20-CH/NL-0451
PART A

Park. A.

SECRET

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Chancellor's (Lawson) Papers:
Health Expenditure.

DD's: 25 Years

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DW

PRIME MINISTER 21 November 1986

HEALTH AND THE MANIFESTO

The polls consistently show that health is one of the top three political issues. Do you and your colleagues believe it is going to stay near the top of the list? The cautious approach is to play down health as an issue by emphasising the Government's achievements and that no big changes are planned. The bolder approach is to accept that health will remain a crucial issue and to set out a distinctive and popular Conservative policy for improving the NHS. A compromise between the options of caution and radicalism may be best: but distinguishing them helps clear our minds in preparing the framework for the Manifesto.

Safety First

The argument for caution is that the NHS is the only popular socialist institution in this country. It was created by a Labour Government, rests on the principle of equal access to health care, and directly provides that care through state employees. Just as defence is a naturally Conservative issue, so the NHS is a naturally Labour one. So the best tactic might be to play down health as a political issue by demonstrating that this Government can be trusted to maintain the NHS as we know it. This approach is epitomised by the statement that "the NHS is safe with us".

The themes become:-

- **Spending:** up to £20 billion next year, as against £7 billion in 1978-79 - a real increase of about 25%;

- **Building:** a £3 billion programme with 380 schemes.

- **Better management:** £400m of cumulative savings from cutting out waste and inefficiency, with another £150m due this year.

- **More patients treated:** in-patient cases up 1m since 1978.

In addition to these themes, we could make more of the evidence that the British people are healthier than ever before. Children born in 1982-1984 can expect a life span two years longer than those born ten years before. And death rates from some serious diseases have fallen dramatically (e.g. from strokes and cervical cancer by 10%)

The Government's record is indeed one to be proud of and Norman Fowler put it across very powerfully in his Conference speech. But there are three problems in such an approach:

(i) It concedes that higher public spending is the test of the extent to which one cares about health. The Labour Opposition will always be able to outbid us with promises of even more spending.

(ii) It does not distinguish between the interests of producers and consumers. Nobody believes that more money for ASLEF will improve the railways or help the commuter. Labour's alliance with NUPE and COHSE should be a similar albatross round its neck.

(iii) It sounds defensive. Some people believe that the praise for the NHS comes through gritted teeth; and that the Government would undermine the NHS if only it dared.

<u>The radical approach</u>

This says that the Government's task is not simply to manage a Socialist NHS better. The NHS is a popular nationwide

insurance scheme combined with a mediocre monopoly nationalised industry. It is the nationalised industry we need to change, not the financing base apart from enhancing the role of national insurance. People want to be assured of treatment if they are seriously ill without financial worry. (Breaking up the financing base of the NHS into competing private insurance schemes is neither popular nor sensible: that is where right-wing critics like the IEA go wrong.)

But the real target is the direct labour organisation by opening up the provision of health services within the framwork of a 'free' Health Service. Then the themes are:-

- **Choice.** Money should go with the patient (just like open enrolment in schools). If we want managers to be more efficient and more patient-minded, then more custom must be rewarded with more income.

- **Standards.** Bad doctors literally get away with murder. The days of cosy and secretive professional scrutiny are numbered in medicine as they are in the City. If patient power is to mean anything, they need more information about the different performance of different hospitals and doctors.

- **Competitive tendering.** If it's alright to buy in ancillary services from the private sector, why not buy in pathology services or operations. After all, GPs remain independent, small businessmen. We are making progress but it is slow because there is not the same political impetus as with ancillary services.

Norman Fowler is worried this approach can be caricatured as privatising a much-loved institution. But it has three advantages:

(i) If the Government doesn't offer a programme of change, then critics fill the vacuum with their own lurid versions of our 'secret agenda'. The more ambitious approach deals with this head-on by publicly setting a programme for the reform of the NHS.

(ii) In the long run, the NHS cannot survive in its present form. It needs private management skills and private capital. We need to grasp that nettle.

(iii) It brings out the fundamental point that Labour backs the health unions but we put patients first.

A Way Forward - Let A Thousand Flowers Bloom

It would obviously not be sensible to put all our eggs in one basket. We should not wilfully refuse to take credit for our spending record. On the other hand, if we just look backwards without offering prospects of reform then Labour can beat us on money and the Alliance can beat us on ideas. We need both to occupy Labour's territory and go further to show that we can do things Labour can't do.

The neatest way to achieve this is by encouraging (though not imposing) alternative patterns of health provision. Now that we have some skilled and enterprising health service managers in place we should encourage them to take initiatives with the private sector and with patient choice, just as Kenneth Baker is doing in education. Some of them are like zoo animals who have been kept in cages for so long that they don't know what to do when they are set free.

Tony Favell's private member's Bill on private provision of kidney dialysis is a good example of the approach I have in mind (see Hansard attached), though compulsion is going too

not

far. If the best way to cut a particular waiting list is to buy in operations from the private sector, then Labour looks mean-spirited in opposing it.

Yours sincerely

DAVID WILLETTS

Ch

The option not covered here but which seems to me to have attractions is a development of the voucher system (discussed briefly in the DHSS working party paper). Doctors (or groups of doctors) could choose to offer enhancements to NHS service for a ~~fee~~ [illegible] — so I could have a <u>choice</u> between a no-frills NHS service at no charge or an enhanced service for the <u>marginal</u> addition cost — avoiding

the cliff-edge of opting out completely and paying the full cost of private health-care. Presumably the same sort of thing could work for hospital treatment, though the link is a bit harder.

This was – as I recall – the sort of thing in the IEA Hobart Paper (which I think you gave Peter Cropper to comment on?)

The emphasis was on giving consumers greater choice about spending/service trade-off

AA

021/412

SECRET AND PERSONAL

From: J Anson
Date: 6 February 1987

CHANCELLOR OF THE EXCHEQUER

cc

Chief Secretary
Sir P Middleton
Mr F E R Butler
Miss Peirson
Ms Boys
Mr Parsonage
Mr Sturges
Mr Cropper
Mr Tyrie

HEALTH EXPENDITURE

You asked me to arrange for some work to be done, by a restricted group within the Treasury, on options which could be put forward in the next Survey for savings in public expenditure on health, including some of the more radical options such as more private care and financing through insurance.

2. I attach a paper by Ms Boys, Mr Parsonage and Mr Sturges which reflects discussions within the group. This reviews a broad range of options, and it would be helpful at this stage if we could discuss it with you and the Chief Secretary so as to narrow down the options on which you may want further work to be done.

3. Paragraph 30 of the paper brings together a selected list of options, which could form an annotated agenda for the meeting. These range from those which could be done under existing powers to radical solutions like a major shift to private provision financed by compulsory insurance (on the analogy of motor insurance). It does not embrace the still more radical option of a major shift to private provision leaving people free to insure or not; this option was excluded by Ministers from the 1981 review, and we have assumed you would not in practice want to contemplate people actually refused admittance to hospital for lack of evidence of means.

4. Much of the ground was extensively gone over in 1981 by an

interdepartmental working party on alternative means of financing health care. For convenience, the report of that review has been attached to our paper. It is not required reading, but is available to dip into if you want more detailed argument on a particular point. As Ministers decided in 1982 to stick with a National Health Service financed largely from taxation, the general landscape has not changed very much since it was written. We have benefited from advice from Mr Parsonage who as it happens was Secretary of the 1981 Review.

5. The paper speaks for itself, but perhaps I could add a few preliminary reactions of my own to the options in paragraph 30 of the paper:

(a) Measures to improve the **efficiency of the present system** - of which there is a menu in paragraphs 11-13 - would all be worth pursuing with DHSS, although significant new reductions in expenditure are unlikely from this source. Given the block budget system for hospitals, and the need to provide an incentive, the efficiency improvements will accrue in the first instance to the hospitals concerned. The likely overall effect will however continue to be taken into account in setting the total allocation to the NHS.

(b) Some proposals on **charges** are already scored in the 1986 Survey and need to be delivered (reducing the exemptions for elderly people, contrary to the 1983 Election pledge). But the others could all be pursued in the next Survey. Charges for GP visits, and for the full cost of drugs (with limited exemptions) look like the most rewarding. These would require legislation. Both might be tempered with some kind of "season ticket" provision. Whether or not all the proposals on charges are pursued immediately, it is most important to avoid statements which would rule them out or further entrench any remaining exemptions.

(c) **Tax relief** for private insurance premiums would have the merit of going some way to reduce the big gap between expensive

I can't see this as a means of saving public expenditure

private care and largely free NHS, and this might help to encourage the growth of the private sector. But it would further complicate the tax system, and have a dead-weight cost of £150 million. A fuller analysis would require consultation with FP and the Revenue, but I doubt if it is worth pursuing.

(d) A switch to a system based on **social security contributions**. It can be argued either way whether this would restrain expenditure (because people would better perceive the cost) or encourage it (because they would be more willing to pay directly towards a service they value). But the essential point is that it would be substituting one tax (or state contribution equivalent to a tax) for another, raising labour costs and with major distributional consequences. These consequences would need to be analysed with DHSS when the change had been more clearly specified. But if the shift was from income tax, some idea of the impact can be obtained from Chapter 7 of the Green Paper on Personal Taxation, which looked at the reverse operation of substituting tax for contributions. Paragraph 7.4 described the main differences between the incidence of the two systems, and the conclusion in paragraph 7.7 still seems valid.

This has very few attractions

A move to contributions might also in principle be associated with a move to a state-run insurance system on the continental model. But as the 1981 review pointed out, this would be substituting demand-led for cash-limited expenditure. From a control standpoint, it would seem better to move the other way and try to cash limit the presently demand-led Family Practitioner Services.

(e) Finally, there is the radical development of **compulsory private health insurance**. Of the more radical options, this has the merit of introducing a genuine element of competition between the insurers, and it would seem worth examining if

I feel these are border-type options before we leap across the great divide ✓

you feel that the time is ripe to reopen the 1982 decision. The scale of the reform should not be underestimated. Even to cover the working population and their dependents, it would involve developing an insurance industry three times the size of the motor insurance industry, and 15 times as large as the present health insurance industry. Some system of phasing would therefore probably be required. And there is a real question how far costs (both medical and overheads) would be kept in check.

J ANSON

SECRET

HEALTH EXPENDITURE: OPTIONS FOR CHANGE

SUMMARY

1 The attached paper examines the present pattern of public expenditure on health and looks at options for reducing that expenditure.

2 The analysis of present expenditure patterns (paras 4-9) shows that there are strong pressures (eg the numbers of elderly, medical remuneration) which are driving up public expenditure on health in the UK (as in other OECD countries).

3 Options for change are examined under three main headings -

- Making publicly financed NHS more efficient (paras 10-13).

- Exploring alternative sources of finance, mainly charging, for NHS treatment (paras 14-19)

- Encouraging or enforcing more private provision (paras 20-28).

4 It seems clear that there is limited scope for public expenditure savings in the short-term. Introducing new charges requires legislation. Major savings could only be achieved by radical measures - eg alterations in basic entitlement to the NHS coupled with compulsory private health insurance. Such measures are essentially long term and would require both public consultation and legislation.

5 In conclusion an illustrative range of measures is floated (para 30) -

a) **measures to take effect in Survey period**

- further NHS efficiency measures - savings uncertain and liable to be recycled into services (paras 11-13)

- restructure existing charges eg prescription charges. Could raise up to £300m pa but £75m from limiting exemptions already scored in Survey but not yet implemented. (paras 14(ii) and (v)).

b) **measures requiring legislation but could take effect by end of Survey period.**

- introduce new charges eg for visits to GPs and hospital stays (Para 14(i), (iii) and (iv)). Could raise up to £300m pa.

- tax relief for voluntary private health insurance. No expenditure savings certain and an initial deadweight cost. (para 21).

- change the basis of NHS financing from the present combination of general taxation and national health contributions to a single contribution. No direct effect on expenditure: arguably as likely to increase as decrease public expenditure in the longer term. (paras 16-19)

Forget this

c) **radical options for longer term**

- restrictions on basic entitlements to NHS for some groups eg working population plus dependents coupled with compulsory private health insurance (paras 22-28). Could reduce public expenditure by up to £9 billion - up to 50% of present public expenditure on health. Savings would be offset by some consequential increases in social security assistance for the low paid and by any safety net provisions.

6 Ministers are invited to indicate which of these options they would like to see worked up for discussion with DHSS Ministers.

PAPER

4.28.8

SECRET

HEALTH EXPENDITURE: OPTIONS FOR CHANGE

1 **Purpose of paper.** This paper seeks to identify options for reducing public expenditure on health not only in the period to be covered by the 1987 Survey but also in the longer term. Ministers are invited to give their views on which of the following ideas they would like to see worked up for discussion with DHSS Ministers.

2 **Scope of paper.** It is assumed that Ministers are content for total spending, private and public, on health as a % of GDP to rise **provided that** the publicly funded share of GDP does not increase or preferably declines. The scope for altering the balance between public and private expenditure on health is examined in the context of:-

a) pressures which could otherwise force up public health expenditure under the present arrangements.

b) the forces which will pull against attempts at radical change.

3 **Previous consideration.** These issues were fully considered in 1981 by a Working Party set up by the then Secretary of State for Social Services, Mr Jenkin. The report of the Working Party on Alternative Means of Financing Health Care (copy at Annex A) was submitted in January 1982 to Mr Fowler who had succeeded Mr Jenkin. Mr Fowler announced the outcome in a reply to a written PQ in July 1982 -

"The Government have no plans to change the present system of financing the National Health Service largely from taxation, and will continue to review the scope for introducing more cost-consciousness and consumer choice and for increasing private provision which is already expanding"

The Working Party report was never published and the Green Paper that it had recommended never materialised. (A consultation document on Primary Health Care was published in 1986 but this had a different and more narrow focus).

4.28.87

SECRET

PATTERN OF PUBLIC EXPENDITURE ON HEALTH

4 **UK public expenditure on health**

Net expenditure on the NHS has increased since 1960 as follows:-

	Cash (£billion)	Real Terms (£bn 1980 prices)	% of GDP
1960	0.9	4.8	3.4
1970	2.0	7.5	3.9
1980	11.6	11.6	5.0
1985	17.8	12.8	5.1
1986/7-est	18.8	13.0	5.0

The GDP share has increased significantly over the period since 1960 but it was no higher in 1986/87 than in 1980.

5 **Financing of UK public expenditure on health.** At present general taxation funds about 85% of public expenditure on health with 12% coming from the health element of national insurance contributions and only 3% from charges. — cf 1950s

6 **NHS expenditure per head by age group (England) 1984/5:**

In 1986/87 expenditure **per head** by age is estimated as follows:

	Hospital and Community Health Services	Family Practitioner Services	Total
	£	£	£
All ages	220	80	300
Births	1225	90	1315
0-4	200	80	280
5-15	90	70	160
16-64	115	70	185
65-74	450	115	565
75 and over	1050	130	1180

Clearly births and the over 65's (and particularly the over 75's) are the most expensive groups per head. The number of over 75s are growing faster than any other age group, see graphs at Annex B.

7 **International comparison of public expenditure on health as % of GDP.** Between 1960 and 1983 OECD countries allocated an increasing proportion of their GDP to public expenditure on health (on average up from 2.5% to 5.8%). The UK also increased its GDP share but only from 3.4% to 5.3%. So from being above the OECD average in 1960, the UK to moved to below the average by 1983 - see table at Annex C, Page 1. These comparisons are of course affected by differences in national financing arrangements and by factors such as medical remuneration (much higher in relation to average wages in the USA for example than in the UK). The UK has a higher ratio of public to private expenditure on health than most other OECD countries (see Annex C).

8 **Influences on future UK expenditure**

There are a range of influences which will tend to push up future public expenditure on health -

- the growing proportion of elderly people in the population, especially those over age 75, (NHS expenditure is projected to rise as a result of demographic pressure by about 0.75% a year in real terms over the next decade)

- real pay increases (pay accounts for about 70% of total NHS expenditure). Unrealistic to assume that future NHS pay increases can be held below the rate of increase in the economy generally in the long term

- cost of medical advance ie new/improved methods of treatment (estimated by DHSS at about 1% per annum in real terms)

- continually rising expectations among general public for more and better health care.

A plausible forecast is that with the present structure, even allowing for efficiency improvements, NHS expenditure will increase by 2-3% pa in real terms. (This compares with average real growth of 4% a year between 1960 and 1985). Under current financing arrangements, these pressures for increases in both the quantity and quality of health care can only be met by increasing the burden of taxation.

? 2-3% pa is equal to real growth in NHS economy, so does not necessarily imply burden of taxation increasing.

OPTIONS FOR CHANGE

9 Possible courses of action aimed at reducing public provision as a % of GDP are explored under three main headings:

a) making publicly financed NHS more efficient.

b) exploring alternative sources of finance for NHS treatment

c) encouraging or enforcing more private provision.

***Making publicly funded NHS more efficient**

10 **Current measures.** There is an existing programme of efficiency savings (the cost improvement programme) already scored in public expenditure provision. This has so far saved £390m (cumulative) with £150m pa further savings planned by health authorities (who keep the savings for use on health care). Introduction of clinical budgeting should increase scope for efficiency savings by making health professionals more cost conscious. DHSS is now considering responses to its Primary Health Care consultation document and some useful changes should follow. However none of these planned efficiency measures will have a significant **new** effect on public spending on health. Even with clinical budgeting the individual health professional has little incentive to reduce costs and patients have no interest in (or knowledge of) costs.

11 **Privatisation**

i) There might be scope for contracting out the management of NHS hospitals to private companies. Some Health authorities are already placing a few patients in private hospitals - eg in efforts to reduce waiting lists. It would be prudent to test the scope for efficiency savings via a pilot project first. We should need to ensure that we had not opened a device for evading expenditure controls on capital.

ii) Contracting with private hospitals for routine operations could reduce pressure on waiting lists. But public expenditure would only be saved on an ongoing basis to the extent that there are efficiency gains.However the additional capacity made available through the use of private hospitals could lead to pressures for more NHS expenditure.

(iii)There may be further scope for contracting out of support services - but health authorities have already taken this into account in their cost improvement programmes.

12 **Family Practitioner Services**

(i) Cash limiting the FPS. Expenditure on the FPS is demand led and has in some years risen faster than expenditure on the rest of the NHS. One option would be to introduce a cash limit. But to make this a reality, FPS expenditure would need to be merged with cash limited budgets of district health authorities, or major policy controls put in the hands of Family Practitioner Committees (eg. controls on ancillary staff employed by GPs, controls on numbers of doctors and dentists, and more controversially controls on drug prescribing).

(ii) Drugs Bill. Some possibilities exist for further savings eg generic substitution which might save £25million pa.

13 **Improve competition between NHS Regions and hospitals.** The present formula used to allocate NHS resources already takes some account of cross boundary flows of patients and hence it pays some regard to the concept of money following the patient. However, it would be possible to reinforce this by encouraging health authorities to offer their patients places in the lowest cost or soonest available beds, regardless of where those beds were located. This is already encouraged by bodies such as the College of Health who publish a Guide to Hospital Waiting Lists. However, this process is unlikely to produce significant savings.

*Alternative sources of finance for NHS treatment

14 **Charges.** There is scope for further introduction of charges - without altering entitlements to receive services. Possible charges could be -

(i) **£5 charge for each visit to GP or £10 annual charge for a place on a GP list.** Could raise up to £250 million pa in either case, assuming present exemptions. Charge per visit would have to be combined with charges for visits to hospital out-patients (see (iii) below) to prevent uneconomic switching between services.

(ii) **Charge full cost of drugs issued on prescription (retain exempt groups as now).** Could raise up to £300 million pa.

(iii) **£5 charge for visit to hospital out-patients.**

Could raise up to £40 million pa.

(iv) **Hotel charge for hospital stays.** A £10 charge per stay of less than a week or per week could produce £25 m pa after allowing for exemptions.

(v) **Charge full cost for dental treatment.** Could raise up to £25 m pa assuming present exemptions.

(vi) **Change basis of exemptions for existing charges.** Already scored in the Survey at £75 million pa (elderly above Supplementary Benefit level to pay).

There would undoubtedly be strong opposition - medical, trade union and from the general public - to the introduction of such charges. But given the rising cost of health care and support for expansion of the NHS, they might prove acceptable, provided that the less well off were exempt. Charging would of course reduce **net** but not **gross** public expenditure. All the changes except (vi) above would require primary legislation (see Annex D).

15 **Changing basis of NHS financing.** At present members of the general public may know that NHS funding is mostly from a combination of taxation and national insurance contributions. But they are not aware of the taxation cost to them as individuals. Many users of the NHS do not pay income tax or national insurance contributions. Demand for improvements in the NHS are therefore made with little or no appreciation of the costs involved or of the consequences on taxation generally, or how those costs translate to individuals.

16 An argument can be advanced that demands for more NHS expenditure would be tempered if the costs were more visible, and if they could be brought home to users. Charging provides the best mechanism for this. But it could also be claimed that if NHS expenditure were met entirely from a single contribution, there might be some dampening effect on continually rising expectations for more NHS expenditure.

17 To illustrate the kind of shift involved in moving to a contribution-based NHS, it should be noted that this would involve an increase of the order of 12-13 percentage points in National Insurance contributions. The corresponding reduction in general taxation would be of the order of half the standard rate of income tax or the whole of the present yield of VAT.

18 However, many of those advocating a single contribution, do so in the belief that it would **facilitate** significant additional expenditure. They wish to find a means of isolating the NHS from normal public expenditure controls. There is a risk that marginal changes in NHS expenditure might appear comparatively cheap to many NHS users - particularly those who were exempt from the contribution in question.

19 But even if the hypothesis in para 16 is accepted, financing the NHS from hypothecated taxation would bring other problems. Funding via increased national insurance contributions would put all the burden on the working population and have major distributional consequences. If employers also contributed, it would increase the cost of employment. It would aggravate the poverty trap unless complex arrangements were made for tapering the cost. Hypothecating an expenditure tax (eg a percentage of VAT) would avoid some of these difficulties, but it is doubtful how far it would be perceived by consumers as paying for the NHS and it would tend to put pressure on prices.

* **Encouraging or enforcing more private provision**

20. Private health care in the UK today. Private health care has expanded rapidly since 1979 as measured by for example, numbers of hospitals, beds, privately insured people (see figures at Annex E). It is now assumed that private health care provision will grow by about 4% p.a. in real terms in the next two years. However there are obstacles to further substantial growth for example -

a) most individuals are reluctant to pay twice for health care (by both taxation and private insurance). There is a

very big cliff edge between the high cost of private care and free NHS provision.

b) it is not possible to pay privately for the **marginal cost** of quicker or better treatment - treatment is typically either all privately funded or all on the NHS. There is little **competition** between public and private health care providers and any desire by individuals to exercise **consumer choice** is limited by the all-or-nothing nature of present financing arrangements.

21 **Tax relief for voluntary private health insurance.** Giving tax relief would reduce the extent to which individuals pay twice when they seek private care and it would be expected to increase the numbers opting out of acute care in the NHS. At present tax relief for health insurance is limited - only individuals who are earning under £8,500 a year and insured in Company schemes are eligible. The introduction of tax relief on all premiums would further complicate the tax sytem. In addition it would involve a deadweight cost of about £150 million in respect of individuals already insured, and there would be a further revenue loss depending on the numbers of additional people taking out private insurance as a result of tax relief. If tax relief led to an increase in private health care it would only reduce the PSBR if it facilitated a larger reduction in NHS resources than the total loss in revenue caused by the tax relief.

22 **Compulsory private health insurance.** Any major alterations in basic entitlement under the NHS would almost certainly have to be accompanied by the introduction of **compulsory** private health insurance. The situation would in some respects be comparable with motor insurance which now covers about 11 million households - with net premiums of £2.3 billion in 1984.

23 Compulsory health insurance might be required for certain groups in the population and/or for certain categories of treatment. Compulsory health insurance for the working population and their dependants could cover about 40 million people and save up to 40-50 of present public expenditure on health (ie up to £9

billion) - if it covered all forms of treatment. Compulsory insurance would of course require legislation(see Annex D).

24 Under such arrangements it would be possible to reduce the standard rate of income tax by about a quarter. Working families would then have to meet the cost of private insurance premiums out of their higher net of tax pay. It is estimated that the cost of health insurance for an average family of four might be of the order of £1,000 a year or £20 a week.

25 At present the majority of those with private health insurance are in Company/ Group schemes. These have the disadvantage that premiums do not fully reflect individual risk status. An alternative would be to require **individuals** to take out insurance. This should

a) to the extent that premiums are related to risk, maximise the incentive to follow healthy life styles and keep premiums low.

b) increase consumer choice and competition among insurers and health care providers.

The disadvantages of individual insurance are -

c) some individuals might be regarded as uninsurable risks adding to the cost of any government safety net.

d) administrative costs are much higher than in Group schemes, so that in consequence there would be very strong market pressures for the development of Group schemes, eg those provided by employers.

26 Even assuming the insurance requirement is limited to those of working age and their dependants, some provision would need to be made for those suffering from long-term conditions or illnesses so serious that their normal insurance cover ran out. If the insurance market could not cope with these cases, some safety net provision would still be needed in the NHS, reducing the amount of the public expenditure savings.

27 The insurance companies would also need to tackle the problem of controlling costs in an insurance-based system, which has proved so troublesome in the United States. It would be necessary to look again at the various remedies which have been proposed for this, such as the idea of "health maintenance organisations" (see Annex A, paras 5.10 ff).

28 The introduction of compulsory private health insurance in the UK on a major scale would be a radical step. A number of possible problems and constraints should be noted -

a) the change could not be introduced quickly. It would take some time for the private insurance industry to adapt and grow. In terms of the value of premiums the market would be at least three times as large as the present motor insurance market and 15 times as large as the present health insurance market.

b) the supply of health resources, especially qualified staff, is limited in the short term. If the introduction of private insurance led to an increase in the overall demand for health care this might cause **either** a bidding up of health costs **and/or** a switching of the better staff to the private sector. The uninsured might therefore get a poorer quality of treatment than they do at present under the NHS.

c) compulsory health insurance for the working population would bear heavily on the lower paid - especially those with large families. This would enhance the disincentive to work. Additional social security assistance would be required for the low paid. Alternatively, some form of means tested voucher system could be introduced. Both of these measures would reduce the public expenditure savings and worsen the poverty trap.

d) there would inevitably be a sizeable administrative and regulatory role for central government, eg in ensuring that all policies provide a minimum standard of cover, enforcing

the requirement for the working population to take out insurance, dealing with borderline groups (eg students, part-time workers, short-term unemployed etc) and policing the safety net provisions.

PATIENTS FROM OVERSEAS

29 This paper has concentrated on UK citizens. It has been assumed that arrangements for overseas visitors would be as now - a mixture of charging and of special entitlements for residents of both the EC countries and those countries with whom the UK has a reciprocal health agreement. These arrangements would need revision if radical options were pursued in the UK eg a major shift to private insurance.

CONCLUSIONS

30 This paper has sought to identify options for changing the pattern of health expenditure rather than to make recommendations. Ministers are now invited to express a view on which options they would like to see pursued. To aid this process an illustrative range of possible measures is -

a) **changes which could be introduced under existing primary legislation in this Survey period.**

- further efficiency measures (paras 11-13) Savings uncertain and liable to be recycled into services.

- restructure existing charges eg prescription charges paras (14(ii) and (v). Could raise up to £300m pa. Savings of £75m from limiting exemptions - already scored in the Survey but not yet implemented.

b) **measures requiring legislation but could begin to have an impact by the end of the Survey period.**

- introduce new charges eg for visits to GPs and hospital stays (para 14(i),(iii),(iv)) Could raise up to £300m p.a.

- tax relief to encourage **voluntary** private health insurance (para 21). No expenditure savings certain and an initial deadweight cost.

- change the basis of NHS financing from the present combination of general taxation and national insurance contributions to a single contribution. No direct effect on expenditure - arguably as likely to increase as decrease public expenditure in the longer term (paras 16-19)

c) **More radical options to tackle the growth of public expenditure on health in the longer term.**

- restrictions on basic entitlements to NHS for some groups eg working population plus dependents coupled with compulsory private health insurance (paras 22-28). Could save up to 50% or up to £9 billion of present public expenditure on health offset by some consequential increases in social security assistance for the low paid and by any safety net provisions.

31 Ministers are invited to express initial views on the options for change in paragraphs 10-28 above. An illustrative range of measures is set out at paragraph 30. The more promising options could then be worked up for discussion with DHSS Ministers.

ST

February 1987

ANNEX A: REPORT OF WORKING PARTY

CONFIDENTIAL

G/1664

6/2/87

REPORT OF THE WORKING PARTY
ON
ALTERNATIVE MEANS OF FINANCING HEALTH CARE

CONFIDENTIAL

REPORT OF THE WORKING PARTY ON ALTERNATIVE MEANS OF FINANCING HEALTH CARE

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1. INTRODUCTION

The Working Party was set up in July 1981 to identify options for alternative sources of finance and for alternative ways of promoting more private sector provision of services, to consider how these options might be grouped into strategies, to carry out a quick initial assessment of these strategies and to consider their implications, as a basis for decision by Ministers late in 1981 as to which strategies should be studied in greater depth. The membership and the terms of reference are set out at Annex A.

1.2 Ministers also identified specific objectives as being:-

- to sustain a National Health Service providing acceptable standards of care, but perhaps with some restrictions in coverage;

- to permit improvements in health care as national prosperity increases but to reduce the extent to which health services are financed by Government whilst enabling market forces to increase the share of GDP devoted to health care further if the public want and are willing to pay for it;

- to secure that the benefits of good health care are distributed equitably between people of different income levels and living in different parts of the UK;

- to maintain and build on the strengths of the present system in the field of primary care, care of the elderly and other vulnerable groups and in the relative ease of relationships with other social services;

- to explore the potential for increased consumer choice;

- to increase the efficiency of health services;

- to improve professional morale and performance.

1.3 In part these objectives reflect the statement made by Beveridge in 1944 that "Attack on disease requires both cure and prevention. For cure there is needed a National Health Service ensuring adequate treatment of all kinds without a charge on treatment ..... But the removal of economic barriers between the patient and treatment is only a minor step, even for the cure of disease. The real task lies in the organisation of the service". Since its inception the NHS has had many achievements, for example in relieving individuals from anxiety over the risks of major costs resulting from serious illness, in spreading the benefits of good health care throughout the nation and in the organisation of health services generally. Over the past 30 years the job the NHS has had to do has changed. For example health issues then were dominated by infectious diseases, particularly tuberculosis and poliomyelitis. Now the main causes of premature mortality are heart disease and cancer. And the NHS is now facing other serious pressures.

1.4 There are likely to be important changes in the age structure of the population. Over the remaining two decades of this century for example, the numbers of very elderly will increase considerably, and these people cost the health service most. At the same time medical developments mean that more can be done for them. To continue to give old people the benefits of these advances requires more money. But the economy is no longer growing as it did in the past. In addition the Government is concerned to reduce public expenditure both to combat inflation and restore incentives, and increase consumer choice.

1.5 The way health care is financed cannot in itself insulate the health services from the impact of economic trends. But it may change the process and mechanisms through which those trends come to play upon health expenditure eg by increasing the input from private monies and reducing the role of central Government. These measures could also allow the market to have some effect on the level and distribution of services.

1.6 Systems where more finance flows directly from the periphery ie from the patient and from private insurance institutions rather than from central Government, can shift the balance of interest. Provided that the physical resources necessary (eg manpower, buildings) can keep pace, there can be greater choice for the patient and a greater degree of patient orientation in the system.

1.7 We have therefore kept the following objectives particularly in mind:

a. to restrain the increasing pressure for public expenditure on health as health needs grow;

b. to increase private participation in the supply of health care;

c. to increase the degree of consumer choice and influence.

The ultimate aim must be of course to increase the efficiency and equitable distribution of resources devoted to health care.

1.8 However, the impact of change in the financing system and in the balance between the public and private sectors will vary

a. by income group;

b. geographically both between the regions of the UK and within them;

c. according to the existing distribution of health facilities;

d. according to the extent to which health services expand and the way in which these new services are distributed.

The extent to which choice can be exercised and the nature of the choice will vary similarly and may depend on increases in the supply of health care (eg in doctor numbers) which can only be developed

over the longer term. The significance and acceptability of these distributional effects under different health care strategies will require further work, although we have attempted to signpost them at this stage where possible.

1.9 At the same time we have interpreted Ministerial guidance that, whatever the system

- no one should be denied adequate treatment for lack of financial cover

- the strengths of the present system should be retained

as ruling out from the start four possibilities:-

a. wholly voluntary private insurance for the whole of the population. If everyone were free to choose, inevitably some patients would be unable to meet the charges for their health care and some treatment would be denied.

b. different funding sources for acute and long-stay institutions. If long-stay geriatric and psychiatric hospitals were paid for out of one pocket (eg tax) and acute hospitals from another (eg insurance) proper placement of the patient could be impeded. Funding distinctions should not therefore be made between "institutions". However, there could be different sources of money for short and long stays in hospital (defined in weeks), or for different kinds of patient (employed, elderly).

c. different funding sources for long-term care and community health services. Considerable attention is already being given to reducing the difficulties in transferring patients between hospital and local authority. But these difficulties would increase if community health services were funded from a third separate source. It could for example become even more difficult to discharge an elderly patient from hospital to receive district nursing care at home, or for parents to keep mentally handicapped children at home. The three strategies described later therefore link responsibility for long-term and community health care for the bulk of the population.

d. direct access to specialist care without going through a GP (except for patients who have opted out). The role of the family doctor and primary care is at the core of the present system and embodied in the British medical code of ethics. Direct access would destroy this, increase costs and possibly involve unnecessary hospitalisation.

1.10 We have taken account also of systems in other countries; reports based on visits to West Europe, America and Canada are at Annex B (BP1, 2, 3). However, it must be said that there is no ready-made system to transplant into the UK. There is evidence that in the absence of central government control, expenditure on health services rises and it is arguable whether it does so on a basis that ensures value for money to consumers. Most countries are finding difficulty in financing the continually-growing demands of health care.

1.11 This report first discusses some general issues and then draws together various elements (referred to in the report as options) into three major strategies based on:-

tax (section 3)

social insurance (section 4)

private insurance (section 5).

2. AN INTRODUCTION TO THE MAIN POSSIBLE STRATEGIES

2.1 Arrangements for the financing and supply of health care differ widely in the countries we have studied, but some patterns are discernible.

Financing of Care

2.2 In all these countries, a fairly small number of people meet the costs of major care directly from their own pockets at the time of receiving care, and many more buy minor care (eg the cheaper drugs and appliances) in that way. But in all of them arrangements are available to help with major care costs (ie those with which we are primarily concerned) by either:-

- provision of services funded from general taxation and free or heavily subsidised at the time of use

- insurance or pre-payment pools. Insurance arrangements can be through the private market and be run for profit or non-profit making; or more commonly through state-managed funds. We have referred to the latter system as social insurance. Social insurance based systems differ from private insurance in that they normally levy premiums based on income not on risk. In effect they act as a huge group insurance. The cost of social insurance contributions is normally shared between employers and employees.

2.3 Both arrangements are usually found together. Where the insurance principle predominates (eg USA, France, Germany, Benelux) some services, or the needs of some groups, or both, are nevertheless financed through tax. In the UK the health element in the national insurance contribution represents a survival from the pre-NHS insurance scheme (which was itself a social insurance arrangement); only about 3% of the costs of major care is financed through direct private payment and private (usually non-profit) insurance.

2.4 Given this background, it is natural that any study of alternative care financing for the UK should cover both the possibility of introducing social insurance arrangements and the scope for very significantly increasing the role of private insurance. This is done in chapters 4 and 5 respectively of this report. But first we look at the scope for retaining general taxation as the predominant source of finance while deliberately widening the finance base to include a greater contribution from non-tax sources. Our work on this possibility is summarised in chapter 3.

2.5 A number of countries share health care financing between central and local government, often with different responsibilities at each level. But difficulties arise in reconciling central and local government ideas on public expenditure, and given the current efforts to control LA spending in the UK, it is difficult to envisage increasing the LA role in provision. Local authority funding could lead to an increase in geographical

disparities of provision and to a measure of local government control which would be strongly resisted by the medical profession. Moreover, arrangements adopted in other countries with strong local government funding for health normally depend on local taxation (income or sales) as a funding base. If the recent proposals along these lines do make progress in this country, the question of local government financing of health care could be re-examined. For the present we have considered that Ministers would not wish to explore this possibility in this study.

Questions arising in more than one strategy

2.6 Opting and Contracting-Out. With both tax and social insurance systems, the right of a patient to pay privately (directly from his pocket or through private insurance) rather than have state cover needs to be considered. In the UK, the existence of private medicine means that everyone can choose to purchase private medical care. However, those who use this right remain entitled to state services, and, subject to some limited tax concessions for health insurance premiums (if their cost is borne by the employer) continue to pay taxes in full. Arrangements of this type are possible in a social insurance scheme as well as in a tax-based system. We refer to them as "opting-out".

2.7 There is a more radical alternative, under which an individual could voluntarily decide to purchase private care, and in return for certain compensations, would lose his entitlement to state care. We call this voluntary contracting-out. In a further variant, certain groups of people (eg the employed, or the wealthy) could be compulsorily contracted-out.

2.8 Two administrative consequences would follow if there were contracting-out on a significant scale:-

- those seeking state services would need to prove entitlement to them (a new departure for most people in the UK)

- to ensure that all the population had access to health care, there would probably need to be some check that those who contracted-out had taken adequate private insurance and consequently there might be a need to regulate the private insurance industry to ensure that it provided suitable cover.

2.9 Supply of Care. In the UK, the tax-based financing is associated with provision through state agencies, subject to strict budgetary control, and employing hospital doctors on salaries. Where the insurance principle predominates, it has often grown up over the years to help patients purchase care in a private market; private sector ownership and management of care facilities are separate from the provision of finance, doctors are self-employed and are remunerated by item of service , and hospitals are paid for patient days on an open-ended basis.

2.10 There is, however, nothing sacrosanct in the relationship between the nature of financing and the arrangements for supply, and variations are common. For example, there is state as well as private capital in the hospitals whose current costs are met through some continental social insurance schemes; and much psychiatric provision on the continent and in the USA is state-provided with salaried doctors, whereas the main US tax-financed programmes (Medicaid for the poor and Medicare for the elderly) enable their beneficiaries to purchase general health care through the private market mechanisms. Most continental social insurance schemes have endeavoured to introduce measures to curb rising expenditure by controls on supply of services (eg the number of hospital beds). In a significant (though still small-scale) development in the USA, private "Health Maintenance Organisations" have undertaken both the financing of care (through pre-payment contributions from subscribers) and its supply, in an attempt to keep costs down. We discuss some relevant possibilities for supply, as well as finance, in the following sections.

2.11 The choice between demand-led or controlled budgeting systems. This choice raises issues fundamental both to the cost and the character of health care. These are explored in paragraphs 3.26 et seq. in the section dealing with a tax-based strategy, though they apply equally to social insurance. In principle it is possible to have a social insurance system with fully controlled block budgets or a tax-based system which is demand-led, ie budgets are based on work done. A private insurance system does, however, normally imply a demand-led system.

2.12 Education and training. In any strategy, special thought will need to be given to the financing of teaching hospitals and the education/training of health staff, particularly nurses. We do not attempt to discuss this now, merely to put up a marker.

SECTIONS 3 TO 5

Sections 3 to 5 of the report discuss 3 possible strategies for financing health care.

Section 3 - tax-based as now, but with increased use of the private sector, more income through charges, and other possible changes.

Section 4 - social insurance, possibly with contracting-out.

Section 5 - private insurance, possibly with health authorities acting as health maintenance organisations.

Some of the options discussed in Section 3 could also apply to the publicly financed elements in Section 4 and Section 5, eg higher charges and payment of hospitals by work done.

3. A NEW TAX BASED STRATEGY

Description

3.1 This strategy is based on the present system; the following possible changes are described:

A - an increased NHS contribution

B - more income from charges, including optional charges for extra amenities

C - privatisation of some NHS services

D - more private sector provision

E - tax concessions or vouchers for private insurance with opting-out

F - contracting-out

G - hospitals paid by work done

H - fees for items of service

I - full cost payment by patients with reimbursement.

3.2 Of the measures suggested, some are viable in their own right; others only become so if the total system is geared towards them. In particular a widespread system for charges spreads the administrative overheads of the charging system and makes practicable a number of small charges which in themselves might not be cost effective.

A. Increasing the NHS contribution

3.3 Increasing the NHS contribution to fund health care has the advantage that the spending is seen to be of direct benefit to the NHS and may thus be more acceptable to consumers than financing the same amount through taxation. However, such a change would not reduce public expenditure under this country's conventions. In a tax-based strategy, the contribution might fund up to say 25% of the cost of the NHS.† (Increases beyond that are considered in the social insurance strategy.) This increases the proportion of cost falling on the working population and thus in principle might be seen as fair. But the change would be regressive since the NHS contribution is proportional up to a fixed ceiling and is levied on all earnings once the lower earnings limit is reached, whereas income tax is charged only on income above a threshold which depends on personal circumstances and is at progressive rates. In order to limit adverse effects on low-paid workers it would be important to remove the upper earnings limit for the NHS contribution before or at the same time as any significant increase in contribution rates. The increased contribution might fund specific services (eg the demand-led family practitioner services) or continue as now to increase the amount generally available.

†This would imply an increase in the joint employer/employee contribution from 1.35% of earnings (from April 1982) to about 3.35%.

B. Charges

3.4 Compulsory charges might be extended and/or increased. At present there are compulsory charges mainly in the dental, ophthalmic and pharmaceutical services; in para 3.10 we discuss privatisation of these services. An alternative would be to retain roughly the present arrangements but make charges more cost-related for non-exempt groups. For drugs this would mean a new system of charging, since at present the chemist does not know the NHS price of the drug at the time of dispensing. Cost-related charges would be more expensive to administer. Administrative costs would be less if there were a limited number of charges each covering prescriptions whose cost fell within a certain band, like the present arrangements for lens charges. Prescription charges could be full cost at the bottom of each band, or less. There would be a maximum charge for all drugs over a certain amount, and the present season ticket arrangements could be retained. Dental charges at present cover full or part of costs; part cost charges could be increased. For glasses, charges already cover most of the cost subject to a maximum, and further major change would mean privatisation.

3.5 Other compulsory charges might be introduced for access to health care, though at a level low enough not to need insurance cover. It would be important not to introduce perverse incentives eg encourage people to use more expensive types of care through charges on less expensive types.

(a) Hospital in-patients

A standard/daily weekly charge for in-patient treatment could be introduced. This would not necessarily be a hotel charge. At present patients pay nothing directly for hospital care, but since most social security benefits are down-rated after a patient has been in an NHS bed for 8 weeks, long-stay patients do in effect pay a substantial charge through loss of income. The benefits affected are those containing an element for day-to-day maintenance and the reduction is made on the grounds that the NHS has now taken responsibility for those needs. In principle, the total value of savings to social security expenditure is allowed for in total NHS spending.

The down-rating means that hospital in-patient charges can effectively be levied only on short-stay patients, which increases administrative overheads in relation to income. One option would be to abolish the down-rating, so that longer-stay patients received full social security benefits. It might then be administratively practicable to collect charges from both long and short-stay patients - the costs of setting up a charging and debt-collecting system with exemptions might not be so high in relation to revenue, and there would be administrative savings in social security offices.

The switch would also have other advantages:

(i) it would increase flexibility between the public and private sectors and improve choice, since the patient could use the money to buy amenity beds in NHS hospitals or contractual beds in private nursing homes (see para 3.7).

(ii) since benefit could be treated simply as one aspect of a patient's income, it would be possible to move towards charging very long-stay patients (eg over 1 year) for whom the hospital had effectively become their home on the same basis as residents in local authority accommodation. This would not only remove an existing anomaly in the treatment of similar patients, but could help to reduce barriers to finding the right places for people.

(iii) it might also be possible to tap other sources of long-stay patient income in order to improve services.

(b) Hospital out-patients, day cases and attenders at day hospitals

These charges would need detailed consideration. An out-patient charge might discourage poor patients from attending hospital when referred by the general practitioner.

(c) GP consultation fee

The argument against a consultation fee has always been that it might deter patients from seeking early diagnosis of conditions which might jeopardise the outcome and later be more costly to treat. Whilst a flat charge of say £2 per visit, with exemptions for low income and children, might not seem a significant deterrent, it could adversely affect those just above the low income level. It would be costly to administer - GPs have no facilities for receipt and handling of money and would seek additional remuneration for handling charges; checking mechanisms would need to be instituted to ensure that they either passed on all charges received or recorded charge income accurately as an offset to their remuneration. On the other hand it could reduce trivial calls on the GP and encourage self-help for minor conditions. GP charges should not be introduced if access to hospital accident and emergency departments is free, since it would encourage patients to go to hospital for illnesses their GP was well able to treat. In foreign systems a consultation fee is mainly seen as a deterrent to excessive use of a demand-led service. Since GPs are largely paid on a capitation basis, that aspect is not as relevant in the UK.

(d) Community Health Services. Prevention and public health

Charges levied on a patient might deter him from treatment necessary on grounds of public health. Ministers may therefore wish to exclude charges for prophylactic measures against infectious diseases like measles, rubella, tetanus etc. Ministers may also wish to exclude charges for proven preventive measures - for example, maternal and antenatal care, cervical cytology and case finding for hypertension. This would leave open the possibility of charging patients for a routine medical check-up in certain circumstances. It would also be possible to charge for district nursing services, domiciliary visits by hospital staff etc, but this would adversely affect the objective set out in para 1.2, to maintain and build on the strengths of the present system in the field of primary care, and might also cause increased pressure on in-patient services. Charges for the services of community midwives or of health visitors would be inappropriate because of the preventive aspects of their work. Overall, administrative costs and arrangements for charging in community health services might be a problem.

3.6 Ministers will probably wish to retain some exemptions from compulsory charges eg on grounds of low income, commonly defined as £2.50 per week above the Supplementary Benefit/FIS level. An increase in the number of low income exemptions would require more DHSS staff to hand out the necessary certificates. However, it may be possible to use evidence of other allowances (eg unified housing benefit) as a passport to low income exemption.

3.7 There could be more optional charges for amenities and choice. The UK system already allows patients to pay extra for an amenity bed if one is available, but the uptake has decreased. This may be partly because they are not advertised and because they are not good enough. There seems scope for a scheme for special charges in some contracted beds in private hospitals. This would have the effect that the patient would choose to pay part of the cost in order to be treated in the private hospital. In particular long-stay patients eg the elderly might want to contribute towards facilities in private nursing homes. The abolishing of down-rating (para 3.5a) could be particularly helpful here. It would be for the health authority to decide how many such patients they could support. Under present legislation we fix charges but it might be desirable to let Authorities also decide what contribution to require of their patients. It would, however, be important to ensure that medical need remained the overriding criterion for a bed.

3.8 With a charging system fully operational, health authorities would then have a suitable framework in which to charge for optional extra amenities which might help to make the patient feel more of an individual, but which it would not be cost-effective to provide or charge for on their own. Where facilities are appropriate, health authorities might offer such extras as private TV, telephones, additions to the menu.

3.9 Payment for choice of hospital or doctor could be considered because, although in theory choice exists for "ordinary" patients, in practice it can be hard to exert. However, this could curtail existing choice eg by limiting free hospital provision to the nearest available with adequate resources, and charging extra for admission to others; requiring patients to pay a fee when changing a GP. Such arrangements could act as incentives to providers to give better services, but they might add to the difficulties of old, poorly equipped hospitals, less well-provided parts of the country and areas where the numbers able to find extra money for health services are disproportionately low. They would also cut across the present right of the GP to refer his patient wherever he thought right. There would also need to be an appeals mechanism to arbitrate on what constitutes "adequate". Though there are difficulties, this possibility could be explored further.

C. Privatising some NHS services

3.10 A major option would be to remove the general dental, ophthalmic and pharmaceutical services from the ambit of the NHS. Drug prices could still be subject to the Pharmaceutical Price Regulation Scheme; there could be exemptions for low incomes and/or for children; season ticket arrangements for patients requiring continuous and/or high cost medication could be incorporated. Dental services for children could be provided through capitation rather than item of service fees to dentists, and the community (school) dental services for children could be retained or even expanded. But for at least half of the population (and probably more as regards dental and ophthalmic services) the services could be completely privatised. It might then be possible to incorporate public expenditure on family practitioner services within a cash limit, as the most variable element (expenditure on drugs) would be significantly reduced.

3.11 An even more radical change would be to privatise the General Medical Service. However, our primary health care service is a recognised strength of the present system. If GPs were outside the ambit of the NHS, it would be difficult to avoid allowing direct patient access to hospital specialist services, which on the analogy of continental systems would lead to inefficient use of total resources and increased costs. It would also weaken the links between hospital and primary and community care, and make it more difficult to treat patients in the appropriate place. However, privatisation of the pharmaceutical services might remove barriers to the growth of private GP services in parallel to the GMS, even if exemptions from prescription charges applied only to prescriptions made out by NHS GPs.

D. More private sector provision

3.12 A reduction in cover of the NHS coupled with a wider range of optional and compulsory charges could have a number of effects on private sector provision:-

(a) More private insurance

If there are more charges in the NHS, the private sector as presently organised might attract more people. But in addition there could develop a market for "topping up" insurance such as exists on the continent ie people insure to meet the cost of compulsory and optional charges. This could encourage extensive "low cover/low premium" schemes.

(b) More use of privately owned facilities

If health authorities could receive a contribution from patients, their use of contractual beds could increase. If private financing increased significantly there could also in the long-term be a shift in the balance of public and privately owned hospitals. The present system of pay beds helps to provide links between the public and private sectors, and pay bed charges which are set at cost influence (and restrain) charges in private hospitals. It would be possible to increase numbers of pay beds and to include a profit element in the charge in order to encourage competition. In any case, pay beds would form a useful control element in the system. But as private financing increases, it will be important to check that more staff are available to meet demand, so that the private sector does not gain at the expense of the NHS.

3.13 Ministers already have a policy of privatising support services eg laundry, catering, cleaning. Another possibility is to bring in a private management team to run a public hospital. In the past this has been discussed with one company, but it came to nothing. However, some success has been reported in the USA, where private management teams have received a proportion of the savings they made. This may be because hospital costs are higher there. But it may be worth further exploration in the UK subject to the reservations that there would need to be monitoring by the Districts to ensure that provision was consistent with District policies, that adequate standards of service were maintained and that patients were not inappropriately diverted elsewhere in order to save money. The possibility of co-ownership of hospitals by the public and private sectors could also be explored.

E. Tax concessions or vouchers for private insurance and opting-out

3.14 A switch to the private sector could also be reinforced by tax concessions, and a paper on this subject is included in Annex B(BP9). For suppliers, there are already substantial concessions and the main obstacle to private development seems to be political uncertainty. The issue of further capital allowances for tax purposes on private hospital building is not separable from the general review of such allowances in the forthcoming Corporation Tax Green Paper, referred to in Annex B(BP9). For the users, tax concessions could take the form of:

(a) tax relief on insurance premiums

(b) special treatment of health insurance provided by the employer as a benefit in kind.

An alternative might be vouchers if these could be devised (see para 3.19 below).

3.15 The Government's principal objectives in the field of taxation are to limit the total tax burden and reduce marginal rates. If tax relief were given to encourage private medical cover, the effect would be to erode the tax base and make these objectives more difficult to achieve. It would also encourage those demanding tax relief for other forms of expenditure, such as the cost of private education, which would further erode the tax base. The introduction of a tax relief at marginal rates would impose a very heavy burden on the Inland Revenue. It has been suggested, however, that a relief in the form of premium relief by deduction (PRBD) might be more attractive than tax relief at marginal rates if the Government decided to use the tax system as a means of encouraging further private medical cover. Under PRBD, which is already in operation for life assurance premium relief, the policy holder pays his premium net of tax relief to the insurance company and the company receives the difference between the net amount it receives and the gross premium from the Inland Revenue. This method has the advantage over allowing insurance premiums as a deduction from taxable income because it imposes a much lighter administrative burden on the Revenue (although problems of misuse remain - see paragraph 16 of BP9). It also assists those on low incomes or who pay no tax.

3.16 It would be for consideration, however, whether such a system would really be a tax relief rather than a direct subsidy. There is no tax relief for private medical care at present: no individual policyholder's tax liability will be increased by an amount corresponding to the relief which he will be getting by PRBD, as happened when life assurance relief was switched from a tax deduction to PRBD. There would of course be much greater flexibility if this aid were presented as a direct subsidy. It could be widened or restricted without regard to tax considerations. Such a subsidy need not necessarily go to companies providing insurance cover. The hospitals and nursing homes providing medical care could be recipients too (or instead). A subsidy would, however, be a straight increase in public expenditure.

3.17 An alternative would be to change the treatment of private health cover provided by the employer. In accordance with the normal tax rules, directors and higher paid employees are liable to tax on this benefit but employees earning less than £8500 a year are not (other benefits in kind are treated similarly). It would be possible to remove the charge to tax from directors and higher paid employees. But this would amount to singling out this benefit for special tax treatment and would run contrary to Government's preference for payment in money rather than in kind. It would also further erode the tax base.

3.18 In considering whether tax concessions might be used to encourage more opting-out of the NHS, it should be borne in mind that an individual who opts out for an episode of ill-health remains entitled to NHS care, and this safety net undoubtedly affects the level of private insurance premiums. Nor does

private medical insurance cover certain risks, and those who opt out therefore normally move between the public and private sectors according to the treatment needed. Savings to the NHS from more opting-out would be small, since private insurance subscribers are in general the good risks and may receive treatments which they would not have received in the NHS at all. Even if these marginal savings to the NHS could be realised, they might not be sufficient to finance tax rebates on the premiums of existing policyholders, who would have to be given relief as well. But the large unmet demand for NHS services means that such savings would not in practice be found. Tax relief would therefore be costly, and might not seem worthwhile given that the number of private insurance subscribers is increasing without the incentive of tax relief. It could, however, be investigated further, and the potential costs and savings could be estimated.

3.19 Another way of increasing access to private insurance would be by developing a system of vouchers exchangeable for insurance premiums. Like PRBD this would assist those on low incomes or who pay no tax. Vouchers would also avoid some of the problems of special tax concessions. They would, however, be expensive. A new mechanism would have to be developed and there would be significant administrative costs in addition to the direct costs. But for the reasons set out in para 3.18 the savings to the NHS would be small or negligible. We think that the public expenditure implications would not be acceptable unless those who received vouchers "contracted-out", ie lost access to the NHS. This is discussed below.

F. Contracting-out

3.20 Contracting-out, like opting-out, could be encouraged either by tax concessions or by vouchers. However, we doubt whether many people would chose to contract-out of the NHS, ie give up their right of access, in return for tax concessions. A voucher system might, however, provide a sufficient incentive. Long-term care would almost certainly remain tax funded (insurance companies find this a difficult area to cover), and community health services should therefore also be tax funded. So those who contracted-out could only do so for part of their health care. There would have to be an administrative system for issuing vouchers, and for ensuring that those who took them up had adequate insurance cover. As explained in para 2.8, there would also have to be some method by which those who had not contracted-out could prove their entitlement to state services.

3.21 If vouchers were given at a flat rate while the private insurance industry continued to price premiums by individual health risk as at present, only the low risks and/or better off would be able to take up the option. An alternative would be to insist that the private insurance industry adopted a community rating policy, ie offered an insurance package based on average risks. The Government might lay down a basic minimum insurance package which would have to be "community rated". All this would mean more intervention in the insurance industry. There might also be a need to monitor the development of private sector facilities and to ensure minimum standards. At present the UK

has a relatively cheap system for the former but supervision of minimum standards would be a new development.

3.22 If Ministers wished to consider such a system further, a lot more work would be needed to devise and cost it.

3.23 We have considered whether certain groups of the population should be compulsorily contracted-out of the NHS. The two most obvious groups are the employed and the wealthy. To move the financing of the health care of the employed (and their dependents) to private insurance would constitute a very major switch; this strategy is considered further in Section 5.

3.24 If the top 20-25% of families in the income distribution were contracted-out, this would cover 10-15 million people and perhaps 15% of present health spending. Those concerned would have to be given tax concessions or vouchers, with all the problems described above. There might also be political difficulties in excluding people from access to the NHS whilst still requiring them to finance part of the cost through general taxation. Ministers may feel there would be no advantage in introducing compulsion where none exists at present.

G. Paying the public hospital by work done

3.25 If private income to public hospitals were significantly increased, the formula for distributing public funds to them would need review. There is an argument for letting hospitals retain their own income as an incentive to "market" their services. But it would be necessary to protect services in areas with little potential for increased private income, and distribution between the regions of the UK would also need to take account of differing scope for income raising.

3.26 It is also possible to consider more radical changes in the method of providing public hospitals with money. As mentioned in 2.10, there is nothing sacrosanct in the links between the methods of raising money for health care and the methods of distributing it to providers.

3.27 The present allocation method for hospital and community services by central block budgeting reflects the health needs of the populations served in different localities, insofar as these can be shown through statistics (notably of age and sex structures, and mortality). Allocations are converted into cash limits which provide full control over the amount actually spent. Health authorities seek to provide the best service they can to meet local demands within their cash allocation. This provides an incentive to deliberate consideration of priorities and to increasing efficiency.

3.28 One result of this system is that health managers at a local level may be more concerned with negotiating with a higher level of the service for funds than with seeking to meet the needs of individual patients. It is often suggested that if hospitals were paid by work done, so that funds came to them as a result of treating patients, they would be more consumer orientated.

3.29 There are various ways of paying hospitals by work done. At one extreme the hospital could calculate in some detail the cost of treating and accommodating each patient and be reimbursed accordingly, but this would be a costly system. More common in practice is reimbursement by patient days, based on average costs for all patients or patients of particular specialties. This has, however, the serious disadvantage of encouraging long hospital stays and hence higher costs. An alternative would be to use numbers of cases as the basis for reimbursement; but there would be difficulties in allowing for differences in the type and severity of case treated. Yet another variant would be to pay for patient days, but with lower payment per day in the later part of the patient's stay.

3.30 Such a system could make geographical redistribution of resources more difficult because localities with fewer facilities could not treat as many patients. Redistribution would therefore have to be capital led in such cases. In addition, where standards and unit costs were low, reimbursement based on national average costs could lead to an improvement of standards. Problems of geographical redistribution might not therefore prove insuperable, but would need careful study.

3.31 No variant, however, overcomes the problems of expenditure control inherent in demand-led budgeting. These can be mitigated by adaptations and special measures such as detailed scrutiny of hospital expenditure, manpower levels, and length of stay by specialty; and stringent medical audit procedures. Other countries have started to use such measures, but they are not finding the problems at all easy.

3.32 If "demand-led" budgeting does make hospitals more consumer orientated, the potential gains would be important, and might include for example a very substantial reduction in waiting lists and (more significantly) waiting times. However, we can see no easy way of achieving them for the generality of public hospital care in this country whilst retaining the sure control over aggregate expenditure which the present system certainly provides, and the encouragement of efficiency and priority-setting which it very probably provides. It is true that in countries where budgeting is largely demand-led the evidence is that certain acute treatments are more promptly provided than in the NHS. But in these countries, numbers of beds and expenditure per capita are higher than here, and that in itself could be the explanation. We could, however, consider further whether there are any ways of improving efficiency and incentives through budgetary mechanisms without losing expenditure control.

H. Paying the doctor by item of service

3.33 We have also considered whether doctors in hospital and in general practice should be paid on a fee-for-service basis as an incentive to efficiency. (Doctors in general practice already have an element of this in their contracts). Such a move might also introduce some element of Government influence on the services provided, through the fee structure. Existing incentives include professional commitment, promotion/merit award, private practice, and the genuine wish of doctors to help patients as much as possible within constrained resources. Problems of any change would be (a) management within a cash limit; (b) difficulty of determining an appropriate fee structure; (c) risk of unnecessary medical activity; (d) adverse effect on recruitment to certain specialties; (e) effect on pay and morale of other staff; (f) special arrangements needed for junior hospital doctors who could not be paid fees for service where they do not carry clinical responsibilities. (a) and (d) could be lessened by an appropriate structure linked to a target income if such a system could be negotiated. An alternative way of encouraging efficiency is through providing doctors with better information about the resources they use (prescribing profiles, clinical budgets). These are already being developed within the present system and might be improved further. We believe that these offer incentives which may be less troublesome than fee-for-service payment.

I. Full cost payments by patients with reimbursement

3.34 At present in the UK the patient pays certain charges for non-hospital treatment, and the provider claims back the rest of the costs from the financing source. In hospital, no compulsory charges are made (except in the case of certain road accidents). However, in many countries, outside hospital the patient pays the full cost of treatment and claims back from the financing source the amount for which he is not liable. In hospital the UK system usually operates, in part because the costs involved are so much higher. Full cost payment by the patient has the advantage that the patient is aware of the expense generated by his health care, and some countries believe that this acts as a useful moderator of demand. On the other hand, reimbursement of costs to individual patients adds significantly to the administration of the system. It can, moreover, create problems for patients who are less well off, and may not be able to find the money even on a temporary basis.

General comment

3.35 Some of these options such as a new pattern of charges and more private provision might be introduced fairly quickly. Some forms of cost related prescription charges, removal of down-rating, GP consultation charges, charges for hospital in-patients and charges for out-patients, day patients and day cases would require primary legislation. Special charges for "amenity beds" under contract in private hospitals would not need primary legislation but optional charges for amenity in NHS hospitals would. There would be increased administrative costs:-

(a) to the NHS, to operate the charging system

(b) to social security because of more means-tested exemptions.

But the charges might allow private payments to increase public and private sector health care, whilst Government retained control of public sector financing, exerted some control on private sector costs through pay beds, and increased patient choice. Other forms of collaboration between public and private sectors, eg use of contractual beds, could be developed.

3.36 The effects on various income groups would depend upon the level of compulsory charges and the income level at which exemptions were pitched; these would need to be considered further. The geographical distribution of public sector finance would also need to be reviewed. The effect on the public sector cost of health services would vary according to regions and the capacity of local populations to pay for services in the light of social and age structure, income distribution, unemployment and other factors.

3.37 The overall effect would be to encourage extensive "low cover/low premium" schemes, eg limiting benefits to a specified amount in a year sufficient for a minor episode; providing patients with money to pay optional charges. Major risks would ultimately be borne by the NHS for the whole population.

3.38 The growth of private insurance, and private provision might be encouraged by tax concessions, which could be introduced relatively quickly, but are open to various objections. Other options, such as privatising much of the pharmaceutical, dental and ophthalmic services, vouchers, contracting-out and fundamental changes in the way in which hospitals and doctors are paid, would take longer and be much more controversial.

4. A STRATEGY BASED ON SOCIAL INSURANCE

Description

4.1 Social insurance describes the provision of finance for health care to contributors on an income-related insurance basis within a contribution and benefit framework laid down by central Government. Where the system exists (ie in most continental European countries), the costs of contributions are normally shared between employer and employee, and subject to any contracting-out provisions it is legally compulsory for the groups that it covers. Contributors make contributions towards it as they do to other parts of the state contributory benefits arrangements (eg for old age pensions).

4.2 If such a system were to be introduced in the UK, there are strong arguments for limiting it to financing services for the working population (employees and self-employed) and their families. Finance for other groups would continue to be provided through taxation. Alternative methods of providing for these groups could be to increase the contributions of the working population to cater for the additional costs; or to increase appropriately social security contributions for unemployment and retirement, transferring the money from the National Insurance Fund to the "sickness insurance fund". Both would have adverse effects on income distribution.

4.3 Effectively tax would therefore form a safety net funding all long-term hospital care (since the people receiving it would be non-working). It is arguable, too, that public sector capital should be tax funded; the alternative would be for health authorities to borrow money on the open market and recover the costs through current expenditure allocations. There would be general objections to borrowing on the open market by health authorities, as in the case of most other public sector bodies, and in fact most continental countries provide central funding for capital developments.

4.4 Within the state system (here embracing tax and social insurance monies) the options described in section 3 could also apply ie compulsory and optional charges; privatisation of dental, pharmaceutical and ophthalmic services; increased use of private facilities by the public sector. These options are not discussed in this section.

The social insurance contribution

4.5 We think that, in effect, the social insurance scheme would be a special part of the National Insurance system, and that legal liability to pay social insurance contributions - eg the determination of "earnings" - should be based on the existing law on NI contributions. If more health spending were financed by employer/employee contributions this would imply reductions in taxation, with consequent major distributional effects. The existing NHS contribution would need to increase as a percentage of earnings by about 4 to 5 points, if it were to cover the costs of hospital and primary care services for the working population and their dependents, taking the combined employer/employee National Insurance and health contribution to about

a quarter of earnings. At this level, the regressive nature of national insurance contributions as compared with tax would become much more significant than in the tax-based strategy where we envisaged contributions amounting to no more than 25% of health costs. To the extent that financing was through employer contributions, the regressive effects might be less, but there would be other implications eg for the costs of production.

4.6 The national insurance system is less equitable than income tax for the following reasons:-

(a) the lower earnings limit (LEL) for NI contributions is below the earnings level at which income tax becomes payable (for married men); in addition, NI contributions are paid on all earnings, once the LEL is reached, not just earnings above the lower limit. A substantial increase in contributions would therefore bear particularly hard on lower-paid workers. There would also be serious adverse effects on incentives at the lower end of the income scale, with consequent implications for the level of unemployment;

(b) there is an upper earnings limit for NI contributions but not on income for tax purposes;

(c) NI contributions are paid as a fixed percentage of earnings between the lower and upper limits, whereas income tax is charged at progressive rates above a threshold which depends on personal circumstances;

(d) NI contributions are paid on earnings only, whereas income tax is paid on income from all sources, including unearned income.

4.7 Abolition of the upper earnings limit for the NHS contribution would be an important step. It would seem proper to remove this both for the employer and employee contributions. The percentage contribution paid by the employer could then be adjusted so that the total burden on the employer remains as now. There would be some marginal differences in the way this affected different industries.

4.8 Further measures to alleviate adverse income distributional effects might be taken via specific reallocations of the tax money "saved". Some (or all) of this could be distributed by a reduction in the basic tax rate; this would go to everyone paying tax, not just workers. The working population would be bound to lose out, though it might also be possible to use some of the money specifically to help low-paid workers with families eg some increase in child benefit. Even so the distributional effects would be severe.

Contracting-out

4.9 In a tax-based system contracting-out would be unattractive because the individual could get back only a proportion of the costs of his insurance (unless a system of vouchers were introduced,

with high administrative costs). In a social insurance system those contracted-out would not pay the social insurance contribution - a direct and substantial saving. The numbers choosing to do so could be considerable.

4.10 There could be competition between private insurers; everyone would be required to have cover for a basic minimum medical package but insurers could offer enhanced packages eg including some dental services. The scope for choice and competition, and the increased incentives for the private sector, would need to be balanced against the regulatory mechanisms required ie

(a) proof of entitlement to tax or social insurance funded care;

(b) checks that those contracted-out were insured.

4.11 If individuals were free to contract-out voluntarily, there would be substantial problems in trying to ensure they were all privately insured. Checking on the self-employed, part-time and casual workers would be particularly difficult and we doubt whether the social security or tax systems could take this on. In any case, with an earnings-related contribution, all better-off people would contract-out, so that contributions for those remaining in the system could increase markedly as a result. At those higher contribution rates, still more would contract-out, until no-one was left. Contracting-out would therefore have to be by employers for groups of employees, and would have to be compulsory for the employees concerned, as would membership of a private insurance scheme.

4.12 An employer could contract-out the whole of his workforce if they wished (but not part of it; that would meet the objections described in 4.11). In this way there would be a spread over income and health risk, and checks would be easier. It would still be possible for social insurance contributions to be distorted because high-risk industries stayed in the state system but low-risk ones contracted-out. Similarly, industries with low wages would stay in and those with high average earnings would contract-out. There would also be a risk that employers would organise better-paid employees into separate contracted-out schemes; this might have to be prevented by legislation, which could be complex.

4.13 Restriction of optional contracting-out in this way does reduce the degree of choice implicit in the basic principle set out above. Moreover it means that unions and management would effectively determine the choice of individuals in a particular firm. Each time an individual changed jobs, he and his family might find that they moved from state funded to privately funded provision or vice versa. People who were contracted-out and who retired, became unemployed or became long-term sick would also have to switch to state-funded provision.

Possible patterns of organisation

4.14 As operated in Europe, the budgeting mechanisms for social insurance systems are demand-led. Patients are treated on the basis of the doctor's assessment of their needs, and the bill is sent to the Fund which meets the cost in whole or in part. In the case of hospital treatment, repayment is usually direct to the hospital.

4.15 We have examined in 3.26 et seq. the arguments for and against demand-led budgeting in this country, and concluded that a change from block budgetary allocation might not be justified. However, just as demand-led budgeting is conceivable in a tax-based financing system, so block allocation would be possible for services financed through social insurance by distributing payments from the central social insurance fund to hospitals on the present basis. This would avoid an additional difficulty that would otherwise occur in a social insurance system which nevertheless co-existed with tax-financed services for those not in employment - ie the risk of separate provision on the basis of the separate financing systems.

4.16 However, since social insurance elsewhere is in practice associated with demand-led budgeting and hence with increased responsiveness to consumer demands, its introduction here with the present block budgeting system instead would greatly diminish any public appeal that it might otherwise have. It might in fact be seen as little more than the transfer of health service financing from general taxation to a specific contribution which - leaving aside the distributional effects already discussed - might appear to many of those who paid it as not much different in character from a tax and therefore a gratuitous complication in their financial relationships with the State.

Financial classification of contributions and expenditure

4.17. It is relevant to the character of any particular scheme considered for adoption that the present conventions under which the UK Government accounts are compiled would require the insurance contributions to any fund that was part of Central Government or was closely controlled by it to be shown as taxation, and expenditure by such a fund to be shown as public expenditure. (Different conventions are adopted elsewhere). Contributions by those contracted-out of the main scheme to other insurance funds, and expenditure by those funds, would not be so shown unless they were closely controlled by the Government. To the extent that a main objective of any change might be to reduce both taxation and public expenditure, these considerations are relevant.

4.18 It is possible that a mainly social insurance fund would not be classified in this way if it were an autonomous statutory agency entirely independent of Government in its operation. It seems unlikely, however, that the Government would feel able to stand completely aside from decisions on the contribution rate

or the principles adopted for the provision of services. Certainly the continued geographical re-allocation of resources postulated above could only be carried out by an organisation which was, in that respect at least, subject to direction by Ministers, even if it was not itself part of Central Government.

General comment

4.19 A social insurance system without contracting-out and with fully-controlled block grant expenditure would be very like the present tax-based system with a change in the form of tax for the working population. This change would have adverse distributional effects. The demand-led features of continental systems could if desired be achieved under a tax-based system without these effects. The crucial feature of social insurance is therefore that it could facilitate contracting-out and privatisation. Contracting-out would, however, have many drawbacks and it is on a judgement of the relative advantages and disadvantages of contracting-out that social insurance stands or falls, in our view.

5. A PRIVATE INSURANCE BASED SYSTEM

Description

5.1 We have considered the possibility of a strategy based entirely on private insurance arrangements for the whole population (apart perhaps for long-term care), supported by some system of subsidies or vouchers to minimise financial hardships for the poor in purchasing a minimum level of cover. But this seems to be inconsistent with Ministerial objectives which require us "to sustain a National Health Service" and "to maintain and build on the strengths of the present system". Moreover, in the absence of a general system of tax credits there would be immense administrative problems in providing vouchers or subsidies on an income-related basis for the whole lower-paid population to assist with the costs of private insurance.

5.2 This section deals therefore with a more limited variant. All services for the non-employed population (elderly, unemployed etc) could be financed from general taxation, but all members of the working population could be required to enrol in private insurance schemes (in effect a tax-based system with compulsory contracting-out for the working population). The strategy offers choices between individual or employment - based insurance with some form of tax concession and individual-based insurance using health vouchers. In addition, there is a choice between complete reliance on private provision and reliance on a combination of private provision and a prepayment health maintenance plan by District Health Authorities.

Individual or employment-based insurance with tax concessions

5.3 In this strategy everyone would contribute through tax to the NHS providing for the elderly, unemployed etc. But in addition over 70% of the population - those in work and their dependents - would have to take out private insurance to cover their immediate health care needs - some 40 to 50% of present health expenditure. The contribution would be largely flat rate

or related to the individual's health risk, as opposed to the proportionate contribution of a tax or social insurance-based system. As such, it would represent a higher proportion of income for the lower paid than the better off. And since the charge would be per head, people with families could also be particularly affected. Special thought would also need to be given to minimising the harmful effects on incentives for the unemployed to seek work, as the compulsory private insurance premiums would act as a kind of tax on employment income.

5.4 There is a potential cut of over £5 billion in public expenditure implied by the strategy. Part of this could be used to abolish the NHS contribution, but some could be available for reducing taxes or increasing cash benefits. Ministers might wish to direct savings as far as possible to the working population, to help with the costs of private insurance premiums. However, a generalised tax cut would give greater proportional benefits to the well-off than to the lower-paid, and would also benefit tax-payers among the non-working population.

5.5 Part of the saving could be used to give tax relief on private insurance premiums. However, as BP9 shows, even if the "life assurance" method were used to avoid the otherwise substantial administrative costs for Inland Revenue, lower paid workers with families would probably still be badly affected. If insurance premiums were paid by employers, they could be treated as business expenses in the usual way. For employees, the insurance provided could be treated as a non-taxable benefit in kind if the Government was prepared to extend the present concession applying only to lower incomes; but this would still make the concession of more value to the higher paid.

5.6 Special help could be given to families with children if child benefit were increased (£1 per week increase costs about £650 million a year). But this would also benefit non-workers with children, whose health care would be financed from general taxation. Their gains might be offset by cuts in other of their benefits. In general it would be difficult to avoid adverse distributional effects from a switch of this kind.

5.7 The strategy offers a choice between basing purchase of private insurance for the working population on employers or on individuals. The former would simplify enforcement of the requirement for individuals to carry insurance and would allow poor risks to be absorbed into group schemes. There could also be significant economies of scale in group insurance. Employer contributions would either reduce wages or increase prices, with different distributional effects. If insurers were allowed to relate premiums to group risk for firms, there might be inequities between blue and white collar industries. A major potential drawback of employment-based private insurance is the risk of rapidly escalating expenditure. Employer involvement in the purchase of insurance tends to discourage cost consciousness by the individual, as the cost to him of employer contributions may not be perceived clearly, and even employee contributions tend to be "just another deduction from the pay packet". In theory the employer should have an incentive to keep premiums down to maintain competitiveness. But experience in the United States has shown that the combination of employer-provided insurance schemes and sizeable tax concessions leads to a highly permissive financing regime, with no obvious incentives for either consumers or suppliers to restrain costs.

Individual insurance with vouchers

5.8 One way being canvassed in the US of avoiding the problem of cost escalation is to move towards insurance by individuals, the objective being to encourage cost consciousness among the purchasers of insurance policies by requiring every worker to make an annual decision about his or her health insurance, in the full awareness of the cost of the various packages on offer.

5.9 In order to help individuals with the cost of insurance premiums, while at the same time dealing with the potentially adverse distributional consequences of tax concessions, it might be possible to devise a system of health vouchers. The vouchers could be used to purchase insurance policies, and individuals could make topping-up payments out of their own resources as desired. Such a scheme would be a new development in this country (and indeed in the US), and a number of major difficulties would need to be overcome. For example, it would need to be decided whether to give the vouchers on a selective or universal basis. Under a selective scheme, health vouchers would cover 100 per cent of the cost of insurance premiums for lower-paid workers and then taper off as earnings rise. (It is estimated that for a family of 4 an insurance policy covering all basic health services would cost about £600 a year). This system has the advantage of minimising public expenditure costs, but would involve a substantial increase in means-testing and/or a serious problem of overlap with other means-tested benefits such as FIS and rent and rate rebates. If a number of means-tested benefits overlap, individuals can be severely penalised by a combination of the withdrawal of those benefits and liability to basic rate tax as gross income rises. On the other hand, to avoid overlap, means-testing needs to be extended higher and higher up the income scale. For example, if given on top of FIS, a health voucher initially worth £600 and tapering off at 25 per cent (ie the voucher reduces by £0.25 for every £1 increase in income) would require means-testing up to an income level of over £6,500 with substantial increases in administrative

costs. Even at this level, there would still be an overlap with means-tested housing benefits and with the means-testing arrangements for assessing parental contributions towards university grants. These various problems could be avoided by giving health vouchers on a universal basis, but this effectively removes any scope for public expenditure savings (unless the vouchers were made taxable). A universal system would also require additional administrative costs in raising large amounts of money through taxation to be re-distributed through the voucher scheme. These administrative costs would be increased still further if the vouchers were made taxable in some way.

District Health Authorities to act as HMOs

5.10 The problems of cost escalation mentioned in para 5.7 arise partly because in a demand-led insurance system, the sources of provision and of finance are separate, and neither has much incentive to keep expenditure down. This has led in the USA to the development (so far on a fairly small scale) of "Health Maintenance Organisations"(HMOs), which both provide care and also finance it through members' prepayments. The conception is that the HMO has a single accountability to its subscribers - both for adequacy of provision and for reasonableness of subscription rates - which should encourage cost control. This approach might be developed in the UK by building on the existing DHAs, and might be worth considering with either employment-based or with individual insurance. The scheme might work as follows:-

a. insurance policies to be offered by private insurance carriers and District Health Authorities, with the latter offering an 'NHS package' at a minimum level of cover on a pre-payment basis (like a Health Maintenance Organisation in the USA);

b. insurance carriers, including DHAs, would be required to accept all comers and to adopt community rating (ie charging all subscribers the same premium irrespective of risk, for a given amount of cover) and

c. a central government equalisation fund, financed from general taxation, could be used if it was thought desirable

that premiums for the basic DHA policy should be the same in all parts of the country. Otherwise areas with middle-aged workers in heavy industries would need to charge more than areas with a predominance of younger white collar workers, to provide the same level of service.

5.11 The main objective of this option is to introduce a large element of private insurance into the financing of health services, with the secondary objective of allowing much greater scope for consumer choice (at least for the working population; choice for the rest could be enhanced by more charging for optional extras, topping-up insurance etc). The risk of escalating expenditure would be minimised by competition between public and private insurance carriers, and by requiring the DHA plans to be organised on a pre-paid basis, with each DHA contracting to provide a comprehensive package of services in return for an annual subscription paid by individual enrollees. The sum of these subscriptions would operate as a form of cash limit, from which the DHA would have to finance all services for its subscribers.

5.12 If a voucher system could be devised, it might be possible to combine individual (rather than employer-based) insurance and the development of DHAs to act as HMOs. The voucher could be used to buy either private or DHA insurance packages.

5.13 The role of the DHA would be substantially changed compared with the present system. As now, the DHA would be responsible for providing all services for the non-employed population, with funds provided from central government which could be allocated between districts in a way that took account of relative needs. But the DHA would have a role in financing as well as providing services for the working population. The DHA would thus become an independent revenue-raising body, and, depending on the numbers of people enrolling with DHA plans, a sizeable element of local

financing would be introduced into the health system. All DHAs would be required to offer a basic package of care at low cost, but they could also be empowered to offer higher-cost policies, providing more benefits (private room, choice of hospital etc), in order to compete on equal terms with the private insurance companies. A more entrepreneurial approach, and a greater awareness of consumer needs, would thus be required if the DHAs were to retain custom among the working population. Some Districts could be very badly placed to compete with the private sector and with each other. As a corollary of this, it might be necessary to allow DHAs some flexibility, eg in raising capital on the open market in order to improve or extend their facilities, if this is indicated by the pattern of consumer demand. One further feature to be noted is that because of the pre-paid nature of financing, DHAs would have a common budget to cover both hospital and primary care services; this might encourage closer integration between hospital and GP services than now.

5.14 The role of the private sector would depend on the ability of private insurance carriers to attract customers in the face of competition from the DHAs, and also on the extent of sub-contracting between DHAs and private hospitals. For the most part, the private sector is likely to compete on the basis of higher-cost, higher-quality insurance plans, but with the greater role for market forces there may also be attractions for the private sector to move into areas of the country where NHS services are currently poor and hence where there exists a sizeable market to be tapped, even among the lower paid. Private insurance companies might also seek to attract young individuals of good health risk by offering policies containing a sizeable element of co-payment (eg the subscriber pays the first £20 of health costs and a certain proportion thereafter). Such policies have the advantage of encouraging the individual to maintain good health and of deterring the unnecessary use of services. But such schemes would need to be regulated to ensure that they were not used to avoid paying adequate insurance and that they did not distort competition between DHAs and private insurers.

5.15 Patients enrolled with private insurance companies could be treated in NHS hospitals in designated pay beds or in private hospitals. Some system of controls might be needed to regulate the building of new hospitals, in order to assist in the planning of services on a district basis and to prevent the duplication of facilities. This system would presumably need to be administered at district level, if a planning function is to be retained, but there should also be the possibility of appeal to central government, to prevent the DHAs from using the controls to stifle legitimate competition. Central government would also need to play a role in regulating the insurance market, enforcing the rules applicable to both public and private insurance plans. As in all strategies in which different population groups are financed from different sources, patients would be required to prove entitlement when they received services.

General comment

5.16 If the problems of a voucher scheme could be overcome, such a scheme might be extended throughout the whole population. This would create a common system of health financing for all, based on free choice of insurance plans and income support for those on low incomes. An element of tax financing would need to be retained, eg for public and environmental health services and perhaps also for long-term care for the mentally handicapped and other vulnerable groups, but the great bulk of expenditure would be channelled through public and private insurance schemes, subject to the various controls listed above. Such a strategy would, however, imply fundamental changes in the organisation and financing of health services in this country and would take many years to achieve. Even a more limited strategy for private insurance for the working population would take time because the insurance industry would have to develop.

It might be possible to start by adopting some of the options to develop private insurance and provision under a tax-based strategy, but with the longer-term aim of moving to private insurance for the working population and (ultimately) the whole population. Meanwhile, it would become apparent whether measures to contain costs in the United States by moving towards cost conscious individual choice of insurance and developing HMOs were succeeding.

6. FURTHER ACTION

6.1 In the next stage of the work, strategies and options which Ministers want studied further would be specified in more detail, and would then need to be evaluated against a number of criteria:-

- Adequacy of access for all
- Capacity for control of public and private expenditure
- Effect on public health expenditure and on health expenditure overall; overall level of health services
- Effect on income distribution and on distribution of services between individuals, client groups and geographical areas
- Effects on standards of health care in different regions with differing social and economic characteristics
- Incentives to efficiency and cost-effectiveness
- Mechanisms for planning and co-ordination
- Extent of consumer choice and consumer orientation
- Administrative costs
- Effects on staff: pay, morale etc
- Effects on activities of Central Government
- Manpower supply and training implications
- Effects on public health and on liaison between parts of the health service and other related public services eg local authority personal social services.

The choice of strategies

6.2 Three strategies have been described in this report:-

(i) Tax-based

The first is essentially the present system but with options for different sources of money for the NHS (increased NHS contributions, optional and compulsory charges) and increased privatisation (dental, ophthalmic and pharmaceutical services; private insurance and private sector provision stimulated by NHS charges, more contractual arrangements and tax-concessions).

(ii) Social insurance

By substituting social insurance funding for the tax-funding of health care for the working population, there is the possibility

of further development of the private sector through contracting-out arrangements. If Ministers wish to relax expenditure control, this system could become more demand-led and patient-orientated by paying suppliers according to the work done and allowing contributions to rise to match expenditure. Detailed central monitoring could be used to superimpose some cost containment. Geographical and income distributional problems would need particular study. It would also be possible to devise a controlled system, though this would not differ greatly from tax-funding.

(iii) Private insurance

Movement towards a largely privatised system depends on enabling those on lower incomes to participate in the insurance market. If the state continued to provide a safety net for the elderly and non-employed, private insurance cover for the working population might be achieved through employment-based schemes or by developing special arrangements such as vouchers to reduce the adverse income distributional effects. If a system of vouchers could be developed, there is no reason why it should not eventually cover the whole population. There could be more local funding of the NHS and an element of cost control by allowing DHAs to offer pre-paid state insurance plans in competition with private insurers, on the same lines as Health Maintenance Organisations in the US. Much more work would need to be done on income distributional effects, the feasibility of a voucher scheme and the speed with which private insurance and suppliers could meet the new demand.

6.3 Some changes within a tax-based system could be introduced relatively quickly. Many of the problems are technical, though fairly extensive primary legislation would be needed and the private insurance industry might need time to adjust to a new role of providing "topping-up insurance". The options need more detailed study to see if they are practicable. However, these changes would not preempt decisions on social insurance or private insurance strategies, and tax based systems could be worked up immediately in parallel with longer term work on the other two strategies.

6.4 Social insurance and private insurance strategies could present more radical changes to our present system. At present they are presented very much in outline form, and considerably more work is needed to produce detailed strategies. Social insurance and private insurance are effectively alternatives, and Ministers might wish to indicate now any preference. Alternatively both could be worked up further before decisions are taken, or both could be put to one side.

6.5 If Ministers are interested in these more radical strategies it will be important to develop a sensible path of change to ensure that private provision and insurers can cope with changed demands and that NHS facilities are not wasted or unnecessarily duplicated while money is invested in new private provision. In any case major long-term change would require the development of some political consensus since the private sector would probably be unwilling to invest if there were a risk of decisions being reversed.

6.6 Ministers are asked to indicate which of the three strategies they wish pursued and on what timescale.

Choices within strategies

6.7 Ministers are also asked to indicate which options within any of the strategies they would like studied further and which they do not wish pursued. Most of the options in the tax-based strategy are also relevant to the social insurance strategy.

TAX-BASED STRATEGY

1. Increase in the NHS contribution to a maximum of 25% of health spending (para 3.3).

2. Abolition of the upper earnings limit on the NHS contribution (para 3.3).

3. Introduction of more compulsory charges, with exemptions

   - cost-related prescription charges for the non-exempt groups (para 3.4)

   - for hospital in-patients, including long stay patients, linked to a review of the system of downrating benefits (para 3.5a)

   - for hospital out-patients, day cases and day patients (para 3.5b)

   - for GP consultations (para 3.5c)

   - for some community health services (para 3.5d).

4. Optional charges for amenities, including more flexible provision of amenity beds and additional facilities, especially in nursing home contractual beds (para 3.7-3.8).

5. Optional charges for choice of hospital or doctor (para 3.9).

6. Privatising the general dental, ophthalmic and pharmaceutical services (retaining protection for children, those on low incomes, and some price and quality controls) (para 3.10), and privatising the general medical service (para 3.11).

7. More private sector provision:

   - contractual beds in private hospitals (para 3.12b)

   - pay beds in state hospitals, possibly with a profit element in the charge (para 3.12b)

   - private management teams to run NHS hospitals (para 3.13)

   - co-ownership of hospitals by the public and private sectors (para 3.13).

8. Capital tax allowances for private hospital building subject to the forthcoming Green Paper on Corporation Tax (para 3.14).

9. Tax relief or PRBD subsidy for private medical insurance (paras 3.15-3.16).

10. No tax liability on private health cover provided by the employer (para 3.17).

11. Voucher scheme to support purchase of private medical insurance (para 3.19).

12. Optional contracting-out supported by a voucher scheme (paras 3.20 - 3.22).

13. Compulsory contracting-out for the wealthy (paras 3.23-3.24).

14. Either a demand-led budgeting system with detailed controls on work done in order to limit expenditure

    Or exploration of methods of introducing further incentives to efficiency through budgetary mechanisms in a controlled system (paras 3.25-3.32).

15. Either fee for service payment systems for doctors

    Or exploration of further incentives to efficiency (para 3.33).

16. Full cost payment by patients and reimbursement (para 3.34).

SOCIAL INSURANCE-BASED STRATEGY

17. Social insurance contributions by employees and employers to cover cost of health care for the working population and their dependents (para 4.2), based on existing liability to national insurance contributions (para 4.5). Abolition of the upper earnings limit on social insurance contribution (para 4.7).

18. Other measures to improve the income distribution effects of a large increase in employer/employee contributions, eg by increasing child benefit (para 4.8).

19. Voluntary contracting-out by employers for their employees (paras 4.9-4.13).

20. Compulsory basic private insurance for those contracted-out, plus regulation of private insurance industry and proof of entitlement to NHS for those not contracted-out (para 4.10).

20a. Demand-led budgets or controlled block budgets (paras 4.15-4.16).

21. Social insurance fund to be an autonomous statutory agency (para 4.18).

PRIVATE INSURANCE STRATEGY

22. Private insurance for workers and their dependents (para 5.2).

23. Tax cuts and other measures (eg increase in child benefit) to minimise adverse distributional effects (paras 5.3-5.6).

24. Employment-based private insurance with tax concessions (para 5.7).

25. Individual insurance with vouchers on a selective or universal basis (paras 5.8-5.9).

26. DHAs to act as HMOs to offer health care insurance packages in competition with private insurers (para 5.10a).

27. All insurers including DHAs to be required to accept all comers and to adopt community rating (para 5.10b).

28. Central Government equalisation fund to enable equal access in all parts of the country to basic DHA health insurance package (para 5.10c).

29. More flexible financial powers for DHAs eg to provide extras or to borrow for capital development (para 5.13).

30. Regulation of private and public insurance market, and further controls on private sector development (para 5.15).

6.8 Generally speaking, these "sub-options" cannot be sensibly pursued except in the context of further work on the strategies of which they might be components. It is also possible that further work would lead to further sub-options, or even some differences of approach to the major strategies.

ANNEX A

TERMS OF REFERENCE

To identify:-

(a) alternative sources of finance for the NHS, including different forms of social and private insurance, new and higher charges, and any other forms of payments or contributions by individuals or groups;

(b) alternative ways of promoting more private sector provision of services, including tax concessions (on investment or private insurance), contracting out of state insurance, reimbursement of treatment costs and discontinuing parts of the NHS.

2. To consider how these options might be grouped to form alternative broad strategies (eg a much higher level of charges might require insurance cover, whilst private insurance financing might require payment by work done).

3. To carry out a quick initial assessment of these strategies having regard to the objectives listed in paragraph 3 of the letter of 22 July to H Committee members from the Secretary of State for Social Services, drawing on relevant information in other countries, and to consider their implications for the overall level of health services and their organisation, delivery, utilisation and control (by Government and by the consumer) as a basis for decision by Ministers late in 1981 as to which strategies should be studied in greater depth.

4. To carry out in the first half of 1982 such further studies as are then commissioned, possibly with enhanced membership, and to present the results in a form which might form the basis of a Green Paper later that year.

ANNEX A (continued)

MEMBERSHIP

DHSS

Mrs Banks
Mrs Firth (replaced in December by Mr Luce)
Mr Hurst
Dr Sweeney
Miss Fraser

Mr James) observers
Mr Hughes)

Secretariat

Mr Parsonage
Miss Moore
Mr Murphy

SHHD

Mr Robertson

Welsh Office

Mr Craig

DHSS Northern Ireland

Mr Treacy

Inland Revenue

Mr Marshall

Treasury

Mr Monger
Mrs Holmans

CPRS

Dr Gibbs

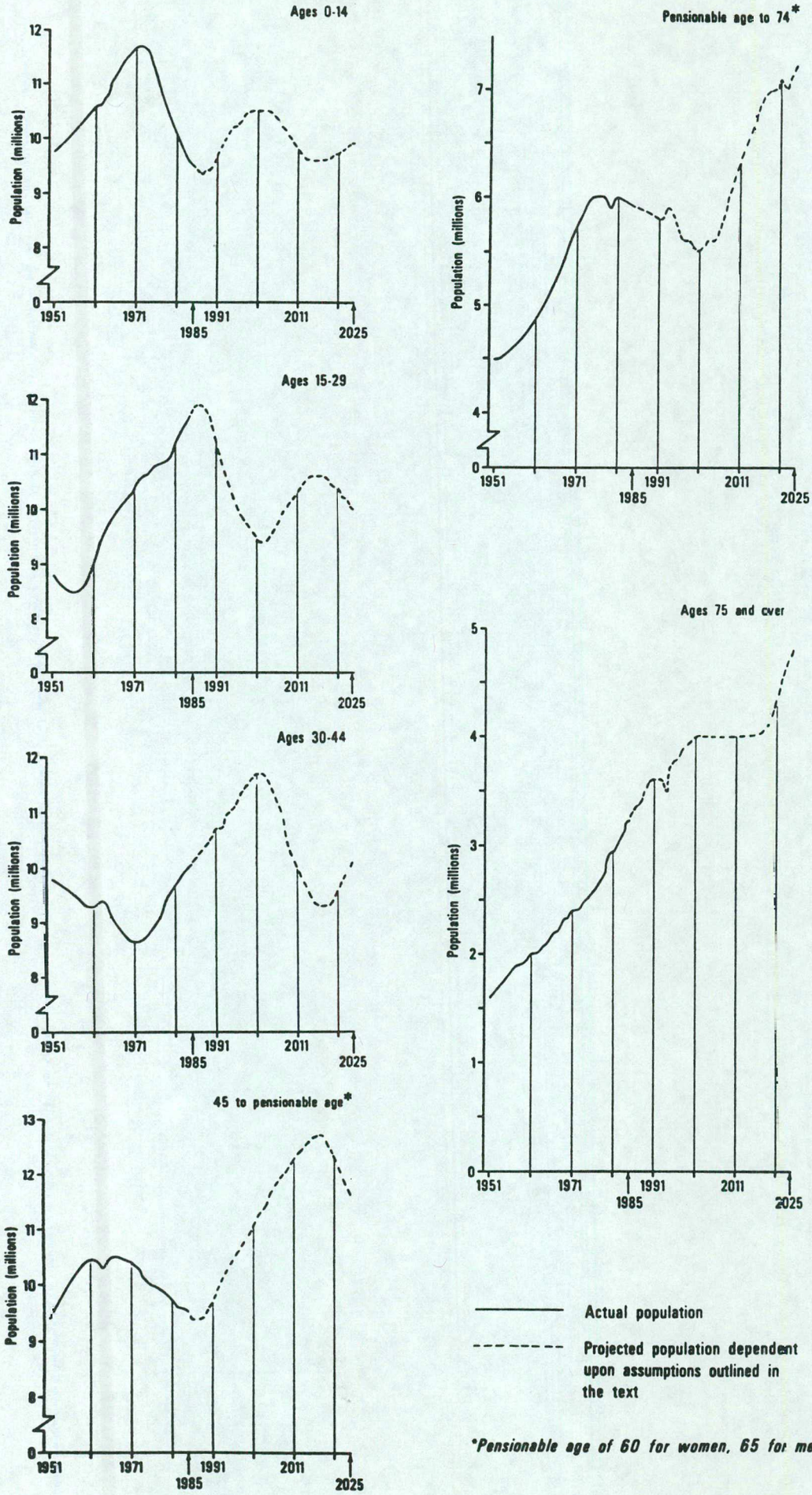
Consultants

Mr Lee
Mr Elwell

ANNEX 6: POP^N BY AGE - ENG+WALES 1951 - 2025

ANNEX B

Figure 1 Actual and projected home population by age-group, England and Wales, 1951-2025



*Pensionable age of 60 for women, 65 for men

ANNEX C: SHARE OF PUB. HEALTH EXP. 1960-1983

4.28.87

SECRET

ANNEX C

THE SHARE OF PUBLIC HEALTH EXPENDITURE IN NATIONAL EXPENDITURE, 1960-1983

	Percentage of public expenditure on Health in GDP						
	1960	1965	1970	1975	1980	1982	1983
Germany	3.2	3.6	4.2	6.6	6.5	6.6	...
Australia	2.4	2.8	3.2	5.6	4.7	4.8	4.9
Austria	2.9	3.0	3.4	4.1	4.5	4.7	4.6
Belgium	2.1	2.9	3.5	4.5	5.5	5.8	6.0
Canada	2.4	3.1	5.1	5.7	5.4	6.1	6.2
Denmark	3.2	4.2	5.2	5.9	5.8	5.9	5.6
Spain	...	1.4	2.3	3.6	4.3	4.6	4.4
United States	1.3	1.6	2.8	3.7	4.1	4.5	4.5
Finland	2.3	3.2	4.1	4.9	5.0	5.2	5.2
France	2.5	3.6	4.3	5.5	6.1	6.6	6.6
Greece	1.7	2.2	2.2	2.5	3.5	3.4	...
Ireland	3.0	3.3	4.3	6.3	8.1	7.7	7.5
Iceland	2.4	2.8	4.1	6.7	6.7	6.6	...
Italy	3.2	4.1	4.8	5.8	6.0	6.1	6.2
Japan	1.8	2.7	3.0	4.0	4.6	4.8	5.0
Luxembourg	...	...	...	5.6	6.6	7.4	...
Norway	2.6	3.2	4.6	6.4	6.7	6.6	6.2
New Zealand	3.3	3.4	3.5	4.3	4.7	5.1	5.3
Netherlands	1.3	3.0	5.1	5.9	6.5	6.9	6.9
Portugal	0.9	1.2	1.9	3.8	4.2	4.0	3.9
United Kingdom	**3.4**	**3.6**	**3.9**	**5.0**	**5.2**	**5.2**	**5.3**
Sweden	3.4	4.5	6.2	7.2	8.8	8.9	8.8
Switzerland	...	2.3	...	4.7	4.7	...	...
Turkey	...	1.2	1.3	...	1.1	0.7	0.6
OECD average	**2.5**	**3.1**	**4.0**	**5.2**	**5.3**	**5.8**	**5.8**

Notes: 1. Some of the underlying time series are discontinuous (eg Belgium from 1977)

2. The OECD average is a twenty-country average, excluding Luxembourg, Portugal, Switzerland and Turkey.

Source: Measuring Health Care 1960-83 OECD 1985.

THE SHARE OF TOTAL HEALTH EXPENDITURE IN NATIONAL EXPENDITURE, 1960-1983

Percentage of total expenditure(ie public and private combined) on Health in GDP

	1960	1965	1970	1975	1980	1982	1983	
Germany	4.8	5.1	5.6	8.1	8.1	8.2	8.2	
Australia	5.1	5.3	5.7	7.6	7.4	7.6	7.5	
Austria	4.4	4.7	5.3	6.4	7.0	7.3	7.3	
Belgium	3.4	3.9	4.1	5.5	6.3	6.2	6.5	
Canada	5.5	6.1	7.2	7.4	7.3	8.2	...	
Denmark	3.6	4.8	6.1	6.5	6.8	6.8	6.6	
Spain	...	2.7	4.1	5.1	5.9	6.3	...	
United States	5.3	6.1	7.6	8.6	9.5	10.6	10.8	
Finland	4.2	4.9	5.6	5.8	6.3	6.6	6.6	
France	4.3	5.3	6.1	7.6	8.5	9.3	9.3	
Greece	2.9	3.1	3.9	4.0	4.2	4.4	4.7	
Ireland	4.0	4.4	5.6	7.7	8.7	8.2	...	
Iceland	5.9	6.1	8.7	...	7.7	7.6	...	
Italy	3.9	4.6	5.5	6.7	6.8	7.2	7.4	
Japan	3.0	4.5	4.6	5.7	6.4	6.6	6.7	
Luxembourg	...	...	4.9	5.9	6.6	6.5	...	
Norway	3.3	3.9	5.0	6.7	6.8	6.8	6.9	
New Zealand	4.4	...	4.5	5.2	5.7	5.7	...	
Netherlands	3.9	4.4	6.0	7.7	8.3	8.7	8.8	
Portugal	...	...	...	6.4	6.1	5.7	...	
United Kingdom	**3.9**	**4.2**	**4.5**	**5.5**	**5.8**	**5.9**	**6.2**	
Sweden	4.7	5.6	7.2	8.0	9.5	9.7	9.6	
Switzerland	3.3	3.8	5.2	7.1	7.2	7.8	...	
Turkey	...	...	...	...	...	...	...	
OECD average		**4.1**	**4.7**	**5.6**	**6.7**	**7.2**	**7.4**	**7.6**

Notes: 1. Some of the underlying time series are discontinuous (eg Belgium from 1977)

2. The OECD average is a twenty-country average, excluding Luxembourg, Portugal, Switzerland and Turkey.

Source: Measuring Health Care 1960-83 OECD 1985.

ANNEX D: LEGISLATION

4.28.87

SECRET

ANNEX D

Legislation likely to need amendment for introduction of charging or more radical options

National Health Service Act 1977

S.1	:	Secretary of State has duty to continue the promotion of a comprehensive health service, free of charge (except where expressly provided otherwise by enactments)
S.2	:	Secretary of State's duty to meet all reasonable requirements for (inter alia) hospital accommodation, medical dental, nursing and ambulance services ante natal care
S.63	:	Restrictions on charges for NHS "amenity beds"
S.77 (& Schedule 12)	:	Restrictions on charging for supply of drugs, medicines and appliances
S.79 (& Schedule 12)	:	Restrictions on charging for dental treatment

ST

February 1987

ANNEX E: PRIVATE HEALTH CARE IN UK

SECRET

PRIVATE HEALTH CARE IN THE UK

ANNEX E

Total private expenditure on health

1 Total private spending on health care as estimated in the national accounts at £2.4 billion (UK 1985). This represents about 12% of aggregate health expenditure, ie public and private combined.

2 The above estimate includes payments to cover NHS charges (£430 million in 1985). These are classified in the national accounts as private expenditure but are of course payments for publicly provided services. Of the remaining £1.9billion, just under half is accounted for by purchases of minor medical goods, such as aspirins and cough medicines, which can be purchased over the counter without an NHS prescription. This leaves around £1 billion representing expenditure on **private health services** (hospital treatment, private consultations with doctors etc). Roughly 60% of this expenditure is covered by **private health insurance**.

Growth of private health services

3 Since 1979 there have been substantial increases in -

- the number of people covered by private health insurance (from 2½ to 5 million).Over half of these are insured in Company schemes,the remainder are insured either as individuals or in Groups.

- the total outlays on private health insurance premiums (from £100m to £600m).

- the number of private hospitals (from 150 to 200).

- the number of private hospital beds (from 6,500 to 10,000).

The providers and financiers of private health services are now planning for 4% p.a. growth in real terms in provision in the next two years.

The public sector/private sector interface.

4 Individuals who pay privately for health services, whether or not via private insurance still have to contribute to the NHS via general taxation and national insurance contributions. The requirement to "pay twice" is a substantial disincentive to seeking private treatment and taking out private insurance.

5 Individuals are unable to pay the **marginal cost** of aspects of health care which are not available on the NHS. The "choice" is typically between treatment wholly on the NHS or on a completely private basis.

6 There is therefore no true **competition** between the private and public sectors. Equally individuals have no real **consumer choice** as decisions tend to be "black and white" - to go private or not rather than being able to pay marginal costs.

7 Tax relief on health insurance would involve an immediate deadweight cost (about £150 million pa) for those currently insured. At present tax relief is limited to individuals earning less than £8,500 pa who are insured in Company schemes.

8 **Cost of administration.** Partly because no financial transactions are necessary for individual patients the management costs of the NHS are low (4.4%). In private insurance about 9% of premium income is spent on administrative costs by a big company like BUPA.

9/52

SECRET AND PERSONAL

BF 6/3.

FROM: A C S ALLAN
DATE: 16 February 1987 13/3

MR ANSON

NA
Phoned David Willetts 20/2 and asked him for note. AA

cc: PS/CST
Sir P Middleton
Mr F E R Butler
Miss Peirson
Ms Boys
Mr Parsonage
Mr Sturges
Mr Cropper
Mr Tyrie

ACSA to ANSON 16/2

HEALTH EXPENDITURE

The Chancellor was most grateful for your note of 6 February and for the attached paper by Ms Boys, Mr Parsonage and Mr Sturges.

2. He felt it was a useful analysis of the options it covered. But before he holds a meeting, he would like some more work to be done on some of the options which are covered only briefly (or not at all) in the paper. These are

(a) the "health maintenance organisations" route.

(b) contracting out with vouchers, so as to reduce the "cliff edge" (1981 Working Party para 3.20).

(c) full cost payments with reimbursment (1981 Working Party para 3.34).

He would also be grateful for a summary of how other countries systems work, and an assessment (albeit brief) of the ideas in the recent IEA Hobart Paper.

ACSA

A C S ALLAN

SECRET AND PERSONAL

87.2.12

FROM: MS P A BOYS
DATE: 12 MARCH 1987

BOYS To ACSA 12/3

1 MR ANSON
2 MR ALLAN

CC: Miss Peirson or
Mr Parsonage
Mr Sturges

HEALTH EXPENDITURE

Your minute of 16 February commissioned further work on three options mentioned in the paper submitted under cover of Mr Anson's note of 6 February, a summary of arrangements in other countries and an assessment of the ideas in Dr David Green's recent book, "Challenge to the NHS ". I attach our response (prepared in the form of further Annexes to the first paper with cross-references where appropriate) as follows

(i) Annex F: a summary of arrangements for health care in OECD countries for which information is to hand; and

(ii) Annex G: a note on vouchers and their possible use to reduce the "cliff edge" between reliance on the NHS and entry to private health insurance;

(iii) Annex H: a note on full cost payments with reimbursement;

(iv) Annex I: a note on health maintenance organisations (the Chancellor may recall his correspondence with Mr Fowler in 1984 on this option - papers are attached);

(v) Annex J: an assessment of Dr David Green's book "Challenge to the NHS".

Penelope Boys

P A BOYS

398

ANNEX F: HEALTH CARE PROVISION: OVERSEAS

SECRET AND PERSONAL

ANNEX F

HEALTH CARE PROVISION: SOME KEY POINTS ABOUT ARRANGEMENTS OVERSEAS

Attached is a note setting out a few of the main points about health care arrangements in 10 different countries - 8 in Western Europe as well as Canada and the USA.

2. There are inevitable difficulties in making international comparisons of health care arrangements because of fundamental differences eg in the relationship between central and local bodies, and in systems of taxation.

3 At a very broad level three main financing systems can be distinguished -

(a) national health systems funded out of general taxation (UK, Canada and the Scandinavian countries).

(b) social insurance systems (most Western European countries).

(c) private insurance systems (the USA).

But these are not hard and fast distinctions. For example, in the USA about 40 per cent of health care is funded directly by the state and another 30 per cent by uninsured private payments. Also, the distinction between tax-based and social insurance systems has become progressively less clear-cut in recent years. Many social insurance systems now provide comprehensive health care for all or virtually all of the population, with contributions for the elderly and other non-employed groups often being paid directly by the state; and in some countries the statutory funds providing sickness insurance have run into financial difficulties, leading to large subsidies from general taxation. In these circumstances there is very little practical difference between national health and social insurance systems - apart from differences in control mechanisms.

4 Health expenditure has been steadily rising as a percentage of national income in all countries. Cost control has become an increasingly important objective of policy. In many countries this has led governments to adopt a more interventionist approach eg in controlling the numbers of hospitals and doctors. In the USA cost containment is being pursued by increased competition.

5. The attached notes are deliberately brief - but more detail could be provided on particular countries if required.

ST March 1987

HEALTH CARE OVERSEAS

AUSTRIA

Compulsory social insurance finances about 50% of total health spending and some 70% of public expenditure on health. The remainder comes from general and local taxes and private insurance. 99% of the population are compulsorily members of a sickness insurance fund. 25% of the population have supplementary private insurance to cover for example better hospital facilities and choice of hospital doctor.

BELGIUM

Compulsory sickness insurance covers all Belgians (although the self employed are covered for heavy risks only). Contributions for the elderly and the unemployed are paid by the state. Sickness insurance covers half of total health spending. About 1/6th of expenditure comes from central and local government funds and about 1/3rd from an extensive system of charging for health services and from voluntary insurance by the self-employed.

CANADA

Canada has comprehensive national health arrangements financed mainly from general taxation. Hospitals are independent and doctors are mainly paid by fee-for-service. About 25% of total health expenditure is privately financed (mainly dental and pharmaceutical care). Private insurers are not allowed to provide cover for services covered by public finance.

DENMARK

In 1973 Denmark switched from an insurance based system to one funded largely from central and local taxation - on a free at the point of use basis. The private insurance market is very small.

FINLAND

Virtually all the population are covered by sickness insurance. Roughly 80 % of health spending is classified as public expenditure, and most of the remainder comes from payments by patients (which are tax deductible up to a certain limit). There is very little private health insurance.

FRANCE

98% of the population are compulsorily covered by social insurance. There is fairly extensive cost-sharing by patients eg 25% of the cost of doctor consultations. About half of the population take out supplementary private insurance to cover these charges. About one third of hospital beds are in privately owned hospitals.

? Full coverage with insurance ?

FEDERAL REPUBLIC OF GERMANY

Most health expenditure is financed through social insurance which covers 93% of the population. Higher income groups have the option of contracting out to a private insurance scheme providing full cover. Many people covered by social insurance take out supplementary private insurance for optional extras eg better hospital facilities.

THE NETHERLANDS

70% of the population are covered for acute care by social insurance - mostly compulsorily. Those not covered by social insurance, mainly the better off, have to make their own arrangements typically by private insurance. However all of the population are covered for exceptional health costs eg care lasting over one year.

SWEDEN

Health care is largely financed out of general taxation. There is also a system of compulsory sickness insurance contributions, but this only covers about 20% of health expenditure. There are very few private hospitals.

UNITED STATES OF AMERICA

The USA has pluralistic arrangements for financing health care which are still evolving. Of total health expenditure roughly 40% is at present financed directly by the government, 30% by private insurance and 30% by direct payments at the time of use. Government expenditure is on two main programmes -

- Medicare, a contributory system providing partial health cover for the elderly

- Medicaid, a tax funded programme for those on very low incomes.

Most people in work are covered by employment based private insurance schemes which attract generous tax relief. But not all employers provide insurance and about 10% of Americans have no health insurance and many others have inadequate cover. Moreover, insurance rarely covers the full cost of care and direct payments are especially important outside hospitals. The ownership of health care facilities is predominantly private.

ST

March 1987

ANNEX G: VOUCHER SYSTEMS

ANNEX G

VOUCHER SYSTEMS

A voucher system could be operated in a variety of ways. The two main contexts in which vouchers might be introduced are as follows:

2 National Health Service. Vouchers could be introduced in the NHS as it is at present. The vouchers might cover a large proportion of the population, who would have to make arrangements to meet any excess costs of NHS care above the voucher value.

(a) Family Practitioner Services. It would be possible to introduce vouchers for visits to GPs and to charge for visits above the voucher value. This might help both make individuals more cost conscious and limit abuse/frivolous demands on GPs. Significant public expenditure savings would only result if there was simultaneously a reform of the basis of GP remuneration so that it was based on numbers of visits . However there are possible drawbacks - vouchers might actually encourage some people to make a greater number of visits, up to the full value of their vouchers.

(b) Hospital Care. Vouchers might be considered as a means of strengthening the role of consumers in health care and promoting competition between NHS and private hospitals. Each individual might be given a voucher covering an average amount of hospital care, and when treatment is required he or she would shop around for the hospital of choice, topping up the voucher as necessary for higher quality services. If vouchers were introduced on this basis without any other changes there would be some difficulties to overcome. Compared with education, expenditure on health care varies unpredictably between individuals and over time - so in a particular year costs to the individual may be much more or much less than the voucher value. Many individuals would not need their vouchers in any one year, and others would require hospital care costing far more than the value of the voucher (if this is assessed on some broad average basis).

It is not feasible to assume that the latter group could directly meet the costs not covered by vouchers out of their own resources. It would therefore be necessary to have some compulsory system of supplementary private insurance. If nothing else, this would require a complete change in private health insurance in its present form (the linking of vouchers to private insurance is discussed further below). In addition, vouchers would lead to a very large once-for-all increase in public expenditure on health, as individuals currently on NHS waiting lists would use their vouchers to seek immediate treatment in any hospital - public and private - where there is spare capacity.

3. Subsidy to private insurance. Alternatively (or in addition) a voucher could be given to people taking out private insurance.

(a) Voluntary private insurance. A subsidy in the form of a voucher could encourage more people to take out voluntary private insurance, by reducing the "cliff edge" between the cost for the individual of public and private provision (see paragraphs 20-21 of main paper). However there would be a large deadweight cost in respect of individuals who already have private health insurance (the total value of premiums is currently in excess of £600 million). There could be a net cost to the Exchequer, unless NHS provision were reduced by more than the cost of the subsidy to private insurance.

(b) Compulsory private insurance. Some form of subsidy would be essential if private insurance were made compulsory (for say the working population) as many people on low incomes would not be able to meet the cost of the insurance without some assistance (see paragraphs 22-28 of main paper). This could be in the form of a voucher. The voucher could be structured in different ways, eg flat rate or as a proportion

of the cost of insurance. A decision would be needed on whether the vouchers should be issued selectively eg according to a means test. Selectivity would inevitably raise the problem of the poverty trap and incentives generally. If vouchers were linked proportionately to the cost of private insurance, there would be a blunting of possible competitive effects - individuals would be less inclined to "shop around". The cost of vouchers would reduce the Exchequer savings from a shift in financing of health care from general taxation to private insurance.

ST

March 1987

ANNEX I: HEALTH MAINTENANCE ORGANISATIONS

ANNEX I

HEALTH MAINTENANCE ORGANISATIONS

What are HMOs?

1. Health Maintenance Organisations (HMOs) are private - usually profit-making - bodies in the US which combine the provision of health insurance with the provision of health care. Subscribers enroll either individually or in company schemes and pay an annual fee fixed in advance; in return the HMO provides all the care they may need during the period covered. The HMO thus acts as both insurer and supplier of services. This is very different from the traditional pattern in the US, in which the organisations providing health insurance are institutionally quite separate from those providing hospital and other services. In some ways HMOs are like miniature versions of the NHS, but they are private, membership is voluntary, and they have to compete for subscribers with conventional private insurance organisations.

2. Although in existence since the 1930s, HMOs have expanded rapidly in the US over the last 15 years. Their numbers have increased from about 50 in 1972 to about 400 now, and over the same period the numbers of subscribers have risen from around 3 million to around 20 million (though this still represents less than 10 per cent of the US population). Expansion was facilitated by the Health Maintenance Organisation Act of 1973, which required employers to include HMOs in the health insurance schemes offered to employees and also granted generous subsidies for that purpose (the subsidies were withdrawn in 1982). About 80 per cent of subscribers are covered by insurance schemes provided by their employer. HMOs do not deal with the elderly; health insurance for this group is provided by the State-run Medicare programme.

3. Compared with conventional methods of private provision HMOs are seen as offering two main advantages:

- First, because they combine the functions of insurance and supply, they have clear incentives to hold down

ANNEX H: FULL COST PAYMENTS WITH REIMBURSEMENT

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ANNEX H

? France

FULL COST PAYMENTS WITH REIMBURSEMENT

1. Within the existing NHS structure it would be possible to require individuals to pay the full cost of certain services and items (eg hospital stays, prescribed drugs) and then reimburse the costs above an agreed amount. A benefit of this type of arrangement is that the patient is made aware of the cost of the service at the time he uses it.

2. Disadvantages are:-

(a) it would be administratively complex and costly .Health service institutions (eg hospitals and chemists) would have to do much more paper work than at present and a large bureaucracy would be required to reimburse generally small amounts of money to large numbers of people.

(b) particularly if the reimbursement system applied to hospital care many patients would be unable to pay the cost of treatment at the time of their stay. Even with the present relatively small UK private insurance market BUPA still have to pay quite a few of their clients' bills direct - because the patients cannot afford to do so. Clearly this problem would be much more acute if a greater proportion of the population, including more people on low incomes, were made to pay the full costs.

ST

March 1987

costs and provide health care as efficiently as possible. Evidence suggests that HMOs have cut treatment costs in many fields by 10-40 per cent without any apparent reduction in quality. It has, however, been argued that the good performance of HMOs may also reflect the specific social and demographic characteristics of the enrolled population.

- Second, because they are required to provide health care on a comprehensive basis, HMOs have an incentive to practise preventive medicine. In principle this should lower costs still further in the long run as well as providing direct health benefits. The actual effect of HMOs on prevention remains to be established. One problem is that prevention is a form of investment, increasing costs in the short term. The outlays can only be recouped if subscribers remain enrolled for lengthy periods, but this cannot be guaranteed when enrolment is on an annual basis and where individual HMOs are relatively small and geographically specific.

Relevance to the UK

4. The US experience with HMOs would clearly be relevant to the UK if it were decided to encourage - or enforce - a major switch from public to private health provision. The rapid expansion of HMOs in the US, albeit from a very small base, suggests that they are a competitive and attractive form of supply, and, although not yet fully substantiated by evidence, the incentives they offer for holding down costs and encouraging prevention are clearly desirable features.

5. The most effective way of expanding private health provision in this country would be by the exclusion of certain population groups, for example the working population and their dependants, from entitlement to free services under the NHS, coupled with compulsory private insurance. It is

open to question whether HMOs would emerge as a natural market response to this change. They have no organisational precedent in this country, so new institutions would have to be created from scratch, whereas the traditional insurance organisations like BUPA and PPP would be expanding to meet new demand from a sizeable existing base. Following the US precedent, possible mechanisms for encouraging the emergence of HMOs include the granting of government subsidies for a limited period and the requirement on employers to offer HMO-type schemes to their employees.

6. HMOs in this country could be organised around the GP system, especially doctors operating in group practices. A group of GPs could combine with an insurance company to offer a comprehensive care service in return for an annual enrolment fee. There would be no requirement for the GPs to own or operate hospitals; in-patient services could be provided on a contractual basis by either private or NHS hospitals (many HMOs in the US contract for hospital care in this way).

7. One drawback of this approach is that individual HMOs would tend to be very small. The list size of the average GP is around 2,000, so a typical group practice of five doctors would cover a population of only 10,000; the numbers paying an enrolment fee would be smaller still given that groups such as the elderly would be exempt from the requirement to take out private insurance. Small scale is a disadvantage because it limits the capacity of an individual HMO to negotiate competitive fees with contracting hospitals and - as indicated above - because it reduces the incentive to practise preventive medicine.

8. A more realistic line of development given existing institutions in the UK, would be to encourage or require District Health Authorities to set up as HMOs operating in competition with private insurance companies. Instead of receiving a single cash budget from central government as at present, each DHA would have to compete in the market for part of its custom (ie the groups required to take out private

insurance). This should provide incentives both to hold down costs and to offer the range and quality of services which consumers are willing to buy. The annual enrolment fees paid by subscribers would operate as a form of cash limit, but DHAs would be able to retain any profits resulting from improved efficiency, including the contracting-out of hospital or other services to private suppliers. A further advantage is that, unlike present arrangements, DHAs would have a common budget for hospital and primary care services; this should lead to the closer integration of hospital and GP services than now.

Problems

9. The development of HMOs on these or other lines would not solve all the problems inherent in any major switch from public to private financing. For example, special arrangements would be needed to deal with the problem of adverse selection, ie the tendency in a competitive insurance market for bad risks, such as those with chronic pre-existing conditions, to be excluded from coverage. In the US this is dealt with by requiring HMOs to accept all comers and by making non-discriminatory pricing of premiums compulsory for the various risk groups. One difficulty with this approach is that, unless these conditions are universally imposed, other types of insurance organisation will bid for the good risks by offering lower premiums, leaving HMOs to pick up all the bad risks.

10. Another difficulty would be the impact of a major shift to private insurance on those with low incomes, especially large families. To the extent that they hold down costs compared with other insurance mechanisms, HMOs offer some help in this regard, but they do not solve the underlying problem of requiring low-income groups to pay more for health care than they do at present. Financial support can be provided by tax reliefs or vouchers, but such devices reduce the public expenditure savings from a shift to private insurance and also introduce administrative and other complications of their own.

Previous Consideration

11. The Chancellor wrote to Mr Fowler on 4 June 1984 seeking his views on HMOs. Mr Fowler's reply of 31 July 1984 (copies of correspondence attached) was cautious about the scope for applying HMO principles to the UK. However, he went on to say that these would be considered in the context of the Green Paper on Primary Care. In the event, this document, published in April 1986, contained only fleeting references to HMO concepts and these were not followed up in the form of specific recommendations.

Conclusions

12. HMOs are widely seen in the US as an important institutional development. They have not solved the problem of under- or non-insurance which is inherent in any system of voluntary private insurance, nor do they provide a solution to the large and ever growing problem of financing health care for the elderly; but they do appear to offer - for some population groups - a competitive, low-cost form of health care of rapidly growing popularity. To the extent that they operate like decentralised versions of the NHS, one potential attraction to the UK in the context of a general shift to private financing is that HMOs could be developed from, and in some respects improve upon, existing institutions. If the Government wished to promote a major switch to private insurance, it would almost certainly want to encourage the development of HMOs, though this would not solve all the problems associated with such a shift in financing methods.

SECRET

Copy 1 of 12

E.6

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

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

31 July 1984

CHANCELLOR
03 AUG 1984
Action Mr Watson
CST, FST, MST
Sir P. Middleton
Mr Bailey, Mr Anson
Mr Scholar, Mr Rayner
Mr Lord, Mr Portillo

Dear Nigel.

HEALTH MAINTENANCE ORGANISATIONS

Thank you for your letter of 4 June.

I agree with you that progress with Health Maintenance Organisations in the United States continues to be worth watching, and that our officials might discuss whether there are particular aspects of health care provision here which might benefit from some further study of HMO development.

But, like you, I am sure that HMOs provide no ready-made solutions for us and there are various cautionary points that we would do well to bear in mind:

(i) the HMO movement in the USA is in fact quite an old one, which has its origins in the 1930s and 1940s. Its development there has been and so far as we can see continues to be fairly slow; it is unlikely that there will have been any dramatic developments since 1981 when, as you say, the interdepartmental Working Party on Alternative Health Finance spent some time looking into it;

(ii) the movement has developed within - and to some extent in reaction against - the health care supply and financing mechanisms prevalent in the USA which underlies the very high rates of expenditure and expenditure increase there - over the last decade, for example, health spending as a proportion of their GNP (which is of course very much larger than ours per capita) has risen from 7.9 per cent to 10.5 per cent; in volume terms it has risen by an average of 4.5 per cent annually, and in cost terms by an average of 5.4 per cent. Some of this rise - and certainly a good

E.R.

deal of the concern about it - is attributable to the lack of control and accountability which comes from separating responsibility for provision (which lies with the doctors) from responsibility for financing (which lies largely with insurance funds). This has deprived both the providers of care and its financers of the combination of means and interest necessary to keep expenditure within bounds, particularly in the hospital and specialist sectors. Our health authorities are, of course, in a very different situation because they have to provide services within cash-limited budgets, and the measures we have in hand to improve the budgeting arrangements for clinicians will enhance still further the relative efficiency of our system. In expenditure terms, the evidence (notably in Harold S Luft's "Health Maintenance Organisations: Dimensions of Performance": 1981) is that HMOs have achieved a slightly lower growth rate than the average for health care generally in the US; which means that their rate of expenditure growth will have been significantly higher than the 1½ per cent annual average in volume terms in our HCHS over the last decade; and is almost certainly higher now than the controlled ½ per cent or so a year we are managing at the moment;

(iii) the Alternative Finance Working Party looked at HMOs as part of its study of the possibility of replacing the NHS with radically new and different systems of supply and financing. Had we decided to go for some major privatisation of the main means of health care supply and financing, I've no doubt that the private market here would have sought to avoid the problems now so obvious in the States by arranging a closer link between financing and provision, whether on the HMO or some other model. But we decided - and for the foreseeable future are committed to - keeping the NHS and reforming it from within. It follows that I do not see any major way in which HMOs as such provide a helpful point of reference to the NHS in its present state of evolution; and if it became known that we were interested in them, there might well be renewed controversy over our commitment to the NHS.

All that said, I do agree that we need to consider the position on two issues. The first is economy of prescribing. As you will know, I have in my letter of 24 July already made proposals to the Chief Secretary which, if adopted, will lead to some limitation on the range of drugs that NHS general practitioners can prescribe, and hence to savings in expenditure. A scheme of this kind would restrict prescribing more systematically than is the practice, so far as we know, in most American HMOs. The second is whether there is anything that, as a Government, we could usefully do to encourage the private sector in Britain to learn from the HMO experience. As you know, they are greatly concerned about cost escalation (which has been much higher than in the NHS). Until very recently, they showed no signs of going down the HMO road; but in the last year or so, one scheme (set up by Aircall in Harrow) has been started which

E.R.

in some fairly limited ways does seem to have some HMO characteristics, though it differs from HMOs in the proper sense of the term in the very important respect that it does not cover hospital services. We shall in any case be considering this in the context of the Green Paper on Primary Care.

I am copying this letter to George Younger, Nick Edwards and John Redwood.

Yours Norman

NORMAN FOWLER

CONFIDENTIAL

cc PS/CST
PS/FST
PS/MST
PS/EST
Sir P Middleton
Mr Bailey
Mr Anson
Mr Scholar
Mr Watson
Mr Rayner
Mr Ridley
Mr Lord
Mr Portillo

Treasury Chambers, Parliament Street, SW1P 3AG
01-233 3000

4 June 1984

E.6

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
LONDON SE1 6BY

Dear Norman

HEALTH MAINTENANCE ORGANISATIONS

I read with some interest the article on health spending by Norman Macrae in the Economist of 28 April, as I am sure you did too. Much of it traversed well-known ground - particularly the analysis of the American problems, and the reasons for NHS shortcomings - and I would certainly not draw from it any ready made solutions. But it has prompted me to conclude that we might profitably look again at experience with health maintenance organisations to consider whether they could have a role here in curbing what otherwise appears to be a limitless demand for more expensive health care.

I understand that when the 1982 Working Party on Alternative Health Finance investigated this area, it concluded that it would be worth watching the developing US experience with HMOs. HMOs do potentially offer a mechanism to encourage both providers and consumers of medical care to look at the cost-effectiveness of diagnostic and treatment techniques and thus counteract the tendency to assume that any marginal improvement is worth having, regardless of cost. This is important in the context of the drugs bill, which I know is one of your major concerns, as well as in relation to the more complex issue of medical advances. I believe HMOs should also encourage preventative medicine - an area where the NHS does not seem to have achieved many major successes so far.

I would not at this stage venture a view on how HMOs might fit into the NHS context; there must be a number of possibilities and it seemed to me that Norman Macrae oversimplified the transitional problems. I think we should need first to examine

/developments

developments elsewhere in the light of experience since the 1982 report which I hope might shed some light on two particular questions:

(i) are consumers prepared to take account of cost effectiveness, or do they still operate on the assumption that the most expensive must be the best and are they prepared to pay accordingly?

(ii) can HMOs keep down their costs by looking at the cost effectiveness of treatments? Or do doctors still tend to go for the 'best' treatment regardless of cost, and economise elsewhere (eg queues, rundown premises)?

If you agree that this is an idea worth pursuing, perhaps our officials might get in touch to discuss the best way to carry the work forward.

Copies of this letter go to George Younger and Nick Edwards and to John Redwood (No 10 Policy Unit).

Yours Nigel

NIGEL LAWSON

ANNEX J: CHALLENGE TO NHS - DAVID G GREEN

25.8.87 **ANNEX J**

Challenge to the NHS: David G Green

Summary

1 Dr Green argues that a competitive market in health will deliver a more satisfactory service to patients than the NHS. He counters some of the criticisms of private medicine advanced by UK academics (in particular, that the NHS provides a better means of controlling costs). But many of his conclusions are based on the assumption that health care is about providing minor elective treatment to otherwise fit, healthy and intelligent people. This pays insufficient attention to the needs of the mentally ill, mentally handicapped, or the elderly suffering from senile dementia. However, his conclusions may be relevant to alternative ways of providing acute health care to those between the ages of 16-60.

Dr Green's General Analysis

2 Dr Green charts what he sees as the rise and fall of medical monopoly power in the USA. He believes that tough anti-trust action has improved the supply of medical manpower and that resulting competition has reduced costs. He believes that similar competitive pressure would produce a much more satisfactory result in the UK. He admits that there are gaps in the US safety net which require urgent attention. Competitive pressure on hospitals, and price controls by Medicare and Medicaid, have worsened the position for those of the uninsured who are poor, unemployed or otherwise disadvantaged. He accepts that the government needs to protect the poor, so that no-one is denied essential health care due to their inability to pay. But with this one exception, the NHS presents a very sorry picture compared with American health services.

3 This is not a view of the US health scene that is universally shared. The attached cutting from the Financial Times, for example, reports growing dissatisfaction with the coverage of present insurance schemes.

4 Dr Green analyses on three main claims put forward by UK academics as reasons why the NHS outperforms a competitive market - medical monopoly, consumers' lack of information and "over-provision" via insurance schemes.

Medical Monopoly

5 Green argues in favour of unrestricted entry to the medical profession, including entry to medical schools. He also favours full application of anti-trust laws against the profession. This would be an important element in securing a competitive market in private health care. However, it will require radical institutional changes in the UK. At present numbers entering medical school are controlled (ostensibly by DHSS to relate numbers to need, in reality by the profession themselves as advisors to DHSS). We should need to ensure that medical school places reflected more closely the demand from suitably qualified applicants, particularly bearing in mind their very high costs compared to students of other disciplines. We should also need to abolish the DDRB and to prevent open access to GPs wishing to contract with the NHS (at present, the more doctors we train, the more public expenditure grows on the FPS).

6 Green also urges the encouragement of physicians' assistants and nurse practitioners. This is a reform which could bring substantial benefits. Nurses are indeed keen to take on more responsibilities. But tackling the professions to permit more flexible use of manpower will be an uphill struggle. It will also be important to ensure that the nursing profession does not extend or enhance its monopoly by over-ambitious entry requirements.

7 The encouragement of "alternative" medicine can also (as Green notes) play a part. But here Government needs to do little. Osteopaths, herbalists, acupuncturists etc are thriving without any prodding from us - and wholly in the private sector.

Consumers' lack of information

8 Green argues that, although individuals can never hope to match the medical expertise of doctors, this asymmetry of information does not preclude people from shopping around for the treatment most appropriate to their needs. He claims that the NHS restricts choice and that doctors themselves withhold information to boost their own power.

9 Whilst there is some truth in these assertions, they do not illuminate the question of whether private or public sector health provision deals best with consumer choice. There certainly are individuals who are ready to challenge medical opinion and to search for treatment most suited to their requirements . But these individuals are to be found both in private medicine **and** in the NHS (where everyone has the right to a second medical opinion if they wish, and where they can change GPs at their own discretion). That still leaves a large number of people who are too ill or frail to exercise choice - but again, this is true whether they are treated in a competitive market or in the NHS. Some doctors may well withhold information (some genuinely believe they are acting in patients' best interests in doing so): but the remedy here is in consumers' own hands. It is interesting that the Consumers Association in the UK is widening its remit to some medical areas - eg the recent **Which?** report on treatment for cancer.

"Over-provision" via Insurance Schemes

10 Green argues that, so long as responsibility for meeting full costs is not divorced from those paying the premia, insurance schemes are more effective than state regulation in keeping down costs. He is firm that tax subsidies for health insurance must therefore not be given, because they lead to a lack of cost-consciousness. He commends self-insurance schemes run by employers, where employers have a direct interest in minimising outgoings. He also favours schemes where users are given an

incentive to go for the cheapest treatment, and where cover is not comprehensive (ie consumers pay a percentage of costs incurred).

11 These are good counters to some of the criticisms made of private health insurance schemes and important safeguards to the efficient working of a competitive market. However, the assertion that health care costs are now reasonably under control in the US could well be premature. It is based on only one or two years' experience. Health expenditure had previously grown so rapidly, and to such a high level, that some degree of retrenchment was both inevitable and relatively easy to achieve. The US devotes 10-11% of its national income to health care, compared to 5-6% in this country. Allowing for differences in national income per head, the comparison suggests that Americans spend about as three times as much per head on health care as the British. It is not obvious what the extra spending buys. Crude indicators of health status, such as average life expectancy of perinatal mortality rates, show little difference between the two countries, and as far as trends over time are concerned the UK experience has in some respects been superior. For example, the perinatal mortality rate has fallen significantly faster in this country than in the US over the last 10, 20, or 30 years.

Innovation

12 A further criticism of the NHS advanced by Green is that it blocks the emergence of innovations. It is true that the US is more innovative as far as financial mechanisms and institutional structures are concerned (eg one day surgery centres, walk in clinics, no-wait diagnostic centres). But the same is not true of **medical** innovations. The implicit notion that the NHS is a monolithic system, requiring all doctors to prescribe the same treatments and so stifling new developments, is a myth. The UK continues to be a pioneer in many fields of medicine.

Conclusion

13 The author concludes that it should be possible to retain the chief virtue of the NHS (its protection of the poor) whilst still

opening up the rest of health care to a market approach. If radical changes were made, this could be true. It might be possible to combine the best of both approaches by retaining NHS for births, treatment of children, those on Supplementary Benefit and the elderly, whilst requiring compulsory private insurance for those between 16 and 60 with incomes above Supplementary Benefit level.

Health insurance is an expensive problem, **Nancy Dunne** reports

Americans count the cost of ageing

MARIE, a short, spry Italian-American in her eighties, is living out her life in the comfort of her long-time family home, but she is a pauper. Nothing remains of the substantial assets she accumulated with her late husband Philip. After her death, her house will be sold and the proceeds will go to the nursing home where Philip, a stroke victim, spent his last years and died.

Death makes everyone equal, but for many Americans the levelling process occurs earlier —when the elderly or infirm enter nursing homes for full-time care. With the average cost about $22,000 (£14,600) a year, few of the 1.5m Americans in nursing homes can afford the long-term, often terminal stay. Bit by bit, their assets are sold off until they are impoverished enough to qualify for government assistance under the Medicaid programme for the poor.

"What most people fear, especially older Americans . . . is that home health care or nursing home bills will eat up their savings . . . and they will go broke, flat-out broke," said Senator John Melcher, chairman of the Senate special committee on ageing.

It was this fear that many Americans hoped the President would set to rest in his long-awaited plan for health insurance against catastrophe. But the proposals made public this month, over opposition from administration conservatives, fell far short of the comprehensive insurance coverage that lobbyists for the elderly wanted.

The President's scheme, developed by Dr Otis Bowen, secretary of Health and Human Services, calls for an expansion of the present Medicare programme which pays about 45 per cent of the medical costs of the nation's 28m citizens over 65 and 3m disabled.

Under the President's plan, for a monthly premium of $4.92, Medicare beneficiaries would receive an unlimited number of days in paid hospital care and the cost of the doctor and hospital bills would be met after the first $2,000 a year. The plan does not cover the cost of medicine, eye and dental care or medicine.

Terry Kirk

Medical bills are a consuming worry for elderly Americans

With Conservatives complaining that the plans is just another "Big Government" solution, many in Congress hastened to praise it as "an important first step." Senator David Durenberger of Minnesota, a ranking Republican on the Senate finance committee, agreed that "it is unconscionable that we have let senior citizens and the disabled impoverish themselves at the very time they are the sickest.

"The most serious criticism that can be offered," he added, "is that it is far too little."

The criticism resounded around Capitol Hill, where the elderly, who constitute a powerful lobbying group have influence far beyond their numbers. A number of legislators say that the first $2,000 cannot be afforded by those who need coverage most urgently—those with incomes between $8,000 and $10,000 a year and who do not qualify for Medicaid.

Others complain that the scheme does not protect the estimated 2.8m individuals under the age of 65, whose medical expenses are now running in excess of $5,000 each year. Nor is help suggested for the 35m Americans who have no health insurance at all, or for those whose insurance does not provide good basic protection, let alone protection against catastrophe—which goes as far as covering for terminal illness.

It is by no means certain that Congress, in its present budgetary straitjacket, can do much more than the President has proposed. In the 21 years since Medicare was enacted, the costs of the biggest US social welfare programme have soared from $3.7bn to more than $70bn.

At the same time, the costs of medical care have rocketed—last year they rose seven times as fast as the consumer price index despite all efforts by the Government to restrain spending.

Several options will be considered in Congress, incuding:

- requirements that employers provide insurance coverage against catastrophe.
- Government subsidies for private insurance.
- Tax breaks to encourage individuals to buy private policies.
- Changes to expand current Medicaid or Medicare coverage.

The President's proposal is likely to pass and the search for further answers will go on.

Even among liberals, any suggestion of socialised medicine remains anathema, but the acute, expensive problem of health care is destined to worsen. The elderly population doubled between 1950 and 1980 and it is expected to double again by 2030, when those over 65 will comprise more than 21 per cent of the population.

Meanwhile, the elderly are living longer. By the year 2040 nearly one-third of those over 65 will have living parents. Already the nursing homes are filled with patients whose visiting children are, themselves, grandparents. The question of who will pay the bills for the growing longevity of the population has barely been tackled.

Tony L
Please keep
handy
Alex

Ch

DO NOT RETURN TO DIVISION YET

AL 7/1/88

One agenda is (flagged)
"options for change" summary.

But you will also want to weave in David Willetts' ideas (summary + paper in separate bundle). His paper not circulated to officials.

AA

Also note by P Cropper & letter Ray Whitney → PM

021/412

SECRET AND PERSONAL

From: J Anson
Date: 16 March 1987

CHANCELLOR OF THE EXCHEQUER

cc

Chief Secretary
Sir P Middleton
Mr F E R Butler
Miss Peirson or
Ms Boys
Mr Parsonage
Mr Sturges
Mr Cropper
Mr Tyrie

HEALTH EXPENDITURE

I attach the additional material requested in Mr Allan's minute of 6 February.

2. I assume you will now wish to have a meeting on this. For that purpose, you may find it useful to have the attached list of all the measures discussed, set under the three broad headings used in the earlier paper, and put roughly in order from less to more radical (although this cannot be precise, because some of the ideas overlap). Items (i) to (iii) are primarily designed to bear down on public expenditure during the Survey period. Items (iv) to (ix) are more concerned with the longer term, ie enabling people to spend more of their income on health if they want to, without adding to the pressures for public spending.

3. Mr Allan told me that you wanted to explore how the cliff-edge between the cost to the individual of public and private health could be reduced, without necessarily going as far as the more radical options. In principle, this can be done either by increasing the cost of NHS services or by reducing the cost of private health. The main instrument for the first is increasing or introducing NHS charges - items (ii) and (iii). The second could be done by some kind of subsidy or tax relief - item (iv); this could however add to the pressures on the Exchequer in the short run, because of the deadweight cost.

4. One possible solution to the cliff-edge might be to put together a package of higher NHS charges and assistance with private health, in which any extra cost of the latter would be offset by the former. But this would restrict the scope for using the higher charges as a means of restraining health expenditure in the Survey.

We wd trade the outside chance of short-term savings for a good chance of longer term savings (& other benefits). NOR said!

J ANSON

HEALTH: OPTIONS FOR CHANGE

(Paragraph numbers are references to the original paper.)

A. Measures to take effect in the Survey Period

(i) Efficiency measures (paras 11-13)

(ii) Action on existing charges (para 14)

B. Measures requiring legislation but could take effect by the end of the Survey period

(iii) New charges (para 14)

(iv) Assistance to voluntary private health insurance
- tax relief (para 21)
- cash subsidy, eg through vouchers (Annex G)

(v) Change basis of NHS financing (paras 16-19)

C. Radical options for the longer term

(vi) Full cost payment for NHS services with subsequent reimbursement (net of charges) (Annex H)

(vii) Full cost payment for NHS services to be met by vouchers - probably also requiring compulsory supplementary private insurance to cover spending beyond the voucher level (Annex G)

(viii) Full cost payment for NHS services (for some categories) coupled with compulsory private health insurance, with some assistance towards the premiums (paras 22-28)

(ix) Health Maintenance Organisations - a competitive development which might be facilitated by (vii) or (viii). (Annex I, and para 27)

RAY WHITNEY, O.B.E., M.P.

HOUSE OF COMMONS
LONDON SW1A 0AA

Please include with papers for NHS meeting. MT.

16 March 1987

Dear Prime Minister,

This letter, like many of the others you receive, may well be unnecessary. I hope so. But I am concerned about how we handle the NHS issue between now and Election Day.

To a considerable extent it has gone off the boil in recent weeks - thanks, in part, to the AIDS problem - but we can be sure the Opposition parties will revive it. They believe that, despite all the solid achievements we can boast, it is something on which we remain vulnerable and see it as a very welcome diversion from topics about which they are sensitive.

RAY WHITNEY MP to PM 16/3

I hope very much that we shall:

a) keep the section on the NHS in the manifesto to the same bromidic level as in the 1983 version, powerfully boosted by the litany of our successes over the past four years with which you are so familiar;

b) avoid giving any pledges in the election campaign which would seal off the possibility of even considering changes in the delivery of health care in this country; and

c) appoint a team of Ministers at the DHSS (preferably the Ministry of Health!) who are prepared to commission at once a study - maximum duration six months - of the inherent dilemmas of the NHS so that any changes can be put into effect within the first two years (three at most) of the next Parliament.

These dilemmas are the ones that Enoch Powell spelled out in his book twenty years ago - the insatiable effect of Bevan's principle of "free at the point of treatment", the rising costs of an ageing population, of medical advances and (much underrated) of higher expectations of care. Today, of course, the political and fiscal pressures are very much more severe and the wolf really will be at the door in the next few years. We need to change the structure so that health ceases to be the political dog fight it uniquely is in

.../...

Britain and, above all, we must find a system which will harness much more private funding for health care. In round terms we spend £20 billion, 6% of our GDP (it was 3% when Enoch said changes were inescapable), most advanced countries spend over 8.5% and the US 11% - with, of course, much higher per capita GDP. We "ought" (whatever that means) to be spending £10 billion more on our health than we do now and that cannot and should not be produced by a Chancellor of any politicial persuasion. Our various efforts at administrative savings, cost improvements, competitive tendering, sale of land, etc. are laudable in themselves but cannot generate more than £500 million a year at best - the proverbial sticking plaster which does nothing for the disease.

We are confronting a problem which needs urgently a level of bold, rigorous and fundamental thinking of a much higher order than we saw in the social security reforms. Without radical changes the NHS will not be safe in anyone's hands.

Yours ever,

Ray.

The Rt.Hon Mrs. Margaret Thatcher, MP,
10, Downing Street,
London SW1.

SUMMARY OF DAVID WILLETTS' PAPER

Rationale

Cutting NHS spending without wider reforms to encourage private finance is screwing down the lid on the pressure cooker. And weaning hospitals off a 100 per cent CG finance should ease political pressures; too much moaning about the appalling quality of their services would drive away commercial donors. What we want is to permit higher total consumption of health services, but with less tax-financed health spending. Ten proposals.

1. The Drugs Bill

Cut down size of prescriptions (perhaps requiring end of flat rate prescription charge regardless of size/cost).

2. Introduce a "lower rate band" for prescription charges

Widen the tax base from present 18 per cent. Avoid commitments in manifesto.

3. Buying extras

Hotel charges probably not politically sustainable. But market additions to basic menu, drinks trolly, video hire etc.

4. Selling Medical Services

NHS to sell time on its scanners, sell blood tests, sell heart check-ups; physiotherapy units to be rented out to sports clubs etc. (You had doubts.)

5. Spreading the income from private services more widely

If we are to encourage more private income generation within the NHS, some of it must go to staff through performance linked bonuses.

6. **Competitive tendering**

Next target should be pathology labs. Get away from assumption that hospitals should be autarkies. In the long run, look for a proper internal market in the NHS, with GPs given referral budgets.

7. **Sponsorship and franchising**

Especially links between local employers and hospitals.

8. **Occupational Health**

Give employers more responsibility for the health of their employees. Get rid of statutory sick pay and industrial injury schemes (but replace with what).

9. **Joint capital projects**

Go for joint developments, which need not be leasing fiddles.

10. **Opting out**

Give someone a contribution to their private health care if we can be sure there won't be a financial burden on the NHS. Perhaps experiment first with old people (eg via HMOs etc).

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WILLETTS to Ch/Ex 20/3

Rt Hon Nigel Lawson MP
H M Treasury
Parliament St
London S W 1

20th March 1987

Ch
Shall I acknowledge? – but not overdue to any Mtgs? AA

yes pse. A v. good paper.

Dear Nigel,

I attach a paper on health spending. It may not be quite what you wanted, but I believe it offers a way of reducing tax-financed health spending that is sustainable, whereas simply going for cuts would not be. Put another way, the political costs of any given cuts which ST can come up with would be lower if a programme along the lines I set out were in place.

I also attach, on a personal basis, a paper I wrote for the Prime Minister for a Strategy Group discussion of health.

I will work a Summary version for NL for Jan Mtg. Pgr issues.

Ch
A good paper, but with a much too defensive covering note!
AA

Yours sincerely,

David Willetts

David Willetts

RESTRAINING PUBLIC EXPENDITURE ON THE NHS

Introduction

Whilst the NHS began as an attempt to extend access to health care its main purpose has now become, ironically, to ration it. The most sophisticated defenders of NHS argue that we are a prey to irrational desires for health care which an American free market would try to meet. The argument goes on that the great achievement of the NHS is to hold down the proportion of GDP which goes on health to about 6% compared with 11% in the USA.

It is this rationing function which is the source of our political problem. The cry for more spending on the NHS is really a cry from an increasingly affluent society to consume more health services. The tax financed NHS just happens to be, for most people, the only vehicle around.

It follows from this analysis that trying to cut NHS expenditure without wider reforms to encourage private finance for health services is simply to screw down the lid on the pressure cooker. So, of the ten proposals listed below, only the first would achieve an immediate reduction in public expenditure on health, though others might count as negative expenditure. But none are intended as leasing type fiddles - they will all make it easier to hold down tax financed NHS expenditure in the course of the next Parliament.

There is another argument for the approach set out below. Whilst hospitals get almost 100% of their finance from central government they will always succumb to the temptations to wave shrouds and exert political pressures on ministers for more spending. Even before the days of the NHS it was cynically observed that the great endowed hospitals need have no financial worries so long as they were bankrupt. But even if only 10% of

a hospital's revenue came from outside sponsorship or the sale of services then their attitudes to finance would begin to change. Too much moaning about the appalling quality of their services would drive away commercial donors or partners. Positive attitudes would be rewarded rather than traditional Health Service griping. Some of the new Griffiths managers would love to be free to do for their hospital what, for example, Professor Ashworth has done for Salford University.

Outside commercial donors or business partners require good accounting and management. This rubs off on the public sector. The quality of financial management at Guys has improved enormously since Gerald Ronson started giving them money but only on condition that he could see that it was properly spent.

1. The Drugs Bill

Drugs expenditure - particularly the £1.2bn incurred by GPs - remains the soft under-belly of the NHS. It is not feasible to save much more by toughening the PPRS - the rates of return of the major drug companies in the UK are not particularly high for successful innovative multi-nationals. The problem lies less with the drug companies than with the GPs and patients who are not price-sensitive consumers.

We should harness the genuine worry amongst health professionals about the stockpiling of dangerous drugs in bathroom cabinets and cut down the size of prescriptions. At the moment 16% of prescriptions are for courses of drugs lasting more than 28 days. Many are not used as patients get better, go into hospital, or forget to keep taking them. We should argue that this is bad medical practice and that after

a maximum course of treatment lasting 28 days a further consultation is necessary.

A compromise would be to allow GPs to issue several prescriptions with separate dates all at one consultation, but the patient would need to go to the pharmacist every 28 days to get a further dose. The pharmacists certainly believe that such a measure would cut down drug use significantly.

2. Prescription Charges: introduce a'lower rate band'

The structure of prescription charges is ludicrous. If we believe in broadening the tax base and lowering the top rates, it seems odd that only 18% of prescriptions now bear charges when they are obtained (a further 6% are obtained on season tickets) but that charges on these few prescriptions have risen tenfold since 1979. There is no particular reason why all pensioners regardless of their means should get free prescriptions. If the 7 million pensioners who are not on SB each had to pay a 50 pence prescription charge this would raise £50 million whereas the recently announced increase in prescription charges to £2.40 will probably raise about £10 million.

3. Buying extras

The NHS is so averse to selling anything that it works on the basis that if a service is worth providing, it is worth providing free. Hotel charges are very attractive in principle but I doubt if they are politically sustainable, and they would do nothing to create a genuinely enterprising commercial attitude in hospitals.

A different approach would be to keep for example one basic free meal but to allow people to choose from a much more varied a la carte for which they would pay. There is enormous scope for marketing services to the captive audience in a hospital - a drinks trolley, flower stalls, the hire of video recorders. If a hospital does this itself or through a franchise operation then it will have an incentive to encourage people to buy rather than reluctantly imposing a charge for which the government is blamed.

4. Selling Medical Services

The principle set out above can also be extended to medical services. The obvious target area is preventive medicine. Many a nervous middle-aged executive would like to have a heart check-up. We would rightly argue that this is not a good use of of public money. At the moment he goes completely outside the NHS and buys such a check-up from BUPA. But instead the NHS should be selling time on its scanners, selling blood tests, selling heart check-ups. Similarly physiotherapy units in hospitals could be rented out to sports clubs.

One enterprising manager in the East End of London was financing his mobile screening unit for the poor council estates by parking it in the City every lunchtime and charging office workers £5.00 for a check-up. He was advised that this was probably illegal.

5. Spreading the income from private services more widely

Some of the opposition to private profit and commercial pricing within the NHS is simply misplaced emotionalism. But NUPE and COHSE also appeal to enormous resentment at the incomes which consultants get from private patients in wings attached to the NHS when none of the benefit goes to the nurses, cleaners etc who also look after his private patients. The enlightened consultants give out bottles of whisky at Christmas to the staff who have worked for their private patients. Many do nothing. If we are to encourage more private income generation within the NHS some of it must go to staff through performance linked bonuses. This will ease the political opposition and will over time make it easier to hold down NHS salaries - just as private practice already enables us to hold down NHS salaries for hospital doctors much below the international average.

6. Competitive tendering

Competitive tendering has already saved us a lot on ancilliary services but the principle is of universal application. We must chip away at the enormous direct labour orqanisation. The next target should be pathology labs. Each major hospital feels obliged to have one when there are enormous economies of scale and rapid technological change is making a lot of the old facilities out of date. In America, Federal Express runs one enormous pathology lab in Georgia which handles samples from all across the country with a 24 hour turn around time. Many hospitals in America also pull the use of other facilities such as scanners or even X-rays.

Instead we have been closing popular and much loved small local hospitals so as to enjoy the economies of scale of a 800 bed DGH. This rests on the false

assumption that hospitals should be autarkies. It also has enormous political costs - the NHS would be more popular if we didn't spend any money on the capital programme at all and stopped closing all the old Victorian hospitals. If the hospitals were put under pressure to buy in services from private providers who themselves enjoyed economies of scale, we would be able to save money and ease the political pressure.

The principles of competitive tendering also apply to medical services themselves. One good example is the private organisation selling kidney dialysis to the NHS in Wales at a lower cost than the NHS could do it itself. This is because inflexible labour practices in the NHS drive up their costs.

In the long run, we should be looking to a proper internal market in the NHS with GPs given individual referral budgets which could be spent at hospitals offering them the best price, public or private.

7. Sponsorship and franchising

NHS hospitals tend to restrict their fund-raising to begging for capital equipment - which can often increase the pressure for more tax-financed spending so that the equipment can be used. There is considerable scope for companies to advertise themselves by sustained financing of health services - why not 'the Glaxo ward'? Links like this between local employers and hospitals would be particularly valuable - the Sainsbury wing of the local hospital might also offer special admission rights to employees.

Such arrangements would probably be illegal at the moment. And the managers in the NHS who contemplate them get no encouragement from the DHSS.

8. Occupational Health

Corporate sponsorship is but a step towards giving employees more responsibility for the health of their employees. If there is to be an alternative structure of financing health care it is likely to grow up at the work-place - employers benefit from a fit work-force, and the firm can pool health risks.

The statutory sick pay and industrial injuries schemes are both economic nonsenses. Tax (or NIC) financing means that in effect the safe, low-sickness employers cross-subsidise the dangerous, high-sickness one. Not only should the administration of these schmes be privatised, but also their financing. If this increase in the net burden on employers is unacceptable, there should be an offsetting reduction in employers national insurance contributions. This is a much better device than tax breaks on health insurance to get companies interested in the health costs of their employees. It creates a direct financial incentive for them to keep their employees fit and healthy and their claims down. BOC has taken the burden of administering the statutory sick pay scheme as an opportunity to track down why they have sickness rates which they had previously passively accepted. Sickness leave remains one of the great blue collar fiddles. Moreover if they have to bear directly the costs of sickness employers start actively promoting the health of their employees, dealing with problems like alcoholism which cost the NHS a lot in the long run.

9. Joint capital projects

The NHS is sitting on enormously valuable capital assets. We are selling a small amount but we may not be getting the best deal. A caricature of our approach would be the hospital somewhere in Essex or Hertfordshire which has been hoarding a couple of adjacent fields for a future development and eventually succumb to pressure from the Region and sells to Wimpeys for a few million pounds. That is not bad, but we might do better by joint developments. Two examples are given below:

(i) An American health company wanted to build a private hospital on such a site, sharing facilities and shifting some of the demand from the NHS into the private sector. But they wanted a joint venture with the NHS. The socialists on the Health Authority were hostile, and the DHSS were wary because receipts in year one were less than if there were an outright sale. But in the long run such a development would do much more to ease the burden on the NHS.

(ii) Developers of nursing homes for seriously infirm old people are interested in such sites as long run joint ventures, enabling old people to be decanted out of geriatric wards.

These sort of schemes will create incentives for managers to get much more out of their capital assets than they do at the moment. They need not be leasing fiddles.

10. Opting out

We need to devise a scheme, analogous to the arrangements for opting out of SERPS, whereby we give someone a contribution to their private health care if we can be sure they won't be a financial burden on the NHS (i.e, even if I am rushed into an NHS accident department, my insurance should cover the cost). Tax breaks for private health insurance are a very clumsy way of achieving this objective. Nor do they deal with the problem that the NHS gets left with all the bad risks.

One place to start experimentally might be old people. This is where there are the greatest possible savings as hospitalisation is most excessive. (The NHS spends £1,420 per annum on someone over 75 as against £180 on someone aged 16-64). Moreover, the care of old people is acknowledged to be a mess, divided up between different budgetary authorities with SB nursing home expenditure rising above £½ billion a year and no prospect of cash limiting it. This is where the Health Maintenance Organisation model is most relevant.

We should learn from US experiments at paying Medicare benefits direct to social HMOs (as HMOs for over 65s are known) in return for their meeting a variety of needs of old people ranging from domestic help to geriatric beds. No such provider organisation yet exists in the U.K. We would have to invite tenders on an experimental basis and see what happened.

It is difficult to imagine that things could be worse than at present.

Conclusion

There are risks in this approach. It requires a big relaxation in control over actions of DHAs, who cannot all be trusted to move the way we want. Hard-nosed Treasury officials will be wary of bogus 'Buzby bonds' for the NHS.

But at the moment the entire health debate focusses on one pressure point - the size of the NHS Budget. It is in the Treasury's interest to dissipate the pressure. Imagine how difficult it would have been to keep pensions linked solely to prices if occupational pensions and private savings had not been rising.

The rise of BUPA and other private health providers helps us, but it is not enough and too slow. The challenge is to permit higher total consumption of health services with less tax-financed health spending. That can only be achieved if the financial regime is liberalised. This liberalisation would itself invite the charge that we were undermining the NHS. But we would have many of the more enterprising managers in the NHS on our side. If handled cleverly, the agenda outlined above could be presented as a response to pressure from within the NHS.

David Willetts

3219/39

SECRET AND PERSONAL

FROM: P J CROPPER
DATE: 25 MARCH 1987

CHANCELLOR

cc Chief Secretary
Sir P Middleton
Mr F E R Butler
Mr Anson
Miss Peirson
Ms Boys
Mr Parsonage
Mr Sturges
Mr Tyrie

HEALTH EXPENDITURE

Reference to Mr Anson's note of 16 March, I suggest that it may be useful to look at Health and Education side by side when considering how to increase the number of people going private - which is, I assume, one of our main objectives.

2. The proportion of the population covered by private sector health arrangements is, apparently, about 9%. The proportion of children in private sector education is only about 6%. Both figures are low. The cliff-edge applies in both health and education. It is the biggest obstacle to expansion of the private sector in both services.

3. A parent has the choice between using State education (for which he is paying already as a taxpayer) or declining to use the state system (but continuing to pay for it) and going private at a cost of between £3,000 and £7,000 a year extra according to the age of the child. The dilemma persists - in the case of any one child - about 14 years. The dilemma in health lasts much longer for any given individual but the annual cost of going private is less - BUPA costs between £400 and £1,000 a year. In neither case is there any middle way between public and private. You must either find £6,000 a year to send your son or daughter to a public school, or you must use the local comprehensive for free. In most localities there is no way of spending, say, £2,000 a year.

4. When it comes to method of payment, there is a fundamental difference between health and education. Education does not involve any great uncertainties. One child needs one course of primary and secondary education, and that is more or less the end of it. In the case of health, however, one individual can incur vastly different medical expenses in a lifetime from another. So education is a subject for vouchers and health is a subject for insurance.

5. The papers under discussion talk mainly of tax relief against the cost of privately incurred health or education expenses. Why not consider simple reimbursement? An individual who offers to educate his child outside the State sector is reimbursed the cost of the State education foregone. An individual who chooses to use a private health service is reimbursed the cost of the NHS service foregone; with which sum he is then able to buy a policy of insurance with e.g. BUPA. It would not be necessary to opt out of the whole of the NHS: one will always want the NHS ambulance to come quickly if one drives at speed into a lamp-post. So one would not expect to be reimbursed the whole cost of one's share in the NHS - just the cost of those parts of the NHS one is committing oneself in advance not to use.

6. The cliff-edge, which arises from the fact that people making use private sector health and education still have to pay, as citizens, for their share of the public services, is a market imperfection. Some would say it was a major injustice. It would not be difficult to remove. The deadweight argument is a poor one; the State should not trade on the determination of the present 5-10 per cent of people who go for private provision. Those people are being done an injustice, and that injustice should be rectified; even if it does cost £150 million a year (for health) and probably a lot more for education.

7. So, before launching into complex new systems like Health Maintenance Organisations and so on, my own inclination would be to look first for ways of removing the discontinuity at the cliff-edge.

P J CROPPER

WILLETTS PAPER

ACSA To WILLETTS 1/4

psl/10A

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

1 April 1987

David Willetts Esq
Centre for Policy Studies
8 Wilfred Street
LONDON
SW1E 6PL

Dear David

The Chancellor has asked me to pass on his thanks for your letter of 20 March and your paper on health spending. He thought it was a very good one, and he is most grateful to you for your work.

Yours
Alec

A C S ALLAN