**10 DOWNING STREET**

Prime Minister

HEALTH

In addition to paper you have previously seen there are 3 new notes:

"A" – A joint ~~paper~~ Policy Unit note which, to some extent, reflects discussions with Nigel and me.

"B" – A Cabinet Office note which covers some of the same ground as "A", both on substance and handling.

"C" – A note from Bernard on the parliamentary/handling aspects of tomorrow's meeting.

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25.
A

PRIME MINISTER 26 January 1988

## REFORMING THE NHS IN STAGES

### The NHS - The Problems We Need To Redress

(1) The NHS has poor information about its own activities. It does not know, for instance, how much a particular operation costs, or the true costs of training nurses for new technology.

(2) As a result, the NHS controls total costs effectively through cash limits, but it has poor control of costs at the "micro" level. In some areas, operating theatres are used only 50% of the available time.

(3) Because the costs of different treatments are unknown, there is no incentive for hospitals to specialise.

(4) This creates perverse incentives for suppliers. An inefficient hospital can only keep its total costs down by closing wards and sacking nurses - thus pushing up its unit costs and complaining of Government stringency on News at Ten and in the Daily Mirror.

(5) Within hospitals, consultants dictate the use of resources, but they are not themselves responsible for managing costs. Half the operation cancellations arise because surgeons or anaesthetists are not available. And consultant preferences often distort the allocation of medical resources through prestige or mere habit.

(6) To deal with the problems thrown up by this perverse system, an excessively bureaucratic structure grows up. Not only is this expensive in itself, but it actually prevents people identifying and correcting the real problems.



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(7) And when these various problems create a demand for more resources, there is no mechanism whereby private spending can automatically rise in line with patient demand.

**Funding Future Health Care**

Solutions to these problems come under two headings. We need

(a) a more flexible system of funding the NHS and

(b) a more competitive structure of the supply of medical care to replace the "direct labour" organisation of the NHS.

(1) Charging is one possibility. As statistics prepared by the DHSS demonstrate (see Appendix 1), it will raise very little revenue on the basis of the existing exemptions. If you were to adopt a system of exemptions based on income, however, quite modest charges (£5 per GP consultation and £5 per day "hotel" charge in hospital) would raise sums of above £1 billion.

ON LOW INCOME EXEMPTION BASIS (30% OF CASES)

Charge

| | | |
|---|---|---|
| £2 | Visit to GP | 240 |
| £2 | Hospital Attendance | 67 |
| £5 per stay | Hospital Inpatient | 22 |
| | | |
| £5 | Visit to GP | 630 |
| £5 | Hospital Attendance | 274 |
| £5 per day | Hospital Inpatient | 113 |

But that would involve removing over half of those currently on exemption rolls and would thus arouse strong political opposition. I would argue that the game is not worth the candle. Charges are better left until the existing bureaucratic NHS has been replaced by a much more competitive and responsive market system. In the meantime, there is much to be said for "permissive" charges for "extras" in the NHS - private rooms, bedside telephones, better, food, etc.

(2) Fiscal incentives for private health insurance are also attractive in theory. But the DHSS figures in Appendix 2 suggest that the net cost to the Exchequer (i.e. deadweight cost minus NHS savings) would be considerable.

ESTIMATES FOR 1988

| | Cost of Tax Relief | | | |
|---|---|---|---|---|
| | Deadweight Cost £m | Extra Subscribers £m | Potential NHS Savings £m | Net Cost £m |
| Tax Relief For All | 164 | 24 | 39 | 149 |
| Tax Relief for those 65+ | 20 | 3 | 4 | 19 |
| Raise Income Threshold to £17,000 p.a. | 83* | 12* | 19* | 75* |

* guesstimates

Note that the least expensive option (i.e. £19 million per annum) is tax relief for an estimated 50,000 people over 65. This can also be justified as enabling retired people to take out private health insurance which, at present, is

financially prohibitive. But the more ambitious schemes do not seem a sensible route to reforming NHS finance.

(3) An explicit system of priorities in treatment might also be used to encourage (a) "queue" insurance and (b) insurance for low priority treatments with a long or indefinite NHS waiting time. This system was explored at some length in an earlier paper.

(4) Social Insurance with Contracting Out on the pension model. If this is merely a larger contribution for the NHS from the National Insurance stamp - which is one proposal in the DHSS paper - then it is merely a more regressive way of financing the present NHS. As the first step to full NHS funding by social insurance, however, it would be a major social and fiscal reform.

CONTRIBUTION AND TAX RATES IN 1988/89 IF COST OF NHS SWITCHED TO CONTRIBUTIONS

| | Existing Rate | Switch all of NHS | | Switch only HNCS | |
|---|---|---|---|---|---|
| | | New Rate | Change | New Rate | Change |
| Contributions* | | | | | |
| employee | 9.00 | 14½ | +5½ | 13 | 13 |
| employer | 10.45 | 17 | +6½ (approx) | 15 | +4½ (approx) |
| Total | 19.45 | 31½ | +12 (approx) | 28 | +8½ (approx) |
| Income Tax** | | | | | |
| Basic Rate | 27 | 17 | -10 | 20 | -7 |

Such a 'Big Bang' solution to the problems of NHS funding would require major consideration by a Committee of Ministers. Appendix 3 outlines the major advantages and

social costs. It could hardly be implemented, however, very quickly. And it would also need to be supplemented by measures to control costs which, under continental systems of social insurance, have run out of control. It would therefore require a bureaucracy comparable to the present NHS.

## Steps to Competition

Whatever the system of financing the NHS, we will still need greater competition in supply to help the patient and improve efficiency. This can be done by a series of steps, each in itself modest, but together building a radically improved system of health provision. A (necessarily simplified) version of this, keeping the present tax-funded basis, might be as follows:

### Laying The Foundations

(1) We would publish better information about the NHS - in particular costs and waiting lists.

(2) District Health Authorities would remain in being, but each hospital and clinic would be an independent cost centre with its own devolved budget.

(3) We would then develop standard measurements of the qualty, cost and time of treatments by diagnostic group - what the Americans call Diagnostic Related Groups. (Some DHAs have already made progress in this area).

(4) Each DHA would then pay a standard amount for a standard treatment of a standard patient and the payment of a fee by the patient's DHA to the hospital could be immediate. That would institute a test against which each 'cost centre' could compare itself. The foundations for the 'internal market' would have been laid.

Operating The Internal Market

(5) The next stage would be for GPs to be encouraged to send their patients to the 'most suitable' hospital for treatment. They can do so at present in law. But, in practice, they tend to direct patients to the same consultants and hospitals out of habit, and DHAs are increasingly forced by cash limits to restrict entry.

Two incentives would then operate. The GP would tend to direct his patients to those hospitals, whether in his DHA or outside it, where the waiting time was short. The DHA, however, would simultaneously have an incentive provided by the DRG standard fee. When the cost of an operation in one hospital or DHA exceeded the DRG, they would lose money by treating patients in-house and thus have the incentive to send them elsewhere. When the cost was lower than the DRG, they would gain the difference and thus have the incentive to advertise for patients (by, presumably, circularising GPs). Since, in general, efficiency would produce both lower costs and shorter waiting times, these incentives would usually be in harmony.

Over time, within the same "travel-to-hospital" area, different hospitals would tend to specialise in different treatments in line with their comparative costs.

(6) The next step would be a further guarantee that if no NHS hospital could provide treatment within a guaranteed maximum waiting time, his GP would be free to send him to a private hospital. That would begin to blur the distinction between public and private. In time, patients would be sent to the lowest-cost hospital regardless of the public/private distinction.

(7) Consultants's contracts would need reforming to give them benign incentives rather than perverse ones. That would involve a fixed tenure of, say, five years; the replacement of merit awards by performance-related bonuses; and their closer involvement in cost control. That would be the logical extension of current reforms like the resource management initiative under which "doctors and other professionals are given detailed information on output and costs and are required to become responsible for arranging the relevant resources".

Introducing Supply-Side Competition

(8) The next step would be a development of the existing "buying-in" operations by the DHSS. These have so far been small scale. But that is no reason why the NHS should not commission the design, building, equipment and operation of NHS hospitals by the private sector. (Portsmouth wanted to try this, but they were warned off by the DHSS.) Or why existing NHS hospitals should not be leased to operating companies (some, perhaps, founded by their present medical, administrative and ancillary staff trained under the resource management initiative). With the right pressure from the DHSS, the hospital service might gradually be transferred into a series of independent, non-profit hospital trusts, treating NHS patients in return for DRG-based fees - "independent state hospitals" in fact.

(9) We would by now have separated supply and demand in the NHS. The supply of medical treatment would be in the private sector. Medical treatment would be purchased for patients by the local DHAs relying on state grants in accordance with RAWP formulae etc. Only three more steps would now be required.

Giving The Patient Power

(10) First, RAWP should be replaced by per capita funding for DHAs. This would be age-related to take account of the great disparities in health spending on the over-60's and over-70's.

(11) Second, GPs would be allowed to register themselves (and their patients and capitation fees) with either a neighbouring DHA or a commercial Health Management Organisation. DHAs would thus become, in effect, competitive brokers or agencies between patients and hospitals. They would guarantee a fixed "NHS minimum" level of comprehensive health care to their patients in return for the capitation fees. And they would bargain with the independent hospitals to secure the lowest cost services. FPCs would be abolished and the GPs' level of service and remuneration would be agreed between him and the DHA in the negotiations over registration. The DHA package would "buy" lower costs with some restrictions on the GP/patient's choice of hospital and/or specialist, but it would presumably allow the GP to send his patient outside the approved list to physicians offering lower-cost treatments.

(12) None of these reforms would, of themselves, require more spending. There would accordingly continue to be waiting lists. The NHS minimum would therefore have to incorporate the priorities and waiting-list guarantees mentioned above. These would constitute an incentive for patients to "top-up" the NHS package with insurance designed to buy them such extras as:

a) privacy, better food, bedside telephone;
b) treatments not provided under the NHS;
c) the avoidance of waiting lists by either "queue" insurance like PPP's low-premium policy which offers private treatment to anyone who waits more than six

weeks for NHS treatment, or insurance for certain categories of treatment.

Safeguarding the Capital

Under this new system, we need to ensure that capital expenditure reflects demand. We should move away from the present needs based system to one in which patients' choice is the prime determinant of where capital expenditure takes place.

To start with, most of the hospitals providing services to the NHS will have been transferred from public ownership to private trusts. We need to establish these on a basis that enables them to compete fairly with the private sector. This means that they must have a capital that matches their market value. They will have to remunerate this capital in their charges just as private sector hospitals have to. A popular hospital should have a higher starting capital than one that is unpopular or provides a less good service.

New hospital buildings in future should generally be financed in the private sector with the capital costs remunerated through charges. Hospital owners will seek to achieve the best balance between capital and current costs, in order to minimise the charge to the NHS for a given level of service. As new hospitals are developed, old ones will find that their custom drains away and that they cannot continue to operate economically. There is no reason why the market should not take care of such a situation - typically a modern hospital might seek to merge one it was superseding, taking on the best staff and disposing of the premises.

But we would naturally wish to avoid a hospital apparently going bust. There might be some public sector regulatory body which could intervene when hospitals get into

difficulties and supervise an orderly transfer to new management.

There are two possible models for giving ex-NHS hospitals the starting capital proposed above:

(13) Either they could raise funds directly from the private sector in order to finance their purchase from the NHS. This approach may be feasible as a gradual, long term plan but in the short term the private sector may not be willing to put up the necessary capital.

(14) Or the independent hospitals could be given a notional starting capital. This process would not involve any public expenditure, essentially because the starting capital raised from the public sector would be exactly matched by a payment to acquire the hospital buildings. Thereafter, the newly independent hospitals would be required to remunerate this capital by means of regular payments to the NHS at a rate reflecting the cost of capital to the private sector. It will be a difficult technical exercise to value all hospitals but once this is done this approach should ensure that they compete fairly with new private sector hospitals and that levels of capital expenditure reflect customer preferences.

That is, of course, only one possible solution. Some hospital managements might prefer to lease the hosital and its equipment from the public sector. Provided the NHS charged a market price for this rental, there could be no objection to this half-way house. In such cases, the NHS could reduce the locked-up capital by selling the freehold and other assets to a private company.

Managing the Reforms

The schedule for these reforms should combine early action by Government with time for reflection.

Virtually all the supply side measures could be introduced without legislation, by a series of executive steps that would give an impression of decisive action to improve the nation's health.

Some - like the reform of consultant contracts or the drawing up of medical priorities - might require the establishment of carefully selected committees of inquiry with instructions to report back within three or four months.

Any major reform of funding could meanwhile be examined in detail by Ministers with a view to a White Paper in late summer and legislation in 1989.

To give urgency and direction to NHS reform, you should:

1. Adopt a general programme of reform and set up a fortnightly meeting of Ministers under your chairmanship to pursue it.

2. Ask the DHSS to submit at least two papers on particular fundamental reforms, as in education, for the first meeting in mid-February.

3. Ensure that private work on similar lines is taking place to familiarise the general public with the ideas underlying likely reforms.

John O'Sullivan

JOHN O'SULLIVAN

SECRET

POTENTIAL INCOME FROM CHARGES

A. ON EXISTING EXEMPTION BASIS (70% OF CASES)

| Charge | | |
|---|---|---|
| £2 | Visit to GP | 100 |
| £2 | Hospital Attendance | 28 |
| £5 per stay | Hospital Inpatient | 10 |
| £5 | Visit to GP | 250 |
| £5 | Hospital Attendance | 78 |
| £5 per day | Hospital Inpatient | |

B. ON LOW INCOME EXEMPTION BASIS (30% OF CASES)

| Charge | | |
|---|---|---|
| £2 | Visit to GP | 240 |
| £2 | Hospital Attendance | 67 |
| £5 per stay | Hospital Inpatient | 22 |
| £5 | Visit to GP | 630 |
| £5 | Hospital Attendance | 274 |
| £5 per day | Hospital Inpatient | 113 |

CONFIDENTIAL

ESTIMATES OF THE COST TO THE PUBLIC SECTOR OF TAX RELIEF ON PRIVATE HEALTH INSURANCE

1. It is assumed that tax relief would be at the basic rate of income tax, that there would be no other concurrent policy changes (no reduction in NHS services, for example) and that the elasticity of demand for private health insurance would be - 0.5.

2. Estimates are provided for three options:

- tax relief for all
- tax relief for the elderly
- raising the income threshold for tax relief from £8,500 to £17,000 p.a.

The figures shown in the following table are estimates or guesstimates for 1988 assuming full adjustment in the first year.

ESTIMATES FOR 1988

| | Cost of Tax Relief | | | |
|---|---|---|---|---|
| | Deadweight Cost £m | Extra Subscribers £m | Potential NHS Savings £m | Net Cost £m |
| Tax Relief For all | 164 | 24 | 39 | 149 |
| Tax Relief for those 65+ | 20 | 3 | 4 | 19 |
| Raise Income Threshold to £17,000 p.a. | 83* | 12* | 19* | 75* |

* guesstimates

3. It is estimated that there would be an increase of 13.5% in numbers insured under all three options: ie of about 800 thousand persons under option 1, of 50 thousand under option 2 and of 400 thousand under option 3.

4. The actual savings to the NHS might be negligible because private insurance is used mainly to cover elective surgery and there are long NHS waiting lists.

5. Of course, if there were concurrent action to restrict access to NHS elective surgery*, the cost of tax relief and the NHS savings might be much larger. The private insurance market doubled in size between 1978 and 1985 with rising incomes and a perceived deterioration in NHS services.

* or levy charges.

CONFIDENTIAL

PAYING FOR THE NHS THROUGH CONTRIBUTIONS

The standard contribution rates for 1988/9 are as follows:

| Per cent of relevant earnings | National Insurance Fund | NHS | Total |
|---|---|---|---|
| Employee | 8.05 | 0.95 | 9.00 |
| Employer | 9.65 | 0.80 | 10.45 |
| Total | 17.70 | 1.75 | 19.45 |

Meeting the <u>whole</u> cost of the NHS system would:

- add about 12% points to the total contribution rate (5½% and 6½% respectively for employees and employers if shared between them in the current ratio)
- give a total NHS contribution of nearly 14% (which could be split roughly 6½% and 7½% between employees and employers)
- reduce basic rate of income tax to about 17p in the £ (compared with an assumed rate of 27p for 1988/9).

If <u>only</u> the cost of <u>the HCHS</u> (<u>hospitals</u> cannot be separated out in the time) were transferred to contributions this would have a somewhat smaller impact

- a rise of about 8½ percentage points on the total contribution rate (split roughly 4% and 4½% respectively between employees and employers)
- a total NHS contribution of just over 10 per cent (about 5 per cent for both employees and employers)
- a cut in basic rate tax to 20p in the £.

NOTES: 1. Because contribution revenue is buoyant as earnings grow, contribution rates could come down if NHS costs were held below the growth of earnings. <u>Alternatively with constant rates NHS</u> income would rise in line with earnings.

for wage demands?

2. The adverse effect on labour costs of a shift to NI contributions could be reduced or virtually eliminated if the increase in rates was loaded on employees.

3. We have assumed the upper earnings limit of £305 a week continues to apply to employees' contributions but not to employers' contributions. Abolition of the employee's ceiling would partly reduce the regressive/effect of a shift to NI.

CONTRIBUTION AND TAX RATES IN 1988/89 IF COST OF NHS SWITCHED TO CONTRIBUTIONS.

| | Existing Rate | Switch all of NHS New Rate | Change | Switch only HCHS New rate | change |
|---|---|---|---|---|---|
| Contributions* | | | | | |
| employee | 9.00 | 14½ | + 5½ | 13 | + 4 |
| employer | 10.45 | 17 | + 6½ (approx) | 15 | + 4½ (approx |
| Total | 19.45 | 31½ | +12 (approx) | 28 | + 8½ (approx |
| Income Tax** Basic Rate | 27 | 17 | -10 | 20 | -7 |

Notes

* per cent of relevant earnings. Increase in contribution rates could alternatively be loaded entirely on employees.

** pence in the pound

KEY DATA

| | | |
|---|---|---|
| NHS spending | £21.8 billion | |
| HCHS spending | £16.0 billion | |
| Total contributions | £30.3 billion | (G.B. only) |
| of which NHS | 3.3 billion | (G.B. only) |

Estimated Income Tax Revenue (at 27p in £) £48 billion.

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PRIME MINISTER

HEALTH
(Meeting of Ministers, 27 January 1988)

(Relevant Papers: Paper dated 15 January from Secretary of State for Social Services; Minute dated 15 January from the Chancellor of the Exchequer)

DECISIONS

This meeting provides an opportunity to discuss the Government's strategy on the National Health Service (NHS) and to map out a new political initiative. You may wish to invite the Secretary of State for Health to outline his thinking, and then focus the discussion on the following points:

a. The need for an initiative. Is it agreed that over the next six months a small group of Ministers should take a radical look at the NHS, including the fundamental problem of reconciling rising demand with limited resources, with a view to announcing decisions, say, before the Summer Recess?

b. The need to improve the present structure. What improvements are possible in the NHS, within the present tax-financed structure, to improve patient services, or to make more resources available without increasing public expenditure (eg by creating an internal market which allows patients greater choice)?

c. The options for radical change. Looking ahead what are the main options which the Ministerial group should consider for making more radical changes in health financing, for example to get away from the present tax-financed basis? This involves deciding what sort of NHS the Government wants in the longer term.



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d. Next Steps. At a practical level, there need to be decisions on whether and how the exercise should be the subject of a public announcement, whether Mr Moore should carry out consultations and how the Ministerial group should be organised. You may also wish to commission papers by the DHSS and Treasury in the light of the discussion.

BACKGROUND

2. Mr Norgrove's letter of 23 December suggested four basic principles in considering options for the future:

a. a high standard of medical care must always be available to all, regardless of income;

b. the arrangements must give the users of health services, whether in the private or the public sectors, the greatest possible choice;

c. any changes must be made in such a way that higher health spending does not lead only to higher incomes for the suppliers of health care;

d. responsibility, whether for medical decisions or for budgets, should be exercised at the lowest appropriate level. Skilled people should not be expected to do work which could be done by people with less skill.

3. Mr Moore's paper describes the substantial increase in public expenditure on health over the last few years. Figures giving the real increase in expenditure on health, after allowing for general inflation, do not give the whole story. They need to be adjusted to allow for:

a. increases in NHS inflation, in particular in pay which accounts for the bulk of NHS costs;

b. the underlying increase in costs resulting from demographic change, in particular the increase in the number of very old people, and expensive advances in medical science.

Paragraph 3 of his paper suggests that after allowing for inflation ((a) above) the increase in resources available to the NHS between 1982-3 and 1986-7 was only 0.1% a year. The demographic changes ((b) above) are usually reckoned to increase costs by some 1.2% a year. These figures may explain the feeling that standards of care have declined over the last few years, despite the massive increase in public expenditure. If so, they demonstrate the case for a fundamental look at present arrangements.

ISSUES

IMPROVEMENTS WITHIN THE PRESENT STRUCTURE

4. There are some interesting options which you may wish to probe.

5. First, there is the question of costs. Proper information about costs is a necessary condition of other management improvements. The DHSS paper (paragraph 12) refers to the 'resource management initiative', which is designed to give doctors and other professionals 'detailed information on output and costs'. But, on the acute side, this initiative at present covers only five hospitals. The intention is to apply it to all 700 acute units by 1993 but you may wish to ask whether this can be accelerated.

6. Also important would be the development of longer-term objectives and indicators to measure progress towards them. Mr Moore mentions this briefly (paragraph 7 of his covering minute) but does not develop it. You may wish to ask about his plans. Such indicators could provide positive information about the NHS. But before the Government finally adopted them it would want to be sure that they really would show a picture of rising standards

of health care, and would not increase pressure for more public expenditure.

7. Another group of questions concerns the control and status of the NHS. It is not independent of the DHSS and the Minister of Health is Chairman of the Management Board. You might ask whether it would be a logical extension of the Griffiths reforms to separate it entirely from DHSS and make it an independent trust, removed from the political sphere and with its own clear lines of responsibility. This has been proposed by the Policy Studies Institute. But is it realistic to suppose that the NHS can be insulated from politics while it is largely tax-financed? Would making it an independent trust be equivalent to setting up a new nationalised industry with its own vested interests?

8. Another possibility is the creation of an internal market. At present the NHS is a planned and centralised bureacracy. The idea would be to introduce competition within the health authorities, between health authorities and between health authorities and the private sector. Such arrangements could take any of the following forms, in increasing order of innovation.

a. Trading agreements between Authorities, so that Authority A could treat patients from Authority B, on repayment, if its costs were lower. Similar agreements could be made between Authorities and the private sector.

b. Competition between Authorities for the allocation of patients by GPs. GPs would have more freedom to direct their patients to authorities whose standards of patient care they judged to be the highest, and the funding of the Authorities would be adjusted accordingly.

c. Competition between Authorities directly for patients. This would be the most radical of these options. It would give to the patient the decision as to where he was treated. This reform would be similar to the reforms now

being introduced in education. It could be combined with a system of health credits, by which the GP could receive a credit note covering the cost to the NHS of providing the treatment he needed. Or we could consider the French system under which the patient arranges and pays for treatment and is then reimbursed the cost. This also has the advantage of bringing the cost home to him.

Whether these or any other models are workable would require detailed study. The Chancellor proposes that DHSS and the Treasury should work up possible options and you may wish to endorse this.

MORE RADICAL CHANGES

9. A more radical change would be to move away from a largely tax-financed system.

10. One option would be to increase NHS charges. The Chancellor has mentioned:

a. broadening the base of prescription charges, by removing the exemption for pensioners above the income support level;

b. charging for visits to GPs;

c. making hotel charges for hospital stays.

You will want to consider whether these or other charging options should be worked up. Charges now provide only a small proportion of NHS revenue, so that substantial increases or major new charges would be necessary to have much impact. They would be controversial.

11. A second option would be encouragement of private sector provision, most obviously through tax relief. Mr Moore mentions this possibility. You will want to consider whether it requires

further study.

12. A third, more fundamental, option would be to change the system over time so that funding was provided not by tax but by either:

a. Social insurance, as in France and West Germany. Finance is provided from a separately identified fund working within a contribution and benefit framework laid down by the Government. In the UK the question is whether such a system could be grafted on to the present National Insurance system.

b. Compulsory private medical insurance, perhaps with continued State funding for the poor or chronically sick.

Here again you may wish to commission more work. We understand informally that Mr Moore's own thinking may be developing on these lines. It might be possible to start by funding health care from the National Insurance Fund, with a consequent increase in NI contributions, but to allow contracting out for employers' schemes or even individuals. This could mean that initially the charge could be small, with tax finance replaced by NIC finance. The system would then allow a gradual movement over time to a largely privately-financed system, as contracting out increased, and would be similar to the approach adopted by the Government on pensions.

**TIMING AND NEXT STEPS**

13. Mr Moore may suggest that he should make an early announcement in Parliament about the Ministerial exercise. This proposal (which overtakes his earlier suggestion of a Green Paper) would have the advantage of allowing the Government to take the initiative in the public debate. But there is relatively little that could actually be said at this stage, beyond the fact that the exercise was taking place. You may wish to explore what he would envisage the announcement saying and what form it would

take (eg formal statement or Answer to a Parliamentary Statement) or PNQ.

14. Mr Moore may also propose a consultation exercise in which he would invite the main interested parties to let him have their views and more generally invite the public to make suggestions about how the NHS could be improved. This would have presentational attractions, but you may wish to discuss how he should carry it out and over what timescale.

15. There will also need to be decisions about what form the Ministerial Group should take. This does not need to be settled at the meeting, but the main options are:

a. a small Cabinet Committee under your chairmanship along the lines of E(EP) which determined education policy last year; or

b. an informal ad hoc group, again under your chairmanship, which would report its conclusions to E(A), or the Cabinet, or both.

HANDLING

16. You will wish to ask the Secretary of State for Social Services to introduce his paper. The Chancellor of the Exchequer will also want to speak to his minute.

R T J WILSON

Cabinet Office
26 January 1988

C

PRIME MINISTER

**HEALTH - PRESENTATION**

The media have known for a few days that you are seeing John Moore this week - and one newspaper has said Wednesday. Neither DHSS nor I have denied it, but I have said that any meeting at this stage is inevitably a preliminary to the exercise you announced last night.

Both DHSS and I will come under pressure tomorrow and television will almost certainly want to come into the street to record comings and goings.

I see no virtue in being coy about the meeting. Indeed, I see every advantage in making a virtue out of it by presenting it as you and Mr Moore immediately getting down to planning the tasks to be done within Government. This demonstrates the urgency and determination you are bringing to the exercise.

I also see great merit in operating exactly as we did - and successfully - over the AIDS Committee. We then were quite open about the initial meeting but we said this would be the first and last time we proposed to discuss its meetings or their outcome. As and when the Government had anything to announce it would do so in the normal course of business.

You have seized the initiative for the Government with the Panorama broadcast and we need to keep it.

I understand Mr Moore has it in mind to give some interviews tomorrow evening and you might usefully encourage him to do so, partly to help get the whole exercise in perspective.

Content?

B Ingham

BERNARD INGHAM
26 January 1988