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PRIME MINISTER

REVIEW OF THE NATIONAL HEALTH SERVICE

1. The next meeting of the Ministerial Group on the NHS next Thursday, 30 June, will have a full agenda:

i. tax relief: a paper by the Chancellor of the Exchequer following up earlier discussion about the elderly and company health insurance schemes. The Secretary of State for Social Services plans to circulate a parallel paper on contracting-out;

ii. financing hospitals: a paper by the Chief Secretary elaborating his idea of holding back a sum of money from annual allocations and using it to reward the more efficient hospitals;

iii. self-governing hospitals: a paper by the Secretary of State for Social Services about giving hospitals greater freedom and responsibility for managing their own affairs;

iv. consultants' contracts) medical audit) two papers by the Secretary of State for Social Services about how these key issues should be tackled.

2. The aim will be to prepare the way for the full morning's session on Friday 8 July when the Group (including the regional Secretaries of State) will look at the overall shape of the package which is emerging.

3. The Chancellor and the Secretary of State have both asked for their departments' papers to be revised, and we have not yet seen them in final form. But it may be helpful to summarise some of the points which are emerging. I will let you have a full brief when we have the papers.

Tax Relief and Contracting Out

4. The Chancellor will continue to resist giving tax relief at the higher rate on private medical insurance for the elderly. He will argue that the benefits are not worth the cost and administrative complexity. In particular, he will probably argue that:

a. higher rate tax relief would increase the cost to the Exchequer from £25 million for basic tax relief to just over £30m;

b. it would only benefit over-60s with incomes above £20,000;

c. there would need to be safeguards to ensure that contributions by children on behalf of parents were genuine.

5. The Chancellor will also argue against raising the limit below which employees escape tax liability on company health insurance schemes as a benefit in kind (eg from £8,500 to £20,000), on the following grounds:

why?

a. it would be an extra complication for employers and would run counter to policy on deregulation;

b. company health insurance schemes have started growing strongly over the last eighteen months and need no boosting (the Treasury are searching for figures to prove this);

c. the concession would lead to pressure to raise the £8,500 P11D limit more generally;

d. it would be seen as unfair by employees whose companies do not have such schemes, and by the self-employed.

6. The Chancellor may however offer a limited concession on benefit in kind for people over 60 who are still in employment and covered by company schemes.

7. Both the Secretary of State for Social Services and Sir Roy Griffiths believe strongly that raising the £8,500 P11D limit for company health schemes would be a valuable boost to private health. I gather that the Secretary of State is tabling his paper on contracting-out primarily as a fall-back position. It will propose that people paying National Insurance contributions should be able to contract out of NHS-funded provision of cold elective surgery in return for an age-related rebate on their contribution. But Mr Moore would much prefer the route of tax relief through raising the P11D limit.

Financing Hospitals

8. The Chief Secretary's paper will propose that most current expenditure would be allocated as it is now, presumably in accordance with the RAWP system: but the extra element provided for real growth in the health budget each year - typically about 2 per cent - would be held back and allocated separately in February to reward efficiency and also, where waiting lists are long, activity.

9. We shall need to see the paper in its final form. But the sort of points which you may wish to concentrate on are:

a. who would get the money? Allocating the money to hospitals would provide the most direct incentives to efficiency, but the proposal may be that it should go to district health authorities;

b. what would be the criteria? If allocations were made on grounds of improvements in efficiency, the scheme might reward those who had been inefficient hitherto, and thus had most scope for improvement, rather than those who had already achieved high standards;

c. would the connection between performance and reward be strong enough? Hospitals would receive their allocations in April on the basis of performance o ver the most recent twelve months for which data is available. This might be as distant as the twelve months to the previous September.

Self-Governing Hospitals

10. Mr Moore's paper will attempt to identify the main ways in which hospitals could be given greater independence compared with the present system. Points for discussion will include:

i. the importance of developing information systems;

ii. the need to involve consultants and clinicians in responsibility for resources (this ties in with the need to revise consultants' contracts);

iii. the concept of 'contracts' between hospitals and district health authorities, and the implications which it has for finance;

iv. the scope for delegating decisions about pay to hospitals;

v. the need to slim down health authorities as hospitals become more independent.

11. It is clear from the drafts which DHSS have produced that a great deal more work needs to be done on how all this would work. You may want to explore the possibility of setting up a pilot

experiment to develop these ideas in practice at a fairly early date.

Consultants' Contract and Medical Audit

12. Mr Moore has asked for his department's papers on these topics to be substantially revised. I have not yet seen the outcome.

Meeting on 8 July: overall Package

13. If the Group can make progress on this material at the next meeting, it ought to be possible to put together quite a substantial package for discussion on Friday 8 July. It might, for instance, cover:

a. a better deal for patients which would include action on waiting time, tax relief and GPs' doing more minor surgery;

b. a more efficient NHS including better information systems, rewards for efficiency and greater use of medical audit;

c. a better organised NHS with steps towards self-governing hospitals (perhaps beginning with teaching hospitals) and slimming down health authorities;

d. a new role for consultants;

e. encouraging a mixed economy of health care with a more vigorous complementary role for the private sector.

14. This work is in hand. The main question is whether it will add up to a sufficiently radical programme of the sort that you had in mind when the exercise began. But it will be easier to judge this when the package is available.

RTJW.

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Cabinet Office
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