PA.
Note Spoke R Lodge and told him to proceed as here then.
RRCG 4/2

Prime Minister
You may like to glance at this work in progress. Sir Roy Griffiths is also working on a note for the weekend.
RRCG 3/2

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P 03005

From: R T J Wilson
3 February 1988

MR GRAY

cc Sir Robin Butler

NATIONAL HEALTH SERVICE

1. Following the Ministerial meeting on 27 January the Cabinet Office was asked to co-ordinate a paper which proposed how the group should proceed in tackling the issues.

2. I attach a draft of such a paper. It is being shown to the Chancellor of the Exchequer and the Secretary of State overnight to check that they are content with it as a basis for discussion. The draft is similar to the one you saw yesterday but reflects comments from the Treasury and DHSS.

3. The draft sets down some preliminary thoughts about the problems which the group will have to analyse and ways in which they might be approached. We will be suggesting in our brief for the Prime Minister for the next meeting what follow-up action she may wish to commission. It is already clear that the problem is going to be how to inject a practical flavour into a subject where there is no end to the ideas which in theory might be explored. We have tried to angle the paper to help deal with this.

4. I would be grateful if you could confirm that the paper is on the right lines, subject to any comments which the Chancellor and Mr Moore may make. We will then let you have it in final form for circulation to the Ministerial Group on Friday.

5. I have pressed the DHSS to let us have a copy of the terms and conditions of consultants' contracts rapidly, hopefully today. I will forward it to you when I get it.

RJW

R T J WILSON

P.S. Mr Moore has now seen this paper and is content with it.
RJW.

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THE NHS

Note by the Cabinet Office

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

Scope and Objective

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

Problems

3. The fundamental problems are:

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

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

c. there is no mechanism for ensuring that most resources go to the most efficient and cost-conscious units, eg the most efficient District Health Authorities (DHAs). Nor, unlike a business, can NHS hospitals increase their funding by increasing output. As the Secretary of State's paper points out, hospitals are not rewarded for attracting patients but suffer financially for it.

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

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

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

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Suggested approach

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

Facts

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

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

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

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

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

e. the terms and conditions of consultants' contracts.

Selected Aspects

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

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

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

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

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

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

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

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

Some possible structures

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

Market mechanism within existing NHS structure

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

A new NHS structure

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

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

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

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

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

- a system of health credits, by which the patient could receive a credit note convering the cost to the NHS of providing the treatment he needed, which he could then use wherever he chose within the Service or, more radically, within the private sector.

A greatly expanded private sector role

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

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

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

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

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

CONCLUSIONS

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

Cabinet Office
3 February 1988

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