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PRIME MINISTER

NHS Review

Meeting of Ministers, 22 March 1988.

This meeting is to take forward the review of the NHS. It has four papers before it:

HC 14	A covering note by the Cabinet Office.
HC 15	Longer-term options for radical reform.
HC 16	Categories of treatment.
HC 17	Waiting lists.

The last three papers have been prepared by the official working group consisting of representatives of the Cabinet Office, Treasury, DHSS and No 10 Policy Unit.

Background

2. All the papers were asked for at the last Ministerial meeting on 29 February. In particular, that meeting decided that the group should start considering options for the longer term. We have steered the work in that direction: hence paper HC 15.

3. We have also developed the concept of there being three categories of health care:

i. essential health care which must be financed by Government because it cannot be insured against and is too expensive for individuals to afford;

ii. health care which Government may finance but which people may wish to provide for themselves and their families e.g. by opting out;

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iii. a small residual category of treatment which people should pay for themselves.

Paper HC 16 attempts a broad analysis under these three headings. It would probably not be fruitful to spend time debating precisely what sort of treatment falls within which heading. In practice it might well be sensible to allow the insurance market to help determine the scope for opting out. The important point is that these three categories provide a basis for analysing the kinds of reform which are needed.

ISSUES

4. You might begin by reaffirming the decision taken at the previous meeting that the Group should consider options for the longer term. The aim is to consider the desirable long-term direction of change, and what short-term steps would begin a gradual move in that direction while also being desirable in themselves.

5. You might then invite the Group to look at the five broad approaches to long-term change which are summarised in paragraph 2 of the Cabinet Office paper and are analysed in more detail in HC 15. These approaches are not mutually exclusive. Indeed the final package of reform may need to draw on elements of all of them.

6. There are then three main points for consideration to be drawn out of the rest of the Cabinet Office note:

i. on any basis there is likely to be substantial continuing expenditure by Government on essential health care. What long-term reforms are needed in this area? The Cabinet Office note identifies independence for hospitals, greater use of topping-up insurance and a drive for greater efficiency and cost consciousness. But those are only examples: the abolition of regional health authorities, greater use of pay incentives, the introduction of no-strike pledges are all examples of what may be needed for the final package.

ii. the most promising area for radical reform is the area of 'acute' treatment, especially 'elective' treatment, which people may prefer to provide for themselves and their families rather than rely on the State. This also happens to be the area where waiting lists are predominant. The Cabinet Office paper suggests that further work should as a next step be carried out on opting out and Local Health Funds.

Opting out

7. You may in particular wish to focus the discussion on opting out as the next main issue which needs to be explored and as the best way of making progress with the Review. It could be combined with greater independence for hospitals and a drive to refurbish the NHS; and it could be a stepping stone towards more radical reform including local health funds on which more detailed work also needs to be done.

8. The first question which would need to be considered would be the category of medical treatment to which it should apply. One obvious solution would be to allow opting out for all treatment which was insurable or affordable by the individual. It is not possible to predict how much of present expenditure on the Hospital and Community Health Service (HCHS) this might cover. A lot would depend on whether more sensitive areas such as, say, maternity care and expensive acute treatments were included. But a decision as to what could be opted out need not be permanent. It would be possible to start with a comparatively short list of eligible treatment, to get the idea accepted, and then gradually extend it.

9. The paper on waiting lists, HC 17, proposes the rather different approach of compulsory insurance funding for all elective surgery, with the Government paying the premiums for those who could not afford to pay. But this change could be made at the same time. There could be both compulsory insurance

funding for elective surgery, and opting out for a wider range of treatment which was not discretionary but still insurable or affordable by the individual.

Incentives

10. The next question to consider would be the incentive for opting out. There are three possibilities:

- Tax relief. But this would complicate the tax system and not offset the full cost of the private treatment.

- Vouchers, covering the cost of treatment in the opting out category, with which individuals could pay for either NHS or private treatment, as they chose. But this would probably mean that the payment for the private treatment would still rank as public expenditure.

- Contribution rebates. This would mean shifting the financing of health care from tax to contributions, either the NIC or a new system of health contributions. (This might also have the advantage of bringing home the cost of health care). Those opting out would then receive rebates related to the cost of the treatment opted out. This would be very similar to the arrangements for pensions.

11. Mr Moore may be attracted to opting out but the Chancellor may be cool. One Treasury concern is "deadweight": that is, that people who already have private health insurance would be given a rebate to do what they are already doing. But is it equitable at present that they are having to pay twice, once through the tax system and once through their insurance premia? Another concern is that the young and healthy would opt out, leaving the NHS with the most expensive cases; a form of adverse selection. This possibility will need to be considered further. But it might be possible to prevent adverse selection by adjusting rebates for age and perhaps other factors such as medical history so that younger people did not get an unfair advantage from opting out.

12. Opting out could also be combined with the development of Local Health Funds (LHFs). It could be made conditional on the payment of a subscription to an LHF to cover the cost of the opted out treatment.

Further work

13. You could commission further papers on opting out for the next meeting. You could ask for these to cover all the options in paragraph 10 above, or you could decide to concentrate on the contribution rebate route. Any such work will need to consider:

- the categories of treatment to be eligible for opting out, both initially and over time;

- the size of the rebate, if the contribution method is chosen. Should it vary with age, and with any other circumstances?

- any condition as to the alternative arrangements to be made by those opting out. Should they for example have to join an LHF?

- the effect on public expenditure, and Exchequer costs more generally;

- how opting out might be combined with other desirable structural options, such as refurbishment of the NHS and creation of independent hospitals;

- how it could be combined with action on waiting lists, as described in HC 17.

This is a substantial exercise and needs to begin soon to keep up the momentum of the Review.

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14. You may also wish to set more detailed work in hand on Local Health Funds, so that it is available when the Group comes to consider this issue.

RTJW.

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Cabinet Office
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