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NHS : PRINCIPLES AND REFORMS

"When the low risk options won't work, then the high-risk option is the low-risk option."

Old saw

Any reform of the NHS must meet five criteria. It must:

(a) Offer unhindered access to free health care;

(b) Include an automatic pilot to contain costs;

(c) Attract private finance into health care;

(d) Undermine producer monopolies of health care;

(e) Expand the range of patient choice.

The NHS itself meets only the first two criteria reasonably satisfactorily. But all the usual proposals for reform fall down at several of the fences. For instance:

(1) Charging Charges for "hotel" hospital costs and GP consultations encounter a very obvious objection. If the usual exemptions for retired and low-income patients continue to apply - which would cover perhaps 70% of patients - they will raise little revenue while being costly to administer. If, however, there are to be fewer exemptions, then that would mean abandoning the basic principle that access to medical care be free and equal

[Patients on social security, of course, already pay such charges through loss of benefit.]

(2) Establishing the NHS as an independent trust might increase administrative efficiency. Beyond that, however, it would achieve little. It would neither bring in private finance, nor increase patient choice, and it might actually strengthen producer monopolies.

(3) National Insurance on the continental model also presents a dilemma. If it continues to be financed by a cash-limited block budget, then it becomes little more than a regressive method of financing the present NHS. If, however, it is demand-led - as most continental systems are - then it ceases to control costs and expenditure rises alarmingly. As the 1982 Working Party on Alternative Means of Financing Health Care (WPAF) pointed out: "In these countries, numbers of beds and expenditure per capita are higher than here." Patients are then called upon to pay charges - leading to the problems cited above in (1).

(4) Private Insurance meets the criteria of private finance and patient choice, but American experience until the 1980s shows that it controls neither costs nor monopoly suppliers. And unless accompanied by open-ended subsidies to low income consumers, it fails the first test of free and equal access.

REFORMS THAT WORK

Where, then does that leave us? Anyone who reviews the various schemes for NHS reform, as Norman Blackwell and I have done in recent months, soon discovers the same broad set of proposals emerging from any serious enquiry conducted from a conservative (or indeed economically literate) standpoint. These proposals are to be found in embryo in

the BMA Committee report in the late 1960s (of which Sir Geoffrey Howe was a member); they emerge as the least-scathed "option" in the 1982 WPAF paper; and they are recommended, with variations, in the papers published this week by the Centre for Policy Studies and the Adam Smith Institute. They are a combination of:

(1) Health Vouchers paid on a universal basis, equal to the average per capita expenditure on health, perhaps weighted for age and other factors, to be spent on -

(2) Health Maintenance Organisations These emerged in the USA to counter the cost-escalation of demand-led private health insurance. They provide medical treatment as needed and finance it from their members' pre-payments (in this case, the NHS voucher). They negotiate in advance the terms of such treatment with hospitals and clinics. In the United States, they have succeeded in substantially cutting medical costs by breaking down supplier monopolies and now cover more than one-third of American health consumers. As the 1982 WPAF report pointed out, this approach might be developed in the UK by building on the existing District Health Authorities (DHAs) (I include an extract from the WPAF scheme in an appendix.)

The voucher could be used to buy a standard "NHS minimum package" from either private HMOs or DHAs. It would be the same in either care. But both organisations could also be empowered to offer higher-cost policies, providing more benefits (private room, choice of hospital, immediate treatment etc)." These "extras" would be paid for by -

(3) "Topping Up Insurance". The "NHS minimum package" is likely - as now but perhaps more explicitly (see below) - to reflect a set of medical priorities expressed in different waiting times for urgent, less urgent and non-urgent kinds of treatment. This problem of priorities is likely to

increase over time. If serious conditions are to be offered a guaranteed maximum waiting time, as we would suggest, then some treatments will have an indefinite waiting time (e.g. hallux valgus, ie bunions) and others (e.g. vasectomies and reverse vasectomies) will not be provided at all. Accordingly, in order to ensure that they receive free and speedy service in areas where the NHS lags, consumers will pay, say, £50 or £100 on top for an "NHS-plus" package. Priorities will play the role of incentives for private insurance that charges play in other models.

NHS-plus packages, moreover, could be provided by DHAs, as well as commercially-founded HMOs. Indeed, as the system gradually developed, DHAs themselves would become "independent trusts" separate from Government. Nor need they continue to supply care; it would be enough that they should buy it from -

(4) Independent Hospital Trusts. Hospitals need not be owned by the NHS, nor indeed by independent HMOs. They might become independent trusts either singly or in regional and district groups. This trend, indeed, is already implicit in the waiting-list initiative which sends patients to private hospitals in cases where NHS treatment is unavailable and in the still patchy and inadequate programme of "buying-in". It needs only to be developed.

The above structure - health vouchers, HMOs, "topping-up" insurance and independent hospital trusts - meets all five criteria for sensible and fair reform of the NHS. It guarantees free access; it contains costs; it attracts private finance; it undermines monopoly; and it guarantees patient choice.

NEW WINE IN OLD BOTTLES

As outlined, however, it may seem a disruptive and unsettling change which cannot be quickly introduced and so is bound to arouse fear and apprehension. But that need not be true as implemented. As the Adam Smith Institute report points out in Chapter 6, we can move to such a system by adapting existing NHS institutions in such a way that the patients experience no "shock" or disruption at all.

The voucher can be a simple capitation fee, paid direct by the DHSS to the HMO for every enrolled person.

The HMO would initially be the patient's present DHA unless he grew dissatisfied and exercised his right to withdraw.

Topping-up insurance would merely be an extra "option", offered by the GP when patients joined his 'list', which patients they could take or leave.

Most ingenious of all, the GP - not the patient - would choose between competing HMOs, - taking his patients and their captitation fees along with him. As now, patients would choose between different GPs who would be offering different packages of medical care, including the NHS minimum with minor frill-like modifications. But when they needed hospital treatment, it would be the GP who would refer them, as now again. If it were not for the increased choice of services they were offered by competing partnerships of GPs and HMOs, they might not notice that any change in organisation had occurred at all.

BEGINNING THE FUTURE

We have the ability to reach our goal of a transformed NHS by a series of modest measures. We must keep this goal in mind throughout and ensure that any reform we take to improve existing conditions is also a step towards it. Over the next two years, we should therefore pursue three major reforms far more aggressively than the DHSS shows any sign of doing:

(1) Contract out services to the private sector - to the point of seeking tenders from private companies to build, equip and run hospitals that would cater mainly or exclusively to NHS patients.

That would be the first step towards independent hospital trusts.

(2) Establish an internal market in which the GPs would simply write "prescriptions" for patients for the relevant operation which they could "cash" in any NHS or private hospital.

That would be the first step towards independent DHAs/HMOs operating in a genuine market in which the patient rules.

(3) Establish an open and explicit system of NHS treatment priorities - with diffferential waiting times for conditions of varying seriousness.

I believe that these could be the first building blocks of a new NHS.

John O'Sullivan

JOHN O'SULLIVAN

APPENDIX

The WPAF scheme might work as follows:

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

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.

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 otpional 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.... The voucher could be used to buy either private or DHA insurance packages... but they could also be empowered to offer higher-cost policies, providing more benefits (private room, choice of hospital etc)."