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PRIME MINISTER

6 May 1988

THE WAY AHEAD ON HEALTH

You have before you three papers: Mr Moore's 'Charting the Way Ahead', the Chancellor's paper on contracting-out, and Mr Wilson's proposed timetable for the remainder of the Health Review.

'Charting the Way Ahead' is built around the central idea of separating the "providers" and "buyers" of health care by making hospitals independent. It is an ambitious, well-worked-out scheme which meets the objectives set out at the start of Mr Moore's paper. I would urge you to give it general support as the basis for future discussion.

But certain points remain to be resolved:

Preserving Patient Choice.

As now, the patients would be allocated to a buying authority on the basis of where they lived. But the freedom of their GPs to refer "could in practice be restrained by the relevant buyer's decisions on the placement of contracts." So patient choice might actually be reduced.

Some patients would find themselves, as now, captives of bad buyers. And no buying authority would have the incentive to improve its performance. Without the need to retain patients, indeed, the buyers would probably maintain a cosy relationship with the hospitals and other suppliers they used to control. Very little would really change.

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Buyers need a competitive stimulus. Dissatisfied patients must be able to take their custom elsewhere. Over time, this might be achieved in several ways:

1. Making it cheaper and easier for people to take out private health insurance (See below).

2. Allowing patients and/or GPs to register with a different competing buyer. (Annex B points out that GPs need not necessarily be located within the buying authority's boundary).

3. Allowing GP group practices to act as the buyers for their patients if they can convince the DHSS of their administrative capacity.

Achieving Diversity

The paper is vague on the size and character of the buying authorities. Presumably the more responsibilities an authority has, the smaller will be its geographical ambit. If the Griffiths report puts the organisation of community care under the same body as the purchase of hospital treatment, that would surely point to authorities smaller than existing districts (with a corresponding need for regional planning and coordination.) If health and community care go under separate bodies, however, that might point to larger DHAs.

But we should consider whether we should have a single type of buying authority at all. It might make better sense to adapt existing bodies and accept a diversity of institutions. District health authorities, family practitioner committees, group practices as above, and private sector insurance companies might all contract to purchase care with the DHSS. In some cases, they would also purchase community care arrangements; in others, not. This

would allow both experimentation and adaptation to differing local circumstances.

Funding the Buyers

How would the buyers be funded - by a RAWP formula or by an age-related capitation fee. This is not clear, but the preference of the DHSS will probably be for a RAWP approach. That would block off a number of useful developments. Under a capitation regime, money would move with the patient. Buyers would receive funds in proportion to the population or, in conditions of competition, to their success in attracting clients. And at some point in the future, the capitation fee could be made wholly or partly transferrable to private sector health buyers.

The Treasury View

Some method of reducing the cliff edge is essential if we are to draw more private money into health care, encourage private insurance companies to market their policies more imaginatively, and in general change the climate in health care. There is no sign that the Treasury accepts this.

The Chancellor's analysis exaggerates the risk of losing control of health expenditure under any scheme to stimulate private health insurance. For instance, the Treasury paper asserts that an expansion of the private sector would produce shorter waiting lists rather than lower costs in the public sector. That would not necessarily be a bad thing. But, in any event, it is not foreordained but dependent upon decisions in the PESC round which the Treasury might hope to influence.

There are strong criticisms to be made of the various schemes for contracting out, on which the paper concentrates its fire, and the Treasury duly makes them. But, even here,

it tends to exaggeration. For instance, it asserts that adverse selection against the NHS is inevitable under contracting-out. This is not so if private insurers in receipt of public money are required to accept applicants in accordance with a scale of fees that varies only according to age.

In addition, the paper narrows the options unjustifiably to "contracting out" and tax relief for private insurance premiums. (Its reluctant support for a minimalist version of the tax relief for the over-65s should nonetheless be welcomed as the thin end of the wedge.) But it includes no examination of transferrable capitation fees as a method of stimulating the private sector. (The nearest we get is a one-line throw-away reference to vouchers in paragraph 17).

Admittedly, the new structure of health care outlined in Mr Moore's paper would need to be in place before such an approach could be tried. Then, however, it would have a number of attractions:

1. It is administratively simple.

2. It requires no recasting of the tax system.

3. It is flexible and can be raised or lowered according to age or social characteristics.

4. It raises no difficulties as between the working and non-working population.

5. It would even fulfil the Treasury's desire to control spending since anyone taking a capitation fee into the private sector might have to accept a lower one.

Proposals

I therefore suggest that you adopt the following course of action.

1. Accept Mr Moore's paper as the basis for future discusson but request more work on the size, structure and funding of the buying authorities, and upon methods to safeguard patient choice.

2. Postpone decisions on major funding changes, notably contracting out, until we have reached agreement on structural change within the NHS (the week beginning 20 June in Mr Wilson's timetable).

3. In the meantime,

   - commission a study of transferrable capitation fees, (which might be introduced when the new structure of buying authorities is in place);

   - accept tax relief for the elderly

   - and seek tax changes to promote employer health schemes (as outlined in the Chancellor's paper).

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