10 (a-k) CCB/OP. a

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P 03162

PRIME MINISTER

REVIEW OF THE NATIONAL HEALTH SERVICE

1. This meeting has a full agenda. You may wish to take the papers in the following order.

PAPER (A)

2. First, tax relief, on which the Chancellor of the Exchequer has circulated a paper. The main issues here are:

i. whether tax relief for the elderly should be at the basic rate for all or whether relief should be allowed at the higher rate as well;

ii. whether the limit below which employees escape tax liability on company health insurance schemes as a benefit in kind should be raised (eg from £8,500 to £20,000); and

iii. whether to accept the Chancellor's compromise. The Chancellor is opposed to concessions on i and ii above but as a compromise has offered relief for the benefit in kind charge on premiums paid by the elderly under company health insurance schemes.

PAPER (B)

The Secretary of State for Social Services has circulated a parallel paper on contracting out. I understand that he would much prefer tax relief for company health insurance schemes but has tabled this paper as a fall-back position.

PAPER (C)

3. Second, financing hospitals. The Chief Secretary's paper reflects his idea of holding back a sum of money from annual allocations and using it to reward the more efficient hospitals. A decision is needed on:

b

iv. whether this scheme of 'top-slicing' is approved in principle, subject to any steer which the Group may give about its main features. If so, a lot more work will need to be done on the details by officials.

PAPER D

4. Third, self-governing hospitals. The Secretary of State's paper attempts to map out a way of giving hospitals greater freedom of responsibility for managing their own affairs. A decision is needed on:

v. whether the approach is approved in principle. If so, officials will need to do a lot more work.

PAPERS E+F

5. Finally, consultants' contracts and medical audit. The Secretary of State's papers outline proposals for renegotiating consultants' contracts and strengthening arrangements for medical audit. The main features reflect earlier discussion in the Group. You may, however, wish to consider:

vi. whether the changes should be negotiated or imposed; and

vii. how far the new arrangements should be extended to all consultants, and not just applied to new consultants on appointment.

BACKGROUND

6. The aim is to clear the ground before the full meeting on Friday, 8 July, at which the Group will consider a paper by the Secretary of State setting out the overall package which is emerging from the Review.

7. In considering the papers before this meeting you may find it helpful to distinguish between those proposals which might be part of a package of immediate, short-term measures reforming the NHS within its present structure to which the Government would be firmly committed, perhaps in a White Paper; and possible radical measures for the longer term which the Government would consider

introducing once the first round of reforms had been implemented, and which might be more suitable for a Green Paper. Thus:

- the Chancellor's paper on tax relief, the Chief Secretary's paper on financing hospitals, and the Secretary of State's paper on consultants' contracts and medical audit are all matters for immediate action which can be undertaken within the present centralised structure of the NHS;

- the Secretary of State's paper on self-governing hospitals begins with action which could be taken now but then suggests a path to full independence which might take some years to achieve and which could be combined with the development of a much less centralised market in health care, which could also include, for instance, opting out by GPs, and more radical financing arrangements based on capitation fees.

One possibility would be to bring the short-term package of measures together with the ideas for the longer term in a White Paper with 'green fringes'. It would be important to ensure that the package was coherent as a whole.

MAIN ISSUES

Tax Relief and Contracting Out.

PAPERS (A)+(B)

8. The Chancellor's paper argues against giving tax relief at the higher rate on medical insurance premiums for the elderly. He believes that the benefits would not be worth the costs and administrative complications. In particular, he argues that higher tax relief would:

(a) increase the cost to the Exchequer from £25 million of basic tax relief to just above £30 million;

(b) have limited impact because the benefit would go only to over-sixties with incomes above £20,000; and

(c) necessitate safeguards to ensure that contributions by children on behalf of parents were genuine.

9. Against this it can be argued that:

a. the objective is to provide a boost for the private sector. In order to do this the tax relief must provide a real incentive. Health insurance premiums for the elderly are very substantial and tax relief at the higher rate is needed to help make them affordable;

b. it seems from the Chancellor's paper that the increase in take up needed to cover the cost would be 150,000 people compared with 100,000 people at the basic rate. Is it so unreasonable to expect relief at the higher rate to produce this extra take up?

c. the point about abuse by children paying their parents' premiums seems exaggerated. There may need to be checks, but would they be any worse than the checks which will be needed for tax relief at the basic rate, which he has already conceded?

10. The Chancellor also argues 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 grounds that:

a. raising the benefit-in-kind limit would be an extra complication for employers (he does not explain why) 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.

11. Against this it can be argued that:

a. tax relief for the elderly on its own, while understandably worthwhile, will not be enough. This concession for company health schemes might do a lot more to stimulate the private health insurance at a deadweight cost of £25 million which is no greater than tax relief for the elderly;

b. the concession would apply to people in the lower income bracket and could not be criticised as divisive;

c. if it is true that demand for private health insurance is growing at the moment, this may be in response to exaggerated fears about the 'crisis' in the NHS. The Government can scarcely plan on the basis of this continuing. The general trend between 1981 and 1986 was for the number of people covered by private insurance to grow slowly (graph attached);

d. employers would not be forced to introduce such schemes if the added complications really were a serious problem. But in practice they would welcome the concession (you might ask Sir Roy Griffiths for his view on this point: he thinks they would welcome it).

12. As a compromise the Chancellor proposes to include benefits-in-kind in the tax relief package for the over-sixties. This would increase the cost of the package for the elderly from £25 million to £35 million, and would benefit 65,000 employees as well as the 300,000 individual policy holders who will benefit from tax relief

for the elderly. You will wish to decide whether this goes far enough or whether it would be better to press for the wider concession for company health insurance schemes.

13. Both the Secretary of State and Sir Roy Griffiths would prefer the wider concession for company schemes. The Secretary of State's paper on contracting-out is only a fall-back position. The arguments against his proposals have been rehearsed at earlier meetings: in essence, the cost would be substantial (between £200m and £300m) and in the Chancellor's view the scheme would not be cost effective in raising the private sector contribution to health finance. Given the other business which the meeting has to get through you may prefer not to spend too long on the Secretary of State's paper: if need be, it could be discussed at the next meeting on Friday 8 July.

FSinancing Hospitals

14. The Chief Secretary's paper proposes that most current expenditure would be allocated as it is now, 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 were long, activity.

15. This would be a minor, not a major, reform of the NHS system as it works now. Depending on the points below, it might be useful but it would in no sense be a radical change. You may wish to concentrate on the following.

a. why would the extra money go to districts rather than hospitals? The aim of the new scheme would be to encourage efficiency, and the paper acknowleges that allocating the money to hospitals would provide the most direct incentives to efficiency. If districts got the money, they might spend it on something else: what would the incentive for the hospital be then?

b. would the connection between performance and reward be strong enough? Allocations would be based on performance over the most recent twelve months for which data is available. This might be as distant as the twelve months to the previous September;

c. would it be right to reward hospitals which improved their efficiency rather than those which were already efficient? The scheme might reward those which had been inefficient hitherto, and thus had most scope for improvement, rather than those which had already achieved high standards;

d. how would the scheme fit in with the longer-term development of the NHS? The paper says that it could be adapted readily to an evolving NHS structure: what does the Chief Secretary have in mind? There is no reference to money following the patient: how would this fit in with top-slicing?

16. Subject to these points, you will wish to decide whether more work should be done on the scheme to work it up for inclusion in a White Paper.

Moving towards self-governing hospitals

17. The Secretary of State's paper proposes a way of releasing hospitals from central control by degrees and gradually developing a market in health care.

a. The first part of the paper (paras. 2 to 6) outlines proposals for building up the hospitals within the present structure of the NHS, in a way which would prepare them for greater independence. It has some similarities with the Ibbs 'Next Steps' proposals. The emphasis would be on developing management systems, establishing framework agreements ('contracts') within which they would operate and giving them

certain limited freedoms to manage their own affairs (eg more flexible pay arrangements, greater control over deployment of staff and - perhaps - freedom over capital).

b. The second part of the paper (para. 10 onwards) sets out proposals for making hospitals statutorily independent. They would be legal entities with their own management boards, and they would be able to enter joint ventures with the private sector, develop new services and sell existing services to the private sector and other NHS hospitals. Legislation would be required.

18. You may wish to explore the following:

a. freedom to do what? The paper is a little thin on what hospitals would be free to do, particularly in the first phase;

b. over what timescale? The paper sets out an action plan. Over what period would Mr Moore expect to introduce statutory independence?

c. is 'evolution' the right concept? Another approach would be to say that any hospital which could pass certain tests should be able to apply to 'opt out' of central control: for instance, if it could demonstrate that it operated with budgetary discipline, that it was efficient and that its consultants were properly integrated in the management of resources under new contracts of employment;

d. what about GPs? Is there an implication that in order to make the system work, GPs would have to be subject to budgets? The risk would otherwise be that there would be diminishing control over NHS expenditure, as the number of independent hospitals grew;

e. is it necessary to retain both regional and district health authorities? The paper talks about slimming them down. But is there a case for abolishing the regions outright?

19. Subject to these points, you will wish to decide whether more work should be done on the proposals for inclusion in a White Paper (or a White Paper with green fringes).

Consultants' Contracts and Medical Audit

20. The Secretary of State's papers on consultants and medical audits follow up earlier discussion on this topic amd make proposals for action. They can be taken together: one main proposal on medical audit is that consultants should no longer be able to refuse to participate.

21. On consultants' contracts the Secretary of State proposes a list of changes in paragraph 5. You may wish to run through this list in discussion and check that you are content. Particular points include:

a. changing the system of distinction awards.. The paper picks up the criticisms which the Review Body made earlier this year. Should the changes affect only new award holders?

b. short-term contracts. Mr Moore says right at the end of the paper (para. 19) that he is 'not necessarily' inclined to include short-term contracts in the package. You may wish to explore his thinking;

c. handling. Mr Moore proposes to introduce a comprehensive new contract for new consultants only and to offer a substantial incentive in terms of higher pay for existing consultants. The cost would fall somewhere between £50 million and £108 million a year.

22. Here again, you will wish to decide whether further work should be done on the proposals in the light of the discussion.

RTJW.

R T J WILSON
29 June 1988

SECRET

CHART 1

PEOPLE COVERED BY PRIVATE INSURANCE

MILLIONS