SECRET

PRIME MINISTER

21 March 1988

CC J. O'SULLIVAN.

NHS REVIEW PAPERS

1. The NHS review papers you have received, though they have been modified in response to criticism from the group, bear some marks of their departmental origin. The "options for change" paper (HC 15), for instance, is in effect a joint Treasury/DHSS paper and reflects the nervousness of the two departments about any proposals which threatens the centralised structure of the present health service (see below). Similarly, the waiting list and categories of treatment papers (HC 17 and HC 16) are products of the DHSS and still retain traces of that department's affection for the bureaucratic allocation of resources.

As a result, the Cabinet Office note is the most balanced and impartial paper before you. And I urge you to support its proposals for two further papers on "opting out" and Local Health Funds (LHFs).

2. My only general criticism of the papers is that HC 15 ranges the options along a radical-status quo spectrum on which they do not fit altogether comfortably. Thus option 1, the patient as buyer, is a proposal for voluntary private health insurance. It is therefore radically different from the other options which are all evolutions from the existing structure of collective provision by the State.

3. But you should be aware of one important point about LHFs. The original DHSS paper mistakenly saw them as a variant of voluntary private health insurance - similar to health maintenance organisations in the USA. Yet every proposal for LHF's in Britain has seen them as public sector organisations, financed by tax-funded capitation fees. In effect, they introduce competitive pressures into the NHS

SECRET

framework of collective provision. Seen in this light, they are very similar to the local health authorities under Option 3 -- the major difference being that GP's and/or patients would be able to choose which LHF to join rather than simply being assigned to a local health authority.

This erroneous view of the LHF concept as a form of private insurance is largely corrected in the paper itself. But you may encounter it in arguments at the meeting.

4. The paper on waiting lists and times contains a useful analysis of the problem, but its conclusions are disappointing. The proposal it favours - intensifying the present waiting list initiative - is a short term palliative. It rests essentially upon providing more information (which is necessary for any reform of waiting times), but it offers no real incentives for DHA managers to seek out lowest cost procedures, or for patients to insure themselves for conditions with long waiting times.

The paper's first of two radical proposals - compulsory insurance funding for elective surgery - goes too far in the other direction. It would breach the principle of a free health service and so would have to be considered in the wider context of the "Options for Change" paper. What we need in the context of waiting times is an incentive for "queue insurance" along the lines pioneered by PPP.

This is precisely what the proposal for guaranteed maximum waiting times offers. The DHSS simply does not understand this proposal. It is not, for instance, "incompatible with cash limits", being designed precisely in order to reduce waiting times within a cash limited system. It would include a "residual category" of non-urgent conditions with an unlimited waiting time. Budgets for this category would lose resources, if necessary, to finance the guarantees for higher priority conditions as the financial year proceeded.

We need to know:

What conditions might reasonably be placed in the residual category?

What percentage of patients wait for x weeks longer than a "reasonable" maximum waiting time for particular urgent conditions?

And how large of perecentage of the residual budget might have to be re-allocated in a typical year to meet a guaranteed waiting time of x weeks for urgent conditions, y weeks for less urgent conditions, etc.

5. Both the DHSS and the Treasury tend to support the present centralised structure of the NHS. The DHSS does so because any proposal for structural change would create havoc with vested medical interests of which it is the sponsoring department. The Treasury believes that the NHS monopsony is a good device for controlling "global" health spending even if it bad at keeping particular costs down (a formula for waste and inefficiency). You may therefore encounter the following arguments at the meeting:

(a) **Deadweight cost. Almost any proposal to encourage private health insurance (e.g. vouchers or opting out) necessarily means that the Treasury will find itself paying for some health insurance premiums now paid by the patient.**

This is so. However, there is a countervailing factor. As more people spend money on health insurance, they reduce the pressure on the public sector. In the long run, the Treasury would gain. Deadweight cost is

therefore largely a transitional problem and way to solve it is by a staggered transition. If deadweight cost were to be regarded as a sufficient obstacle to any proposals for reform, it would prevent any reform that might expand the private health sector.

(b) **A larger private sector will increase competition for doctors and nurses and other medical resources. This will "bid up" wages, salaries and other medical costs, thus increasing public expenditure on health.**

In general, the Treasury is inclined to like the centralised NHS because it enables the centre (i.e. itself) to determine what the salaries of doctors generally should be, and what treatments are "necessary". But the Treasury does not decide what all lawyers, or all journalists, or all architects should earn. Nor what court caes are "necessary". Nor should it.

For health, however, it prefers a socialist system of remuneration which Mr Gorbachev has rightly described as "We pretend to pay you and you pretend to work." This goes a considerable way to explaining bad consultant practices.

Principally, however, the bidding up argument ignores the pressures for improved performance in a competitive system. Over time, the supply of doctors would tend to increase if demand for their services grew. And in the meantime, a shortage of medical resources under conditions of competition would encourage their more efficient use.

SECRET

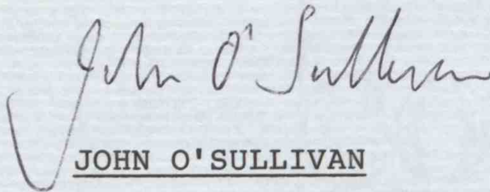
RECOMMENDATIONS:

You should commission three papers on

(a) opting out

(b) Local Health Funds (making clear that these should be seen as operating initially within the public sector)

(c) guaranteed maximum waiting times.



JOHN O'SULLIVAN