

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

29.1.3

SECRET

FROM: R B SAUNDERS

DATE: 29 JANUARY 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir Peter Middleton
Mr Anson
Mr Kemp
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Call

Ch/ Any comments by first thing Monday?
MPW 29/1

REVIEW OF THE NHS

1. Following your meeting with us yesterday, we have had some further discussions with DHSS and with Cabinet Office about how to carry the exercise forward. We understand that the Prime Minister is likely to call a further meeting early the week after next, which will take a paper on the way forward.

2. The paper will be masterminded by the Cabinet Office. The intention is for officials from Cabinet Office, DHSS, Treasury and No 10 to produce something which can be shown in draft to Ministers around the middle of next week before final circulation for the weekend. The contents will be discussed at a meeting which has been called by Mr Wilson of the Cabinet Office at 10 am on Monday. It is agreed that DHSS and Treasury officials will each produce at that meeting copies of notes setting out their ideas.

3. I attach a note which we propose to table. It seeks to point up simply and clearly the problems and the possible ways to tackle them. It deals with most of the points we have discussed in the last few days, save a tighter definition of what we mean by the "internal market". This is something on which we shall start work in earnest next week.

SAUNDERS REVIEW OF NHS 29/1

SECRET

4. We are told that the DHSS paper is likely to suggest the following work programme

- how to widen consumer choice; who should drive the system - hospital management, doctors or patients

- cost information and control, including a description of what is already in hand

- relations with the medical profession, including how to improve accountability for the use of resources, and a review of consultants' contracts

- greater use of the private sector

- X alternative sources of finance.

We understand that these will be little more than headings, promising a series of papers to be prepared in the order indicated above. The note will probably attempt little, if any, analysis.

5. I should be grateful for any comments on the attached note, and any other points you would like us to make at Monday's meeting, by 9.45 am on Monday.

R B SAUNDERS

29.1.1

SECRET

THE NHS: ISSUES

Note by HM Treasury

1. The initial objective is to consider what structure is needed to ensure the most cost effective and responsive delivery of an efficient universally available and accessible health care system. Financing and resources can be considered later when we have devised a structure which will make best use of whatever resources are available from whatever source. While the main focus is on health authorities (ie hospitals), they cannot be considered in isolation from primary care (GPs) and the private sector.

2. The fundamental problems are:

- no mechanisms to bring cost and cost effectiveness to bear on individual transactions and clinical decisions; cost controls are "top down" and hence diffused

- inflexibility of response to mismatches between patient needs and available services; institutional boundaries ("cliff edge" between public and private sectors, relations between GP and hospital service, between health authorities and between NHS and local authorities)

- manpower inflexibilities

3. Pre-requisites of improvement are:

- up-to-date information about unit costs, quality of output, use of resources and waiting lists; this needs to be available both to users and to health managers

- budgetting at all levels

- financial incentives for cost-effective decision-taking

4. Good things already happening. Performance indicator package a potentially powerful tool which health authority managers are starting to use to improve allocation of resources and service to patients. Local public/private sector links developing. Resource management initiative has potential to improve radically clinical accountability. But three problems

- initiatives are fragmented and not perceived as priorities or part of a clear strategy
- they are producer-driven, not user-driven; they will improve efficiency but not necessarily responsiveness.
- they do not generally extend to GPs.

And only slow progress is being made on the vital issue of costing.

5. More radical approach needs to build on this. Possibilities include:

- introduction of charging between cost centres in hospital service (clinical teams, pathology laboratories, physiotherapy departments etc) perhaps linked to service contracts to provide agreed service within agreed budgets
- trading of services between districts and between public and private sectors, encouraging growth of private sector and cost consciousness in referral decisions; combination of this with better information should widen choices open to patients
- more sophisticated relating of patient charges to costs as a price mechanism
- possibly longer term, develop financial mechanisms to bridge primary and hospital services

SECRET

- review use of medical manpower, including consultants' contracts (tenure, employing authority, etc), contractual independence of GPs, scope for delegation of work, pay systems (including respective roles of review bodies and Whitley Councils)

- independent published audit reports comparing performance across health districts and individual units, providing better consumer information and pressure to raise standards

HM Treasury
ST2 Division
29 January 1988

psl/20A

AIDE MEMOIRE ON HEALTH

Procedure

OK to Richard Wilson co-ordinating preparation of paper for next meeting?

Substance

2. We see paper needing to cover three main areas:

objectives; obstacles; and what we need to overcome obstacles.

Objectives

3. Need to set out what an efficient and cost-effective health service would look like. Absolutely right to examine structure and control of costs, before looking at funding and resources.

Obstacles

4. These include:

(i) lack of costings of services;

(ii) compartmentalisation - managers and medics don't talk to each other;

(iii) lack of cross-fertilisation between public and private sectors;

(iv) labour inflexibilities;

(v) inflexibilities on drugs (no generic prescriptions etc.)

What do we need.

5. Must have:

(i) via audit, adequate information on costs and efficiency;

(ii) as part of this, systems to enable everyone to see where shortages and surpluses are. (can't take as long as DHSS say)

(iii) leads on to internal market ("patient-related funding"?) as important means of evening out demand and promoting efficiency.

Family Practitioner Service

6. Even though rightly concentrating on hospital service, some interaction with Family Practitioner Service (which is fastest growing element of health budget; non-cash limited, and now a third of total - arguably at expense of hospital service). Mainly via referrals. Links with prescription charges and review of doctors' contracts.

Nurses' pay

7. You are seeing Cleminson tomorrow to follow up earlier discussion abour nurses' pay.

RM2.70 SECRET

pmp

FROM: MOIRA WALLACE
DATE: 1 February 1988

pmp

MR SAUNDERS

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Mr Kemp
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Call

WALLACE REVIEW OF NHS 1/2

REVIEW OF THE NHS

The Chancellor has seen your minute of 29 January. He has commented that it is essential that any consideration of alternative sources of finance be left to the very end. As I said on the phone, the Chancellor has also made a number of suggested amendments to the Treasury note you attached:

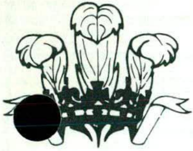
Point 2, first indent: Amend to read "... present cost controls are global and hence crude and unfocussed."

Point 2 second indent: Amend opening to read "inflexibility of response to mismatches between patient demands and available capacity; ...

Point 5, fourth indent: The Chancellor queried this point, and you agreed that it might be better to drop this for the moment.

MPW.

MOIRA WALLACE



CARLTON CLUB POLITICAL COMMITTEE

From the Hon. Librarian
Michael Silverman

pnp

Please reply to:
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MAS/NM

PRIVATE & CONFIDENTIAL

The Rt Hon Nigel Lawson
Chancellor of the Exchequer
11 Downing Street
London SW1

2 February 1988

Dear Minister,

The NHS : Ministerial Review
Findings & Recommendations following the Carlton Club/
Conservative Medical Society Investigation & Seminar
November 1987

We have much pleasure in enclosing herewith a copy of our latest paper on the NHS. This contains finite evidence, specific ideas and proof that an independant integrated Public and Private Health Service would benefit the nation. Suggestions as to means for implementation are contained in our text.

I hope that you find our Carlton Paper both of interest and value. We would welcome your reverting to us if clarification is required on any specific issue. We have offered to assist The Rt Hon John Moore MP and his team of advisers in any manner they may so designate.

I hope our contribution is beneficial to your deliberations.

Warmest personal regards.

Yours sincerely,

Michael A Silverman
Hon Librarian : Carlton Club Political Committee
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Mr Kemp

I attach some drafting suggestions. Para 13 is horrible and I see no alternative to major surgery. My other comments are, I hope, less contentious.

M. Parsons
3/2

CABINET OFFICE

70 Whitehall London SW1A 2AS Telephone 01-270

SECRET

P 03006

cc Miss Peirson
Mr Saunders
Mr Satchwell

S T Heppell Esq CB
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

3 February 1988

Dear Strachan,

NATIONAL HEALTH SERVICE

As promised I attach a further redraft of the paper which we discussed this morning which you may wish to show your Secretary of State tonight. We aim to finalise it tomorrow.

I am copying this to Peter Kemp.

Yours sincerely

Richard.

R T J WILSON

SECRET

THE NHS

Note by the Cabinet Office

This note sets out some of the main questions that will have to be considered in the internal review of the NHS.

Scope and Objective

2. The objective is to devise a structure for health care in this country which is responsive to the needs and wishes of patients and available to all, but at the same time cost-effective and efficient. The review will place special emphasis on the hospital service, but the latter cannot be considered in isolation from the primary care sector and the private sector. The level of financing and resources can be considered later when Ministers have decided on a structure which will make best use of whatever resources are available from whatever source.

Problems

3. The fundamental problems are:

a. there is very little consumer freedom of choice. Most people who are ill have little or no say in when, where, how or by whom they are treated.

b. present cost controls are crude. Patients have no idea what it costs to treat them. Those who treat them have no incentive to drive down costs or to consider which course of treatment is the most cost-effective.

c. there is no mechanism for ensuring that most resources go to the most efficient and cost-conscious units, eg the most efficient District Health Authorities (DHAs). Nor, unlike a business, can NHS hospitals increase their funding by increasing output. As the Secretary of State's paper

SECRET

points out, hospitals are not rewarded for attracting patients but suffer financially for it.

d. the system is not good at dealing with mismatches between patient demands and available capacity (eg waiting lists) produced partly by institutional boundaries between public and private sectors, between GPs and the hospital service, and between health authorities.

e. there is insufficient management flexibility from consultants down to the most junior grades, as regards either the use of staff or the method of determining their pay,

4. In short the NHS lacks a market mechanism under which the patient chooses, in full knowledge of the costs, who shall provide his health care, how when and where, and resources are allocated to the hospitals, doctors and GPs who are most successful, again taking account of the costs, in meeting the consumer's demands.

Suggested approach

5. We suggest that the Ministerial Group should approach this problem from three angles: facts, detailed investigation of selected aspects and options for changes in structure.

Facts

6. At an early stage Ministers may wish to commission factual papers on such matters as:

a. what public expenditure on the NHS actually buys, in terms both of inputs (eg pay, hospital buildings, drugs, information technology) and outputs (eg treatment of different kinds of illnesses, elective and non-elective, care of the elderly);

b. how far information about costs in the NHS is already available, what it shows (eg regional differences) and the present state-of-play on the Resource Management Initiative;

c. the comparison, on cost and other grounds, between the NHS and the private sector in this country (eg BUPA, and the experience of the 10 best private hospitals), and between the NHS and ~~other countries (e.g. New Zealand, and the diagnostic-related groups set up to contain costs in the United States).~~ health systems in other countries;

d. what is known about the way patient care is shared between different parts of the NHS, and between the NHS and local authorities; (for long-term care)

e. the terms and conditions of consultants' contracts.

Selected Aspects

7. The Group may also wish to consider papers discussing how particular aspects of the NHS problems could be tackled. These papers of their own will not suggest a complete answer, but coupled with factual material they might help build up a coherent picture.

a. Provision of information. Information is an integral part of the market mechanism. In the case of the the NHS, up-to-date information is needed about unit costs, quality of output, use of resources and waiting lists. To be most useful it needs to be coupled with some form of competition and to be available to both users and health managers.

b. Introduction of financial incentives and effective budgeting ~~procedures~~ systems to encourage cost-effective decision-taking, and to help ensure that resources are channelled to the most efficient hospitals and doctors.

SECRET

c. Ways of introducing greater competition into the NHS, again to promote the efficient allocation of resources.

d. Ways of developing the role of the private sector, both as provider of some services to the NHS and as providing care to its own patients.

e. What more might be done to promote patient freedom of choice, both as a desirable end in itself and as a way of helping to promote competition.

f. Ways of tackling consultants' contracts and tenure and other restrictive practices in the medical field.

g. The scope for introducing some form of publishable independent audit of efficiency, possibly on the lines of the Audit Commission.

Some possible structures

8. The common theme is that more might be done to introduce a market mechanism. There are various structural changes which could be made to achieve this. The following are some possibilities. They are not exclusive, in the sense that they shade into each other, and it would be possible to start with one of the early options, and then develop the system gradually towards the later options. Running through all the options is the need to distinguish between those who buy health care and those who provide it.

Market mechanism within existing NHS structure

9. The first group of possibilities would introduce more market discipline into the existing NHS structure. This could be first by means of provision of more cost information, publication of efficiency audit reports and making individual hospitals cost centres. Going beyond this, there could be more trading of services between authorities, so that Authority A could treat patients from Authority B on repayment if its costs were lower.

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Consultants' contracts and pay mechanisms more generally could be reviewed.

A new NHS structure

10. The second group of possibilities would introduce more competition in the NHS, involving radical changes in the existing NHS structure, while still leaving it mainly tax-financed.

11. One way to do this would be to provide for District Health Authorities to compete for the allocation of patients by GPs and for their funding to be adjusted according to their success. GPs already have freedom to direct patients to the authorities of their choice, but in practice may not always use it fully, while authorities ~~who are successful in attracting patients do not receive extra funding.~~ have little financial incentive to attract extra patients.

[As it stands, this is wrong, as RAWP does compensate for cross-boundary flows - but in a very cumbersome way.]

12. A further step down the same path would be for the Authorities to act as Health ~~Management~~ Maintenance Organisations. HMOs, which were originally developed in the United States, contract to provide all necessary treatment for a fixed sum for a fixed period. The DHA/HMOs could then place patients on contract with hospitals, which in turn could compete among themselves. The DHA/HMOs could also compete with private sector HMOs.

[This is the correct term if referring to US model]

13. Going still further, steps could be taken to involve the patient himself more directly in the choice of treatment and payment for it. There could be ways of achieving this, even within a largely tax-financed system by for example a system of health credits or vouchers, though there would be important implications for the present methods of expenditure control.

- ~~the French system under which the patient at first pays the cost of his treatment, and is then reimbursed, in most cases in full by the State. This system brings home to the patient the costs of the treatment;~~

- ~~a system of health credits, by which the patient could receive a credit note convering the cost to the NHS of providing the treatment he needed, which he could then use~~

[These are crackpot wheezes which we should keep off the agenda as far as possible at this stage.]

SECRET

SECRET

~~wherever he chose within the Service or, more radically, within the private sector.~~

A greatly expanded private sector role

14. All the alternatives so far have been consistent with the bulk of health care continuing to be provided within the NHS, and the bulk of the funding continuing to come from tax. The last group of possibilities involves both increasing the role of the private sector in the provision of care, and increasing the role of private finance in funding it.

15. At present, people can already choose to pay for private provision, normally for the less expensive or more optional treatment. This process could be encouraged by tax relief for private medical insurance premiums.

16. More radically, people could opt out for at least some of their medical care which they could then buy either privately or from the NHS. Opting out could be either by individuals or by employers. The essence of this system is that those concerned would no longer pay the NHS for the cost of the treatment they would seek outside. It would not of course be possible to opt out of payment of tax , but if NHS care were to be financed through National Insurance Contributions, or some similar payment, established for health, it would be possible to contract out from their payment. There could be a gradual development of contracting out. The system would be similar to that decided on by the Government for pensions. Such a system would probably work work most easily if the health care contracted out was of the less expensive or more elective kind. The more urgent or expensive long-stay treatment would probably have to stay within the NHS, and the size of the contribution rebate would have to allow for that.

17. The most radical solution of all would be a system under which all who could do so would be required to provide for their own health care, probably by insurance, which could be arranged

either individually or through employers' schemes. The State would still need to make arrangements for the very poor or the uninsurable.

18. These are only illustrations of possible options on which Ministers may wish to commission further work.

CONCLUSIONS

19. Ministers are invited to decide whether they wish to proceed on the above lines and which specific aspects they wish to consider first.

Cabinet Office
3 February 1988

ps2/64M

UNCLASSIFIED

pmp

FROM: MISS M P WALLACE
DATE: 3 February 1988

WALLACE NHS LETTERS 3/2

MR CALL

cc Mr Cropper

NHS LETTERS

The Chancellor was most grateful for your minute of 1 February. He ... has slightly amended your draft, and I attach an amended version which can now be a basis for replies to other letters.

MPW.

MOIRA WALLACE

MC39

DRAFT REPLY TO NHS LETTERS

Thank you for your letter of 7 January concerning tax cuts and the National Health Service.

I entirely agree with you on the importance of the National Health Service. I cannot, however, accept that the Health Service is being run down. The figures show it to be otherwise and I must ask you to believe them.

Since this Government first took office, the proportion of public expenditure going to health has risen from under 12% to over 14%. Over the same period the money spent on the National Health Service has risen by 30% over and above inflation. And our plans for the coming year show the largest increases ever: we are planning to provide at least £1,100 m more than we are spending this year, and there are to be similar increases in the following years.

Again, since 1979, the Government has carried through about 250 major hospital building projects, each costing at least £1 m. Many of these new hospitals have been built to replace older ones, as part of the process of modernising the NHS. Far from being a symptom of the NHS being run down, the fact that some old hospitals are being closed is a sign of the progress that is being made in upgrading the care that is provided. Meanwhile, a further 530 major schemes are at various stages of planning, design, and construction, including 140 schemes due for completion in the next 3 years alone.

What of people who work in the hospitals? There are now 64,000 more nurses and midwives in the NHS than there were in 1979. There are 13,000 more doctors and dentists. Despite these substantial increases, there are difficulties in attracting suitably qualified nurses in certain areas and certain specialities. So, while there are 1,600 more paediatric nurses than there were five years ago, bringing the total number to 9,300, more are needed. The Government is tackling these problems. Since it first took office in 1979, nurses' pay has increased by some 30 per cent more than the cost of living, and the Government now wants to see a change in the existing grading structure in order to provide better rewards for nurses with special skills and responsibilities. The Nurses Pay Review Body is considering these proposals and the Government expects to be able to announce the new rates of nurses' pay in April.

By any standards this is a record of substantial improvement, and any talk of running down the NHS simply does not square with the facts.

Equally, however, it is clear that something is seriously amiss with the Health Service, which goes far deeper than the amount of money spent on it. That is why we are undertaking a thorough review and will make known our conclusion as soon as we can.

In the meantime it is important to recognise that there is no conflict between judicious tax cuts and efficient public services. Quite the reverse in fact. When this Government came into office in 1979, the British economy was stagnant, and the public services

had been cut back very severely by Labour. Since 1979 we have been transformed from one of the most sluggish economies in the industrialised world into one of the fastest growing.

This economic success is the result of 8½ years of policies which have created the conditions in which industry and business prosper. These measures have included reducing the burden of taxation on individuals and companies, to encourage them to work hard, export, and innovate. That is the only way to create the resources which will ensure that we can enjoy better public services, including the health service, in the years ahead.

MC41

Ch/ content?

OK as is

mpw 1/2

FROM: MARK CALL
DATE: 1 FEBRUARY 1988

CHANCELLOR

cc Mr Cropper

CALL 1/2

NHS LETTERS

The attached draft should contain most of the elements needed for replies to letters on the NHS in the pre-Budget period. It incorporates your amendments to Peter Cropper's draft reply to Mrs Pressler (Very Disgruntled of Lutterworth).

2. Does it now look suitable for Mrs Pressler, and as a basis for response to other letters? If so, are you content that I circulate it to other Treasury Ministers?

3. If you are agreeable, I will send a copy to the Special Adviser at the DHSS, so they have a form of words to address the tax cut/supply side points.

MC

MARK CALL

ENC

M[illegible]

DRAFT REPLY TO NHS LETTERS

Thank you for your letter of 7 January concerning tax cuts and the National Health Service.

I entirely agree with you on the importance of the National Health Service. I cannot, however, accept that the Health Service is being deliberately run down. The figures showed it to be otherwise and I must ask you to believe them. Since this Government first took office, the proportion of public expenditure going to health has risen from under 12% to over 14%. Over the same period the money spent on the National Health Service has risen by 30% over and above inflation. And our plans for the coming year show the largest increases ever: we are planning to provide at least £1,100 m more than we are spending this year, and there are to be similar increases in the following years. Since 1979, the Government has carried through about 250 major hospital building projects, each costing at least £1 m. As new hospitals are built, so some older ones must close in order to continue the process of modernising the facilities in which the NHS operates. Far from being a symptom of the NHS being run down, those closures are a sign of the progress that is being made in upgrading the care it provides. And so a further 530 major schemes are at various stages of planning, design, and construction, including 140 schemes due for completion in the next 3 years alone.

If the hospitals are being developed rather than run down, what of people who work in them? There are now 64,000 more nurses and midwives in the NHS than there were in 1979. There are 13,000 more doctors and dentists. Despite these substantial increases, there are difficulties in attracting suitably qualified nurses in certain areas and certain specialities. So, while there are 1,600 more paediatric nurses than there were 5 years ago, bringing the total number to 9,300, more are needed. The Government is tackling these problems. Since it first took office in 1979, nurses' pay has increased by nearly 1/3rd ahead of prices, and the Government wants to see a change in the existing grading structure in order to provide better rewards for nurses with special skills and responsibilities. The Nurses Pay Review Body is considering these proposals and the Government will make known its plans in April.

By any standards this is a record of substantial expansion, and only a very prejudiced observer could describe it as running down the NHS.

Equally, however, it is clear that something is amiss with the Health Service, which goes far deeper than the amount of money spent on it. That is why we are undertaking a thorough review and will come up with a solution to the problem as soon as we have completed it.

In the meantime it is important to recognise that there is no conflict between judicious tax cuts and efficient public

services. Quite the reverse in fact. When this Government came into office in 1979, the British economy was stagnant, and the public services had been cut back very severely by Labour. Since 1979 we have moved from being one of the most sluggish economies in the industrialised world into being one of the fastest growing. This economic success is the result of 8½ years of Conservative policies, which have aimed to create a framework in which industry and business can prosper. These measures have included reducing the burden of taxation on individuals and companies, to encourage them to work hard, export, and innovate. And it is precisely because these policies have brought economic success and new prosperity that we have been able to increase in real terms expenditure on health, as well as on social security, defence, and education. That is what we aim to continue to do.

NMW: [illegible] [illegible]

Ch/ <u>Timing</u> of next week's NHS meeting not finalised yet – they had hoped to slot it in at 4.00pm on Tuesday which you cannot make (flying back from ECOFIN). We have urged them to find another time that you <u>can</u> make. We will then fix up briefing meeting.

MPW 3/2

3.2.6

SECRET

FROM: R B SAUNDERS

DATE: 3 FEBRUARY 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir Peter Middleton
Mr Anson
Mr Kemp
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Satchwell
Mr Cropper
Mr Tyrie
Mr Call

Ch/ We do not yet have comments from all HMT officials - and they may want to pick up one or two factual errors etc once they have your comments on the general thrust of the paper.
MPW 3/2

THE NHS

1. Since my submission of last Friday, we have had two meetings with Cabinet Office, No 10 and DHSS officials. I attach a draft paper by the Cabinet Office which, if all Ministers concerned are broadly content, it is intended to circulate on Friday for next week's meeting with the Prime Minister. It is being shown tonight to the Prime Minister and to Mr Moore as well as yourself.

2. The paper falls broadly into two parts. The first (paragraphs 1-7) is an analysis of the main issues. As you will see, much of it has been directly taken from our paper, and I think all our main concerns are covered. In contrast, the paper which DHSS produced at the beginning of the week has failed to survive in any form.

I'm not so sure - still a lot of DHSS's pet ideas in there - eg para 16.

3. The second half of the paper is the more difficult. It seeks to identify a number of possible models at which we might be aiming, if not in the short term then in the longer term. It is the result of considerable discussion between officials and, while none of use are entirely happy with everything it contains, we think it probably gives a good enough basis for an initial Ministerial discussion.

4. The paper tries to avoid, on the one hand, conducting the debate at so generalised a level as to be of no use in working up practical options and, on the other, getting bogged down in specific proposals selected from the wide range of those currently on offer.

5. I should be glad to know whether you are happy for this to be circulated for discussion or whether there are points you would like us to feed into Cabinet Office tomorrow. We have left open the option of your putting in your own paper, although at this stage see no need for that next week. We will however let you have briefing on the paper by the weekend. You may wish to discuss this with us before the Prime Minister's meeting.

R B SAUNDERS

SECRET

THE NHS

Note by the Cabinet Office

This note sets out some of the main questions that will have to be considered in the internal review of the NHS.

Scope and Objective

2. The objective is to devise a structure for health care in this country which is responsive to the needs and wishes of patients and available to all, but at the same time cost-effective and efficient. The review will place special emphasis on the hospital service, but the latter cannot be considered in isolation from the primary care sector and the private sector. The level of financing and resources can be considered later when Ministers have decided on a structure which will make best use of whatever resources are available from whatever source.

Problems

3. The fundamental problems are:

a. there is very little consumer freedom of choice. Most people who are ill have little or no say in when, where, how or by whom they are treated.

b. present cost controls are crude. Patients have no idea what it costs to treat them. Those who treat them have no incentive to drive down costs or to consider which course of treatment is the most cost-effective.

c. there is no mechanism for ensuring that most resources go to the most efficient and cost-conscious units, eg the most efficient District Health Authorities (DHAs). Nor, unlike a business, can NHS hospitals increase their funding by increasing output. As the Secretary of State's paper

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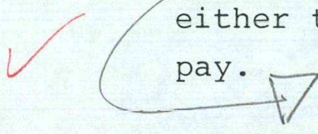
SECRET

points out, hospitals are not rewarded for attracting patients but suffer financially for it.

d. the system is not good at dealing with mismatches between patient demands and available capacity (eg waiting lists) produced partly by institutional boundaries between public and private sectors, between GPs and the hospital service, and between health authorities.

e. there is insufficient management flexibility from consultants down to the most junior grades, as regards either the use of staff or the method of determining their pay.



4. In short the NHS lacks a market mechanism under which the patient chooses, in full knowledge of the costs, who shall provide his health care, how when and where, and resources are allocated to the hospitals, doctors and GPs who are most successful, again ~~taking account~~ of the costs, in meeting the consumer's demands.

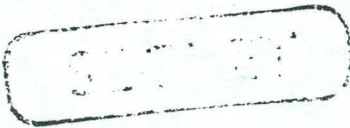
Suggested approach

5. We suggest that the Ministerial Group should approach this problem from three angles: facts, detailed investigation of selected aspects, and options for changes in structure.

Facts

6. At an early stage Ministers may wish to commission factual papers on such matters as:

a. what public expenditure on the NHS actually buys, in terms both of inputs (eg pay, hospital buildings, drugs, information technology) and outputs (eg treatment of different kinds of illnesses, elective and non-elective, care of the elderly);



b. how far information about costs in the NHS is already available, what it shows (eg regional differences) and the present state-of-play on the Resource Management Initiative;

c. the comparison, on cost and other grounds, between the NHS and the private sector in this country (eg BUPA, and the experience of the 10 best hospitals), and between the NHS and other countries (e.g. New Zealand, and the diagnostic-related groups set up to contain costs in the United States).

d. what is known about the way patient care is shared between different parts of the NHS, and between the NHS and local authorities;

e. the terms and conditions of consultants' contracts.

Selected Aspects

7. The Group may also wish to consider papers discussing how particular aspects of the NHS problems could be tackled. These papers of their own will not suggest a complete answer, but coupled with factual material they might help build up a coherent picture.

a. Provision of information. Information is an integral part of the market mechanism. In the case of the the NHS, up-to-date information is needed about unit costs, quality of output, use of resources and waiting lists. To be most useful it needs to be coupled with some form of competition and to be available to both users and health managers.

b. Introduction of financial incentives and effective budgetary procedures to encourage cost-effective decision-taking, and to help ensure that resources are channelled to the most efficient hospitals and doctors.

c. Ways of introducing greater competition into the NHS, again to promote the efficient allocation of resources.

d. Ways of developing the role of the private sector, both as provider of some services to the NHS and as providing care ~~to its own patients.~~ outside the NHS.

e. What more might be done to promote patient freedom of choice, both as a desirable end in itself and as a way of helping to promote competition.

f. Ways of tackling consultants' contracts and tenure and other restrictive practices in the medical field.

g. The scope for introducing some form of publishable independent audit of efficiency, possibly on the lines of the Audit Commission.

Some possible structures

8. The common theme is that more might be done to introduce a market mechanism. There are various structural changes which could be made to achieve this. The following are some possibilities. They are not exclusive, in the sense that they shade into each other, and it would be possible to start with one of the early options, and then develop the system gradually towards the later options. Running through all the options is the need to distinguish between those who buy [pay for?] health care and those who provide it.

Market mechanism within existing NHS structure

9. The first group of possibilities would introduce more market discipline into the existing NHS structure. This could be first by means of provision of more cost information, publication of efficiency audit reports and making individual hospitals cost centres. Going beyond this, there could be more trading of services between authorities [and systems], so that Authority A could [or from the private sector] ~~treat patients~~ [buy care] from Authority B ~~on repayment~~ if ~~its~~ [their] costs were lower.

SECRET

Consultants' contracts and pay mechanisms more generally could be reviewed.

A new NHS structure

10. The second group of possibilities would introduce more competition in the NHS, involving radical changes in the existing NHS structure, while still leaving it mainly tax-financed.

11. One way to do this would be to provide for District Health Authorities to compete for the allocation of patients by GPs and for their funding to be adjusted according to their success. GPs already have freedom to direct patients to the authorities of their choice, but in practice may not always use it fully, while authorities who are successful in attracting patients do not receive extra funding.

12. A further step down the same path would be for the Authorities to act as Health Management Organisations. HMOs, which were originally developed in the United States, contract to provide all necessary treatment for a fixed sum for a fixed period. The DHA/HMOs could then place patients with hospitals, which in turn could compete among themselves. The DHA/HMOs could also compete with private sector HMOs.

13. Going still further, steps could be taken to involve the patient himself more directly in the choice of treatment and payment for it. ~~There could be ways of achieving this, even within a largely tax-financed system by for example:~~ There could, for example, be:

? do we want to pick a few ideas out of the part like this?

- ~~the French system under which the patient at first pays the cost of his treatment, and is then reimbursed, in most cases in full by the State. This system brings home to the patient the costs of the treatment;~~

- a system of health credits, by which the patient could receive a credit note convering the cost to the NHS of providing the treatment he needed, which he could then use

SECRET

SECRET

wherever he chose within the Service or, more radically, within the private sector.

13A. It would also be helpful to see what can be learned from the different systems in operation in, say, France and Germany.

A greatly expanded private sector role

14. All the alternatives so far have been consistent with the bulk of health care continuing to be provided within the NHS, and the bulk of the funding continuing to come from tax. The last group of possibilities involve both increasing the role of the private sector in the provision of care, and the role of private finance in funding it.

15. At present, people can already choose to pay for private provision, normally for the less expensive or more optional treatment. This process could be encouraged by tax relief for private medical insurance premiums.

16. More radically, people could opt out for at least some of of their medical care which they could then buy either privately or from the NHS. Opting out could be either by individuals or by employers. The essence of this system is that those concerned would no longer pay the NHS for the cost of the treatment they would seek outside. It would not of course be possible to opt out of payment of tax , but if NHS care were to be financed through National Insurance Contributions, or some similar payment, established for health, it would be possible to contract out from their payment. There could be a gradual development of contracting out. The system would be similar to that decided on by the Government for pensions. Such a system would probably work work most easily if the health care contracted out was of the less expensive or more elective kind. The more urgent or expensive long-stay treatment would probably have to stay within the NHS, and the size of the contribution rebate would have to allow for that.

indeed!

17. The most radical solution of all would be a system under which all who could do so would be required to provide for their own health care, probably by insurance, which could be arranged

either individually or through employers' schemes. The State would still need to make arrangements for the very poor or the uninsurable.

18. These are only illustrations of possible options on which Ministers may wish to commission further work.

CONCLUSIONS

19. Ministers are invited to decide whether they wish to proceed on the above lines and which specific aspects they wish to consider first.

Cabinet Office
3 February 1988

HEALTH LOTTERIES

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

FINANCIAL SECRETARY
REC. 4 FEB 1988
Mr Rich
PPS CST PMG EST
Sir P. Middleton
Mr Anson Miss Peirson
Mr Peretz Mr Turnbull
Miss O'Mara
Mr Saunders
Mr Tyrie
Mr Cropper Mr Call

The Rt Hon John Wakeham
Lord Privy Seal and
Lord President of the Council
Lord President's Office
Whitehall
London
SW1

Ch/ relevant to lotteries meeting. MPW 4/2

3 February 1988

Simon Burns has given notice that on Tuesday 16 February he intends to seek leave to introduce a Bill under the Ten Minute Rule provision. The Bill would produce legislation to establish a national lottery whose main purpose would be to provide additional funds for the National Health Service.

MOORE TO WAKEHAM 3 FEB

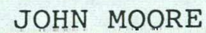
Although this proposal undoubtedly enjoys much popular support, we do not think the Bill should progress to a second reading, essentially because it could do more harm than good. Many people come across the glossy promotions which other countries give to their national lotteries, and think we ought to do something similar. What they do not realise, however, is that the cost of prizes, promotion and administration usually consumes a large proportion of the takings - sometimes as much as 60 per cent - and the net benefit is comparatively modest. Apart from that, such schemes do not enjoy consistent support: after the first year or so people tend to lose interest and new incentives must be devised to try to maintain support.

What we are most concerned about, however, is the effect that a national lottery would have on the many voluntary and charitable groups who do a lot of good work to raise money locally for NHS hospitals. These people work to low overheads and, by choosing a specific fund raising target such as the purchase of an advanced piece of equipment, attract considerable support from the local community. We would not want to see that support undermined by some counteraction such as a national lottery, with its conversely small net return.

E.R.

I do not think it is necessary to oppose the motion, and if there is a division I suggest that Ministers should be advised to abstain. Subsequently, however, I recommend that arrangements should be made to prevent such a Bill receiving a second reading.

I am sending copies of this letter to the Secretaries of State for Wales, Scotland and Northern Ireland, to other members of L Committee and to Sir Robin Butler.



JOHN MOORE

ps2/69M

SECRET

pmp

WALLACE THE NHS 4/2

FROM: MISS M P WALLACE
DATE: 4 February 1988

MR R B SAUNDERS

cc Chief Secretary
Paymaster General
Sir P Middleton
Sir T Burns (with copy of Mr Saunders' minute)
Mr Anson
Mr Kemp
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Satchwell
Mr Cropper
Mr Tyrie
Mr Call

THE NHS

The Chancellor was grateful for your minute of 3 February. In general, he has commented that the present draft of the paper is rather repetitious, and could be shortened without losing any points at all. He is broadly content with the general thrust of the paper, although he thinks it essential that there should be some mention of:

- the need for greater use of charging in the NHS (and the reasons why); and
- the timescale of possible reform.

The Chancellor would be interested in any comments Sir T Burns may have on the paper, and I am sending him a copy with this minute.

2. The Chancellor had a number of more detailed comments on the draft:

<u>Paragraph 2, first sentence</u>: replace "but" with "and".

<u>Paragraph 3b, second sentence</u>: amend to read: "Those who treat them are seldom aware of the costs of the treatment they are giving, and even if they are aware have no incentive ...".

<u>Paragraph 3c, second sentence</u>: amend to read: "Nor, unlike a business, can the most efficient and low-cost NHS hospitals increase their share of the market (and hence of revenue) at

the expense of the less efficient. As the Secretary of State's paper ...".

Paragraph 3e: amend to read: "There is insufficient management flexibility in the use of staff - from consultants down to the most junior grades - or the method of determining their pay.".

Paragraph 4: amend to read: "... and resources are allocated to the hospitals, doctors and GPs who are most successful, again in full knowledge of the costs, in meeting the consumer's demands in the most cost-effective way.".

Paragraph 6a: list of NHS outputs should include mention of paediatrics.

Paragraph 6b: amend to read: "How far disaggregated information ...".

Paragraph 6c: add West Germany and France to the list of other countries.

Paragraph 6d: amend to read: "... the way patient care is shared between different parts of the NHS, with particular reference to the need to avoid upward drift, and between the NHS and local authorities.".

Paragraph 7a: in general, this should focus more on the need to set up information systems, where such slow progress is being made. Final sentence to read: "To be most useful it needs to be systematically available to both users and health managers, and to be coupled with some form of competition.".

Paragraph 7d: amend to read: "... provider of some services to the NHS and as providing care outside the NHS.".

Paragraph 9, third sentence: amend to read: "Going beyond this, there could be more trading of services between authorities and sectors, so that Authority A, or indeed the private sector, could treat patients from Authority B on repayment if their costs were lower.".

Paragraph 13: delete present second sentence, and replace with: "There could, for example, be a system of health credits, by which ...";

then remove present section on the French system, and add, after the passage on health credits, the following: "It would also be helpful to see what can be learned from the different systems in operation in, say, France and Germany.

4. Finally, I should add that the No.10 meeting has now been fixed for 5 o'clock on Tuesday, which both the Chancellor and the Chief Secretary can make. We will hold a briefing meeting on Monday.

MPW.

MOIRA WALLACE

CONFIDENTIAL

FROM: S P JUDGE
DATE: 4 February 1988

APS/CHANCELLOR

cc PS/Chief Secretary
Sir Peter Middleton
Sir Terence Burns
Mr Anson
Mr Kemp
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Saunders
Mr Satchwell
Mr Cropper
Mr Tyrie
Mr Call

A good point.

THE NHS

The Paymaster General has seen Mr Saunders' submission of yesterday to the Chancellor. He will look at the final version again over the weekend.

His only comment at this stage is that he hopes someone somewhere is talking in an organised way to the general managers who were recruited to the NHS from outside and have since left, on the grounds that it is unmanageable.

The Paymaster realises their evidence may be a bit tainted, but it is also relevant.

S P JUDGE
Private Secretary

papers on X please

M

Ch/

So far only Mr Kemp has seen Mr Whitney's book. X

Would you think it appropriate to show the proof, and Mr Kemp's note, to the CST?

+ my comments ✓

Ch/

Yes

MPW 12/2

I think you must still have Mr Whitney's book. If you can let us have it back I'll show to CST. MPW 15/2

You now have it.

ps2/47A

CONFIDENTIAL AND PERSONAL

~~BF 12/2~~

FROM: MISS M P WALLACE
DATE: 5 February 1988

pmp

MR KEMP

... I attach a proof copy of Ray Whitney's forthcoming book on the NHS, which he has sent to the Chancellor - as he has to the Prime Minister and Mr Moore - on a personal basis. The Chancellor would be grateful if you could have a look at it, and then return it.

MPW.

MOIRA WALLACE

SECRET

pmp

CIRCULATED PAPERS

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

CH/EXCHEQUER
REC. 05 FEB 1988
ACTION Mr SAUNDERS
COPIES TO CST, PMG, Sir P. MIDDLETON, Mr ANSON, Sir T. BURNS, Mr KEMP, MISS PIERSON, Mr TURNBULL, Mr PARSONAGE, Mr SATCHWELL, Mr CROPPER, Mr TYRIE, Mr CALL

5 February 1988

Dear Geoffrey,

NHS REVIEW

Next week's meeting of the Review Group will now take place on Monday 8 February at 1730 hours. I enclose two papers for discussion:

(i) a note co-ordinated by the Cabinet Office setting out suggestions for a work programme;

(ii) a paper by Sir Roy Griffiths on NHS costing estimates, which is particularly relevant to paragraph 6 of the Cabinet Office note.

I am copying this letter to Alex Allan (H M Treasury), Jill Rutter (Chief Secretary's Office), Jenny Harper (Minister of State, DHSS) and Sir Roy Griffiths, Sir Robin Butler, Richard Wilson and John O'Sullivan.

Yours,

Paul

PAUL GRAY

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

SECRET

Ch/ your specific drafting points taken on; they but have not added anything on charging or timescale.

MPW 5/2

THE NHS

Note by the Cabinet Office

This note sets out some of the main questions that will have to be considered in the internal review of the NHS.

Scope and Objective

2. The objective is to devise a structure for health care which is responsive to the needs and wishes of patients and available to all, and at the same time cost-effective and efficient. The review will place special emphasis on the hospital service, but the latter cannot be considered in isolation from primary care and the private sector. The level of financing and resources can be considered later when Ministers have decided on a structure which will make best use of whatever resources are available from whatever source.

Problems

3. The fundamental problems are:

a. consumers have very little freedom of choice. Most patients have no say in when, where, how or by whom they are treated.

b. present cost controls are crude. Patients have no idea what it costs to treat them. Nor usually do those who treat them. Even if they do, they have no incentive to drive the costs down or to consider which course of treatment is the most cost-effective.

c. there is no means of channelling resources to the most efficient and cost-conscious units, eg the most efficient District Health Authorities (DHAs). Nor, unlike a business, can the most efficient and low-cost hospitals increase their share of the market (and hence their revenue) at the expense of the less efficient. As the Secretary of State's paper points out, hospitals are not rewarded for attracting patients but suffer financially for it.

d. the system is not good at dealing with mismatches between patient demands and available capacity (eg waiting lists) produced partly by institutional boundaries between public and private sectors, between GPs and the hospital service, and between health authorities.

e. there is insufficient management flexibility in the use of staff - from consultants down to the most junior grades - and in the method of determining their pay.

4. In short the NHS lacks a market mechanism under which the patient chooses, in full knowledge of the costs, who shall provide his health care, how, when and where, and resources are allocated to the hospitals, doctors and GPs who are most successful, again in full knowledge of the costs, in meeting the consumer's demands in the most cost-effective way.

2nd Half to what matters

Suggested approach

5. We suggest that the Ministerial Group should approach this problem from three angles: facts, detailed investigation of selected aspects and options for changes in structure.

Facts

Urgent

6. Ministers may wish to commission early factual papers on:

a. what public expenditure on the NHS buys, in terms both of inputs (eg pay, hospital buildings, drugs, information technology) and outputs (eg treatment of different illnesses, elective and non-elective, paediatrics, care of the elderly);

b. how far detailed information about costs in the NHS is already available, what it shows (eg regional differences) and progress with the Resource Management Initiative;

c. the comparison, on cost and other grounds, between the NHS and the private sector in this country (eg BUPA, and the experience of the 10 best hospitals), and between the NHS and other countries (e.g. New Zealand, West Germany and France, and the diagnostic-related groups set up to contain costs in the United States).

d. what is known about the way patient care is shared between different parts of the NHS, with particular reference to the need to avoid upward drift, and between the NHS and local authorities;

e. the terms and conditions of consultants' contracts.

f. facts of waiting time – & why

Selected Aspects

7. The Group may also wish to commission papers discussing how the following aspects of the NHS's problems could be tackled. With the factual papers they might help build up a coherent picture.

a. The provision of up-to-date information in the NHS about unit costs, quality of output, use of resources and waiting lists. To be most useful this information needs to be systematically available to [both users and] health managers, and to be coupled with some form of competition.

b. The introduction of financial incentives and budgeting systems to encourage cost-effective decisions, and to ensure that resources are channelled to the most efficient hospitals and doctors.

Essential

c. The scope for more charging in the NHS, to increase awareness of costs and help moderate the 'all or nothing' choice between public and private sector provision.

SECRET

d. Ways of introducing greater competition into the NHS to promote the efficient allocation of resources.

e. How to develop the role of the private sector, both as provider of some services to the NHS and as providing care outside the NHS.

f. How to promote patient freedom of choice, both as a desirable end in itself and to promote competition.

g. Ways of tackling consultants' contracts and tenure and other manpower inflexibilities.

h. The scope for introducing some form of publishable independent audit of efficiency, possibly on the lines of the Audit Commission.

Some possible structures

8. The common theme is the need to introduce a market mechanism. Various structural changes could be made to achieve this. The following are some possibilities. They are not exclusive, but they shade into each other. They could also be introduced on different timescales: it would be possible to start with one of the early options, and then develop the system gradually towards the later options. Running through all the options is the need to distinguish between those who buy health care and those who provide it.

Market mechanism within existing NHS structure

9. The first group of possibilities would introduce more market discipline into the existing NHS structure. This could be first by publishing more cost information and efficiency audit reports and by more decentralised budgeting to and within individual hospitals. Going beyond this, there could be more trading of services between authorities and sectors, so that Authority A, or indeed the private sector, could treat patients from Authority B on repayment if their costs were lower.

A new NHS structure

10. The second group of possibilities would introduce more competition in the NHS, involving radical changes in the existing NHS structure, while still leaving it mainly tax-financed.

11. One way to do this would be for District Health Authorities to compete for the allocation of patients by GPs and for their funding to be adjusted according to their success. GPs already have freedom to direct patients to the authorities of their choice, but in practice do not always do so, while authorities have little financial incentive to attract extra patients.

12. A further step down the same path would be for the Authorities to act as Health Maintenance Organisations. HMOs, which were originally developed in the United States, contract to provide all necessary treatment for a fixed sum for a fixed period. The DHA/HMOs could then place patients with hospitals, which in turn could compete among themselves. The DHA/HMOs could also compete with private sector HMOs.

13. Going still further the patient himself could be involved more directly in the choice of treatment and payment for it. There could for example be a system of health credits, by which the patient could receive a credit note covering the cost to the NHS of his treatment, which he could then use wherever he chose within the Service or, more radically, within the private sector. And there are systems in other countries which could be studied: for instance, those in France (where the patient pays the cost of his treatment and is then reimbursed, usually in full, by the State) and Germany. These ideas could however have important implications for present methods of expenditure control.

A greatly expanded private sector role

14. All the alternatives so far have been consistent with the NHS providing most of the health care and most of the funding continuing to come from tax. The last group of possibilities would increase both the role of the private sector in the provision of care, and the role of private finance in funding it.

15. At present, people can already choose to pay for private provision, normally for the less expensive or more optional treatment. This process could be encouraged by tax relief for private medical insurance premiums.

16. More radically, people could opt out for at least some of their medical care which they could then buy either privately or from the NHS. Opting out could be either by individuals or by employers. Those concerned would no longer pay the NHS for the cost of the treatment affected. It would not of course be possible to opt out of payment of tax, but if NHS care were to be financed through National Insurance Contributions, or some similar payment, established for health, there could be a gradual development of contracting out, similar to that decided on by the Government for pensions. Such a system would probably work most easily if the health care contracted out was of the less expensive or more elective kind. The more urgent or expensive long-stay treatment would probably have to stay within the NHS, and the size of the contribution rebate would have to allow for that.

17. The most radical solution of all would be to require all who could do so to provide for their own health care, probably by insurance, which could be arranged either individually or through employers' schemes. The State would still need to provide for the very poor or the uninsurable.

CONCLUSIONS

18. Ministers are invited to decide which specific aspects they wish to consider first.

Cabinet Office
5 February 1988

SECRET

FROM: E P KEMP
5 February 1988

CHANCELLOR OF THE EXCHEQUER

cc Chief Secretary
Paymaster General
Sir Peter Middleton
Sir Terence Burns
Mr Anson
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Saunders
Mr Satchwell
Mr Cropper
Mr Tyrie
Mr Call

THE NHS

Mr Saunders has prepared a note against next week's meeting (now I understand fixed for Monday rather than Tuesday evening), which he had to put together before we saw the final version of the Cabinet Office paper. I have now got this, which is attached. It does not reflect in detail every point which you made (all of which we communicated to the Cabinet Office) but I do not think it is a bad basis for next week's discussions; after all it is not much more than an annotated agenda.

2. I am sure it is right that at next week's meeting Ministers should agree to ask officials to push ahead urgently with the fact finding material suggested in paragraph 6 of the paper, and work on some if not all of the various points suggested at paragraph 7. (It will not be possible, for another Ministerial meeting to be held in a couple of weeks or so, to do much but certainly we can press forward to produce something.) All this will, as the Cabinet Office paper puts it, "help to build up a coherent picture".

3. But even at this early stage it would also be useful if Ministers could give us some indication as to the direction in which they want to go. Clearly, as Mr Saunders suggests, we need to point in the

KEMP 5/2

direction of improved efficiency, costing and information exchange, improvements to consultants contracts and pay etc arrangements, and so on, in the NHS as such, coupled with the introduction of a market mechanism as mentioned in paragraph 9 of the paper. I would hope we could also assume that Ministers want to look in the direction of the new NHS structure discussed in paragraphs 10 to 13 of the paper, although as we move down towards paragraph 13 we do get into questions of expenditure control. But it seems to me that Ministers will want to have these paths actively explored.

4. The most interesting and difficult extension of all this, however, would be exploring into the greatly expanded private sector dimension, discussed in paragraphs 14 to 17 of the paper. Clearly no decision can or should be taken about any elements here yet. But it would be helpful in informing the next stage of the work if we knew that Ministers were prepared to consider going down this path. If I may say so, I think they should. What we want ultimately is a cross pollinated nation-wide health provision service, partly public partly private, with public and private money financing care in one or the other as may be most effective and as reflects consumers' choice, on the basis of economic charging. It should be noted that this does not necessarily mean that the patient should himself have directly to foot the bill for his care; once the information is available and the costings established, it would be possible to create, at least to start with, a surrogate charging system whereby care for an individual was "paid for" either directly by that individual, or by somebody on his behalf (his employer, or his spouse's employer, or his insurance company) or by the local authority, or, ultimately, by the State but recognisably so. It is not too fanciful to imagine the creation, in the somewhat well worn jargon, of a "customer contractor" relationship between the providers of health care (public and private) on the one hand, and the patients, or entities on their behalf, on the other; eventually on a compulsory basis. This is all a long way off, but if this were seen, provisionally, as an ultimate goal then we would be better able to orient the immediate work.

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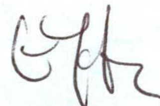
5. The Cabinet Office paper does not discuss timing (although we suggested it to them, at your behest, that it should.) Clearly something is going to have to be said before the Summer Recess. And what is said then will have to cover financing of health care, (as well as structure, efficiency etc) provision, although financing is not on the table just at the moment. That will involve decisions on, or at least mention of, elements like tax relief for private care, lotteries, charging on a wider basis, and inevitably ordinary additional public expenditure provision, not least because the next public expenditure Survey will be on us in not so many months' time. I would guess that this immediate review ought to be allowed to get on to financing by April or May. As to actual implementation of changes, clearly there are some things that can be done relatively quickly - for instance improved audit arrangements, a better internal market within the NHS, better costing and better exchange of information, and (up to a point) more direct patient charging. Other developments might take longer, especially if (as seems to be inevitable) at some stage legislation is required. Looking far ahead, Ministers might want to give preliminary consideration to whether they want radical changes in place before the next Election or merely signalled as intentions for a fourth term. I would have thought quite a lot could actually have been put in place.

6. I should mention one other point which I understand is concerning the Cabinet Office and on which they will be briefing the Prime Minister, and this concerns the Griffiths Report on Community Care. Whatever DHSS may think, the penny has dropped within No 10 that this is integrally bound up with the present review, even though the present review is, at least on paper, targetted on the hospital service mainly. Not having seen the Griffiths Report one cannot tell exactly how much intereaction there is in detail, but at next week's meeting you may simply like to confirm that you agreed that this is all part of a seamless robe and that the handling of the Griffiths Report, including whether and when it is published and what is said on publication, must be seen alongside the wider picture.



E P KEMP

Spare pmp. Recd 4.20pm 5/2/88

SECRET

THE NHS

Note by the Cabinet Office

This note sets out some of the main questions that will have to be considered in the internal review of the NHS.

Scope and Objective

2. The objective is to devise a structure for health care which is responsive to the needs and wishes of patients and available to all, and at the same time cost-effective and efficient. The review will place special emphasis on the hospital service, but the latter cannot be considered in isolation from primary care and the private sector. The level of financing and resources can be considered later when Ministers have decided on a structure which will make best use of whatever resources are available from whatever source.

Problems

3. The fundamental problems are:

a. consumers have very little freedom of choice. Most patients have no say in when, where, how or by whom they are treated.

b. present cost controls are crude. Patients have no idea what it costs to treat them. Nor usually do those who treat them. Even if they do, they have no incentive to drive the costs down or to consider which course of treatment is the most cost-effective.

c. there is no means of channelling resources to the most efficient and cost-conscious units, eg the most efficient District Health Authorities (DHAs). Nor, unlike a business, can the most efficient and low-cost hospitals increase their share of the market (and hence their revenue) at the expense of the less efficient. As the Secretary of State's paper points out, hospitals are not rewarded for attracting patients but suffer financially for it.

d. the system is not good at dealing with mismatches between patient demands and available capacity (eg waiting lists) produced partly by institutional boundaries between public and private sectors, between GPs and the hospital service, and between health authorities.

e. there is insufficient management flexibility in the use of staff - from consultants down to the most junior grades - and in the method of determining their pay.

4. In short the NHS lacks a market mechanism under which the patient chooses, in full knowledge of the costs, who shall provide his health care, how, when and where, and resources are allocated to the hospitals, doctors and GPs who are most successful, again in full knowledge of the costs, in meeting the consumer's demands in the most cost-effective way.

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Suggested approach

5. We suggest that the Ministerial Group should approach this problem from three angles: facts, detailed investigation of selected aspects and options for changes in structure.

Facts

6. Ministers may wish to commission early factual papers on:

a. what public expenditure on the NHS buys, in terms both of inputs (eg pay, hospital buildings, drugs, information technology) and outputs (eg treatment of different illnesses, elective and non-elective, paediatrics, care of the elderly);

b. how far detailed information about costs in the NHS is already available, what it shows (eg regional differences) and progress with the Resource Management Initiative;

c. the comparison, on cost and other grounds, between the NHS and the private sector in this country (eg BUPA, and the experience of the 10 best hospitals), and between the NHS and other countries (e.g. New Zealand, West Germany and France, and the diagnostic-related groups set up to contain costs in the United States).

d. what is known about the way patient care is shared between different parts of the NHS, with particular reference to the need to avoid upward drift, and between the NHS and local authorities;

e. the terms and conditions of consultants' contracts.

Selected Aspects

7. The Group may also wish to commission papers discussing how the following aspects of the NHS's problems could be tackled. With the factual papers they might help build up a coherent picture.

a. The provision of up-to-date information in the NHS about unit costs, quality of output, use of resources and waiting lists. To be most useful this information needs to be systematically available to both users and health managers, and to be coupled with some form of competition.

b. The introduction of financial incentives and budgeting systems to encourage cost-effective decisions, and to ensure that resources are channelled to the most efficient hospitals and doctors.

c. The scope for more charging in the NHS, to increase awareness of costs and help moderate the 'all or nothing' choice between public and private sector provision.

d. Ways of introducing greater competition into the NHS to promote the efficient allocation of resources.

e. How to develop the role of the private sector, both as provider of some services to the NHS and as providing care outside the NHS.

f. How to promote patient freedom of choice, both as a desirable end in itself and to promote competition.

g. Ways of tackling consultants' contracts and tenure and other manpower inflexibilities.

h. The scope for introducing some form of publishable independent audit of efficiency, possibly on the lines of the Audit Commission.

Some possible structures

8. The common theme is the need to introduce a market mechanism. Various structural changes could be made to achieve this. The following are some possibilities. They are not exclusive, but they shade into each other. They could also be introduced on different timescales: it would be possible to start with one of the early options, and then develop the system gradually towards the later options. Running through all the options is the need to distinguish between those who buy health care and those who provide it.

Market mechanism within existing NHS structure

9. The first group of possibilities would introduce more market discipline into the existing NHS structure. This could be first by publishing more cost information and efficiency audit reports and by more decentralised budgeting to and within individual hospitals. Going beyond this, there could be more trading of services between authorities and sectors, so that Authority A, or indeed the private sector, could treat patients from Authority B on repayment if their costs were lower.

A new NHS structure

10. The second group of possibilities would introduce more competition in the NHS, involving radical changes in the existing NHS structure, while still leaving it mainly tax-financed.

11. One way to do this would be for District Health Authorities to compete for the allocation of patients by GPs and for their funding to be adjusted according to their success. GPs already have freedom to direct patients to the authorities of their choice, but in practice do not always do so, while authorities have little financial incentive to attract extra patients.

12. A further step down the same path would be for the Authorities to act as Health Maintenance Organisations. HMOs, which were originally developed in the United States, contract to provide all necessary treatment for a fixed sum for a fixed period. The DHA/HMOs could then place patients with hospitals, which in turn could compete among themselves. The DHA/HMOs could also compete with private sector HMOs.

13. Going still further the patient himself could be involved more directly in the choice of treatment and payment for it. There could for example be a system of health credits, by which the patient could receive a credit note covering the cost to the NHS of his treatment, which he could then use wherever he chose within the Service or, more radically, within the private sector. And there are systems in other countries which could be studied: for instance, those in France (where the patient pays the cost of his treatment and is then reimbursed, usually in full, by the State) and Germany. These ideas could however have important implications for present methods of expenditure control.

A greatly expanded private sector role

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CONCLUSIONS

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Cabinet Office
5 February 1988

5.2.3

SECRET

FROM: R B SAUNDERS

DATE: 5 FEBRUARY 1988

CHANCELLOR

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

THE NHS

1. The Prime Minister's meeting has now been brought forward to Monday afternoon. At the time of dictating this brief, I have not yet seen the Cabinet Office paper, but I assume it is broadly as we saw it earlier this week, incorporating most if not all your amendments.

Now enclosed, + Griffiths paper

2. You are fully familiar with the issues. I offer below a few points to look out for during the meeting. Mr Kemp may offer some thoughts separately.

3. First, it is important to keep in view the longer term objectives. We have found in discussion at official level how easy it is to get sidetracked at great length into the merits and demerits of particular wheezes. There is a very large number of these on offer. When we have a broad idea of the direction in which we are going, we can start to whittle them down and look for the good bits in the various schemes that have been proposed. But first we need to set the direction.

4. Second, timing. Our view is that the order in which the possibilities are laid out in the second half of the paper is roughly the order in which they should be tackled. We should try as soon as possible to build on the present initiatives - resource management, Korner performance indicators, the growing co-operation at local level between public and private sectors, etc.

SAUNDERS THE NHS 5/2

Some political push needs to be put behind them, setting them in the broader context of the strategy described in the paper. At the same time, we should move in the direction indicated in paragraph 9 of the paper: the introduction of cost centres within hospitals, with trading within and between health authorities as a consequence. These changes should not require much, if any, primary legislation, and should be put in hand quickly.

5. Moving on from that, we come to the various ways of reorganising the NHS. Some options may involve amalgamating FPCs with health districts. The abolition of regions may follow naturally once a more market-based approach to management begins to permeate the NHS. Changes of this sort would require legislation and a somewhat longer timescale. It is important that organisational change should be pursued only if it is a natural consequence of the new mechanisms we build into the system, and not for its own sake.

6. Similarly, the options involving private sector financing (as well as provision) will require primary legislation. It is unlikely that we can get to them in one step. The reforms under the first group of options would need to be seen through first, so that the mechanisms were in place to allow change. But the reorganisation to be pursued at that stage would probably be different from that under the second group of options, which retain public sector financing.

7. Finally, a couple of points of old-fashioned Treasury caution.

a. A lot of the ideas floating around are potentially very expensive. Some imply open-ended commitments: the Policy Unit idea of guaranteed maximum waiting times; or the idea of extra funds for authorities who increase their efficiency, unless the additional money was taken away from those who did not. Others would mean new subsidies to the private sector: for example, health credits or vouchers could easily turn into a way of financing publicly operations which are now paid for privately. While financing is not meant to be at the

top of the agenda, and we may at the end of the day have to concede some extra public expenditure on health, potential costs to the Exchequer need to be borne clearly in mind when looking at different options.

b. Expanding the private sector could have supply side effects which increase public expenditure. So long as private work is in large measure a sideline for consultants whose main efforts are concentrated on prestigious positions at teaching hospitals, there is little danger of the private sector bidding up medical pay. But if the private sector expanded considerably, and began to employ many more doctors and nurses full time, pay pressures could build up. This would be exacerbated by the prospective shortage of nurses in the 1990s. Reducing the monopsony purchasing power of the NHS could also result in higher prices for medical equipment - although probably not drugs, where the PPRS seems unlikely to be holding down prices. The point is therefore that the supply side effects of a bigger private sector are not all one way.

R B SAUNDERS

SECRET

10 DOWNING STREET

LONDON SW1A 2AA

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From the Private Secretary

9 February, 1988.

Dear Geoffrey,

NHS REVIEW

The Prime Minister yesterday held a meeting to discuss the review of the National Health Service (NHS). Those present were the Chancellor of the Exchequer, the Secretary of State for Social Services, the Chief Secretary, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. John O'Sullivan (No.10 Policy Unit). The meeting had before it a note by the Cabinet Office on the work programme of the group, and a paper by Sir Roy Griffiths on the NHS costing systems.

In discussion the following were the main points made:

a. Thinking needed to start with the fundamentals. What was the State's responsibility for ensuring that health care was available when needed? If it had such a responsibility how was it best discharged? It did not necessarily follow that the State itself should provide the treatment. Considerable thought had been devoted to these questions among those interested, both in this country and abroad, and Sir Roy Griffiths undertook to provide the group with a reading list.

b. Ideas for an internal market in the NHS needed to be treated with caution. Markets usually worked because participants were motivated by the desire to make profits and create wealth. For a market approach to be effective, a major change in attitudes by those working in the NHS would be needed. One of the key issues was how this change of attitude could be brought about.

c. The resource management project in the NHS was of major importance. What took time was not so much the construction of the new management systems as the process of involvement and commitment by NHS staff. But even if for this reason it was bound to take time to implement the new system, it should be possible to evaluate the project earlier than was now proposed. It would be useful for the group to consider a paper setting out the

NOTE OF MTG 8/2

SECRET

lessons - however tentative - which had been learned already and reviewing the timetable for evaluation and implementation. It would be desirable for some evaluation of the project to be ready by July this year if possible.

d. All the work suggested in paragraphs 6 and 7 of the Cabinet Office note was worth undertaking. It would also be useful to add to the list in paragraph 6 a paper on waiting times, and to extend the scope of the paper in paragraph 6(e) to cover the monopoly position of other providers of health care.

e. While radical change was very desirable in the long term it was not realistic to expect it to be fully brought into effect during this Parliament. The group might therefore also consider what practical steps could be taken in the shorter term. For this purpose, a distinction might need to be made between changes that would require legislation and those that would not. It was, however, essential for any medium-term measures to be compatible with the desired longer term direction of change.

f. It was probably too soon for the group to consider possible structures for a reformed NHS. The choice of a structure was, however, the most important and difficult question it would face, and should not be deferred too long. As a first step, it would be greatly helped by having a full description of the structure of health care in selected other countries (e.g., the United States, Germany and New Zealand).

g. A programme of informal discussions might be arranged with those who could provide helpful comment and information, both from this country and abroad. These discussions would need to take place privately, and to be handled with great care, since those who were not consulted must not feel left out, and no indication could be given at this stage of the Government's own views.

The Prime Minister, summing up the discussion, said that the Cabinet Office should now arrange for work to be set in hand on all the papers described in paragraphs 6 and 7 of its note. Two papers should be added: one describing the structure of health care in selected countries abroad, and one on waiting times. The paper on consultants' terms and conditions (6e) should be extended to cover other monopoly suppliers of health care. The group would not consider structures further until this work had been done. The Secretary of State for Social Services should arrange for a paper to be prepared on any lessons so far learned from the resource management project, and on possibilities for accelerating its timetable. Sir Roy Griffiths had undertaken to circulate a reading list. The Minister for Health and Mr. O'Sullivan should make suggestions as to individuals who might be consulted informally. The group recognised that it would take some time for all this work to be completed, but a

first batch of papers should be circulated in about a fortnight, for a meeting in three weeks' time.

I am sending a copy of this letter to the Private Secretaries of the Ministers at the meeting, and also to the others present.

Yours,

Paul.

Paul Gray

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