PO-CH/NL/0410

PART E

Part E.

SECRET

(Circulate under cover and notify REGISTRY of movement)

Begins: 22/3/88.
Ends: 16/12/88.

PO -CH /NL/0410
PART E

Chancellor's (Lawson) Papers:

REVIEW OF WELFARE PROVISION AND THE NATIONAL HEALTH SERVICE

DD's: 25 Years

18/1/96

PO -CH /NL/0410
PART E

MC3.25

PERSONAL

FROM: MARK CALL
DATE: 22 MARCH 1988

CHANCELLOR

cc Chief Secretary
Mr H Phillips

NHS

I have received the attached invitation from Ray Whitney, who I met at the recent CPS Seminar. Would it be useful for me or others to go? His line is predictable, and Treasury presence may add to his credibility. On the other hand, it could be a useful opportunity to gauge the mood among participants.

Mc
MARK CALL

ENC

4/91

RAY WHITNEY, O.B.E., M.P.

HOUSE OF COMMONS
LONDON SW1A 0AA

18 March 1988

Dear Mark,

Many ideas are now emerging on how the NHS might be reformed. I believe it is important that there should be the widest debate of all the possible options before the Government comes forward with its own proposals.

As you know, I recently set out my own ideas*. They were based on the proposals for a health voucher scheme put forward by a Committee chaired by Dr.Ivor Jones, and of which Geoffrey Howe was a member, which reported in 1970. Although the BMA set up the Committee, it ignored its recommendations when they appeared. My scheme also seeks to benefit from the experience in the United States of the Health Maintenance and the Preferred Provider Organisations in developing primary care here. Other elements of my system would be the establishment of NHS hospitals as free-standing community hospitals, non-profit making but economically viable, and the development of topping-up of health care provision through insurance cover.

I should very much like to discuss these and related ideas for improving the NHS with you and others with an interest in this field. To this end, I am arranging a small seminar on Tuesday, 19th April, which will be held in the Jubilee Room in the House of Commons. The plan is that we should assemble for coffee and then a prompt start at 10.00 a.m, winding up proceedings at 12.15 p.m. I should be grateful if you would fill in and return the slip below or 'phone my office (219 5099) to let me know whether you will be able to join us.

Sincerely,
Ray.

*National Health Crisis: A Modern Solution
Shepheard-Walwyn £4.95

To: Ray Whitney,MP,
House of Commons,London SW1A 0AA

I can/cannot participate in your health seminar beginning at 10.00 a.m. on Tuesday, 19th April, in the Jubilee Room of the House of Commons.

(name).....

SECRET

SECRET

BE 29/3 pmp

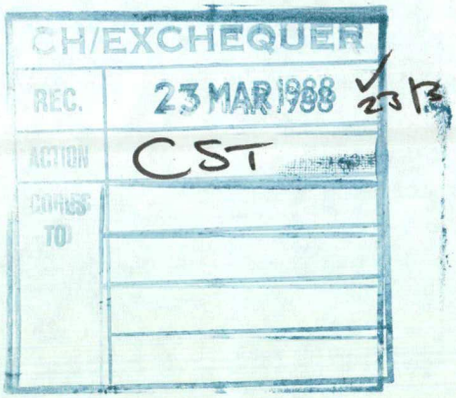
NB X

pmp

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary



22 March 1988

NOTE OF MTG 22/3

Dear Geoffrey,

NHS REVIEW

The Prime Minister this morning held a further meeting to discuss the review of the National Health Service, the fourth meeting in the present series. Those present were the Chancellor of the Exchequer, the Secretary of State for Social Services, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. O'Sullivan (Policy Unit). The meeting had before it four papers, HC14 to 17, circulated by the Cabinet Office.

In discussion the following were the main points made:

a. Although change might have to be gradual, it was important to establish its direction, so that short or medium term decisions could be taken against a long term strategy.

b. Option (i) in HC14 (the patient as buyer) was very far into the future and the Group did not wish further detailed work to be carried out on it now.

c. The improvements in option (v) (refurbishment of the NHS) were likely to be required on any basis and further work on them would be needed in due course.

d. Local health funds (option (ii)) could be an effective means of controlling costs, a consideration of great importance in the review. And they could be developed gradually into private sector bodies. On the other hand, if they were public sector bodies they carried the risk of an increase in bureaucracy. They might be part of the long-term development of health care but it was not clear that the Government need actively encourage their development at this stage.

e. Independent hospitals (option (iii)) had major attractions. One of the biggest defects of the present

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NHS was that it provided hospitals with no incentives to improve performance. There was also excessively rigid control from the centre. These weaknesses could be corrected if a way were found of allowing hospitals to opt out from the health authorities' control, and receive finance beyond a base-load level according to their success in attracting patients. Such a reform would be similar to the Government's reforms in education, and would produce similar benefits. The greater diversity of provision of health care, no doubt with a gradual growth in the private sector share, would be valuable in itself. And independent hospitals could be introduced gradually, if necessary on an experimental basis. The implications needed to be explored in more detail. For instance, there might be scope for the simplification of the structure of health authorities with the abolition of Regional Health Authorities. Doctors and nurses would be employed directly by hospitals, and there could be much greater use of regional pay negotiations at the local level.

f. Option (iv) (opting out for individuals) would encourage the growth of private care and could lead to more consciousness of costs. There were, however, objections of principle to opting out from taxation, and there was a risk that a system of vouchers would increase costs. The most obvious route would therefore be to allow contracting out from a contribution, as with pensions. There were a number of difficulties, one being that national insurance contributions were, within limits, related to income. But the option needed further examination.

The Prime Minister, summing up the discussion, said that the group had identified a promising option in the introduction of independent hospitals. It should be developed in more detail. The group also wished to consider further the case for opting out by individuals, possibly restricted to elective treatment. Tax reliefs and vouchers seemed unlikely to be suitable means of opting out and the work should include the possibility of contracting out from a health contribution

As to next steps, the Secretary of State for Social Services had offered in discussion to put forward his views on the right strategy for the Government to follow, and on the practical steps that might be taken in the medium term to give effect to it. Such a paper would be most useful and should be prepared, taking account of the points made in discussion, for the next meeting of the group after Easter. The Chancellor of the Exchequer should also prepare for that meeting a paper on opting-out including the financial implications of contracting out from a health contribution. The Cabinet Office should co-ordinate a further paper by officials on the concept of independent hospitals as it had been developed in discussion.

I am sending a copy of this letter to the Private Secretaries of the Ministers present, to the others at the meeting and to Sir Robin Butler.

Yours,
Paul

(PAUL GRAY)

Geoffrey Podger, Esq.,
Department of Health and Social Security.

mjd 3/49m

PERSONAL

FROM: MISS M P WALLACE
DATE: 23 March 1988

MR CALL

cc Chief Secretary
Mr Phillips

NHS

The Chancellor has seen your minute of 22 March. On balance, he would advise you not to go to this, but to procure (discreetly, from another source) a brief note of the proceedings.

MOIRA WALLACE

RM6.78

UNCLASSIFIED

FROM: MOIRA WALLACE
DATE: 28 March 1988

BF
18/4

MR ANSON

cc PS/Chief Secretary
PS/Paymaster General
Sir P Middleton
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Saunders
Mr Griffiths
Mr Tyrie
Mr Call

DYSON PAPER ON THE REFORM OF THE NHS

The Chancellor has seen a copy of Professor Dyson's paper, circulated by Sir T Burns. He thinks it a very perceptive analysis, with an interesting conclusion. He would be grateful for your views on it.

MOIRA WALLACE

29.3.2

SECRET

FROM: R B SAUNDERS

DATE: 29 March 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir Peter Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mr Culpin
Miss Peirson
Mr Turnbull
Mr McIntyre
Mr Parsonage
Mr Griffiths
Mr Tyrie
Mr Call
Mr Kuczys - IR

Ch/ST would like any general comments asap tomorrow. I've scribbled some queries and drafting points. But for the present more important is sort out structure, which I still find rather confusing.

MFPW 29/3

NHS REVIEW - OPTING OUT

1. I attach a draft of the paper commissioned from the Treasury at the Prime Minister's last meeting.

2. This will need to be circulated on Friday 8 April. It is in the form of a note by Treasury officials. You may like to consider whether you would like a short covering note in your own name.

3. I am sending this at the same time to Cabinet Office and DHSS officials, and we are to discuss it with them at 10 am tomorrow. If possible, it would be helpful if you could say before then whether you think the paper is on broadly the right lines.

4. While the paper does not draw any conclusions, it is pretty clear from the analysis that none of the options is attractive. The main points to emerge are perhaps the following.

a. A switch to hypothecated national insurance contributions would have significant economic and other effects. It looks impossible to devise any equitable system for giving rebates to those who opt out.

b. The alternative of a flat rate hypothecated charge makes it easier to operate rebates, but has massive implications for income distribution, social security expenditure, etc.

c. A system of vouchers would have a large initial deadweight cost, followed by loss of control over health expenditure.

d. There are severe problems in defining which NHS services would be given up by those who opted out.

e. Adverse selection is a serious problem with all schemes of opting out.

5. If we wanted to go down this general route, the least unattractive option would be to encourage people to take out private health insurance by means of a tax relief. The Inland Revenue are doing further detailed work on the feasibility of this, following the discussion at the Budget Overview meeting on 25 January. There are some paragraphs on this at the end of the paper, which have not at this stage been shown to Cabinet Office and DHSS. There is something to be said for going into all this now, given that tax relief was mentioned at the Prime Minister's last meeting. If it is not covered in some detail, it will be seen as a lacuna in the paper. But you will want to consider carefully how far to expose to colleagues outside the Treasury your thinking on a new tax relief.

R B SAUNDERS

24.3.1

SECRET

BF 31/3

FINANCIAL IMPLICATIONS OF INDIVIDUAL OPTING OUT FROM THE NHS

Note by HM Treasury

What we mean by opting out

1. People can already opt out of the NHS in the limited sense that they can choose to pay for private medical treatment while retaining their right to NHS treatment. Put at its loosest, further opting out could simply mean encouraging people to do this more, perhaps with some financial incentive. An alternative - and more rigorous - interpretation would mean that people would be given a financial incentive actually to give up their rights to NHS treatment in whole or in part. This paper looks at both.

2. The purpose would be to achieve some mix of the following desirable objectives:

- enhancing individual choice about how much and what sort of health care people want

- ~~reducing the alleged unfairness that those who choose private treatment must also, in effect, pay for the NHS through taxation~~

- encouraging the growth of private sector health provision and greater competition between public and private sector hospitals

Very dangerous ... omit all reference to this ... look at consequences for education

- bringing more private sector finance into health care

- relieving some of the burden on the public sector as those patients in a position to do so go elsewhere.

Mechanisms for opting out

3. Three broad financing mechanisms may be identified: tax relief, health contributions, and vouchers.

i. Tax relief

[To follow]

ii. Health contributions and rebates

4. The NHS might be financed from a specific health contribution rather than largely out of general taxation. At present, a small proportion of national insurance contributions go to finance health expenditure, although this was raised for 1987-88 and 1988-89 in response to an emerging national insurance fund surplus. This sum is equivalent to about 19% of NHS expenditure in 1988-89 (and about 11% of NIC revenue). These proportions are too low to form the basis of an adequate rebate for anybody opting out of the NHS. A new health contribution would need to cover a much greater proportion, perhaps 100%, of NHS expenditure.

5. The first question is what form the new tax might take. One obvious option would be to use the existing NIC system. The contribution paid by any individual to the cost of health care for himself and his family would be related to his income, subject to the lower and upper earnings limits, and so long as he is in work. The retired (who are proportionately the biggest users of the NHS) would not contribute, and nor would the unemployed or the non-working disabled.

6. If the contribution covered the full cost of the NHS, with no increase in the Exchequer contribution to pensions and other national insurance benefits, employer NICs would rise from 10.45% to 14.2%, and employee contributions from 9% to 13.2%. Such a change would also give scope for reducing income tax. A switch in this way from tax to national insurance would have consequences for income distribution. The tax burden would be shifted from the non-working population to the working population, in particular to low and middle income earners, and to employers. There would be an adverse effect on work incentives. The cost of employing labour would rise, with a potential impact on unemployment, and business competitiveness could be affected. Further work would be needed on these economic implications.

7. A new income-related tax might be devised, based not on the NIC system but on a percentage of all income. This might avoid some of these problems, but would look very much like income tax. Nor would it tackle the problems of an opting-out rebate in paragraph [ ] below.

8. Alternatively, a flat rate charge per person might be contemplated, along the lines of the community charge. This would mean that contributions reflected the average use ~~that people were likely to make~~ of the service, rather than their income. While it might be possible to draw up a charge related to age, this would put a burden on the elderly (perhaps £1500 a year for those over 75), ~~which is probably unacceptable.~~ Another question would be whether the charge should be payable in respect of children (some £250-300 a year); if it were, there would be strong pressure for an increase in child benefit. There would also of course be major distributional consequences, with a shift in the tax burden from those on higher income to those on low to middle incomes. If there were rebates for those on low incomes, as with the community charge, there would be a significant increase in social security expenditure, and pressure to extend social security help further up the income scale.

9. Decisions would be needed about who would collect the new contribution. A system based on national insurance contributions would logically be administered by DHSS and Inland Revenue through the NIC system. A different form of tax might, depending on how it was set up, be more appropriately collected by the Inland Revenue. A lot more work would be needed on the administrative implications if the idea of a health contribution is to be pursued further.

10. A specific health contribution could incorporate a rebate for opting out. This would be applicable in general to "rigorous" opting out - a positive decision by the individual to forgo some or all categories of NHS treatment. The idea of rebates in a system based on national insurance contributions, however, presents serious problems.

a. Those who did not pay NICs (eg the elderly) could not benefit from opting out, and those who paid a reduced rate (eg 3% between £41 and £70 a week) only marginally.

b. A reduced percentage rate of contribution would mean a larger cash rebate for higher earners, up to the upper earnings limit of £15,860 a year. While this is perfectly logical for pensions, where one contracts out of an earnings-related state scheme, it is less easily justifiable for health care.

c. It would bear heavily on large families. Multiple rebates would not be possible for single earner couples with children, and so would not cover their private health insurance premiums.

11. These would be less problematic in a system based on a per capita charge: the rebate would be the same for every individual, and families with children would receive rebates which more closely reflected the insurance premiums they would face. The actual insurance premiums faced by those who opt out would be related to the age and medical history of individuals and might not bear a close relation to the value of the rebate given.

12. A further option would be to combine the desirable features of both: the administrative simplicity of using the existing NIC system, while making rebates of a fixed cash amount, possibly related to age, to those who opt out. This would be rather like a system of vouchers, which is discussed next.

Is X meant to be cost of NHS ÷ population, or a larger number? Are those remaining in NHS entitled to care above voucher levels? Pressure to give people NHS care upto voucher levels (their "right.") And possible to replenish

iii. Vouchers

13. The idea of health vouchers is quite similar to that of education vouchers. Each individual would be given a voucher (or rather than entitlement to have a certain sum of money paid on his behalf) which he could use as a form of insurance premium either to secure NHS treatment or to enrol with an alternative private sector body. The premium or subscription charged by the private sector body might be higher than the value of the voucher, which he would "top up" from his own resources. The 1987-88 cost per head of the NHS in the UK is around £[370]. The range is from some £[200] for those aged between 16 and 64 to approaching £[1500] for those over 75. The value of the voucher could be set either at a single rate for everybody, or related to age and sex. These values would in practice be determined by what was needed to buy (at annual average rates) an acceptable standard of care in the NHS.

14. This arrangement would maximise individual choice. It would encourage private finance to be brought in through "topping up". But the cost of vouchers, unlike that of tax relief or NI rebates, would count as public expenditure and would probably be heavy.

15. First, a universal voucher would mean that the Government would immediately pay a large subsidy to private treatment which is at present financed privately. About £1bn a year is spent on private treatment, insured and out-of-pocket. Vouchers would cover a substantial proportion of this.

16. Costs could also be expected to rise steeply thereafter. As more people opted out of the public sector, they would tend to be the younger, fitter, better off ones representing the lowest risk. The cost per head to the NHS of providing services to the remainder would therefore rise. This would be reflected in the voucher values, and the cost per head of the private sector subsidy would also rise. This problem of adverse selection is discussed further in paragraph [ ] below.

17. Other factors would also tend to push up costs to the NHS. Pay might rise as private sector employers competed for doctors, nurses and other staff. There might be pressure for the NHS to provide equivalent treatments or non-clinical "extras" if the private sector improved its standards. Health provision would tend to increase in response to demand, but with the Government financing the great bulk of it through the vouchers. The public expenditure costs could be very large indeed.

Exclusive to whom?

but is it in para 13?

18. This might be alleviated if the value of the voucher were not explicitly related to the per capita cost of the NHS. Costs would still rise as more people opted out, since it would be difficult to secure commensurate reductions in NHS costs (see paragraph [ ] below). And there would be pressures to increase the voucher values to compensate for inflation in medical costs.

Related to what instead?

Do following paras apply to all options above?

Regulation

19. A "rigorous" opting-out system would require some Government regulation of private schemes. The contributions rebate, tax relief or other subsidy would be payable only to individuals who

had enrolled with approved schemes run by approved intermediaries. These intermediaries might be insurance companies, provident associations or individual employers who organised private health provision for their staff directly. In order to gain and subsequently keep approval, they would have to satisfy set criteria governing, among other matters:

- the minimum range of services they undertook to provide, which would correspond to those which the individual was no longer entitled to receive from the NHS;

- any rules they operated about who they were and were not prepared to take on, which is relevant to the question of adverse selection - see paragraph [ ].

Doesn't this directly contradict para 19?

20. Enforcement also needs to be considered. Depending on how the system is set up, an individual might be able to opt out but fail to enrol with an approved intermediary. Assuming it would be unacceptable to refuse to treat him if he fell ill, one possibility might be to treat him but then charge him the full cost of the NHS treatment. This might however be unduly harsh financially, particularly for a serious condition.

Full or partial opting out?

21. If opting out is to take the "rigorous" form, the question arises whether the individual gives up the right to all NHS treatment, or only some. In a system based on a health contribution, his contribution would be fully rebated in the first case, but only in part in the second.

?

What about flat-rate charges ? vouchers?

SECRET

Doesn't this repeat points in para 19? Amalgamate?

22. The first is the easier to specify. Private intermediaries would be required to provide care which, taken as a whole, was no less comprehensive than that provided by the NHS. The Government would then need to work out detailed ground rules for individual approvals. There would have to be a much wider range of services than private insurers are now prepared to cover, including geriatric, psychiatric, and other long-stay care. Many of the services are already available in the private sector, or through pay beds in NHS hospitals, but are not now regarded as insurable risks. Many services - for example accident and emergency - might continue to be supplied by NHS hospitals, who would send bills to the insurers of opted-out patients.

23. "Partial" opting out would offer something much closer to what in practice exists now, by covering, say, elective surgery and certain other forms of acute care. The individual who effectively opts for private treatment now could do so formally by signing away his rights for NHS care in these areas, thus relieving himself of the burden of paying twice through his insurance premiums and through tax.

delete? 2. (See para 2 above)

24. But codifying the position in this way would raise problems of definition and administration. The patient - and his doctors - would need to know with precision what services he could not expect from the NHS. There is no clear-cut definition of the terms "elective" and "acute". There is frequently no unambiguous medical diagnosis, nor unanimity among doctors about the appropriate treatment for a particular patient. The diagnosis may change in

the course of treatment. While some cases would be clear, others would not. Whatever procedures were devised to deal with cases at the margin there would be scope for dispute between insurers and health authorities about particular cases, since the sums of money at stake would be considerable. If extensive litigation is to be avoided, a special arbitration panel would need to be set up. Further work is needed before it can be said confidently that partial opting out is workable.

25. For completeness, the option of <u>compulsory</u> contracting out for certain groups should be noted. This might apply to all those in employment, or perhaps those meeting some other criterion such as membership of an occupational pension scheme. Another method employed in the Netherlands is obligatory contracting out for those earning above a certain income. This note does not seek to explore these further. Clearly, more work would need to be done if the Group thought them worth pursuing.

better earlier in paper?

<u>Selection</u>

26. This is a problem with any scheme of opting out. When faced with a choice, those who take advantage of it will be those with most to gain. Thus, a subsidy (including a tax subsidy) for opting out will tend to be taken up by those for whom the subsidy is the most valuable - in other words, the younger, fitter, low risk people who would be charged the lowest insurance premiums by the private sector. Individual calculation of the rebate would be quite impracticable. It would be possible to base the subsidy on some broad banding by risk - for example, an age-related voucher

(earnings-related)

And, if it is an NI rebate, the <u>richer</u> people.

value. But within any group the selection principle would apply, with the lower risk people more likely to opt out and the most expensive groups - the senile, the mentally handicapped, etc - tending not to take up the option. This would drive up the average costs per head of treating people who do not take up the option. This is of particular relevance when considering schemes based on vouchers (paragraph [ ] above), but has implications for all forms of voluntary opting out.

27. A related problem is the freedom of health insurers and providers to refuse customers. HMOs in the United States who opened their doors to all-comers were undercut on subscription by those who accepted low risk people only. Such people were lured away from the HMOs with wider coverage, thus pushing up unit costs and widening the disparities further. The response in the US has been to legislate to require HMOs to take all-comers. This would need to be a feature of any regulatory system in this country (paragraph [ ] above).

Other effects

28. Such research as there has been into the behavioural effects of subsidies for private health insurance (mainly in the US) suggest that demand would increase by about ½% for every 1% fall in the cost of premiums. In other words, full tax relief at the basic rate would increase by roughly 12½% per cent the numbers taking private health insurance. It is of course highly questionable whether this relationship would hold good if the change were being introduced as part of a package of health

reforms. But it suggests that the financial incentive would need to be quite large if it is to have a significant effect on the numbers who opt for private insurance.

29. The effect of opting out on public expenditure on the NHS is unclear. If more people sought private treatment instead of NHS treatment, the demand for NHS services might fall. This is not inevitable, however, since there is thought to be unexpressed demand for health services which would simply take its place. And even if demand did fall, there would not necessarily be a matching decrease in supply: the slack might be used to reduce waiting lists instead. Unless there were such a major shift into private treatment that NHS activity clearly needed to be reduced, therefore, the extra Exchequer costs of opting out would not automatically be matched by reduced public expenditure. (mention also bidding up of pay costs etc by private sector?)

30. Opting out implies, of its nature, major income distribution effects. The NHS redistributes income from high earners to low earners, and from the working population to children and the elderly. To the extent that people opted out of the NHS, they would opt out of the process of income distribution. This would imply new strains on the social security system to compensate losers.

perhaps too bald for PM?

HM Treasury
March 1988

→ move earlier in paper?

SECRET

DRAFT PARAGRAPHS ON TAX RELIEF

1. Under this option, premiums or subscriptions paid to an approved scheme would attract income tax relief. This could be either at the basic rate or at the individual's marginal rate. Administration would be simplified by giving the tax relief at source, by analogy with the MIRAS scheme. Also by analogy with MIRAS, non-taxpayers too would pay premiums net of tax, thus receiving a direct (public expenditure) subsidy. Indeed, a tax relief given at a flat rate, which would be administratively the best option, would have many of the characteristics of a direct subsidy. Payments made by employers to approved schemes (including a non-insurance scheme run by the employer himself) would not be taxable under the benefits-in-kind legislation.

2. It is for consideration whether the relief would extend to out-of-pocket payments for private treatment. This in part depends on whether one is taking the "loose" or "rigorous" view of opting out. If it is seen as simply an encouragement to seek private treatment, there are good grounds of equity for extending the relief to non-insured private treatment, although safeguards against abuse would have to be devised. These might be tricky and complicated. If, on the other hand, the strict form of opting out was being pursued, the case would be much less strong, since the purpose of the relief would be to encourage people to take out comprehensive insurance so that they were no longer a burden on the NHS. Tax relief for individual items of expenditure would however be very much more complex to administer than tax relief for insurance - and particularly difficult to police.

3. Another drawback is that a new tax relief would run counter to the Government's policy of simplifying the tax system and broadening the tax base. It might also stimulate demands for other reliefs in analogous areas - for example, for school fees or for the cost of child care for working mothers. Tax relief - particularly if confined to the basic rate - would be only a partial subsidy, and might not be considered an adequate compensation for forgoing NHS treatment completely.

4. The initial cost of giving tax relief on existing private health insurance premiums would be around £200m a year. This is probably a reasonably good guide to the initial cost of a tax relief for opting out, at least if opting out was confined to, say, elective surgery. The cost could be expected to increase as the numbers opting out expanded in response to the relief, or if people could opt out of all NHS treatment.

, Dyson

FROM: J. ANSON
15th April, 1988.

CHANCELLOR OF THE EXCHEQUER

c.c. Chief Secretary
Paymaster General
Sir P. Middleton
Sir T. Burns
Mr. Phillips
Miss Peirson
Mr. Turnbull
Mr. Parsonage
Mr. Saunders
Mr. Griffiths
Mr. Sussex
Mr. Satchwell
Mr. Tyrie
Mr. Call

DYSON PAPER ON THE REFORM OF THE NHS

You asked (Miss Wallace's note of 28th March) for my views on Professor Dyson's paper.

2. I thought the first half of the paper (paragraphs 1-6), which looks at the demand pressures on the NHS, was a good piece of analysis. Although his analysis of supplierinduced demand is not new, it is better articulated than some of the other comments we have seen; and his categorisation of the various types and stages of demand is a helpful aid to understanding this phenomenon.

3. He offers three solutions. The first, which is the most radical, is to seek a medical consensus on a distinction between clinical demand, which is to be treated under the NHS, and social demand, which is not. The other two are to control the growth of the number of paramedicals; and to encourage the Medical Research Council to devote more of its resources to reducing costs and simplifying procedures in respect of known conditions for which there is already heavy demand; and less to extending the boundaries of medical science ("rejuvenating skin cream for 94 year olds").

4. On the first of these, I think his solution is less well thought out than his earlier analysis. The problem,

as he recognises, is how to come up with workable definitions of clinical and social demand. Any such distinction presupposes that enough of medicine is a sufficiently precise science for it to be broken up into these discrete parts.

5. It is easy to think of examples "where at one end of the spectrum the provision is clearly clinical and at the other end of the spectrum the provision is social". But the areas where it would be generally accepted that the provision is obviously social (some cosmetic surgery, for example) are tiny at present in NHS expenditure terms. The problem is defining the dividing line for the rest - bearing in mind that decisions in accordance with any such criteria would be open to legal challenge in malpractice suits. He talks about "social hysterectomies", but does not indicate what he sees as the essential distinction between these and the clinical variety. The history of the controversy over abortion is an illustration of the difficulty of distinguishing the clinically necessary from purely social demand. Mental illness is another area where doctors have enough trouble agreeing on what is illness and how it should be treated, still less whether its treatment would, in these terms, be clinical or social.

6. Professor Dyson mentions that these issues already confront HMO-type organisations in the United States. However, although they have a financial interest in excluding social demand, he admits (paragraph 7) that they have not been rigorous in dealing with it, but have tended to accept some social demand as clinical rather than make the hard choices involved in excluding all social demand. But if it is difficult in this way to deal with the individual case, it is even more likely to be difficult to define general criteria. And both medical and public perceptions on where the boundary might be drawn would change over time.

7. Professor Dyson is no doubt right in saying that any progress in this direction would need to be supported by

the medical profession and also accepted by the community. But it is doubtful whether his idea of a "national body led by senior and eminent doctors and supported by a number of non-medical commissioners" would make much headway in finding general definitions which would command that kind of broad assent. The NHS review touched briefly on this subject at one of its earlier meetings but did not pursue it. The trouble is that it is expecting regulation, in a very sensitive area, to substitute for the complete absence of a market. To tackle the problem of social demand one has to come back to the difficult area of charging, or other ways of mitigating the cliff-edge such as those which we discussed before your departure for Washington. I think these are generally more profitable lines to pursue than Professor Dyson's idea. That is not to say, however, that we should not seek to stop the NHS expanding in those few areas, like cosmetic surgery, which are clearly very close to the social end of the spectrum.

8. Of his other two proposals in paragraph 11, the first (reducing the number of paramedical professionals and putting more responsibility onto the shoulders of GPs) has some of the same definitional problems as his main proposal. We certainly want GPs to take on more responsibility and not refer cases unnecessarily for medical or paramedical attention. But there could be a good deal of controversy about when a dietician starts being a slimming adviser and stops performing (as he or she would no doubt claim) a vital advisory role in the prevention of bowel cancer. The important thing, I think, is that any claims for this and other brands of preventive medicine should be carefully evaluated, to see whether they are in fact having a perceptible effect on the incidence of the conditions they are seeking to prevent. This is not just a question of whether, say, better diet would help to avoid bowel cancer, but of whether good advice is in practice heeded and implemented.

9. His other suggestion (redirecting MRC effort to less glamorous work) is one which makes a lot of sense in principle. It would not slow down the advance on the frontiers of medicine, since given the international nature of the drugs and medical equipment industries, it is not long before medical advances in one country lead to pressures for them to be taken up in another. But there would be merit in directing more priority to evaluating existing medical technologies, rather than developing new ones. The Medical Research Council has of course a good deal of independence, and would probably regard it as beneath its dignity to go into matters like the life and maintenance costs of medical equipment. Such research would more likely have to be carried out by DHSS, so that his suggestion would amount to cutting back the MRC budget in order to release funds for such work. At a time when there is pressure for more basic research work on AIDS, etc, this would not be easy to bring about. But we do seek in the Survey to keep the insatiable demand for more science research funds under control, and if it was really true (which I doubt!) that they are researching rejuvenating skin creams for 94 year olds, we would certainly use that in evidence.

10. In short, while his paper is good on analysis, it is short on workable solutions. On his main point, I would prefer to concentrate on the ideas we are currently exploring. On the other two, it would be worth asking DHSS for their reactions to the growth of paramedicals and what they are doing to evaluate their usefulness; and we will continue to scrutinise the MRC's budget in the Survey context.

J. ANSON

15.4.1

SECRET

FROM: R B SAUNDERS

DATE: 15 April 1988

minute attached
1. MR ANSON VA 15/4

Copies attached for:

Chief Secretary
Paymaster General
Sir Peter Middleton
Sir Terence Burns
Mr Tyrie
Mr Call

2. CHANCELLOR

cc Mr Phillips
Mr Culpin
Miss Peirson
Mr Turnbull
Mr McIntyre
Mr Parsonage
Mr Riley
Miss Sinclair
Mr Griffiths
Mr Macpherson
Mr Satchwell

Mr Kuczys - IR

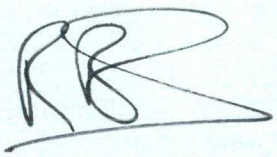
NHS REVIEW: CONTRACTING OUT

1. I attach a revised version of this paper following your meeting on Tuesday. It incorporates comments from Mr Anson and other copy recipients. There is also a first shot at a possible covering note by you.

2. The paper follows your suggested approach of developing what looks the most reasonable option and concluding with some pros and cons (largely cons, it has to be said). I am pleased to report that it now contains more figures. I would draw your attention in particular to the arithmetic in the Annex on financing a higher proportion of NHS expenditure from NICs and increasing the Treasury Supplement. We have not displayed the NIF surplus or raided it in the calculations. This is so as not to concede further reductions in the surplus if it is decided in the event not to go ahead with this particular scheme.

SECRET

3. We are to have a further meeting with DHSS and Cabinet Office officials on Tuesday. We are hoping that we shall be shown a first draft of Mr Moore's paper for the Prime Minister's meeting on 27 April. In the light of that, we may need to make further changes to our paper - perhaps by dealing at greater length with the principle of hypothecation. We should like to show them this new draft (though not of course your cover note). Are you content that we should do so?



R B SAUNDERS

SECRET

A SCHEME FOR CONTRACTING OUT OF THE NHS

Note by the Treasury

1. At present, the NHS is overwhelmingly free at the point of use, whereas fees and charges for private health care reflect the full cost of the service. The NHS is financed out of general taxation (including that paid by those who choose not to use it), while the private sector is paid for by its customers. There is therefore a financial disincentive to make use of the private sector, and hence a major obstacle to the development of private health care, which might otherwise provide a means of easing the pressure on the NHS.

2. One obvious way to reduce this "cliff edge" between the public and private sectors would be wider use of charging in the NHS. Those who chose the private sector would then avoid that expense. Otherwise, there are two broad ways in which the problem might be tackled:

a. Some form of Tax relief for the cost of private health care. ~~/ insurance?~~

b. Some form of remission from national insurance contribution for those who chose to contract out, in some sense, of the NHS. ~~/ take up private insurance~~

3. These options are by no means mutually exclusive. Indeed, it is possible to combine elements of each within one package: for example, a rebate of national insurance contributions for those ~~of working age~~ working, tax relief for the elderly, and more use of charging

in the NHS. This paper deals mainly with the option of remission for those who contract out. But the issues raised by the idea of tax relief are also germane, and these are considered first.

A tax relief

4. The most frequently canvassed option is to give tax relief for private health insurance premiums. A parallel option would be to exempt premiums paid by employers under a company scheme from taxation as a benefit in kind in the hands of the employee. We also need to consider whether money spent in paying directly for treatment should qualify for tax relief. Total private health insurance premiums were just over £600m in 1986. Direct expenditure on private health treatment was a further £500 million.

5. Bills for medical treatment tend to be unpredictable and large. If private health provision is to be encouraged, people will need to be encouraged to take out insurance. It would seem preferable, therefore, to concentrate relief on insurance rather than direct payments for private treatment. This would also avoid the need for the Inland Revenue to vet claims for individual payments according to whether or not they were medically necessary, with Ministers having to defend the resulting decisions. As well as being contentious, this would need extra staff.

6. Any relief on premiums could be targetted on those who find it most difficult or expensive to obtain private health insurance. At present, the most heavily discouraged group is the elderly. About 170,000 policyholders (15% of those not in company schemes) are over 65. But most schemes will not take on new customers over 65, and those who are already in the scheme face very steep increases in their premiums. This effect would be even more pronounced for those previously in company schemes whose premiums had been paid wholly by their employers. Tax relief would mitigate the increase experienced on reaching the age of 65. It might also encourage insurance companies to begin offering more schemes covering acute care for the elderly.

7. The other possibility would be to encourage the growth of company schemes by exempting premiums from the benefits in kind legislation. Such a step might trigger a further significant spread of company schemes, and encourage firms to extend to all the workforce those schemes presently confined to managers.

8. It might however be difficult to justify a relief for company schemes but not for premiums paid by small businesses, the self-employed, and individuals. There would be pressure to extend tax relief to all private health insurance premiums. This would in turn lead to pressure for concessions in other areas - for example, those who opt out of state education by educating their children privately, or those who pay for child care when at work, which would substantially undermine the Government's policy of simplifying the tax system and reducing special reliefs. A relief confined to the elderly would be less liable to provoke this kind of demand.

9. There would be an initial "deadweight" cost because those who already pay for themselves would get the new relief. The initial cost of tax relief at the basic rate for uninsured private treatment would depend on the scheme's coverage (ie how strictly "medical" expenditure was defined), but could be well over £100m a year. Tax relief for private health insurance premiums would cost £200m a year initially, made up of £80m for exempting employer-paid premiums from the benefits in kind charge, £100m for basic rate relief for premiums paid by individuals of working age, and £20 million for the cost of tax relief for pensioners. The cost of any relief could be expected to increase subsequently as more people took it up.

A rebate for contracting out

10. The most obvious option here is to use the existing national insurance system. Part of the revenue from national insurance contributions is already allocated by statute to the NHS.

National insurance contribution rates 1988-89

Employee:	NI Fund	-	2.05-8.05%
	NHS	-	0.95%
	Total		3-9%
Employer:	NI Fund	-	0.4 -9.65%
	NHS	-	0.8%
	Total		1.2-10.45%
Self-employed:	NI Fund	-	£3.42pw + 5.15%
	NHS	-	£0.63pw + 1.15%
	Total		£4.05pw + 6.3%

The 1988-89 total NHS contribution of £3.3bn is about 16% of net NHS expenditure. This would be insufficient to underpin a viable contracting out scheme, since acute services (which are what private insurance would cover) account for around a third of NHS expenditure. If the NHS element of NICs were increased, the income

of the National Insurance Fund would fall. The shortfall could be made good by increasing the Treasury Supplement to the Fund, thus leaving overall tax and NIC rates unchanged. The supplement is currently 5% of gross contribution to the NI Fund, but was 18% as recently as 1979. The Annex illustrates how this might be done: the Treasury supplement is increased to 17½%, still just below the 1979 level.

11. Contracting out might be considered by analogy with contracting out of SERPS. In return for giving up a right to certain categories of treatment under the NHS, individuals could make their own arrangements and receive a rebate as a contribution towards the cost.

12. The analogy could not however be pressed too far. In its most rigorous sense, contracting out would imply that the individual formally relinquished rights to certain precisely defined categories of treatment which the state would no longer be obliged to provide for him. He would however continue to receive other types of treatment under the NHS, which were not available in the privately insured sector - geriatric, chronic disease, other long stay care, maternity and so on. This would bring the state directly into decisions about whether particular individuals at particular times fell on the NHS or contracted-out side of the line. There would be highly contentious individual cases, with the prospect of political controversy and litigation. Private health schemes would have to be heavily regulated to ensure that they continued to offer adequate cover so that the NHS did not have to step into the breach. Individuals might feel obliged to carry some form of identification indicating whether their health cover was public or private sector. These are very unattractive features.

13. There are however other ways of approaching this. The rebate could be conditional on two slightly looser requirements: that the insurance scheme met a certain minimum level of cover, and that those who took private insurance undertook not to seek NHS treatment in cases covered by their policy. Systems would need to be set up to ensure that insurers were billed for any treatment provided in NHS hospitals. Responsibility for assessing individual cases would thus rest with the insurer, and not with the state. Where a case was not covered, for example on grounds of cost or length of stay in hospital, the excess would be provided under the NHS. Where cover was refused on grounds that the particular procedure was not medically necessary, it would, as now, be for the individual to meet the cost himself.

14. Individuals who contracted out would receive a rebate of some or all their NHS contributions. This would further complicate the national insurance system. Those who did not pay NICs (eg the elderly) could not benefit from contracting out. The elderly are proportionately the biggest users of the NHS and their average income has been rising faster than the rest of the population. To encourage them also to take out or continue private insurance, therefore, NIC rebates might have to be supplemented by a tax relief for the elderly along the lines discussed in paragraph 6. There would be pressure to extend this to others who do not pay NICs, including for example non-working widows and those who have taken early retirement (although those who had done so on health grounds might be unable to obtain private insurance in practice).

(A further question would be whether rebates in respect of those in employer-paid company schemes should be paid to the employer, to the employee or split between the two.)

Structure of the rebate

15. The first main alternative would follow SERPS by providing a ~~reduced rate of~~ percentage rebate contribution for those contracted out. This would have the merit of simplicity for both the DHSS and employers. But it also has problems:

a. ~~SERPS is an~~ In both state and contracted-out pension schemes the benefits are earnings-related, ~~scheme,~~ so an earnings-related rebate is appropriate. This is not the case for health care.

b. Higher earners would get bigger rebates. The rebates might even exceed the cost of private health insurance, so that they made a profit by contracting out. On the figures suggested in the Annex, the annual NHS contribution by those at or above the earnings limit (£15,860 a year) would be £380. Somebody on £50 a week by contrast would pay an NHS contribution of £62 a year, and would hence get a rebate of only one-sixth that of the higher earner.

Nor would a flat rate rebate, I assume

c. This approach would not allow multiple rebates for dependants. Contracting out would thus be more attractive to single people than to families.

16. The other alternative would be a flat rate rebate payable weekly or monthly. This could be regarded as essentially a form of voucher scheme. The system would more readily allow children as well as adults to contract out, since rebates could be payable in respect of both individuals and their non-working dependants. For

2.1

why? We would be rebating something for which there was no contribution?

Point re dependants in 15(c) & 16 not at all clear

some individuals, particularly in lower income groups with families, the rebates would exceed what they paid in NHS contributions or even total NICs. In such cases, the excess of rebates over NHS contributions would score as public expenditure, in the same way as payments to non-taxpayers under the mortgage interest relief scheme.

17. How big should the rebates be? The average cost per head of the NHS is at present around £375 a year, of which some £120 is for acute hospital services. But there is wide variation with age, as illustrated by the following table of very approximate projections for 1988-89:

	All NHS services	Acute hospital services
age 0-4	£350	£150
age 5-15	£220	£55
age 16-64	£230	£65
age 65-75	£650	£250
age 75+	£1500	£550

for what services?

The average private health insurance premium was some £120 per head in 1986; extrapolating from past trends the figure is likely to be nearer £150 per head in 1988.

breakdown by age?

18. In considering the appropriate rebate, the following factors are relevant.

a. Insurance cover for primary care and geriatric, chronic and other long stay treatment is unlikely to become available in the short term. The second column of the above table is the more relevant comparison with the cost of private insurance.

b. "Adverse selection" - the tendency for any choice to be taken up wholly or mainly by those with most to gain from it - would be found. Thus, those who contracted out would tend to be the younger, fitter and better off who already have private insurance or who would be charged the lowest premiums by private insurers. Those who contracted out would tend to cost the NHS less than the average, while those who stayed behind would be more expensive.

c. The option of contracting out would be available to those in work who, as the above table shows, cost less than the national average.

19. Taking all these factors into account, and including a loading for adverse selection, a contracted out rebate of around £50 a year per head would probably be appropriate. (This is probably around one-third the average insurance premium per head.)

Financial implications

20. It is difficult to quantify with any certainty the financial consequences of a scheme on these lines. This would depend on the amount of the rebate, on the numbers taking advantage of it who would not otherwise have taken out private health insurance and on the extent to which the premium structure was affected by the rebate. Take-up is obviously related to the size of the rebate; but it is very difficult at this stage to assess the likely size of the effect. Such research as has been done (mainly in the USA) suggests that demand for private health care rises by about ½% for every 1% fall in the cost of premiums. But this may not be a good guide to the consequences of introducing a major new scheme of the

sort discussed in this paper.

21. Exchequer costs would increase by the cost of the rebate, less any reductions in expenditure on the NHS. The deadweight cost of a £50 rebate to the 5½ million people already covered by private health insurance would be just under £300m. As more people took advantage of the rebate and contracted out, the cost would rise. The suggested rebate of £50 a year would reduce the cost of insurance premiums by about one-third. If the elasticity suggested above is correct, there would be a further 1 million people contracting out, at an additional cost of £50m. If the effect was in fact greater, with, say, 3 million more contracting out, the cost would rise to £450m.

22. In the short term, it is unlikely that NHS costs would fall significantly from what they would otherwise have been. While the higher numbers contracting out would reduce the pressure of demand on the NHS, this ~~might simply go to shortening~~ waiting lists or ~~bringing about~~ other improvements in service. ~~There is unlikely to be any offset to the cost of the rebates~~.

23. In net terms private resources going into health care would in the first instance decline, because £300m would be met from public funds rather than private hands. Again, however, the picture would change as more contracted out. Assuming a £50 rebate and an average premium of £150, net private sector payments for health care would rise by £100m for every further million people who contracted out. It would however need 3 million more to contract out (a relatively high elasticity of demand) before net private sector resources even got back to their present level.

24. There would be other cost pressures over time. Some of the rebate might feed through to higher costs rather than increased private sector activity. And there would be strong pressure for annual uprating of the rebate.

25. The result would be an overall increase in the resources, both public and private sector, devoted to health care as more people contracted out. But, unless the response to the new rebate was very big indeed, the increase in total health expenditure might be less than the increased cost to the public purse. Even on optimistic assumptions about people's response, the proportion of health care financed privately would probably be less than it is now.

HM Treasury
April 1988

CONFIDENTIAL

ANNEX

NATIONAL INSURANCE FUND AND NHS FINANCING 1988-89

The table below sets out the present flows of NIC and general taxation revenue into the NIF and NHS this year, based on GAD figures for national insurance and PEWP figures for the NHS. All figures are GB. The NHS figures are net of charges. It shows for comparison an alternative model under which the NIC element of NHS funding is increased from £3.3bn to £6.7bn to cover the cost of acute hospital services, with the resulting shortfall in the NIF met by an increased Treasury supplement. It is assumed that the increased NHS allocation is provided by doubling the contribution by the self-employed, and raising the balance largely from employees. The scope for increasing employer contributions is limited by the very low NIC rates payable for some employees. There are of course other possible combinations. This one is set out simply to exemplify the principle.

	Present position		Alternative	
	£ bn	rate	£ bn	rate
NIF income				
Employees	11.9	2.05-8.05%	9.3	0.6-6.6%
Employers	14.3	0.4-9.65%	13.6	0-9.25%
Self employed	0.7	£3.42+5.15%	0.6	£2.80+4%
Treasury Supplement	1.6	5%	5.0	17.5%
	28.5		28.5	
NHS income				
Employees	1.7	0.95%	4.3	2.4%
employers	1.5	0.8%	2.2	1.2%
self employed	0.1	£0.63+1.15%	0.2	£1.25+2.3%
general taxation	17.8	-	14.4	-
Total	21.1		21.1	
NICs				
Employees	13.6	3-9%	13.6	3-9%
Employers	15.8	1.2-10.45%	15.8	1.2-10.45%
Self employed	0.8	£4.05+6.3%	0.8	£4.05+6.3%
Tax contribution to:				
NHS	17.8		14.4	
NIF	1.6		5.0	
Total	19.4		19.4	

NHSR

Many Thanks. Much better.
I have made a number of comments + suggestions.
I think a covering note from me will be sensible, but this could wait until after we have finished the main paper. NL.

SECRET

FROM: J. ANSON
15th April, 1988.

CHANCELLOR OF THE EXCHEQUER

Ch/Better - but still some muddles, eg
- section on tax relief needs to distinguish between tax relief for premia and full costs of care clearly
- do we want tax relief section to come first? and if we do, why do we return to it in the middle of the NIC section?
- do we want to give families rebates from one earner's NICs (I find this an extraordinary idea)
- X in para 13 seems v. odd
- most importantly, I would not have thought we wanted to push tax relief for OAPs so much - better tactically to let others press us + then give in gracefully

c.c. Chief Secretary
Paymaster General
Sir Peter Middleton
Sir Terence Burns
Mr. Phillips
Mr. Culpin
Miss Peirson
Mr. Turnbull
Mr. McIntyre
Mr. Parsonage
Mr. Riley
Miss Sinclair
Mr. Griffiths
Mr. Macpherson
Mr. Satchwell
Mr. Tyrie
Mr. Call

Mr. Kuczys - IR

NHS REVIEW: CONTRACTING OUT

At your meeting before you left for Washington, you asked for a revised paper on this subject. The attached paper by Mr. Saunders, which builds on the outline you sketched out, is the product of extensive discussion among those concerned, and I think it will provide a useful basis for a discussion in the Ministerial Group. It can be polished up in the next few days in the light of any further comments from yourself and the Chief Secretary.

2. You will want to consider whether to put your own covering paper on top of it, or to leave it to be put in as a discussion paper by officials. We have provided a draft so that you can consider this further. The disadvantage of a covering paper is that, even if your colleagues decide to shelve the idea of contracting out, you may thereby be more committed than you would like to the idea of tax relief. On the other hand, a Ministerial paper enables the essential difficulties of contracting out to be deployed more forcibly, and the paper does not

MJOW 15/4

commit you to more than considering tax relief for the elderly, which I think you felt was probably the minimum response given the pressure to do something in this general area.

3. I would also just draw attention to the point in Mr. Saunders' minute about the NIF surplus. At your meeting you pointed out that the switch in the Treasury Supplement could be somewhat smaller by cutting the NIF surplus. If the contracting out scheme is pursued, this is a point we would need to go into further, having regard to the prospects for the NIF surplus in future years. But it seemed to me that to exemplify a reduction in the NIF surplus in this paper might be a hostage to fortune, since it might be used later by other Ministers as a peg for suggestions that the surplus should be reduced (and, for a given PSBR, general taxation increased) quite separately from the present context. The arithmetic of the example is also rather simpler if one omits this extra complicating factor.

4. We should be grateful for your comments on this draft. It would also be very helpful if, as suggested below, we could show the note by officials (but not the draft cover note) to the Cabinet Office and DHSS on Tuesday. The paper has been considerably changed, and it would be useful to let them see it in order to prepare the ground for the Ministerial meeting on the 27th. We would of course present it as our own draft, without committing you to any policy conclusions.

J. ANSON

mjd 3/107m

SECRET

FROM: MISS M P WALLACE
DATE: 18 April 1988

MR ANSON

cc Chief Secretary
Paymaster General
Sir P Middleton
Sir T Burns
Mr Phillips
Mr Culpin
Miss Peirson
Mr Turnbull
Mr McIntyre
Mr Parsonage
Mr Riley
Mr Saunders
Miss Sinclair
Mr Griffiths
Mr Macpherson
Mr Satchwell
Mr Tyrie
Mr Call

NHS REVIEW: CONTRACTING OUT

The Chancellor was most grateful for your minute of 15 April, covering Mr Saunders' minute and a revised version of the NHS paper. The Chancellor thinks a lot of progress has been made on the paper, and his detailed comments are set out below. He thinks a covering note from him would be sensible, but thinks this will need to be finalised once we have the final version of the main paper. ... (I attach for you and Mr Saunders only, his preliminary manuscript comments on the draft covering note.)

2. On the main paper the Chancellor's comments are as follows.

(i) Paragraph 2(a) - amend to read: "Some form of tax relief for the cost ..."

(ii) Paragraph 3, second sentence - amend to read: "...a rebate of national insurance contributions for those in work, tax relief...."

(iii) Paragraph 4 - amend third sentence to read: "An alternative approach might be to allow tax relief for money spent in paying directly for treatment." The Chancellor has also asked whether the figure of £500 million for expenditure on

private health treatment is right. Does it include payments by the insured, as well as the uninsured?

(iv) Paragraph 5, third sentence - to read: "It would seem preferable, therefore, if there is to be any form of tax relief, to concentrate that relief on insurance rather than direct payments...". Also amend final sentence to read: "...this would need substantial extra staff."

(v) The Chancellor had a number of amendments to paragraph 9. The first sentence should read: "..those who already insure for themselves..." He would then like the second sentence deleted. Finally, he wonders why it has been assumed that only basic rate relief would be given for premiums: many of those who belong to BUPA etc will be higher rate taxpayers, and the cost of the relief will accordingly be higher.

(vi) The Chancellor would like the table of NIC rates expanded and explained more fully. And he has a number of small drafting amendments to the text in paragraph 10. The passage in brackets in the second sentence should read: "which are what private insurance would presumably cover". And the first sentence on the next page should be amended to read: "...increasing the Treasury Supplement from general taxation to the Fund,...."

(vii) Paragraph 11 - amend to read: "Contracting out of the NHS might be seen as analogus to contracting out of SERPS."

(viii) Paragraph 12, third sentence - amend to read: "probably geriatric, chronic disease, ...". The Chancellor has also asked whether maternity care is really not available under BUPA. He would also like the last sentence of paragraph 12 amended to read: "These are not very attractive features."

(ix) The Chancellor was puzzled by the suggestion in paragraph 13 that those privately insured should undertake not to seek NHS treatment. His assumption was that strictly

speaking they would be able to seek NHS treatment, but would have to pay for it.

(x) The Chancellor would like paragraph 14 reordered. The last sentence ought to be put in brackets and moved up so that it comes after the present second sentence. The existing third sentence ought to begin a new paragraph. And the present fourth sentence ought to be shortened to read: "Yet the elderly are proportionately the biggest users of the NHS." This paragraph should also point out that two-thirds of pensioner households do not pay income tax, and so would not be affected by the introduction of tax relief.

(xi) A couple of drafting amendments to paragraph 15 - amend first sentence to read: "..providing a percentage contribution rebate for those contracted out." And amend first sentence of first indent to read: "In both state and contracted-out pension schemes the benefits are earnings-related, so an earnings-related rebate is appropriate."

(xii) The Chancellor thinks that the point about multiple rebates for dependents touched on in paragraph 15(c) and paragraph 16 needs clarification.

(xiii) He would also like the final sentence of paragraph 17 expanded.

(xiv) Some small drafting points on paragraph 18: amend indent(b) to read; "There would inevitably be 'adverse selection' - the tendency for any choice to be taken up wholly or mainly by those with most to gain from it." Also amended indent (c) to read: "...would be available only to those in work..."

(xv) Finally, the Chancellor would like the last two sentences of paragraph 22 shortened and redrafted to read: "While the higher numbers contracting out would reduce the pressure of

demand on the NHS, this would be likely to reflected in shorter waiting lists or other improvements in service." (Delete last sentence)

MOIRA WALLACE

SECRET

A SCHEME FOR CONTRACTING OUT OF THE NHS

Note by the Chancellor of the Exchequer

1. I attach the paper on contracting out of the NHS which was commissioned from the Treasury at our last meeting.

2. After surveying the range of options and variants, the paper concentrates on one which seems to be the most promising if this line were pursued. Its main features are as follows.

- A significant increase in the NHS element of national insurance contributions with an offsetting increase in the Treasury supplement to the National Insurance Fund and no change in tax or NIC rates.

- A rebate payable to those who "contracted out" by taking private health insurance cover satisfying some minimum requirements.

- Those who contracted out would not formally give up their rights to NHS treatment; rather they would undertake to pay for all treatment within the terms of the insurance policy, even where it is provided in NHS hospitals.

- The rebate would be a flat rate of perhaps £50 a year per head.

- Since the rebate would not be available to the elderly, they ~~(and possibly other groups who do not pay NICs)~~ would instead be entitled to tax relief on premiums paid to private health insurance schemes.

3. The main alternative to a scheme on these lines would be one simply based on tax relief for private health insurance premiums. The case is strongest for the elderly. This has already been advocated by a substantial group of our supporters in the House, led by Sir Philip Goodhart. A case could be made for extending it to company health schemes (by exempting employer-paid premiums from tax as a benefit in kind), but once this was done it would become more difficult to contain repercussions in education or other areas. I am most concerned that we should not do anything to reverse the progress we are making in simplifying and streamlining the tax system.

4. The financial implications of contracting out are discussed at the end of the paper. The calculations are necessarily a bit speculative, but the message is disturbing. The result could quite possibly be increased expenditure on rebates and on the NHS, but without any assurance of an increase in the net private sector contribution to financing health care. If - as is possible - the increase in total health expenditure is less than the increase in public expenditure, is that a cost effective use of public funds?

5. There is also a major distributional point. The first beneficiaries of such a scheme would be those who already pay for private health care and who tend to be the better off section of the population. It would be particularly difficult to defend after

the present controversy over the social security changes and the community charge. Moreover, one of the reasons people would subscribe to private health care with these incentives would be to get what they perceive as better or more timely treatment. We would have to be prepared to deal ~~robustly~~ with accusations that we were ~~helping~~ the better off to jump the queue. If we are going to spend ~~considerable~~ sums of public money on health, is this the best way?

6. I am forced to the conclusion that formal contracting out should not be pursued on this occasion. ~~I should be prepared to consider~~ further the merits of a limited form of tax relief for the elderly. But some of the arguments against an NIC rebate will apply equally to a tax relief.

001/4209

SECRET

FROM: CHIEF SECRETARY
DATE: 18 April 1988

CHANCELLOR

cc:
Paymaster General
Sir Peter Middleton
Sir Terence Burns
Mr Anson
Mr H Phillips
Mr Culpin
Miss Peirson
Mr Turnbull
Mr McIntyre
Mr Parsonage
Mr Riley
Miss Sinclair
Mr Griffiths
Mr Macpherson
Mr Satchwell
Mr Tyrie
Mr Call

NHS REVIEW: CONTRACTING OUT

I have seen the Treasury Paper and have the following comments.

2 Firstly, I do not think contracting out is very attractive. It has too many problems for too few rewards (and they are uncertain).

3 Nor do I relish introducing tax reliefs to promote private care for the familiar reasons we all know. They are good reasons and I would not myself be inclined to hint that limited tax relief for the elderly was possible.

4 Insofar as the Paper is concerned:-

Paragraphs 7-8

Exempting premiums in company schemes from the benefits-in-kind legislation looks odd in the wake of the Budget.

Paragraph 10

It is correct to imply that private insurance predominantly covers acute services? I would have thought not.

Paragraph 19

I very much doubt that a flat rate rebate (if pitched at £50) would be at all effective. £1 a week would be seen as derisory by those who favoured the approach and offensive by those who did not.

JOHN MAJOR

ps2/30M

SECRET

FROM: MISS M P WALLACE
DATE: 19 April 1988

PS/CHIEF SECRETARY

cc Paymaster General
Sir P Middleton
Sir T Burns
Mr Anson
Mr H Phillips
Mr Culpin
Miss Peirson
Mr Turnbull
Mr McIntyre
Mr Parsonage
Mr Riley
Miss Sinclair
Mr Griffiths
Mr Macpherson
Mr Satchwell
Mr Tyrie
Mr Call

NHS REVIEW: CONTRACTING OUT

The Chancellor was most grateful for the Chief Secretary's minute of 18 April. He would be grateful if the Chief Secretary's points on the general unattractiveness of contracting out, and in particular the arguments against introducing new tax relief, could be incorporated in the Chancellor's covering note for the paper.

MOIRA WALLACE

Ch/Can I just check how you would like paper amended at X? Do you mean:

(a) public Expenditure treatment problem only arises on flat-rate option

Or (b) rebate for non-working dependents only feasible under scheme of flat-rate rebates?

Yes: I have amended.

mpw 2/4

week.18.4/m.10

SECRET

FROM: H PHILLIPS
DATE: 20 April 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir P Middleton
Sir T Burns
Mr Anson
Mr Culpin
Miss Peirson
Mr Turnbull
Mr McIntyre
Mr Parsonage
Mr Riley
Miss Sinclair
Mr Griffiths
Mr Macpherson
Mr Satchwell
Mr Tyrie
Mr Call

CH/ Happy with paper as amended.
Content to issue covering note, or wait until after you've read Moore paper?

nps
20/4

NHS REVIEW: NEXT MEETING

Attached for your approval is a further draft of our paper on contracting out of the NHS (flagged A). It takes account of Miss Wallace's minute of 18 April containing your comments on the last draft. You will now also wish to decide whether you wish to put forward a covering note of your own and a redrafted version of this is attached (flagged B), revised in the light of the Chief Secretary's comments.

The Treasury Paper

2. I should offer you a response to a few of the questions you raised on the last draft.

(a) Why assume basic rate relief only? The paper now assumes relief at the marginal rate. This has the advantage from our point of view of displaying the highest figures. If however the question is to be pursued further, the Revenue

may wish to argue for basic rate relief only on grounds of lesser cost (particularly deadweight cost), equity and administrative simplicity. (but read-across to NIR?)

(b) Expand the table in paragraph 10. We have dealt with this by taking out the text table altogether, and instead attaching a full table of NIC rates taken from the Government Actuary's latest valuation of the Fund.

(c) Maternity? Generally it appears that cover is available only where complications arise or have arisen. BUPA, for example excludes benefit for "any treatment arising from pregnancy or childbirth (other than for abnormal conditions arising at least ten months after entry into any BUPA scheme)". In practice, however, I believe that private insurers and some consultants are prepared to be quite liberal in their interpretation of 'abnormal conditions', and to allow benefit to be paid for successive pregnancies or births if payment had been made for a previous pregnancy or birth.

3. We tabled our latest draft at the meeting of officials yesterday but there was no substantive discussion of it. The only reaction was that it appeared to be a weighty document (in content rather than length) and less negative in tone than our first effort. The main point we made was to underline the fact that a rebate system was not necessarily the key which would unlock a rising proportion of privately financed healthcare.

4. Your meeting with the Prime Minister is on Wednesday 27 April and the Cabinet Office have asked that the papers should circulate on Friday 22 April. Subject to any further views you have on the draft I should be grateful if your office could arrange for the circulation. If you wished to reflect on the terms of your covering note over the weekend, which would enable you to see the final version of Mr Moore's paper, a Private Secretary letter could indicate that you would put in your personal comments on Monday 25 April.

Mr Moore's Paper

5. The current draft of Mr Moore's paper: "NHS: The Way Ahead" is attached (flagged C). He is making two sets of linked proposals. The first is to recommend that the structure of the NHS, and its management, differentiates clearly between buyers and providers of health services. The second is to argue the need for financial incentives for individuals to make more provision for themselves and to do so through a modified version of the national insurance scheme with rebate arrangements.

Structure and Management

6. I told DHSS officials that at first sight there seemed a good deal in the structural and management aspects of Mr Moore's proposals that we felt we could commend to Treasury Ministers. They explicitly recognise the need for expenditure control limits on the buyers of healthcare services and are open to the suggestion of cash limiting family practitioner services. If a way can be found to create an internal market in healthcare which prevents new open-ended arrangements from arising then that will be an achievement. To introduce new expenditure control limits would be even more so.

7. The present draft of the paper (paragraph 5) abolishes existing health authorities, both regional and district, and family practitioner committees. They would be replaced, on the one hand, by buying agencies at a higher tier than DHAs but lower than regions and, on the other, by hospitals and other service providers, who were more closely rooted in particular localities and managed as independent units. I have mentioned to the DHSS that Ministers will be rather wary of a whole new set of high tier bureaucracy and that the concept they have in mind could enable greater delegation on the buying as well as the providing side. I have also said to them that Ministers might want to consider, in the light of the model they are now canvassing, whether there is a useful link here with the Griffiths proposals on community care. The health buyer looked very much like the community care

'enabler', especially as one policy objective was to try to get more of, for example, the elderly out of hospitals and for them to be more economically looked after in the community.

8. In addition to these general points we have said to them that we thought that Treasury Ministers might wish to look carefully at

(a) how much choice was opened up for whom (there are risks under these proposals that the degree of patient choice that now exists might actually be reduced);

(b) whether they were serious about cost control, including the handling of capital expenditure - it was not clear from their proposals who was planning future hospital provision;

(c) what they thought would happen to pay under arrangements where hierarchies would allegedly be stripped away and local management of the provision of services freed up to compete; and

(d) what the role of Government would actually be - it could be that the DHSS and their Ministers would have to step in and fill more gaps in the new system than they now had to.

9. Paragraphs 12-15 of the existing draft indicate the scale of the changes required to bring about the sort of model which Mr Moore's paper outlines. Many of the steps along this road are ones which the Treasury is anxious to see taken anyway eg changing employment structures and contracts; and stepping up the quality and quantity of audit activity along with better measures of comparative costs.

Financing and Contracting Out

10. Mr Moore's outline approach to financing healthcare is set out in paragraph 9-11. This is at a high level of generality and is no more than a stance. Our paper covers a lot more of this ground and in a much more substantive way. We touched in our official discussion on the disadvantages of an hypothecated

healthcare tax, and the disadvantages of trying to specify services which rebate-receivers would forego.

11. I think the final version of Mr Moore's paper will look rather different from this draft, though the basic thrust will be the same. You should know that the last paragraph of the draft, paragraph 16, will be removed and the diagram at the back is also likely to be dropped. Some of the detail in the annex about what various parts of the proposed system would do may be brought into the text as examples and the annex reduced in length.

12. We will provide you with proper briefing on Mr Moore's paper when we see it in final form.

HP.

HAYDEN PHILLIPS

SECRET

A SCHEME FOR CONTRACTING OUT OF THE NHS

Note by the Treasury

1. At present, the NHS is overwhelmingly free at the point of use, whereas fees and charges for private health care reflect the full cost of the service. The NHS is financed out of general taxation (including that paid by those who choose not to use it), while the private sector is paid for by its customers. There is therefore a financial disincentive to make use of the private sector, and hence a major obstacle to the development of private health care, which might otherwise provide a means of easing the pressure on the NHS.

2. One obvious way to reduce this "cliff edge" between the public and private sectors would be wider use of charging in the NHS. Those who chose the private sector would then avoid that expense. Otherwise, there are two broad ways in which the problem might be tackled:

a. Some form of tax relief for the cost of private health care.

b. Some form of remission from national insurance contribution for those who chose to contract out, in some sense, of the NHS.

3. These options are by no means mutually exclusive. Indeed, it is possible to combine elements of each within one package: for example, a rebate of national insurance contributions for those in

work, tax relief for the elderly, and more use of charging in the NHS. This paper deals mainly with the option of remission for those who contract out. But the issues raised by the idea of tax relief are also germane, and these are considered first.

A tax relief

4. The most frequently canvassed option is to give tax relief for private health insurance premiums. A parallel option would be to exempt premiums paid by employers under a company scheme from taxation as a benefit in kind in the hands of the employee. An alternative approach might be to allow tax relief for money spent in paying directly for treatment. Total private health insurance premiums were just over £600m in 1986. Direct expenditure on uninsured private health treatment was a further £500 million.

5. Bills for medical treatment tend to be unpredictable and large. If private health provision is to be encouraged, people will need to be encouraged to take out insurance. It would seem preferable therefore, if there is to be any form of tax relief, to concentrate that relief on insurance rather than direct payments for private treatment. This would also avoid the need for the Inland Revenue to vet claims for individual payments according to whether or not they were medically necessary, with Ministers having to defend the resulting decisions. As well as being contentious, this would need substantial extra staff.

6. Any relief on premiums could be targetted on those who find it most difficult or expensive to obtain private health insurance. At present, the most heavily discouraged group is the elderly.

About 170,000 policyholders (15% of those not in company schemes) are over 65. But most schemes will only take on new customers over 65 with limited cover, and those who are already in the scheme face steep increases in their premiums. This effect would be even more pronounced for those previously in company schemes whose premiums had been paid wholly by their employers. Tax relief would mitigate the increase experienced on reaching the age of 65. It might also encourage insurance companies to begin offering more comprehensive schemes for the elderly. On the other hand, around two thirds of pensioner households pay no income tax, and so could not benefit from a new relief.

7. The other possibility would be to encourage the growth of company schemes by exempting premiums from the benefits in kind legislation. Such a step might trigger a further significant spread of company schemes, and encourage firms to extend to all the workforce those schemes presently confined to managers.

8. It might however be difficult to justify a relief for company schemes but not for premiums paid by small businesses, the self-employed, and individuals. There would be pressure to extend tax relief to all private health insurance premiums. This would in turn lead to pressure for concessions in other areas - for example, those who opt out of state education by educating their children privately, or those who pay for child care when at work, which would substantially undermine the Government's policy of simplifying the tax system and reducing special reliefs. A special relief from the benefits-in-kind charge would also be counter to the changes made in the last Budget. A relief confined to the elderly would be less liable to give rise to problems of this sort.

9. There would be an initial "deadweight" cost because those who already insure themselves would get the new relief. Tax relief for private health insurance premiums would cost £230m a year initially, made up of £80m for exempting employer-paid premiums from the benefits in kind charge, £130m for relief for premiums paid by individuals of working age, and £20m for the cost of tax relief for pensioners. The cost of any relief could be expected to increase subsequently as more people took it up.

A rebate for contracting out

10. The most obvious option here is to use the existing national insurance system. Part of the revenue from national insurance contributions is already allocated by statute to the NHS, as the attached table shows.

11. In 1988-89 total NHS contributions will be some £3.3bn, or about 16% of net NHS expenditure. This would be insufficient to underpin a viable contracting out scheme, since acute services (which are what private insurance would presumably cover) account for around a third of NHS expenditure. If the NHS element of NICs were increased, the income of the National Insurance Fund would fall. The shortfall could be made good by increasing the Treasury Supplement from general taxation to the Fund, thus leaving overall tax and NIC rates unchanged. The supplement is currently 5% of gross contribution to the NI Fund, but was 18% as recently as 1979. The Annex illustrates how this might be done: the Treasury supplement is increased to 17½%, still just below the 1979 level.

12. Contracting out of the NHS might be seen as analogous to contracting out of SERPS. In return for giving up a right to certain categories of treatment under the NHS, individuals could make their own arrangements and receive a rebate as a contribution towards the cost.

13. The analogy could not however be pressed too far. In its most rigorous sense, contracting out would imply that the individual formally relinquished rights to certain precisely defined categories of treatment which the state would no longer be obliged to provide for him. He would however continue to receive other types of treatment under the NHS, which were not available in the privately insured sector - probably geriatric, chronic disease, other long stay care, maternity care where complications do not arise, and so on. This would bring the state directly into decisions about whether particular individuals at particular times fell on the NHS or contracted-out side of the line. There would be highly contentious individual cases, with the prospect of political controversy and litigation. Private health schemes would have to be heavily regulated to ensure that they continued to offer adequate cover so that the NHS did not have to step into the breach. Individuals might feel obliged to carry some form of identification indicating whether their health cover was public or private sector. These are not very attractive features.

14. There are however other ways of approaching this. The rebate could be conditional on two slightly looser requirements: that the insurance scheme met a certain minimum level of cover, and that those who took private insurance undertook to pay the full cost of

any treatment within the terms of their policy which they received from NHS hospitals. Systems would need to be set up to ensure that insurers were billed for any treatment provided in NHS hospitals. Responsibility for assessing individual cases would rest with the insurer, and not with the state. Where a case was not covered, for example on grounds of cost or length of stay in hospital, the excess would be provided under the NHS. Where cover was refused on grounds that the particular procedure was not medically necessary, it would, as now, be for the individual to meet the cost himself.

15. Individuals who contracted out would receive a rebate of some or all their NHS contributions. This would further complicate the national insurance system. (A further question would be whether rebates in respect of those in employer-paid company schemes should be paid to the employer, to the employee or split between the two.)

16. Those who did not pay NICs, notably the elderly, could not benefit from contracting out. Yet the elderly are proportionately the biggest users of the NHS. To encourage them also to take out or continue private insurance, therefore, NIC rebates might have to be supplemented by a tax relief for the elderly along the lines discussed in paragraph 6. There would be pressure to extend this to others who do not pay NICs, including for example non-working widows and those who have taken early retirement (although those who had done so on health grounds might be unable to obtain private insurance in practice).

SECRET

Structure of the rebate

17. The first main alternative would follow SERPS by providing a percentage contribution rebate for those contracted out. This would have the merit of relative simplicity for both the DHSS and employers. But it also has problems:

a. In both state and contracted-out pension schemes the benefits are earnings-related, so an earnings-related rebate is appropriate. This is not the case for health care.

b. Higher earners would get bigger rebates. The rebates might even exceed the cost of private health insurance, so that they made a profit by contracting out. On the figures suggested in the Annex, the annual NHS contribution by those at or above the earnings limit (£15,860 a year) would be £380. Somebody on £50 a week by contrast would pay an NHS contribution of £62 a year, and would hence get a rebate of only one-sixth that of the higher earner.

18. The other alternative would be a flat rate rebate payable weekly or monthly. This could be regarded as essentially a form of voucher scheme.

19. Under either scheme, rebates could be payable in respect of both individuals and their non-working dependants. For some individuals, particularly in lower income groups with families, the rebates would exceed what they paid in NHS contributions or even total NICs. In such cases, the excess of rebates over NHS

contributions would score as public expenditure, in the same way as payments to non-taxpayers under the mortgage interest relief scheme.

20. How big should the rebates be? The average cost per head of the NHS is at present around £375 a year, of which some £120 is for acute hospital services. But there is wide variation with age, as illustrated by the following table of very approximate projections for 1988-89:

	All NHS services	Acute hospital services
age 0-4	£350	£150
age 5-15	£220	£55
age 16-64	£230	£65
age 65-75	£650	£250
age 75+	£1500	£550

Do we not need to give same breakdown as for ave cost of NHS?

The average private health insurance premium was some £120 per head in 1986; extrapolating from past trends (under which the average premium has been growing in recent years at about 10-12% a year, reflecting both increasing medical costs and a changing age structure of the insured population) the figure is likely to be nearer £150 per head in 1988.

21. In considering the appropriate rebate, the following factors are relevant.

a. Insurance cover for primary care and geriatric, chronic and other long stay treatment is unlikely to become available in the short term. The second column of the above table is the more relevant comparison with the cost of private insurance.

b. There would inevitably be "adverse selection" - the tendency for any choice to be taken up wholly or mainly by those with most to gain from it. Thus, those who contracted out would tend to be the younger, fitter and better off who already have private insurance or who would be charged the lowest premiums by private insurers. Those who contracted out would tend to cost the NHS less than the average, while those who stayed behind would be more expensive.

c. The option of contracting out would be available only to those in work who, as the above table shows, cost less than the national average.

22. Taking all these factors into account, and including a loading for adverse selection, a contracted out rebate of around £50 a year per head would probably be appropriate. (This is probably around one-third the average insurance premium per head.)

Financial implications

23. It is difficult to quantify with any certainty the financial consequences of a scheme on these lines. This would depend on the amount of the rebate, on the extent to which it is passed on in the form of lower premiums and on the numbers taking advantage of it who would not otherwise have taken out private health insurance. Take-up is obviously related to the size of the rebate; but it is very difficult at this stage to assess the likely size of the effect. Such research as has been done (mainly in the USA)

suggests that demand for private health care rises by about ½% for every 1% fall in the cost of premiums. But this may not be a good guide to the consequences of introducing a major new scheme of the sort discussed in this paper.

24. Exchequer costs would increase by the cost of the rebate, less any reductions in expenditure on the NHS. The deadweight cost of a £50 rebate to the 5½ million people already covered by private health insurance would be just under £300m. As more people took advantage of the rebate and contracted out, the cost would rise. The suggested rebate of £50 a year would reduce the cost of insurance premiums by about one-third. If the elasticity suggested above is correct, there would be a further 1 million people contracting out, at an additional cost of £50m. If the effect was in fact greater, with, say, 3 million more contracting out, the cost would rise to £450m.

25. In the short term, it is unlikely that NHS costs would fall significantly from what they would otherwise have been. While the higher numbers contracting out would reduce the pressure of demand on the NHS, this would be likely to be reflected in shorter waiting lists or other improvements in service.

26. In net terms private resources going into health care would in the first instance decline, because £300m would be met from public funds rather than private hands. Again, however, the picture would change as more contracted out. Assuming a £50 rebate and an average premium of £150, net private sector payments for health care would rise by £100m for every further million people

who contracted out. It would however need 3 million more to contract out (a relatively high elasticity of demand) before net private sector resources even got back to their present level.

27. There would be other cost pressures over time. Some of the rebate might feed through to higher costs rather than increased private sector activity. And there would be strong pressure for annual uprating of the rebate.

28. The result would be an overall increase in the resources, both public and private sector, devoted to health care as more people contracted out. But, unless the response to the new rebate was very big indeed, the increase in total health expenditure might be less than the increased cost to the public purse. Even on optimistic assumptions about people's response, the proportion of health care financed privately would probably be less than it is now.

HM Treasury
April 1988

Rates of Class 1 contributions for 1988-89

	Primary contribution (employee)			Secondary contribution (employer)	
	Standard rate		Reduced rate for married women and widow optants	Not Contracted out rate	Contracted out rate††
	Not Contracted out rate	Contracted out rate††			
	%	%	%	%	%
National Insurance Fund	-				
Weekly Earnings					
£41.00 - £69.99	4.05	2.05	2.90	4.20	0.40
£70.00 - £104.99	6.05	4.05	2.90	6.20	2.40
£105.00 - £154.99	8.05	6.05	2.90	8.20	4.40
£155.00 and over†	8.05	6.05	2.90	9.65	5.85
National Health Service†	0.95	0.95	0.95	0.80	0.80
Total					
Weekly Earnings					
£39.00 - £64.99	5.00	3.00	3.85	5.00	1.20
£70.00 - £104.99	7.00	5.00	3.85	7.00	3.20
£105.00 - £154.99	9.00	7.00	3.85	9.00	5.20
£155.00 and over†	9.00	7.00	3.85	10.45	6.65

Notes: † The contribution rates apply to earnings up to the upper earnings limit for employees and to all earnings for employers.

†† Applies only to earnings between the lower and upper earnings limits. The corresponding not contracted-out rate applies to earnings below the lower earnings limit and, for employers, to earnings above the upper earnings limit.

CONFIDENTIAL

ANNEX

NATIONAL INSURANCE FUND AND NHS FINANCING 1988-89

The table below sets out the present flows of NIC and general taxation revenue into the NIF and NHS this year, based on GAD figures for national insurance and PEWP figures for the NHS. All figures are GB. The NHS figures are net of charges. It shows for comparison an alternative model under which the NIC element of NHS funding is increased from £3.3bn to £6.7bn to cover the cost of acute hospital services, with the resulting shortfall in the NIF met by an increased Treasury supplement. It is assumed that the increased NHS allocation is provided by doubling the contribution by the self-employed, and raising the balance largely from employees. The scope for increasing employer contributions is limited by the very low NIC rates payable for some employees. There are of course other possible combinations. This one is set out simply to exemplify the principle.

	Present position		Alternative	
	£ bn	rate	£ bn	rate
NIF income				
Employees	11.9	2.05-8.05%	9.3	0.6-6.6%
Employers	14.3	0.4-9.65%	13.6	0-9.25%
Self employed	0.7	£3.42+5.15%	0.6	£2.80+4%
Treasury Supplement	1.6	5%	5.0	17.5%
Total	28.5		28.5	
NHS income				
Employees	1.7	0.95%	4.3	2.4%
employers	1.5	0.8%	2.2	1.2%
self employed	0.1	£0.63+1.15%	0.2	£1.25+2.3%
general taxation	17.8	-	14.4	-
Total	21.1		21.1	
NICs				
Employees	13.6	3-9%	13.6	3-9%
Employers	15.8	1.2-10.45%	15.8	1.2-10.45%
Self employed	0.8	£4.05+6.3%	0.8	£4.05+6.3%
Tax contribution to:				
NHS	17.8		14.4	
NIF	1.6		5.0	
Total	19.4		19.4	

13.4.2

SECRET

A SCHEME FOR CONTRACTING OUT OF THE NHS

Note by the Chancellor of the Exchequer

1. I attach the paper on contracting out of the NHS which was commissioned from the Treasury at our last meeting.

2. After surveying the range of options and variants, the paper concentrates on one which seems to be the most promising if this line were pursued. Its main features are as follows.

- A significant increase in the NHS element of national insurance contributions with an offsetting increase in the Treasury supplement to the National Insurance Fund and no change in tax or NIC rates.

- A rebate payable to those who "contracted out" by taking private health insurance cover satisfying some minimum requirements.

- Those who contracted out would not formally give up their rights to NHS treatment; rather they would undertake to pay for all treatment within the terms of the insurance policy, even where it is provided in NHS hospitals.

- The rebate would be a flat rate of perhaps £50 a year per head.

- Since the rebate would not be available to the elderly, they would instead be entitled to tax relief on premiums paid to private health insurance schemes.

3. The main alternative to a scheme on these lines would be one simply based on tax relief for private health insurance premiums. The case is strongest for the elderly. This has already been advocated by a substantial group of our supporters in the House, led by Sir Philip Goodhart. A case could be made for extending it to company health schemes (by exempting employer-paid premiums from tax as a benefit in kind), but there would be strong pressure then for a corresponding concession in respect of all premiums, however paid.

4. However, there are significant drawbacks about introducing tax relief to promote private health care. Our general policy is to widen the tax base in order to be able to reduce tax rates, so as to leave people with more of their own money and the freedom to choose how to spend or save it. I am therefore most concerned that we should not do anything to reverse the progress we are making in simplifying and streamlining the tax system. Moreover, the introduction of tax relief for private health care would make it more difficult to justify the absence of tax relief for private school fees or other areas. And many of the arguments against an NIC rebate (see below) would apply equally to a tax relief.

5. Returning to the NICs proposal, the financial implications of contracting out are discussed at the end of the paper. The calculations are necessarily a bit speculative, but the message is

disturbing. There is a significant initial cost in paying the rebate to those who already have private insurance. This would at once reduce net private funding. A lot more people would need to contract out and top up from their own resources to make good this loss. But the rebate is unlikely to be large enough to attract additional people into taking out private insurance in sufficient numbers. Thus, there would be higher costs to the public purse without any assurance of an increase in the amount of private money going into health care. Is that a cost effective use of public funds?

6. There is moreover a major distributional point. The first beneficiaries of such a scheme would be those who already pay for private health care, and who tend to be the better off section of the population. This would be particularly difficult to defend after the present controversy over the social security changes and the community charge. Moreover, one of the reasons people would subscribe to private health care with these incentives would be to get what they perceive as better or more timely treatment. We would have to be prepared to deal with accusations that we were providing tax relief to help the better off to jump the queue. If we are going to spend an additional sum of public money on health, is this the best way?

7. I am forced to the conclusion that contracting out is unattractive and should not be pursued on this occasion. It has too many problems for too few (and uncertain) rewards.

SECRET

DRAFT (14.4.88)

NHS REVIEW: THE WAY AHEAD HC

NOTE BY THE SECRETARY OF STATE FOR SOCIAL SERVICES

Introduction

1. Our work so far has identified three main elements of a health care system:

- buying health services
- providing health services
- financing these transactions

My paper focusses primarily on the first two elements. It deals with the third only where it is directly relevant to the other two.

2. My objective is to set out an alternative structure for health care which meets the key aims we have identified. This enables us to consider in more depth:

- the practical implications of such a structure
- the impact of such proposals on the public and on those who work in the NHS
- the stages we should need to go through in putting such a structure in place.

My proposed structure is not intended to be a full or final blueprint. But we need to examine a test model in some detail if we are going to be able to gauge the strengths and weaknesses of our general approach.

Summary of approach

3. The table below summarises the key aims I believe we have agreed on and the key changes which I consider would enable us to achieve those aims.

Key aims for improving NHS

1. More choice and competition
2. More flexible less monolithic system, with more freedom for hospitals.
3. Better incentives for good management and effective cost controls and better quality services, applying to both administrators and professionals.
4. Encourage people to spend more of own money on health care.
5. Well accepted mixed economy of public and private health care.

Key changes to achieve aims

1. Self governing hospitals
2. Separation of buying and provision of health care. 'Buyer' makes contracts with GPs and hospitals, whether public or private, for provision of care.
3. Buyers would be responsible for service needs of resident population.
4. Providers would be responsible for health care itself and for containing costs, including the cost of employing capital within contract prices.
5. Retain expenditure control through limits on buyers at least in respect of hospital expenditure
6. Cost control through published standard health care tariffs by DHSS for contract pricing purposes. On lines of DRG (diagnostic related group) approach.
7. Fiscal incentives to take out health care insurance. Preferred model: build on National Insurance arrangements but modified to suit health care.

Self governing hospitals

4. The annex examines what the key proposal, the separation of the buying and provision of health care, would mean in practice. In broad terms, it means that in future hospitals would be able to run themselves, while responsibility for ~~ensuring~~ purchasing that health care was available would rest with the 'buyer'. The buyer which would have a dual role:

- to ensure that the health care needs of their population were met; and

- to give the best value for money for public funds.

5. The buyers, the successors to the present health authorities, would be funded by government and would have no responsibility for the provision of services. Instead they would place contracts, wherever possible on a competitive basis, with whichever providers of health care could deliver the required services most acceptably. These bodies would be rather larger in geographical terms than most present District Health Authorities and would also take on the responsibilities of the present Family Practitioner Committees.

6. The buyer would be responsible for buying services to meet all the health care needs recognised by the NHS for the population resident in their defined area. This would include family practitioner services and community services, as well as hospital services. The buyer would lay down the price and quality for each of the services required in explicit contracts. There would be some standardisation in these contracts which would reflect standard tariffs for contract pricing purposes published by DHSS, on the lines of the DRG approach. The basis of charging would vary according to the nature of the service in question.

7. We need, correspondingly, to open up the provision of health care by encouraging more diversity and greater local autonomy. The emphasis will be on local management and responsibility; this is the best way of releasing the enthusiasm and enterprise of the people who provide services. The present NHS hospitals and other service units would remain public sector bodies but they would be competing on equal terms both with each other, and with private sector providers, for contracts from the buyer. Public sector service providers would also be free to compete for the business of the private sector buyers of health care such as individuals, insurance companies, or employers. We would thus be giving considerable impetus to a health care "mixed economy".

8. Each service provider would be an autonomous body, employing directly the staff necessary for their business. They would have considerable freedom to determine how, to provide their service. For example, a provider could sub-contract out aspects of the overall service to other units. The "contracting unit" need not be a whole hospital, but could be an

entrepreneurial group of doctors and managers who can offer a high quality yet cost-effective service package to health authorities. To ensure that public providers offered fair competition and that all costs were properly allowed for, the cost of servicing capital would have to be met.

Financing health care

9. We will be in a better position to reach decisions on the financing of health care when we have settled the main structure of buying and providing care. But the elements are closely interlinked:

first, because we can only go so far in developing competition and choice through internal restructuring. We need a better mixed economy. To achieve that we need a better means of encouraging more people to put more of their own money into health care, particularly those aspects where personal choice can be an important element like elective surgery. In my judgement, to make a real impact on this we need to introduce more fiscal incentive for individuals and their employers.

second, the cost of health care needs to be better understood not just by those buying and providing it but by those receiving it. One way of doing this is for people to know how much they are contributing to the cost of health care.

10. Taken together, these factors underline the advantages of paying for health care through a modified version of the national insurance scheme, which includes a rebate for those who contract out of certain NHS services into an approved private or occupational health care scheme. The existing national insurance arrangements would not be entirely suitable. We would have to look in particular at the contribution structure so that it did not worsen work incentives and at the rebate arrangements so that they were fair to older as well as younger people. But the overall advantages of this approach remain.

11. Contracting-out would apply only to certain services. For example to elective surgery, the area in which waiting lists build up most heavily. Buyers would continue to place contracts for such services, for those who do

not contract out. But those who contract out would have an opportunity of greater choice and could elect to spend more of their own money than the health authority would have spent on their behalf.

Implications of new structure

12. We should not under-estimate the scale of the changes implied by the model I have described. While my aim is for the NHS to look much the same to the patient, who would continue to go to the GP and hospital for free treatment, the structure underlying it would be very different. And this would be very plain to those working in the NHS at all levels. The present hierarchial structure would go. The basis of employment would change. And the introduction of contracts and competition would make life look very different. All in all, the changes would be much greater than any of the reorganisations since 1948.

13. The role of Government would not change fundamentally. We should still have overall responsibility for financing health care, for its strategic direction and for overseeing its purchase and quality. Under the new structure, the Government would need to secure effective means for regulating and auditing health care services, both public and private sector. Government would also need to monitor the quality and quantity of education and training for medical and paramedical professions. In all these areas, accountability to Parliament would continue.

Approach to change

14. The fundamental nature of the changes underlines the importance of the way in which we move towards our goals. We need to do so in a way which:

- is incremental, so that we are able to modify our approach as we go.

- minimises the impact on patients, so that they do not feel they are losing what is now valued in the NHS, especially the ready access free of charge

- reduces as far as possible the concern about turbulence that will be felt by those working for the NHS

- recognises the costs of change, including the resource costs of a more tightly managed system

15. These factors all point to an approach which opens up the NHS to organic change rather than to imposed reorganisation from the top. A number of initiatives for "re-furbishing the NHS" were set out in HC15. Pushing down budgetary responsibility, and making related changes in information systems, would be essential. It might also help to develop an internal marketing approach, perhaps on an experimental basis in the first instance. We should need to judge at what stage the responsibilites and geographical scope of health authorities should be changed in the way I have proposed. In this way we could bring forward our proposals as a rolling programme for improving the NHS, moving towards the more radical reforms I have set out in this note. We can fairly present this as a continuing process of consultation and change, allowing reform to be taken at an acceptable pace.

16. Carrying through any proposals on these lines will take time and careful preparation. We must secure a sympathetic hearing for them before they are published and substantial support before they are implemented. When we have agreed the main elements of our rolling programme, we start signal them informally before publication. We could follow that up with a White Paper which set out the main directions of change, whilst leaving the details to be completed in the light of the response to the White Paper. If all went according to plan, we could then aim for legislation in 1989/90

ANNEX

SECRET

DRAFT (14.4.88)

SELF-GOVERNING HOSPITALS

How it might work

The main elements of the new system are set out diagrammatically in the chart below. This shows the contractual relationships, patient paths through the system, and the input from Government. A brief summary of the main "activities" of each "participant" in the structure is as follows:

1. Patients would in general see an unchanged though improved NHS. In particular they would continue:

- to be entitled to a comprehensive range of health care, free at the point of use
- to have access to the system mainly through GPs and specialists.

2. Buyers would

- be responsible and accountable to Government for

  a. ensuring that the service needs of their resident population were adequately met, and

  b. staying within cash-limited revenue allocations.

- put each service, or group of services, out to tender
- contract with providers, including GPs, for particular services over a specified period.
- monitor the providers' performance.

3. GPs would

- retain full clinical responsibility for their patients
- remain as independent contractors to the buyers, providing a primary health care service
- continue to act as "gatekeepers" to specialist services through their referral of patients
- be constrained in their referrals by the buyer's decisions on service contracts with specialist providers.

4. Consultants would

- retain full clinical responsibility for their patients
- be either full or part-time employees of hospitals or clinics
- be able to assemble "service packages" to offer to buyers.

5. Hospitals and clinics would

- be self-governing, with a management board
- be independently managed, individually or in groups.
- employ all professional and lay staff.
- seek to attract services for their local communities.
- offer specialist facilities to other providers on a sub-contract basis.

6. Providers generally would

- offer to provide particular services, or groups of services (NB: not necessarily wholly based within a hospital or clinic), to NHS buyers.
- be free also to bid for private sector business.
- buy in any additional facilities they need from other NHS hospitals and clinics or from the private and voluntary sectors.
- be accountable through contracts with buyers for meeting cost, volume and quality standards
- bid for capital investment from public funds.

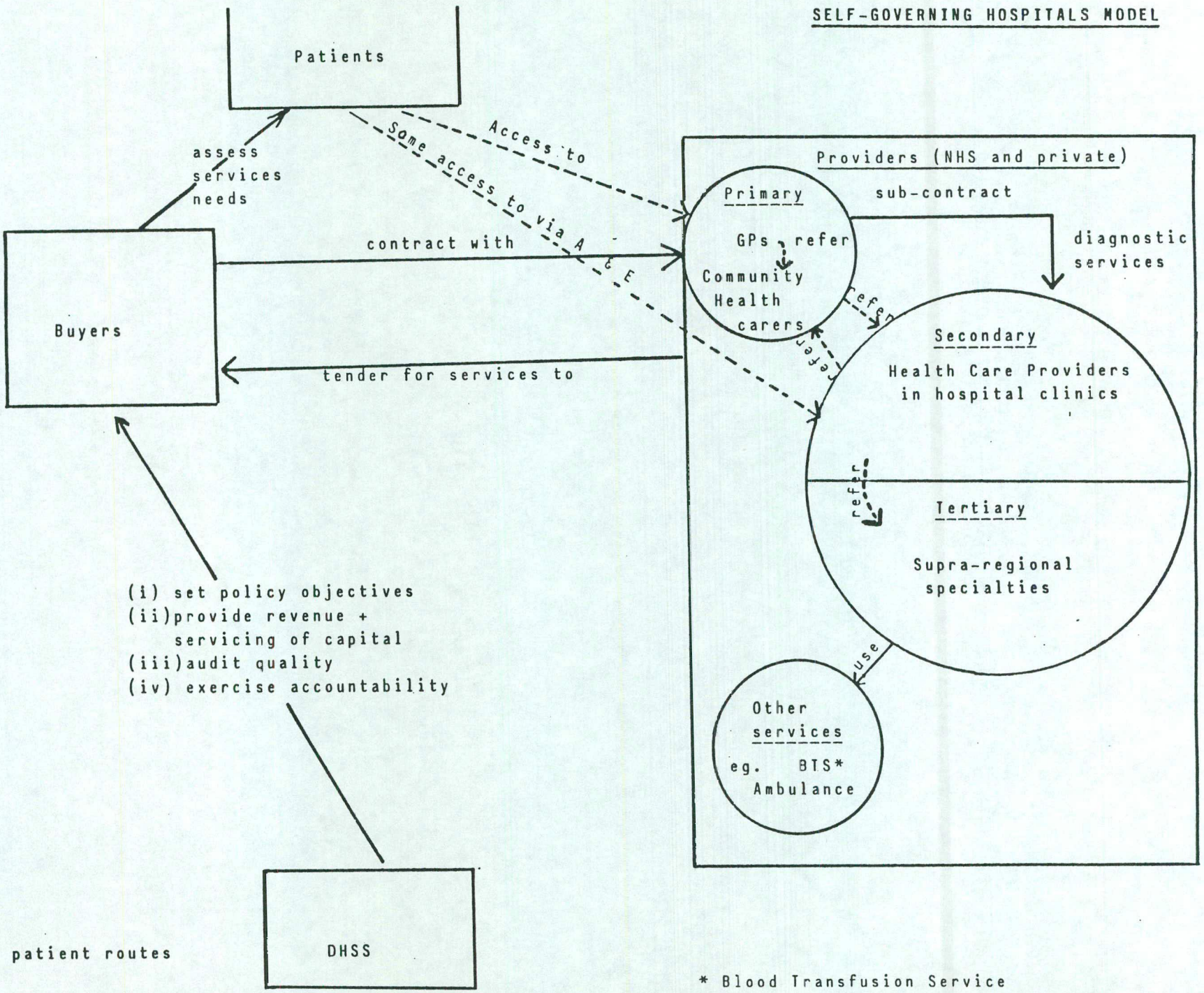
7. The DHSS would

- work primarily through buyers in setting policy objectives, allocating revenue and securing accountability
- encourage development of clinical audit (including peer review)
- ensure that adequate capital funds are available (see below).
- secure the integration of service and resource plans, both within each buyer's area and nationally.
- ensure that there are adequate levels of trained manpower, and that professional training overheads of providers (including those of teaching hospitals) are funded.
- publish standard (say, DRG-based) tariffs for contract pricing purposes
- ensure effective regulatory and audit arrangements.

8. A mechanism would be needed to look after capital assets and capital investment matters, and in particular to:

- be responsible and accountable for funding short-term and long-term investment plans eg buildings and equipment
- acquire, hold and dispose of capital assets, consistently with public policy and accountability.

SELF-GOVERNING HOSPITALS MODEL



mjd 3/113m

UNCLASSIFIED

FROM: MISS M P WALLACE
DATE: 21 April 1988

MR ANSON

cc Chief Secretary
Paymaster General
Sir P Middleton
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Saunders
Mr Griffiths
Mr Sussex
Mr Satchwell
Mr Tyrie
Mr Call

DYSON PAPER ON THE REFORM OF THE NHS

The Chancellor was most grateful for your minute of 15 April. He agrees that it would be worth asking the DHSS for their views on the growing numbers of paramedicals. He would be grateful if you could take this forward.

MOIRA WALLACE

mjd 3/116m

SECRET

FROM: MISS M P WALLACE
DATE: 21 April 1988

MR H PHILLIPS

cc Chief Secretary
Paymaster General
Sir P Middleton
Sir T Burns
Mr Anson
Mr Culpin
Miss Peirson
Mr Turnbull
Mr McIntyre
Mr Parsonage
Mr Riley
Miss Sinclair
Mr Griffiths
Mr Macpherson
Mr Satchwell
Mr Tyrie
Mr Call

NHS REVIEW: NEXT MEETING

The Chancellor was most grateful for your minute of 20 April. Subject to a few minor queries/amendments, set out below, he is content for the paper to be circulated before the weekend. When we have a final version from ST, we will arrange circulation, under a slightly amended covering note (new version attached, amendments side-lined).

2. His comments on the main paper are as follows:

- Paragraph 18 - redraft second sentence to read "this would in some ways be analogous to a voucher scheme."
- Amend paragraph 19 to read: "Under a flat rate rebate scheme, rebates could in principle be payable in respect of both individuals and their non-working dependents. This would, of course, increase the number of cases in which the rebates would exceed what individuals paid in NHS contributions or even total NICs. [continue as drafted]"

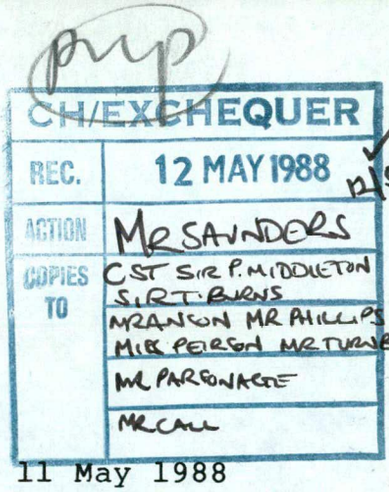
- In paragraph 20, the Chancellor would, if possible, like to give the same break-down of average private health insurance premiums as we give for average costs of the NHS.

MOIRA WALLACE

SECRET

10 DOWNING STREET

LONDON SW1A 2AA



NOTE OF MTG 9/5

From the Private Secretary

11 May 1988

Dear Geoffrey,

NHS REVIEW

The Prime Minister held a further meeting on 9 May to discuss the review of the National Health Service, the fifth meeting in the present series. I should be grateful if you and copy recipients would ensure that this record of the discussion is shown only to those with an operational need to see it.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Social Services, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr Wilson and Mr Monger (Cabinet Office) and Mr O'Sullivan (Policy Unit). The meeting had before it:

- 'Charting the way ahead', a paper, HC18, by the Secretary of State dated 22 April;

- 'a scheme for Contracting out the NHS', a minute by the Chancellor dated 22 April;

- 'an outline timetable for the review', a note by the Cabinet Office dated 4 May.

In discussion of the paper by the Secretary of State, the following points were made:

(a) The purpose of the proposed new structure was to separate buying from provision of health care. This had been identified by the group at a previous meeting as a promising approach. It would introduce competition and force the buyer to look for the most effective providers, and the providers to improve their services so as to attract buyers.

(b) A great deal still remained to be worked out, however, as to how the approach would work in practice. One of the most important questions to be decided was the identity of the buyer. It was argued that at least at first there was little practical alternative to giving the District

Health Authorities (DHAs) that role. It would indeed be consistent with the evolutionary approach to change which the group regarded as desirable. But it was essential not to entrench NHS bureaucracy. The case for some competition between buyers should also be considered and so should the implications for the future of the Regional Health Authorities. The group needed to discuss a paper on the identity of the "buyer" at its next meeting.

(c) In principle, an alternative to use of a statutory buyer was direct referral by the GP to the hospital of his choice. But it was not immediately clear how this would in practice be consistent with effective financial control, which was essential. Nevertheless, even within the system of statutory buyers, there had to be some arrangement by which the GP, if he wished, could refer his patient to a provider of his own choice. Reconciling GP freedom with proper financial control would not be easy.

(d) The more effective the provision of health care became, the greater the potential pressure on resources would become. The need for financial controls in the new system was therefore paramount. One solution might be to impose cash limits on the buyers. Medical audit would also have an important part to pay in ensuring financial discipline. And it was essential that funding should follow the patient, so that successful hospitals were rewarded, as they were not under the present system. The group should consider the financial arrangements, on the basis of a further paper, at its next meeting.

(e) The same arrangements would not necessarily apply under the new structure to accident and emergency (A&E) cases as to others. It was important to identify practical and politically acceptable arrangements for dealing with A&E cases. But there might be a number of ways of doing so. Even under the present system there were a number of options, depending for example on the degree of centralisation of A&E treatment within an area. Further study might disclose ways of reducing the costs of this treatment.

(f) Paragraph 7 of the paper envisaged the possibility that not all hospitals would be self-governing and that the providers might be based on larger management units. It was not clear that this was right. It was argued that the presumption should be that the providing unit was the hospital and that all hospitals were self-governing. The Special Health Authorities set up under the present system might provide a useful precedent.

(g) The system could work only if there was adequate information about costs, so that buyers could choose the most efficient providers. Although some progress had already been made towards setting up a better information system, it was disappointing that it was not already in

place. A paper should be prepared on the subject for the group to consider at its next meeting.

The Prime Minister, summing up this part of the discussion, said that more work was needed on the details of the new structure. It was essential for the group to be satisfied that it would work on the ground and would represent a substantial improvement on present arrangements. A number of aspects had been identified on which further discussion was required, in particular the identity of the buyers, the arrangements for funding and controlling expenditure, the nature of the contracts between buyers and providers, and the development of adequate information systems. The Secretary of State should arrange for a paper to be prepared on these and other practical aspects of the proposed structure for the group to consider at its next meeting.

The Chancellor of the Exchequer, introducing his paper on contracting out of the NHS, said that, as the group had asked, it considered how a contracting out system could best be made to work. But his own study of the option had led him to the conclusion that it was unattractive. This was mainly because of the high deadweight cost and the probability that it would lead to pressure for a similar concession for education. There was, however, an option of providing relief for private health insurance premiums paid by the elderly. There were disadvantages in this too but there was some political pressure for it and it seemed a more promising option to pursue.

In discussion, the following were the main points made:

(a) There was a strong case for encouraging a movement towards the private sector. This was necessary to provide downward pressure on NHS costs in the long run.

(b) One means by which this movement might take place was through the expansion of company health schemes. The group should consider how such an expansion might be promoted. One apparently promising possibility would be to exempt premiums paid by employers under a company scheme from taxation as a benefit in kind in the hands of the employees.

(c) The idea of a contribution rebate needed further consideration. If the NHS were made more efficient and responsive to consumers, the private sector might become comparatively less attractive and the upward pressure on NHS costs would become still greater. The assessment of the balance of advantage in a contribution rebate should be based on a dynamic not a static analysis. More particularly, a rebate for contracting out of the NHS for cold surgery would help to reduce waiting lists, which were made up mainly of those awaiting such treatment.

(d) A possible improvement in the working of the NHS which should be examined further was the removal or modification of the present restrictions on the number of

consultants. These restrictions resulted partly from the application of cash limits but partly also from restrictive practices operated by the profession itself. An increase in the number of consultants, accompanied by a reduction in the time individual consultants had to give to the NHS, might help to contain public expenditure.

The Prime Minister, summing up this part of the discussion, said that the group were agreed that it was desirable to encourage the growth in the private sector. Before they could form a view on the part which action on tax or contributions might play in achieving this, more work and discussion was necessary. A meeting on the subject should take place in the week beginning 6 June. Meanwhile, the group had identified two particular possibilities: tax relief for private health insurance premiums paid by the elderly, and exemption from tax as a benefit in kind of premiums paid by employers under a company scheme. The Chancellor should arrange for a paper to be prepared on these options, for consideration at the meeting in the week of 6 June.

Finally, summing up a brief discussion of the Cabinet Office note on the future timetable for the review, the Prime Minister said that the group endorsed its proposals for their fothcoming meetings. The form in which the outcome of the review was published would need to be considered at a later stage. But there was a distinction between the changes that would have to take place quickly and those that would develop over the longer term. For purposes of presentation, it might prove desirable to concentrate on the immediate changes.

I am sending copies of this letter to the Private Secretaries to the Ministers at the meeting, and to the others present.

Yours,
Paul

PAUL GRAY

Geoffrey Podger, Esq.
Department of Health and Social Security

SECRET

NOTE OF MTG 24/5

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

25 May 1988

Seen by Ch

Dear Geoffrey,

NHS REVIEW

The Prime Minister yesterday held a further meeting to discuss the review of the National Health Service, the sixth in the present series. I should be grateful if you and copy recipients would ensure that this record of the discussion is shown only to those with an operational need to see it.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Social Services, the Chief Secretary, Treasury, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. O'Sullivan (Policy Unit). The meeting had before it a paper by the Secretary of State for Social Services dated 20 May, 'NHS Review: Self-Governing Hospitals' (HC 21) and a minute by the Chancellor of the Exchequer dated 23 May.

The following were the main points made in discussion:

a. The essence of the structure proposed in HC21 was the separation of the buying of health care from its provision. This structure would open up the system to competition between the providers and ensure greater responsiveness to patient needs. It was needed to produce the major change in attitudes which was required in the NHS.

b. One objection to the proposed structure was that it would entrench NHS bureaucracy. The buying agencies would be too much like the present District Health Authorities under another name. It would be simpler for GPs to deal direct with the hospitals, or at least to use an intermediary body as no more than their agents. On the other hand, it was argued that the structure proposed in the paper was necessary to retain effective cash-limiting, which was essential.

c. Another possible objection was that the role for the GPs in the new structure was unclear. GPs might complain that their freedom of referral would be effectively reduced.

d. In view of these difficulties, the Group should consider whether it could better achieve its main objectives by changes which, at least at first, were within the present structure. One of the most important of these objectives was that money should follow the patient, so that successful hospitals were rewarded rather than being penalised, as at present. One method of doing this would be by not allocating to hospitals in advance all the money that was available, but withholding a proportion which could later be distributed to those hospitals which had been successful in attracting more patients by greater efficiency. An important question to consider on this approach was whether it might lead to higher expenditure, because in practice the reserve might have to be additional: in principle it should be possible to make offsetting reductions in allocations to the less efficient hospitals.

e. Whatever the precise approach adopted for the buying of health care, other changes within the present structure which would be important in meeting the Government's objectives, and should be considered further, were: the creation of independent hospitals (with each hospital being independent as far as possible, although some grouping might be necessary); acceleration of the resource management initiative; better value for money audit; medical audit; extension of competitive tendering; reform of professional practices; and encouragement of the private sector.

f. Changes of this sort in the short term were compatible with moving in the medium and longer term in the direction described in the Secretary of State's paper. For example, more buying-in of services by District Health Authorities was desirable on any account and taken far enough would lead to the separation of buying and provision of health care.

The Prime Minister, summing up the discussion, said that the Group saw considerable attraction in proceeding by changes within the present structure. They believed that it would be unwise to try to do too much too quickly. They were particularly interested in the proposal which had been put forward for withholding part of the financial allocation to the hospital service for later distribution to the more successful hospitals. But the Group would need to consider as a whole all the changes within the present structure which had been identified at the meeting.

For the next meeting of the Group on 7 June, it had already been agreed that they would consider a paper by the Secretary of State on greater involvement by the private sector, and a paper by the Chancellor on tax incentives to the private sector. They would also wish to consider in more detail at that meeting the proposal for topping up allocations to the more successful hospitals. The Chancellor should arrange for such a paper to be brought forward. At the subsequent meeting in the week of 23 June they would want to

consider a further paper bringing together the other changes within the present structure which had been identified at the meeting; and also a paper on the method of allocating captial to hospitals. The Secretary of State should arrange for these papers to be prepared, in close consultation with the Chancellor of the Exchequer.

I am copying this letter to the Private Secretaries of the Ministers at the meeting, and to the others present.

Yours,
Paul

(PAUL GRAY)

Geoffrey Podger, Esq.,
Department of Health and Social Security.

10 DOWNING STREET

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SE

NOTE OF MTG 7/6

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

7 June 1988

Dear Geoffrey,

0000020

NHS REVIEW

The Prime Minister held a further meeting today to discuss the review of the National Health Service, the seventh in the present series.

I should be grateful if you and copy recipients would ensure that this record of the discussion is shown only to those with an operational need to see it.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Social Services, the Chief Secretary, Treasury, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. O'Sullivan (Policy Unit). The meeting had before it minutes dated 3 June from the Chancellor of the Exchequer, 'NHS Review: Tax Relief', and from the Secretary of State for Social Services, 'A Mixed Economy of Health Care'.

In discussion the following were the main points made:

a. It was essential to achieve substantial growth of the private sector. Otherwise the growing demands for health care meant the costs of the NHS would continue to escalate. The rate of growth in private health care had been relatively slow over the past few years, and this suggested that a major boost was now needed. Action on the supply side, for example on the restrictive practices of the professions, would be important, but by itself was unlikely to be enough. Action to stimulate demand for private care would also be necessary.

b. There was a very strong case for tax relief for private medical insurance premiums paid by the elderly. Although contrary to the general thrust of tax policy in recent years, it stood a good chance of being cost-effective in encouraging more private provision and should not be unduly repercussive. It would also be politically attractive, especially if

it were extended, as described in the Chancellor's minute, to premiums paid in respect of the elderly by younger members of their families.

c. The mechanism for tax relief for the elderly described in the Chancellor's minute had many advantages. It would be right for the relief to start at age 60 and a MIRAS-type arrangement would have the attraction of providing the same relief for non-taxpayers as taxpayers, even though relief for non-taxpayers would score as public expenditure. It was doubtful however whether it would be right to restrict the relief to the basic rate. The argument against extension to the higher rate was that it would make the relief much more complicated for the sake of a small minority of taxpayers (a higher proportion of whom were likely already to have private health cover). On the other hand, premiums for the elderly were so substantial that relief at the higher rate might be necessary to provide them with enough incentive to take out private insurance. This aspect of the scheme should therefore be looked at further.

d. It was argued that exemption from tax as a benefit in kind of premiums paid by employers under company schemes raised much more difficult issues of tax policy. The deadweight cost of this relief would be high (about £80 million), and it was unlikely to be good value for money in promoting an expansion of private insurance. It was also likely to be repercussive. On the other hand, it was argued that tax relief going beyond the elderly was required to give the necessary boost to the private sector, and that relief for company schemes would respond to the growing pressure from employees for the introduction of such schemes.

e. The relief for company schemes might be better targeted, and therefore more cost-effective, if it did not apply to premiums paid in respect of people at the highest levels of income, who were the group most likely to have taken out private medical insurance already. A way of achieving this would be to raise from £8,500, for health insurance premiums only, the level of income above which benefits in kind were taxed. This option should be further considered.

f. The option of some form of contracting out should also be considered further. It could be restricted to cold elective surgery and would then make a contribution to cutting queues, which were largely made up of people awaiting treatment of that sort. There would be dead-weight costs, but in assessing the balance of costs and benefits it was important to take account of the behavioural consequences of introducing the scheme.

The Prime Minister, summing up the discussion, said that the group were agreed that a substantial boost to the growth of the private sector was required, through action on demand as well as supply. The group saw considerable attraction in tax relief for health insurance paid by or for the elderly, along the lines set out by the Chancellor of the Exchequer. They saw some objection however to the restriction of the relief to the basic rate. This aspect should be looked at further, and the Chancellor of the Exchequer should arrange for a paper to be circulated to the group accordingly. The main question however was whether tax relief should extend more widely than the elderly. One possibility was the exemption from tax as a benefit in kind of premiums paid by employers under company schemes. The group saw arguments for such a concession, in view of the need to make a big impact on the growth of the private sector. But it also raised difficulties from the point of view of cost and tax policy. Before taking a final decision the group wanted to consider whether there were ways of improving the targeting. One way which had been suggested was that the relief should apply only to those with earnings up to a specified level, which would have to be much higher than the level of £8,500 above which benefits in kind generally were taxable. The Chancellor of the Exchequer should arrange for this option to be considered further, and a paper prepared for the group.

On a separate matter, the Chancellor of the Exchequer had agreed to send her a note on the tax treatment of employees in relation to provision of workplace nurseries.

The Secretary of State for Social Services had suggested that another option was the introduction of a system of contracting out for cold elective surgery. It was unlikely that it would be right to have both contracting out and extensive tax reliefs. But the group agreed that the contracting out option should be considered further and the Secretary of State should prepare a paper on it, in consultation with the Chancellor of the Exchequer.

It had already been agreed that for the next meeting of the group papers should be prepared on a number of practical aspects of change: on financing hospitals, self-governing hospitals and capital allocation, issues to do with the professions, and audits. These papers should be discussed between Departments in the Cabinet Office group before circulation to the Ministerial group. Thereafter the group would need to have a more extensive discussion of the whole package as it was now developing. The further papers which had been commissioned at this meeting on tax relief for the elderly, tax relief for company schemes, and contracting out should be ready for that discussion. In looking at the whole package, the group would need to consider whether it was sufficiently radical. Radical change would be necessary if the growth of public expenditure on health was to be contained. The option of major changes in structure was still open. In particular, the method of financing hospitals would need to be radically changed so that they receive their income under contract; and the future of the health authorities

needed to be reassessed.

I am copying this letter to the Private Secretaries of the Ministers at the meeting, and to the others present.

Yours,
Paul

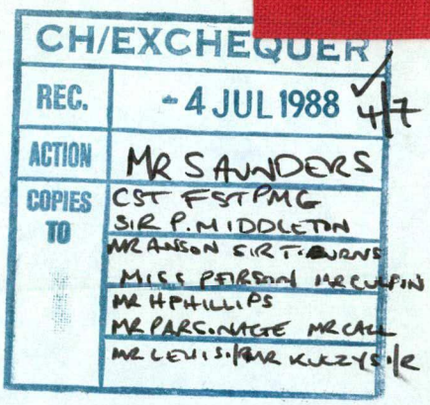
PAUL GRAY

Geoffrey Podger, Esq.,
Department of Health and Social Security

SECRET

10 DOWNING STREET

LONDON SW1A 2AA



From the Private Secretary

1 July 1988

Dear Geoffrey,

NHS REVIEW

The Prime Minister held a further meeting yesterday to discuss the review of the National Health Service, the eighth in the present series.

I should be grateful if you and copy recipients would ensure that the record of this discussion is shown only to those with an operational need to see it.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Social Services, the Chief Secretary, Treasury, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office), and Mr. O'Sullivan (Policy Unit). The meeting had before it papers dated 28 June from the Chancellor of the Exchequer on tax relief, from the Chief Secretary, Treasury, on financing hospitals, and from the Secretary of State for Social Services on contracting out, self governing hospitals, consultants and medical audit; and a minute dated 28 June from the Chancellor of the Exchequer on Supply and Demand.

NOTE OF MTG 30/6

The group first considered tax relief and contracting out. The Chancellor of the Exchequer said that since the last meeting he had reconsidered, in the light of the points made at that meeting, the scope for tax relief for private insurance premiums. He started from the view, set out in his minute of 28 June, that the problems in health were on the supply side, to be solved mainly by supply side measures. There was no shortage of demand, and indeed demand exceeded supply. To increase demand by extensive mesures of tax relief would therefore run a substantial risk of simply putting up prices. Despite this, there was a political case for tax relief on premiums paid by the elderly, as he had suggested earlier. He now proposed a modest extension of this to provide relief from the benefits in kind charge on premiums paid in respect of the elderly by employers.

But he was convinced that, against the supply and demand background he had described, it would be a mistake to go further. There were also more specific arguments against the possible extension of relief which had been mentioned at the last meeting. Relief at the higher rate for premiums paid by or for the elderly would complicate the administration of the relief, increase the cost and substantially reduce the political attractions of the change. The other proposal was that the income limit above which benefits in kind were taxed should, for private health premiums paid by employers, be raised substantially above £8,500. Such a change did not seem necessary to promote the expansion of company schemes, which were now growing at the rate of 7 per cent a year. But it could prove highly repercussive, especially in encouraging pressure, which was already considerable, to raise the income limit for benefits in kind generally.

In discussion the main points made were as follows:

a. The acceleration in the growth of company schemes was very recent, and perhaps only a response to the current controversy over the NHS. If the other changes being discussed succeeded in improving the NHS, the relative attraction of the private sector would be reduced. It could not be assumed therefore that the recent spurt in the growth of company schemes would be sustained.

b. The fundamental question for the Government was whether it wanted the great bulk of the population to continue to be dependent on the NHS for all their medical treatment. Such a situation would mean high and growing calls on public expenditure and inadequate freedom of choice for the patient. Procuring a substantial shift to the private sector in the longer term was a very high priority of policy.

c. Company schemes had the great advantage that they gave employers an incentive to hold down the costs of private medical treatment.

d. It was not clear that there was a real shortage in the supply of medical services. There was evidence of a surplus of medically trained people, both in this country and abroad.

e. Another method of encouraging growth of private insurance among the working population would be the contracting out scheme, limited to cold elective surgery, suggested by the Secretary of State for Social Services. Growth of individual insurance would not have the advantage of growth of company schemes in giving employers an interest in holding down medical costs. It might therefore not be as attractive as tax relief, but it should certainly be considered if tax relief going beyond the elderly were rejected.

The group then considered the papers by the Chief Secretary on the financing of hospitals and by the Secretary of State for Social Services on self-governing hospitals.

The main points made in discussion were:

a. The group had earlier identified a major defect in the present arrangements for funding hospitals. This was that they did not get more money if they attracted more patients. The proposal put forward by the Chief Secretary was designed to improve this situation by holding back the money provided each year for real growth in the health budget - typically about 2 per cent - and allocating it separately to reward performance.

b. This proposal would however have an effect only at the margin. The great bulk of funding for hospitals would continue to be provided under the present procedures. It would be better to make a more fundamental change under which all the money for a hospital was paid under contract in payment for services provided by it. The need for the hospital to win contracts, and perform them satisfactorily, across the whole range of its activities would be a powerful incentive towards greater efficiency.

c. On the other hand, the proposal by the Chief Secretary should be seen as providing only the first steps in a long-term programme of change. It was certainly desirable to move towards making hospitals dependent on performance under contract for the whole of their revenue. This would be acheived when self-governing hospitals were fully developed, and the papers on financing hospitals and self-governing hospitals therefore needed to be considered together. But here as elsewhere the difficult question was how to manage change and to move gradually and without upheaval to the right long-term position.

The group then proceeded to the papers by the Secretary of State for Social Services on consultants' contracts and medical audit.

The following were the main points made in discussion:

a. There was no doubt that the consultants' present practices made the proper management of NHS resources more difficult, and that action was needed. But it was important to attack the right target. The question of where the consultants' contracts were held was not for example of great practical importance. The objective was to ensure more flexibility in the use of consultants, especially through the power to transfer them between hospitals, and to get their participation in management.

b. It should not be assumed that the necessary changes would require changes in the contracts. Pressing for changes in the contracts might lead to a confrontation with the profession, and be expensive if the existing contracts had to be bought out. In practice some improvements had already been made in working practices within the terms of existing contracts. The first step for the Government should be to see how far it could achieve its objectives for the profession without changes in these terms.

c. Proper arrangements for medical audit were most important and the objective was to make participation in them obligatory for consultants. How this could best be achieved required further consideration. The profession itself seemed anxious to move in this direction. It might well be that this was a change which could be made without a formal change in the contracts, which indeed already implied participation in audit arrangements.

d. The fundamental solution to the problem of consultants would be to make them independent and self-employed, selling their services to the hospitals under contract.

The Prime Minister, summing up the discussion, said that the group had not yet made a definite decision about the extent of tax relief, or about contracting out. These issues would require further consideration.

As to consultants' contracts, it would be helpful if Sir Roy Griffiths could circulate a note to the group setting out in particular the changes which in his view could be accomplished without changing the contracts.

More generally, it was important that the changes proposed by the Government should be coherent and have a clear direction. Recent discussions had perhaps been too concerned with detail and had lost sight of the overall strategy. It was clear that more must be done to encourage the growth of the private sector and to move towards a situation in the NHS in which suppliers of health care were paid according to the services they provided. There was much to be said for a solution broadly along the lines proposed by Lord Trafford and his colleagues. Under this the district health authorities would become buyers of services from hospitals. Family Practitioner Committees would be abolished and their work absorbed into that of the district health authorities, as in Northern Ireland. The regional health authorities might also be abolished. Hospitals would depend for their income entirely on winning and retaining contracts from the buyers, and this would put them under effective pressure to be efficient. The problem of the consultants might also be dealt with by making themn self-employed contractors selling their services to the hospitals. This solution needed to be considered further.

In public presentation it would be important to bear in mind the distinction between the changes that would be made quickly, and the longer term objectives. One solution might be to have a White Paper with green 'fringes', setting out firm proposals for the present and more tentative thinking about how longer term objectives could be achieved.

At the next meeting arranged for 8 July, Ministers would want to assess the overall package and in particular consider whether it was sufficiently comprehensive and coherent. For that meeting, the Cabinet Office should circulate a note summarising what the package would look like on the basis of the discussions so far.

I am sending copies of this letter to the Private Secretaries of the Ministers attending the meeting, and to the others present.

Yours,
Paul

PAUL GRAY

Geoffrey Podger, Esq.,
Department of Health and Social Security

SECRET - CMO

COPY NO: 2
OF 14 COPIES

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

12 July 1988

Dear Geoffrey,

NHS REVIEW

The Prime Minister held a further meeting on 8 July to discuss the review of the National Health Service, the ninth in the present series.

I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with the CMO arrangements.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Northern Ireland, the Secretary of State for Scotland, the Secretary of State for Social Services, the Chief Secretary, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office), and Mr. O'Sullivan and Mr. Whitehead (Policy Unit). The meeting had before it a paper dated 6 July by the Cabinet Office 'The Overall Package: A Summary of Conclusions So Far', and also one dated 4 July by Sir Roy Griffiths on consultants' contracts.

In discussion the group went through the Cabinet Office paper, and this record refers to paragraphs in that paper.

Paragraph 4

Following discussion, the Prime Minister said that the group agreed that there was a strong case for re-merging the Family Practitioner Committees (FPCs) and the District Health Authorities (DHAs), as in Scotland and Northern Ireland. This change should be transferred from Part III to Part II of the paper. The group also saw some attraction in cash limiting all the operations of the merged bodies. This was not a necessary consequence of the amalgamation, but it would have the advantage of effectively cash limiting primary care. It had, however, been argued that such cash limiting would antagonise the profession and jeopardise its reception of the rest of the reforms. The Secretary of State for Social Services should prepare a paper examining in detail the possibility both of amalgamating the FPCs with the DHAs and cash limiting the combined bodies.

NOTE of MtG. 8/7

Paragraph 5

The Prime Minister said that the group agreed this paragraph subject to the following main points:

(a) The word 'long-term' should be deleted from the introduction;

(b) The reference to the effect on services to the patient should be brought from the end to the beginning of the paragraph. Here and elsewhere it was important to emphasise the practical benefit the reforms would bring to patients;

(c) The paragraph should reflect the group's belief that there was a strong case for slimming the operations of the regional health authorities. They might in time become regional offices of the DHSS;

(d) It should also cover the need to remove the political element from the district health authorities. The group attached considerable importance to this.

It was argued that the group should also consider the case for ending the provision of inessential treatment, such as cosmetic surgery, by the NHS, except at a charge. At the same time the practice of charging private patients in full for their prescriptions might be reconsidered, although it had the important advantage of discouraging over-prescription. The Prime Minister asked the Secretary of State for Social Services to prepare a paper for the group examining these possibilities.

Paragraph 8

The group agreed that there should be better information for GPs subject to resolution of expenditure aspects (item i); that GPs should carry out more minor surgery (item iii); and that there should be more schemes for the purchase of optional extras and topping-up (item vi). In discussion of the 'top slicing' financial arrangements in item ii, the following points were made:

(i) 'Top slicing' would represent too small a change from the present position. The RAWP system would remain essentially in place, with its doubtfully justifiable regional effects and its bureaucracy. Only a very small proportion of hospitals' funding would depend on their success in attracting patients. It was desirable to move quickly to a position in which much more of it was. Hospitals must be paid for what they did, not for just being there;

(ii) The principle that money should follow the patient, and that hospitals should receive their funding for services they performed, was central to the review. But it could not be introduced immediately, and the question was how best to work towards it. 'Top slicing' would be the

first step down that path. What mattered in practice was the proportion of funding to which it was applied, and that could be steadily increased.

The Prime Minister, summing up this part of the discussion, said that the funding mechanism required more work. The Cabinet Office, in consultation with the Treasury and the Department of Health and Social Security, should co-ordinate a paper on it for the next meeting of the group.

Paragraph 9

The group agreed that better information was important and that the Resource Management Initiative should be extended to the whole country next year. The group also agreed that effective audit arrangements for money spent and for value for money (item iii) were essential. This audit would have to be by a body independent of the NHS and there seemed a strong case for using the Audit Commission for this purpose. More work was however needed, and the Prime Minister asked the Secretary of State for Social Services, in consultation with the Chancellor, to bring a paper on the subject before the group.

Paragraph 10

In discussing this paragraph, the group also considered Sir Roy Griffiths' note dated 4 July on consultants' contracts.

The Prime Minister, summing up this part of the discussion, said that the group were agreed that changes in consultants' practices were an essential part of the reform of the NHS. In particular the group believed that:

(a) It was important to stop current abuses of the merit award system. For example, many awards were paid shortly before retirement, and added to pensionable pay, as a means of increasing consultants' pensions. The Government were already reviewing the system, on the recommendations of the Review Body. But since merit awards often formed a large part of total remuneration, any radical change could lead to renegotiation of the contracts and an increase in basic pay. The question had to be handled with great care, in the light of these risks;

(b) There were major objections to the current method of calculating the remuneration of consultants working part-time for the NHS, and in particular the arrangement by which they might be paid a proportion of the full-time salary which exceeded the proportion of their time they devoted to NHS work. It was desirable to develop a more flexible system producing a closer match between these two proportions;

(c) Contracts should be short term, on a rolling basis, with an enforceable period of notice;

(d) A significant increase in the number of consultants was very desirable. It would weaken one of the main supply side constraints operating in the provision of health care. The figure of 200 mentioned in Sir Roy Griffiths' paper might well be insufficient, although the cost of an increase, allowing also for the cost of any associated staff that might be necessary, had to be borne in mind;

(e) There was a strong case for transferring the contracts from regions to districts. It had been argued that the location of the contract was of secondary importance but it had to be remembered that under other proposals in the package the regions would become less significant.

The Prime Minister said that the group's view was that new contracts should be changed to take account of these points. Changing existing contracts would however raise major difficulties, and could be expensive. There were therefore attractions in trying to achieve the Government's objectives by working within existing contracts, if this were possible. It was for instance for consideration whether it would be possible to reform the merit award system, as it affected consultants covered by existing contracts, without formally changing the terms of those contracts. The Secretary of State for Social Services should bring forward a paper making proposals on the subject of consultants' contracts for the group's next meeting, in the light of this discussion.

Paragraph 11

The Prime Minister said that the group agreed the proposals in this paragraph subject to the following points:

(a) It was necessary to be sure that a practical way could be found of giving hospitals more freedom to determine local pay and conditions (item iii);

(b) There was a case for pilot experiments on independence for hospitals (item iv). But some experience of this independence had already been gained from the teaching hospitals and this could be used to ensure that the transition to the new system was not unduly delayed;

(c) The Community Health Councils could usefully be kept as a way of channelling the energies of local politicians if they no longer had a place on the DHAs.

Paragraph 12

The Prime Minister said that the proposals in this paragraph were agreed subject to a point on item i. It was very desirable to encourage joint ventures but more discussion was needed between the Treasury and DHSS to establish the financial regime to apply to them. Treatment of capital expenditure raised particular difficulties, both in relation to joint ventures and more generally under a regime in which hospitals were given greater freedom and eventually independence. The two Departments should prepare a joint

paper on the subject.

Paragraph 14

The Prime Minister said that the group attached importance to the principle of independent hospitals as described in this paragraph. Legislation would be needed in the 1989-90 Session to provide for them. Some experiments would be necessary to ensure that the system really would work, but maximum advantage should be taken of previous experience, for example with the operation of some hospitals as Special Health Authorities.

Paragraph 15

The Prime Minister said that the group endorsed the general approach in this paragraph subject to further consideration of two important points:

(a) It was not easy to reconcile the GPs' freedom of referral with maintenance of effective cash limits. The earlier paper by the Secretary of State for Social Services had however suggested a way in which they might be combined. The issue should be considered further in the paper on funding for which the group had already asked;

(b) The group accepted the principle that DHAs should act as buyers but needed to see how the arrangement would work in practice. A particular point to consider was how it would work when the hospitals were, at first, still owned by the DHAs.

Paragraph 16

The group agreed that there would need to be a change in the roles of District and Regional Health Authorities: see comments on paragraph 5 above.

Annex A

The Prime Minister said that the group agreed this list of papers, subject to the deletion of papers 2 (manpower and training issues) and 4 (action plan for the private sector), and the following additions, most of which had already been discussed:

(a) The case for ending the free provision by the NHS of inessential treatment such as cosmetic surgery. It would be useful in considering this to look at the measures recently taken in Germany. This paper could also consider the case for changing the present practice of charging private patients in full for their prescriptions, although the group were not at present convinced that such a change was justified;

(b) A package of changes that would improve the treatment of patients: for example, in the appointments system for outpatients, the physical surroundings in which they were

seen, the attitude of reception staff, visiting hours in hospitals and the management of the waiting lists for hospital treatment. Improvements in such areas would be important to public perception of the reform package;

(c) The method of funding health care, both when the changes set out in Part II of the paper were in operation, and when those in Part III had been put into effect;

(d) The treatment of capital, again under the proposals in both Part II and Part III;

(e) The treatment of consultants' contracts.

The paper on funding should be co-ordinated by the Cabinet Office, in consultation with the Treasury and DHSS. The other papers should be prepared by the Secretary of State for Social Services, in consultation with the Chancellor of the Exchequer.

Annex B

The Prime Minister, summing up the discussion, said that the group broadly endorsed the timetable set out in Annex B. At their next meeting in the week of 26 July, they would consider the papers on funding, consultants' contracts and the treatment of capital which had already been commissioned. The Cabinet Office should also revise in the light of the discussion the paper they had prepared for this meeting. As to the later stages, the objective at present should be to have a White Paper, which should be short, ready for publication in the second half of November.

I am sending copies of this letter to the Private Secretaries of the Ministers at the meeting, and of the Secretary of State for Wales, and to the others present.

Yours,
Paul

Paul Gray

Geoffrey Podger, Esq.,
Department of Health and Social Security.

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

7 September 1988

Dear Geoffrey,

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister held a further meeting on 6 September to discuss the review of the National Health Service, the tenth in the present series.

I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with the CMO arrangements.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Northern Ireland, the Secretary of State for Health, the Chief Secretary, the Minister of State, Department of Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson (Cabinet Office) and Mr. Whitehead (Policy Unit).

The meeting had before it papers by the Secretary of State for Health on the overall package (HC37) and by his predecessor on consultants (HC36). A paper on funding arrangements (HC35), co-ordinated by the Cabinet Office, was also circulated.

Introducing his paper on the overall package the Secretary of State for Health said his main proposal was that GPs should be responsible for purchasing elective acute services on behalf of their patients and should be given budgets for the purpose. He believed that this would build on what had already been agreed in the group, particularly the need for money to follow the patient. He was concerned that relying on District Health Authorities (DHAs) as buyers for all services might not bring the benefits which were intended, because DHAs would feel loyalty to their staff rather than to patients, and patients would find it difficult to identify with them. If GPs were given budgets as he proposed, they would be able to act in effect as the customer choosing between DHA hospitals, independent hospitals and private hospitals, as they judged best. Consultants would come under pressure to compete for contracts to treat patients. DHAs would have an incentive to make sure that their hospitals were well managed and successful in winning business. Regional

Health Authorities (RHAs) would have a continuing role, managing the change. Once the necessary legislation was through he proposed that there should be an experiment in a suitable region, possibly East Anglia. He did not rule out the possibility of experimenting with different versions of the scheme in different parts of the country. If the idea of GP budgets succeeded and was popular, it could be extended throughout the country.

In discussion the following main points were made:

a. The idea of giving responsibility for purchasing certain hospital services to GPs and their patients had attractions in principle, but it was not clear that it would be workable in practice. Some GP practices would be too small to bear the risk of a lot of patients all needing operations at the same time. It would be highly undesirable for GPs to run out of money half way through a financial year. There would need to be a move to sizeable group practices, with professional managers to operate them, in order to create a big enough pool of patients to bear the risks. This would be a move in the direction of US-style Health Maintenance Organisations (HMOs) which the group had already rejected, without some of the advantages which HMOs offered. There would also be a risk that GPs would in practice not be able to control their budgets because consultants in hospitals would prescribe treatment and take key decisions which influenced expenditure.

b. These problems could in part be avoided if charging by hospitals was based on a system of <u>average</u> costs for each particular kind of operation. A doctor running a small practice of his own would then be able to contract with his local hospital that they would take all his cases at a specified level of service. But this might be seen as a reduction in the right of patients to have a say in where they were treated, and be considered less satisfactory than the present position where the GP was seen as independent.

c. One of the main arguments for the scheme was that GPs would come under pressure from their patients to make the best use of their budgets. They would have a real incentive to attract patients, for instance by shopping around hospitals for shorter waiting times and offering attractive deals on particular kinds of operation. A GP who did not do so would lose his patients to other GPs who did. Similarly if a GP was inefficient, consistently prescribing the most expensive treatment for his patients or referring too many to hospital instead of treating them himself, he would run out of money, build up longer waiting lists than other GPs in his area and start losing patients.

d. Against this, it could be argued that the incentives might not work in this way. Patients might seek out those GPs who offered the most expensive treatment. If

those GPs ran out of money, they would complain that their budgets were too small to enable them to buy their patients the treatment which in their medical opinion was essential. The effect might be greatly to increase the lobby for more money for the NHS, and to create two tiers of waiting lists, one with hospitals and one with GPs. In rural areas where there was only one hospital within reasonable distance the idea of GPs shopping around for shorter waiting times might be impracticable. More generally, for most GPs the proposed budgets would be their first experience of cash limiting. Even if they did not exceed their budgets there would be a natural inclination to spend up to the limit. For all these reasons, there would be the potential for cost explosion. There would therefore need to be sophisticated monitoring of each GP's financial programme during the course of a year. This would be administratively cumbersome.

e. On consultants, the group were agreed that the aim should be to achieve the Government's objectives within consultants' existing contracts. This was subject to the need to achieve major changes in the distinctions award system. The group also wished to keep open the possibility of taking on additional consultants, some on short term appointments, as discussed on 12 July. The important thing was to motivate hospitals to manage their consultants properly. Money following the patient was critical in this context. The present system paid hospitals and consultants for being there: the aim should be to fund them in a way which reflected the work which they actually did. If a consultant failed to carry out the number of operations expected of him, the hospital would not receive the money which it needed to employ him and would not be able to afford to keep him.

f. The key question was how the funding should be handled. It was common ground that the GP, with the patient, should choose the hospital where the treatment was to be carried out. Giving the GP a budget as well, with direct responsibility for funding the hospitals, would encourage consultants to build up a practice of GPs and to be responsive to their patients' needs. On the other hand it would have the monitoring and other problems already identified. The alternative was to build on DHAs (incorporating Family Practitioner Committees), as envisaged in the group's work hitherto. Hospitals would operate on performance-related budgets and would have to tender for 'top-sliced' money to reduce waiting lists. They would still have the incentive to get the best out of their consultants.

g. The Secretary of State's proposals implied a timetable in which legislation would be passed in the 1989/90 Parliamentary Session followed by an appropriate period for experiment. This would have the advantage of allowing time for the further development of the Resource Management Initiative. On the other hand, legislating for an experiment would convey the impression that the

Government did not know where it was going, and there would be nothing to show for the Government's policies at the next Election. The issues had to be faced and decided now. It might however be possible to put forward the idea of GP budgets, not as a main plank in the immediate package of measures, but as a possible further development for experiment in the longer term.

Summing up the discussion, the Prime Minister said that the group were agreed on a number of important points. The funding of hospitals needed to be changed to reflect their performance and to enable money to follow the patient. Consultants needed to be properly managed. GPs and their patients should be able to choose where the patient was treated. There needed to be more detailed work however on who would do the funding and how the arrangements would work. Patient choice, which the Secretary of State emphasised in his paper, was important but the group was not convinced that it would be right to give budgets to GPs because of the monitoring and other problems which would be involved. It was essential that whatever solution was adopted should be administratively practicable. The Secretary of State should consider the options further in the light of the discussion and provide a paper for the group's next meeting on 14 September. In the meantime it would not be possible to make progress with the drafting of a White Paper until the main lines of policy had been decided.

The Prime Minister also agreed that it would be helpful if your Secretary of State could discuss the issues on capital, outlined in paragraph 12 of his paper, with the Chief Secretary and let the group have a paper on them in due course.

I am sending copies of this letter to the Private Secretaries of the Ministers at the meeting, and of the Secretary of State for Scotland, and to the others present.

Yours,
Paul

(PAUL GRAY)

Geoffrey Podger, Esq.,
Department of Health.

SECRET : CMO

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

15 September 1988

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister held the eleventh meeting of the group discussing the review of the National Health Service on 14 September. **I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with the CMO arrangements.**

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Northern Ireland, the Secretary of State for Health, the Secretary of State for Scotland, the Chief Secretary to the Treasury, the Minister of State, Department of Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. Whitehead (Policy Unit).

The meeting had before it a paper by the Secretary of State for Health, "Funding Elective Surgery" (HC 38). In discussion the following were the main points raised:

a. The paper took as its starting point the method of funding hospital treatment generally which had already been broadly agreed. It was concerned only with the funding of elective surgery. This represented a comparatively small part of hospital treatment, although it was a politically important part if only because it accounted for the bulk of waiting lists. It was important that work on other aspects of the Review, where there was a lot of common ground, should move ahead quickly.

b. The question raised by the paper was how the new funding arrangements should operate at the local level, and how GPs could best be fitted into them. It was of great importance since GPs were the patients' main point of contact with the NHS and since the absence of cash limits on them posed major difficulties for expenditure control. In its work before the recess, the group had already identified one way of giving GPs a proper place in the new structure. This was by merging the FPCs and DHAs and making the combined body responsible for buying elective surgery as well as other

hospital treatment for its population. Local politicians would be excluded from the boards of the new bodies and GPs given a substantial representation on them. The participation of GPs would ensure that the new bodies were properly responsive to GPs' and patients' needs, and dealt fairly with independent hospitals. The merged bodies would be cash limited and there could also be a cash limit on elective surgery alone within the general cash limit. This approach was clearly workable and should be considered further. HC 38 did not propose its rejection and indeed it could be viewed as a variant of Method 1; but the description of Method 1 in the paper left out some essential features of this approach, such as the FPC/DHA merger and the cash limiting of the combined body.

c. HC 38 put forward a second method for experiment - GP buying of elective surgery - because it would make the system more responsive to the needs of GPs and patients. But the group had already expressed severe reservations about whether this would be workable in practice. There must be considerable doubt whether GPs generally would be competent to manage a budget, and the problem of monitoring would be formidable. Above all, individual GPs' practices would be too small to provide a reasonable spread of risk. One way of dealing with these problems would however be to provide that GPs could choose to "opt out" of DHA/FPC buying of elective surgery. The "opting out" process could be controlled so as to ensure that the buying role was undertaken only by those practices competent to perform it. In particular it should be restricted to practices containing a minimum number of GPs, perhaps six. Large practices would have the spread of risk which was essential.

d. If experiments on opting out by large groups of GPs were to be considered further, it was important to establish more exactly how they would work in practice. What type of contract would GPs place with the hospitals? How would the price be fixed? Would GP freedom of referral or patient choice be constrained, and would it matter if they were? What would happen if the money ran out in the year? What should be the distribution of risk between the GP and the hospital? These and similar questions should be properly thought out before the Government committed itself.

e. GPs' budgets must not be open to abuse by unscrupulous GPs increasing their incomes by spending less on their patients than they should. It would be politically very damaging if the system was seen as likely to work that way. This aspect needed to be further considered. Such a result should be avoided by the introduction of an

hospital treatment for its population. Local politicians would be excluded from the boards of the new bodies and GPs given a substantial representation on them. The participation of GPs would ensure that the new bodies were properly responsive to GPs' and patients' needs, and dealt fairly with independent hospitals. The merged bodies would be cash limited and there could also be a cash limit on elective surgery alone within the general cash limit. This approach was clearly workable and should be considered further. HC 38 did not propose its rejection and indeed it could be viewed as a variant of Method 1; but the description of Method 1 in the paper left out some essential features of this approach, such as the FPC/DHA merger and the cash limiting of the combined body.

c. HC 38 put forward a second method for experiment - GP buying of elective surgery - because it would make the system more responsive to the needs of GPs and patients. But the group had already expressed severe reservations about whether this would be workable in practice. There must be considerable doubt whether GPs generally would be competent to manage a budget, and the problem of monitoring would be formidable. Above all, individual GPs' practices would be too small to provide a reasonable spread of risk. One way of dealing with these problems would however be to provide that GPs could choose to "opt out" of DHA/FPC buying of elective surgery. The "opting out" process could be controlled so as to ensure that the buying role was undertaken only by those practices competent to perform it. In particular it should be restricted to practices containing a minimum number of GPs, perhaps six. Large practices would have the spread of risk which was essential.

d. If experiments on opting out by large groups of GPs were to be considered further, it was important to establish more exactly how they would work in practice. What type of contract would GPs place with the hospitals? How would the price be fixed? Would GP freedom of referral or patient choice be constrained, and would it matter if they were? What would happen if the money ran out in the year? What should be the distribution of risk between the GP and the hospital? These and similar questions should be properly thought out before the Government committed itself.

e. GPs' budgets must not be open to abuse by unscrupulous GPs increasing their incomes by spending less on their patients than they should. It would be politically very damaging if the system was seen as likely to work that way. This aspect needed to be further considered. Such a result should be avoided by the introduction of an

effective system of medical audit, which was indeed an essential feature of the new arrangements as a whole. Even so, some sort of incentive for GPs would be needed. It might be right in certain circumstances to provide for part of surplus income to be retained and invested in the practice.

f. There was a powerful case for cash limiting GPs. The group favoured this in principle. The question was how it could best be achieved. On one view the best approach was through merging FPCs and DHAs. On another view it was argued that cash limiting was a separate question from that of the organisation of buying, and it required closer control of the total number of GPs, of their allocation to practice, of their prescribing habits and of their referral patterns. Each of these would require a major cultural change and would be fiercely resisted. Cash limiting might need to be introduced on a phased basis, starting with elective surgery.

g. HC 38 also suggested as a subject for experiment a third option, that of the FPC buying elective surgery. It was a way of achieving a reasonable spread of risk, but would require a substantial increase in FPC staffing and could produce a conflict with the individual GP's freedom of referral. If, however, opting out of the larger GP practices was to be considered, opting out by FPCs was another possibility.

h. The treatment of consultants would need further work. At its previous meeting the Group had come to the view that the necessary changes could be made by better management of consultants within the broad essentials of their existing contracts. But more detail was needed on exactly how present management practices would be varied so as to achieve these changes. It was especially important to ensure that the system of merit awards could be reformed and that there was a proper relationship between pay and time worked. It was arguably not realistic to think that contracts could be terminated at less than six months' notice.

i. Under the new arrangements, the DHA's buying role would be important. Many DHAs would not be competent to perform it with their present management. The Government needed to consider what management standards were desirable and how they could be attained. This aspect too required further work. The setting of standards would probably be a matter for the NHS Management Board and the present weaknesses showed yet again the importance of effective audit arrangements.

The Prime Minister, summing up the discussion, said that there was considerable common ground. In particular, the group agreed that RAWP should be abolished, and replaced by a simpler capitation-based approach, weighted as appropriate; that hospitals should be given much greater independence and where they had the competence made fully self-governing (the teaching hospitals could provide a useful precedent for such an arrangement); that they should be funded on a contractual basis and according to their success in attracting business; that the accountability of consultants should be strengthened by medical audit and by money following the patient; that hospitals should be given incentives to better performance and should be more responsive to the needs of GPs and their patients; and that effective audit arrangements were crucial.

There were however many matters of great practical importance still to be worked out. The group had discussed the position of consultants and agreed that the broad essentials of the present contracts would remain but a precise statement was needed of the substantial management changes that would be needed to achieve the Government's objectives. Satisfactory audit arrangements had still to be worked out: papers were needed both on medical audit and on an audit commission for the NHS. Another area which the group would need to consider was what the practical arrangements would be for a hospital which wished to become fully independent. It was important to ensure that there was fair play for independent hospitals when it came to funding: there could be a conflict of interests for a DHA which both bought services from hospitals and ran some of them itself. Further work was also needed on the suggestion which had been made at the meeting that the Government needed to decide how to set and enforce - perhaps through the NHS Management Board - the higher standards of management competence that would be required of the DHAs. Treatment of capital under the new arrangements still had to be resolved: joint work on this was in hand by the Department of Health and the Treasury. The group also still wished to consider the case for withdrawing some inessential treatment altogether from the NHS, at least unless it was charged for. The Secretary of State for Health should bring papers before the next meeting of the group listing all the outstanding points and his proposals for resolving them. These and all the papers to be circulated for the next meeting should first be discussed in the official group under Cabinet Office Chairmanship.

Turning to HC 38, the group had agreed that further work was needed to specify in detail how viable options for the buying of elective surgery would operate. One important option which needed to be pursued was that FPCs and DHAs should be merged, and that the buying of elective surgery, like that of hospital treatment generally, should be undertaken by this merged body which should become cash-limited. The group believed that cash limits on GPs' expenditure were right in principle.

The group had ruled out the option of giving budgets for elective surgery to every GP, but saw attractions in allowing GPs to opt out of whatever funding arrangements were decided, provided that opting out was limited to large practices, probably those with at least six GPs. It was for consideration whether budgets for those who opted out might extend beyond elective surgery, so that GPs could vire between different types of treatment. Such an arrangement would be consistent with the dispersal of responsibility to as low a level as was reasonably practicable, which was one of the main themes of the review. GPs who opted out would attract more patients if they were successful. The idea would be to have an experiment to test the possibility, but it was important first to answer the practical questions as to how it would operate which had been raised in the discussion. The Department of Health and the Treasury should consider this with a view to agreeing practical arrangements and the Secretary of State for Health should bring a paper on the subject before the Group's next meeting.

Finally, it was important to make progress with the White Paper, which was in danger of slipping behind the timetable earlier set. The Secretary of State for Health should bring a draft outline of the White Paper before the next meeting of the Group. What was emerging was a White Paper with 'green edges'. But it was important that any experiments should not give an impression of muddle or of the Government not knowing its own mind.

I am sending copies of this letter to the Private Secretaries of the Ministers attending the meeting, and to the others present.

PAUL GRAY

Geoffrey Podger, Esq.,
Department of Health.

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10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

6 October 1988

Dear Geoffrey,

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister held the twelfth meeting of the group discussing the review of the NHS on 4 October. The meeting considered papers HC39 to HC44 previously circulated by the Department of Health.

I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with the CMO arrangements.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Health, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. Whitehead (Policy Unit).

In discussion of paper HC39, on self-governing hospitals, the following were the main points made -

a. The Government would need, when it produced its proposals, to say in detail how the transition to independence would be made and how it would work. There must be convincing answers to all the questions that were bound to be asked about the practical effect of the proposals. It would not be sufficient to rely on statements of general principle or the outcome of experiments. More work was needed before the Government was in the position to answer such questions.

b. One important set of questions which required further work concerned the transition to the new arrangements. Who should take the initiative in proposing that a particular hospital should become self-governing? What constituted a hospital for this purpose? Would new institutions have to be set up in each hospital? HC39 suggested answers to these questions. In particular it suggested that proposals for moving to a new status would normally be made by the hospital management team, although sometimes they could come from the DHA. But this required further thought.

NOTE OF MTG 6/10

Even if some DHAs might be far-sighted enough to propose self-government for their hospitals, most would regard it as against their interest to do so. Management teams as at present constituted did not have the competence either to decide when self-government was desirable or to run the hospital after it was achieved. One possibility to be considered further was that the Regional Health Authorities could identify and prepare the hospitals for self-government. Another was that the Government itself should decide which hospitals were candidates and drive through the change.

c. Other aspects also needed further thought. HC39 proposed that major assets should be vested in the ownership of the Secretary of State, that continuing central controls would be necessary over training and other manpower matters and that consultants' contracts might not be held by independent hospitals. There was a risk that these proposals would unduly detract from the freedom of the hospitals to manage their own affairs, and they should be reconsidered. More work also needed to be done on the implications of the new arrangements for public expenditure. This should look at pay and the income of hospitals as well as at treatment of capital, on which consultation was already taking place.

d. A move to self-governing hospitals could be seen as a reversal of trends in the NHS over recent years, and there was a danger that the self-governing hospitals would bid up demand for manpower and other resources. Self-government would, however, provide hospitals with the ability to run their own affairs. This would be attractive to the ablest consultants. It would improve motivation and raise efficiency. The group had therefore at an early date identified self-governing hospitals as an essential part of the necessary reforms. But this did not mean that self-government would necessarily be appropriate for all or even a majority of hospitals. It was most likely to be suitable for teaching hospitals and others in big cities. For hospitals in remoter areas, where there was little effective competition, it was less likely to be suitable. Further thought should be given to the question of what number of hospitals the Government would wish to see move towards self-government.

e. If a move to self-governing hospitals could be achieved without statutory provision it would have some advantages. This possibility needed to be further explored.

The following were the main points made in discussion of HC40, on GP practice budgets -

a. The principle of opting-out by some GPs was an attractive element in the reform package. Many GPs were likely to welcome the opportunity for greater freedom to run their own affairs, and the result should again be better motivation and higher efficiency. As with the

proposal for independent hospitals, opting out by GPs would also help to blur the distinction between the public and private sectors; such an outcome was one of the most important benefits to be gained from the package of reforms.

b. Again, however, more work was needed to ensure that the Government had an answer to all the questions that would be asked about how the opting-out would work in practice. In particular, the scope of the expenditure to be covered in the opted-out GPs' budgets needed to be further considered. It was agreed that outpatient referrals should be covered. There was also a strong case for covering expenditure on drugs. This would bring much better control on major items of expenditure, and allow opted-out GPs more scope for viring so as to stay within their budgets.

c. The group also needed to be absolutely clear about what would happen if opted-out GPs overspent or underspent. On overspending, if there was a major and unforeseeable event like an epidemic, provision would of course have to be made for the necessary treatment, probably from a contingency to be held by the FPC. Otherwise, it was up to the GPs to budget prudently. If they failed to do so, they would be subject to audit, and their opted-out status could be terminated. If they underspent, there was a good case for allowing them to use the surplus to develop the practice. This could reduce subsequent referrals to hospitals. But there was some risk of abuse of complete freedom to plough back the surplus. Further consideration should be given to whether there was a need to define the uses to which a surplus could properly be put within the practice, without bureaucracy.

In discussion of HC41, on merging FPCs and DHAs, the following were the main points raised -

a. It would be a mistake to merge FPCs and DHAs. The Government's main objective in its relationship with GPs was to get their spending under better control and in particular to reduce hospital referral rates and expenditure on drugs. The way to do this was to strengthen the FPCs and their ability to monitor and control doctors' practices. The strategic aim was to move towards management of GP contracts by the FPCs. Merging them with DHAs would be inconsistent with this. It would also tend to make GPs more subservient to hospitals, contrary to one of the main themes of the review.

b. On the other hand, it was argued that the Government's objective of getting better control over GP spending could best be achieved by merging FPCs with DHAs and cash limiting the combined body. The cash limiting would be practical because of the opportunities created by the merger to vire between hospital and GPs'

expenditure. This change was not ruled out by any assurances which had been given to the profession. The fact that it was a reversal of the previous decision to separate the FPCs from the DHAs need not prove embarrassing, since it could be presented as one of the large number of changes emerging from the current review.

c. HC41 proposed that the contractor professions should be removed from membership of the FPCs. This change was designed to make them more independent and therefore better able to take on the task of managing the contracts. But it ran contrary to the Government's general aim of involving the professions more directly in management. If the calibre of professional members was a problem, the solution was to find better members.

d. Another approach to the problem of getting better control over GPs' spending was possible. This was that FPCs themselves should be given responsibility for general budgets covering all the expenditure of their contractors, except those who had opted out. Since the FPCs covered a large number of GPs there would be a good spread of risk, although they would still need to operate a contingency reserve. Individual GPs would as at present receive their funding from the FPCs, and this could be used to increase the control FPCs exercised over their expenditure. They would not be subject to a cash limit, but if their spending threatened to exceed the level which the FPC regarded as reasonable and consistent with their own budget, they would be subject to audit, both efficiency audit and medical audit. Such an arrangement would be a development of the present policy, which was already producing results, of giving FPCs greater influence over GPs' expenditure. It was an attractive option, and needed to be considered further.

The Prime Minister, summing up the discussion, said that the review must have a convincing outcome. It must be seen to lead to substantial changes. Tinkering with the present system after such a long process of consideration would undermine the Government's credibility. The Government must also show that it had made up its mind on the main points at issue. It would be damaging if it was seen as waiting for the results of experiments. Finally, it must be able to explain in detail, step by step, how the changes it was proposing would be made, and how they would operate. More work was needed to enable the Government to answer all the questions that would inevitably be asked about the practical effects of their proposals.

The Group had reaffirmed that the introduction of independent, self-governing hospitals would be an important change to come out of the review, although it recognised that there might be many hospitals for which this status would not be appropriate and which would not proceed further than the present process of devolution. The Department of Health should now undertake further detailed work to show exactly how the change would operate and should put forward detailed

proposals for achieving it. This work would need in particular to consider who would take the initiative in proposing a move to self-governing status for individual hospitals and how the transition would then be achieved. It should cover the suggestion made in discussion that the Government itself should identify the candidates for this status. It should also include proposals, whatever the route to self-government, on how many hospitals might be suitable for it. The Group was unconvinced of the need for the Secretary of State to own the hospitals' assets, or for the continued operation of some of the other central controls recommended in HC39. These aspects should be further considered. There should also be a fuller statement of the implications of the new arrangements for public expenditure. Finally, the further work should explain how far it would be possible to make hospitals self-governing without statutory provision.

The Group had agreed that provision for opting out by GPs in large practices was an important part of the package of reforms. But more work was needed on the scope of the expenditure to be covered in the opted-out GPs' budgets. In particular, the Group believed that there was a strong case for including expenditure on drugs, as well as out-patient referrals. More work should also be done on the practical consequences of overspending or underspending by the opted-out GPs. It should make proposals on the re-investment of a surplus in the practice, including the possibility of allowing GPs to build up reserves.

As to the future of the FPCs, the Group believed that there was a strong case against removing the contractor profession from membership, as had been proposed. More generally, they were attracted by the proposal to give the FPCs responsibility for general budgets covering all their contractors' expenditure, with individual GPs becoming subject to audit by the FPC if their spending threatened to become excessive. This proposal should be worked up in detail.

The Group had briefly discussed the constitution of the DHAs and RHAs. It had reaffirmed the view that local politicians should be excluded from them, while noting that such a step could be controversial with the Government's own supporters. A paper should be prepared on the exact form the reconstitution of these authorities should take.

The Group had agreed the proposal in HC42 that the Audit Commission should be responsible for the external audit of the health authorities and FPCs. More work was however needed on medical audit, the effective development of which was central to the whole package of reforms. A paper should be brought forward setting out exactly how medical audit would work, and how it should be introduced.

The Group believed that it was important for the new policy to blur the boundary between the public and private sectors. Many of the reforms already discussed would help to do this. But the Department of Health should prepare a paper

considering whether there were other possible ways of doing so, or of strengthening the private sector.

Finally, the Group had asked for a paper on how to improve the working of cross-boundary flows.

All these papers, and any others on points which needed to be resolved before the White Paper could be drafted, should be prepared for the next meeting of the Group, to be held at 10.30 am on Monday 17 October.

I am sending a copy of this letter to the Private Secretaries of the Ministers at the meeting, and to the others present.

Yours,
Paul

PAUL GRAY

Geoffrey Podger, Esq.,
Department of Health

SECRET : CMO

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

9 November 1988

Dear Andy,

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister yesterday held the fourteenth meeting of the group reviewing the National Health Service. The meeting considered papers HC50, 49, 52 and 51, circulated by the Secretary of State for Health.

I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with the CMO arrangements.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Health, the Secretary of State for Scotland, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. Whitehead (No. 10 Policy Unit).

Medical audit

In discussion of the paper on medical audit (HC50) the following were the main points made:

a. The paper proposed that peer review findings in hospitals would normally be confidential to the consultants involved, unless they agreed otherwise. It was argued that this proposal reflected the very specialised nature of medical audit. Efficiency, and value for money, which were of special interest to management, would be the concern of the Audit Commission and the new advisory service suggested in HC53. It also had to be recognised that medical audit was still only at the development stage. It was essential to obtain the co-operation of the professions in its systematic application, and they would not give this co-operation if they thought that management would participate, and use it for its own purposes. On the other hand, it was argued that the alternative was not for management to participate directly in purely medical audit but for it to have access to the general results of audits. Unless this happened, it was unlikely that the audit process would be effective.

SECRET - CMO

Professionals left to themselves would not be sufficiently rigorous in correcting any defects which it revealed.

b. There was also a question whether the results of medical audit should be published. It was argued that already, much information was published to show how well hospitals did against specified performance indicators. This was in practice sufficient to allow a judgement to be made about their efficiency. To go further and require the publication of the outcome of medical audit would jeopardise the co-operation of the profession in its introduction. On the other hand, it was argued that the fullest possible information for patients was essential to the working of the new system. There could of course be no question of publishing the outcome of audit in individual cases. But publication of information about the medical record of individual hospitals or units would help patients to form a better judgement about their relative merits, and would be only an extension of what happened already.

c. As the paper recognised, there was a considerable overlap between medical audit and management audit. It would be wrong if the establishment of a system of medical audit were to strengthen the hand of the profession in trying to exclude management from studies which covered both medical and management issues. The suggestion in the paper that medical audit could cover the use of resources demonstrated the management interest in medical audit. One way of dealing with the overlap would be to establish a mixed procedure, combining medical audit and audit by the Audit Commission, where both medical and management issues were involved.

d. The proposals for medical audit of GPs seemed less developed than those for hospitals. The application of medical audit to GPs required special care, since the technique was still being developed and since GPs could plausibly claim that it would involve them in extra costs. It would be wrong therefore to try to go too fast. But there was little doubt that some GPs had slipped into slack ways which a proper system of medical audit could correct. One way of strengthening the system once it had been developed would be to put a term into GPs' contracts requiring them to participate in medical audit.

e. The proposals in the paper for the private sector did not go far enough in ensuring that it had adequate medical standards. Unless potential patients were confident that it had such standards, its growth would be very slow. The possibility of more direct Government action to enforce standards, in the way that it did for independent schools, had

to be considered.

f. The group had already discussed the treatment of consultants. Its general view had been that existing contracts should be better managed. But it had not yet discussed in detail how this better management should be achieved. This needed to be pursued.

The Prime Minister, summing up this part of the discussion, said that the group accepted the recommendations in HC50, subject to a number of important points. First, the general results of medical audit must be available to management: this was essential. Second, information about the medical records of individual hospitals or units must be published. Third, there must be provision for the possibility of a joint enquiry combining medical and management audit in cases where both types of issue were involved. Fourth, a term should be inserted into GPs' contracts requiring them to participate in medical audit once a satisfactory system had been developed. Fifth, the possibility of Government action to ensure that the private sector had adequate medical standards should be further considered. Finally, the group attached importance to there being clear plans on how the better management of consultants' contracts was to be achieved: outstanding issues would need to be resolved.

Funding

The main points made in discussion of the paper on funding issues (HC49) were:

a. The paper appeared to be inconsistent with the conclusions so far reached by the group on funding, on the lines set out in HC35. It had already been agreed that RAWP should be abolished, and replaced by a capitation-based system weighted for factors such as demography and morbidity. A capitation-based system would be simpler to operate and understand, and would be more acceptable to many than RAWP. Most fundamentally, it was necessary for the introduction of self-governing hospitals and GPs practice budgets, two of the most important elements in the package agreed by the group. It must of course be recognised that it was not practical to move at once to a capitation basis and that there would need to be a transitional phase in which there would need to be limits on the extent of the movement in each year (just as there were transitional arrangements for 'gainers' and 'losers' under the Community charge). But a capitation basis must be clearly set as the objective.

b. By contrast, the paper appeared to propose intensification of RAWP at the regional level, by payment of a special sum in 1990-91 to those regions which were significantly below their RAWP

targets. At the district level, the proposal was apparently that RAWP-type redistribution would continue for some time. The paper gave the impression that a capitation-based approach was not practicable (for instance, in paragraphs 10 and 14) and that the status quo would broadly be maintained.

c. More emphasis should be put on performance funding, as a way of making the system more responsive to the needs of the patient and raising efficiency. There could even be a case, if a substantial measure of performance funding were to be introduced, for allowing RAWP to continue until its effects were worked out. The remaining redistribution to be achieved according to RAWP criteria was relatively limited. It might be possible to establish a capitation-based system which produced results very close in practice to those which would follow from RAWP. If such a system were to be introduced, one valuable improvement over the present system, which could be introduced relatively easily, would be to relate allocations to prospective rather than historical population.

d. On the other hand, it was argued that the paper did propose the abolition of RAWP at the regional level, and also ending the use of sub-regional RAWP targets for allocation at the district level. But a pure capitation-based method of funding for the NHS was not practical politics. People did not use NHS services on a per-head basis. Any reversal of the redistribution achieved by RAWP over the last ten years would arouse a storm to protest.

e. Any further work on the subject should take into account the absence of effective management and management techniques in the NHS. Because hospitals did not have proper balance sheets or revenue accounts there was not at present sufficient information to take proper decisions on the allocation of resources. And the quality of financial management was generally very low. Unless these defects were corrected, the other changes being discussed would be of no effect.

The Prime Minister, summing up this part of the discussion, said that the group were concerned that the recommendations in HC49 were unclear and appeared to be inconsistent with the conclusions it had earlier reached. In particular, it appeared to reject a capitation-based method of funding and to continue with RAWP-type redistribution. It was also for consideration whether more emphasis could be put on performance funding in establishing the new arrangements. The Chief Secretary, Treasury, and the Secretary of State for Health should now reconsider funding in the light of the discussion and sort out a paper on the subject for the next meeting of the group.

Reconstituting health authorities

The group then discussed the paper on reconstituting health authorities (HC52). The following were the main points made:

a. The proposals in the paper, although necessary for the efficient functioning of the authorities within the reformed NHS, would be perhaps the most controversial part of the Government's package. The proposal to exclude local authority representatives from the boards of the district health authorities (DHAs) would be especially controversial, even with the Government's own supporters.

b. Regional Health Authorities (RHAs) were now required by statute to consult a variety of bodies before appointing members of DHAs, including local authorities and trade unions. Legislation would of course be necessary in any event, and it would be possible to remove this requirement to consult. There was indeed a strong argument for doing so, on the ground that it would complete the depoliticisation of the DHAs. On the other hand, the proposal to exclude local authorities from membership was likely to prove so controversial that it must be very doubtful whether Parliament would accept also removing from them the right of consultation.

c. The proposal was that the RHAs would continue to appoint members of the DHAs other than the Chairman. It certainly seemed impractical for this power of appointment to be transferred to the Secretary of State when some 1,000 DHA members were involved. But in principle it would be possible for the RHAs to appoint unsuitable members of DHAs. The fact that the RHAs were themselves appointed by the Secretary of State should provide a safeguard against this, but there was much to be said for establishing guidelines for the exercise of the RHA power of appointment.

d. The paper proposed that the National Health Service Management Board should be under Ministerial not independent Chairmanship. This was largely on the ground that it was not realistic to suppose that the NHS could be divorced from politics, or that Ministers would not be held responsible for its actions. On the other hand, Ministerial Chairmanship might appear to be inconsistent with the Government's emphasis on the importance of introducing better management into the Service. It would in practice lead to interference with management for political reasons.

The Prime Minister, summing up this part of the

meeting, said that the group broadly endorsed the conclusions in HC52. They believed however that further thought should be given to the case for setting guidelines for RHAs for the exercise of their power to appoint members of DHAs. They had some doubts about the continuation of Ministerial Chairmanship of the NHS Management Board, but had not decided to reject it.

Family Practitioner Services

In a first discussion of the paper on managing the Family Practitioner Services (HC51) the following were the main points made.

a. It was argued that the Family Practitioner Committees (FPCs) should be merged with the DHAs, as they were in Scotland and Northern Ireland. This would avoid the creation of another bureaucracy as FPCs were strengthened to manage GPs' contracts; would make for closer integration between the family practitioner services and the hospitals; and would allow for cash limiting these services. On the other hand it was argued that the merged bodies would be dominated by the hospitals side and so would be less effective than separate FPCs in the crucial task of achieving better management of GPs' contracts; that cash limiting required effective control of the main items of expenditure for which GPs were responsible, and could not be produced simply by organisational change; and that the merged bodies would be subject to conflicts of interest, since they would be responsible both for GPs and for hospitals which did not become self-governing.

b. The route described by the paper for controlling GP numbers was not the right one. The tendency for these numbers to increase was a result of the present system of remuneration under which the capitation fee accounted for less than half a GP's income. The right solution was to increase this proportion, so that GPs' incomes were more closely related to the number of patients on their lists. This would put effective downward pressure on GP numbers. On the other hand, such an approach, attractive though it might be in principle, would mean a radical change in policy, as most recently expressed in the Primary Care White Paper.

c. The proposal for setting GP practice budgets did not appear to take account of the fact that some GPs would have patients on their lists who were covered by private insurance and would not therefore involve as much expenditure as those covered by the NHS.

The Prime Minister, summing up this part of the discussion, said that the group believed that the possibility of merging FPCs and DHAs should be mentioned as

an option in the White Paper: it would be a 'green' element in the Government's proposals. They had agreed that more thought needed to be given to the present structure of GPs' remuneration and the possibility of changing it so as to encourage a reduction in numbers. The Secretary of State for Health should set this in hand. Otherwise, discussion of this paper would have to be resumed at the next meeting of the group, in about a fortnight's time. That meeting would also discuss the other papers listed in the Department of Health letter of 3 November, and the new paper on funding which the group had commissioned at this meeting from the Chief Secretary, Treasury, and the Secretary of State for Health.

I am sending copies of this letter to the Private Secretaries of the other Ministers at this meeting, and the Private Secretary to the Secretary of State for Northern Ireland, and to the others present.

Yours,
Paul

Paul Gray

Andy McKeon, Esq.,
Department of Health.

SECRET - CMO

10 DOWNING STREET

LONDON SW1A 2AA

21 October 1988

From the Private Secretary

Dear Andy,

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister held the thirteenth meeting of the group which is reviewing the NHS on 17 October. The meeting considered papers HC46 and HC47, circulated by the Secretary of State for Health.

I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with the CMO arrangements.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Northern Ireland, the Secretary of State for Health, the Secretary of State for Scotland, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson (Cabinet Office) and Mr. Whitehead (No. 10 Policy Unit).

In discussion on self-governing hospitals (paper HC46) the following were the main points made:

(a) It was very important not to tie down self-governing hospitals with needless bureaucratic constraints. The proposals - for instance, that disposals of assets by self-governing hospitals would have to be approved by the Regions - needed to be looked at critically in that light. It was also important to ensure that self-governing hospitals were treated fairly by District Health Authorities when competing with hospitals run by the latter.

(b) The procedure whereby hospitals could become self-governing was too elaborate. The arrangements for consultation in paragraph 44 of the paper and the criteria set out in paragraph 45 might mean that in practice no hospital ever became self-governing, and were not acceptable. It was essential to avoid any consultation process which might in effect give a veto to those who were opposed to the policy. The important thing was to mobilise the support of local people and

NOTE OF MTG 17 OCT

those who worked in the hospitals, perhaps through some active local grouping pressing for self-governing status.

(c) It was important to make early progress with the establishment of self-governing hospitals. Five or six by April 1991 and 30-40 by April 1994 was too slow. The question therefore was what could be done within existing legal powers. It was argued that these powers were too uncertain to be relied on and that action would have to wait until legislation had been passed. But against this there were strong attractions in starting with an existing legal model, such as Special Health Authorities, without waiting for legislation; and then using that legislation to develop the model and take whatever further powers or provisions proved necessary or desirable. This should be explored further.

(d) The concept of self-governing hospitals would need careful public and political presentation, to avoid the false impression that hospitals would be opting out of the NHS, and to retain the support of staff. This was another reason for building on an existing model like the Special Health Authority. The more that self-governing status could be publicly presented as the devolution of responsibility to the local level, the weaker the case would be for an elaborate process of local consultation.

(e) It was essential to make early progress with the discussion between the Treasury and the Department of Health on the treatment of capital. This was relevant to the proposal that self-governing hospitals should be subject to the market discipline of paying charges for their own assets. There was agreement that the hospitals should own those assets, maintain them and finance their depreciation. But the rationale for charging hospitals rent for assets which they already owned needed clearer explanation. It was another area where needless bureaucracy should be avoided.

(f) The proposal that the Government should match £ for £ any money raised locally for worthwile capital investment in a self-governing hospital should be considered further in the discussion on capital. On the face of it, this approach had disadvantages, not least that the Government's liability to contribute would be unlimited. Another approach which might be explored would be to put capital schemes out to auction; or to invite the private sector to build facilities and rent them to the NHS. Whatever approach was adopted, it was important to avoid subjecting capital plans to prolonged, detailed scrutiny by

central Government.

(g) On consultants' contracts the proposal was that in general these contracts would continue to be held by Regional Health Authorities, but that where a hospital became self-governing the contracts would be held directly by the hospital. The mechanics needed to be carefully worked out. In particular it was not clear how on the one hand consultants would be employed by the hospital but on the other would have their pay determined by the Review Bodies. It ought to be possible, for instance, for consultants to contract to work a certain proportion of their time at a self-governing hospital, another proportion at a DHA-run hospital, and the rest in the private sector, and to be paid only for what they did.

(h) There needed to be discussions between the Department of Health and the Treasury about detailed pay aspects of the Review, both as regards consultants and more generally. It was for instance unsatisfactory that nurses benefited from having both a Review Body and a Whitley Council.

(i) The proposal that boards of management should include two non-executive members from the local community needed further thought. The important thing was to have boards which would ensure that the hospitals were efficiently managed. There was a risk that the proposals for community involvement would run counter to this. It might be possible to avoid the worst pitfalls by drawing the representatives from non-political organisations (e.g. the "Friends of the Hospital") and by specifying that there should be "up to" two representatives. But the responsibility for looking after the interests of patients rested ultimately with GPs who if dissatisfied could advise their patients to go elsewhere. There were objections to the idea of "hospital clubs" for similar reasons.

(j) It was essential that the board of management should include a strong financial director of the hospital. The appointment of executive directors should be a matter for the non-executive directors, not the board as a whole.

(k) The introduction of self-governing hospitals should lead to greater efficiency in running the hospitals and thus to a reduction, not an increase, in their costs. There was no presumption that self-governing status would require more money or more staff.

Summing up this part of the discussion, the Prime Minister said that the Group had already agreed that the

introduction of self-governing status for hospitals would be an important outcome from the Review. The detailed paper before the meeting had enabled them to make good progress in working out how the new arrangements would work in practice. The Secretary of State should now further develop his proposals in the light of the points made in discussion.

The Group attached great importance to ensuring that self-governing hospitals were free from bureaucratic controls. The proposals needed to be appraised carefully in that light. In particular the procedure whereby they became self-governing was too elaborate, an the Group were not convinced that the proposed consultation process was necessary. It was also important to make early progress with the development of self-governing hospitals. The proposal that five or six should be established by April 1991 was slow. The Group were strongly attracted by the possibility of starting with an existing legal model - probably the Special Health Authority - and using subsequent legislation to develop and add to that model as necessary.

Further work was needed on the treatment of capital. The discussions between the Treasury and the Department of Health should be completed with a view to bringing forward a paper for the next meeting of the Group, covering both self-governing hospitals and those which remained with District Health Authorities. There also needed to be discussions between the Treasury and the Department on pay aspects of the Review, including the position of consultants.

Finally, on the boards of self-governing hospitals the aim should be to create non-political bodies which could get on with the job of managing the hospitals efficiently within a clear financial framework and proper arrangements for medical audit, free from bureaucratic or other needless interference. It was essential that the hospital's finance director should be on the board. The non-executive directors should be the sort of people who could keep a critical watch on how things were going. The proposal for representatives from the local community needed further thought in the light of the discussion.

In discussion of paper HC47 on budgets for general practice, the following were the main points made:

(a) There were three main areas where action was needed to bring costs under control. One was outpatient referrals: the paper proposed that these should be included in GP practice budgets for those practices which opted out. The other two were expenditure on drugs and control over the number of GPs.

(b) The paper did not propose including drugs in GP practice budgets, but only that those practices which opted to have their own budgets should have the further option of a drug budget. The argument for not including drugs was that those who ran out

of money would claim that they were being denied the resources to treat their patients. The proposal would also be opposed by the pharmaceutical companies. On the other hand, there were strong arguments for including drugs in GP practice budgets in the interests of better cost-effectiveness in the NHS. The right way to deal with GPs who over-prescribed was to publish the factual information about their drugs bill, with comparisons for other GPs in the same locality. This information was becoming available to Family Practitioner Committees (FPCs). There would be objections from the medical profession but the Government would have to make a stand.

(c) There was also a strong case for introducing a restriction on GP numbers. The arrangements would need to be worked out. It would for instance be important not to lock out bright new recruits to the profession. But in principle it was unacceptable that there was no limit on numbers.

(d) Another possible area for inclusion in GP practice budgets was expenditure on accident and emergency department spending. Although there was some uncertainty about practicability, there was scope for experiments to see how far this category of expenditure could be included.

(e) It was not clear how the arrangements for GP practice budgets would tie in with the proposals for 'top-slicing' aimed at reducing waiting lists for elective surgery. Discussion so far had been on the basis that this money would go to hospitals, but if GPs were to have budgets for elective surgery it could be argued that the money should go to them. More work was needed to clarify this point.

(f) There was a risk that the patients of smaller GP practices, not eligible for opting out, would spend longer on waiting lists. Large GP practices which opted out would be able to negotiate favourable waiting times in their contracts with hospitals, and other GP practices would suffer accordingly. There might need to be some protection against this. On the other hand, the effect in the longer term might be to encourage smaller practices to join together to form a larger practice with consequent gains in efficiency.

(g) It would be very important for the Government to present its proposals for GP budgets convincingly and to mobilise support for them. There would be attempts to misrepresent them; but, if properly explained, the public would welcome the benefits from greater cost-effectiveness.

(h) There was a good case for allowing GP practices with budgets to carry forward overspends, as the paper proposed, but the arrangements for reconciling this with public expenditure controls needed further clarification. The important thing was to devise a system which was not too complicated and encouraged underspending, perhaps by allowing the GP to build up a reserve. Whatever the arrangements, the Department of Health would need to be prepared to find extra funds in the event of a real epidemic.

(i) It was likely that the practices which would apply for GP practice budgets would be the best and most efficient ones, and that FPCs would be left with a fair proportion of those which were less good. It was therefore important to have effective arrangements to enable FPCs to influence those practices which did not opt out. In this context paragraph 16 of the Annex was unclear and unconvincing. There needed to be some form of cash-limiting on FPCs, and effective powers for FPCs to pass on the discipline to those practices which remained under them. More work was needed on how this was to be done. The proposal for bonuses in paragraph 20 of the Annex was not acceptable.

(j) It was also important to strengthen the composition of FPCs, and to give them adequate managerial staff, to make sure they could do their job properly. Reducing the professional representation to a clear minority would be controversial but was essential to avoid the conflict of interest inherent in the present system. The other members of the FPC would need to be of sufficient calibre and independence to stand up to professional interests when necessary and to take a tough line with inefficient GP practices. More work was needed on who these people would be, and how the strengthening would be brought about in practice. There was also the question of what arrangements there would be to ensure that FPCs were operating effectively, and perhaps to hear appeals from GP practices which believed they had been unfairly treated.

(k) Overall, the proposals gave a key role to FPCs and in effect were creating a third tier in the structure of the NHS. It was questionable whether this was the right approach. The alternative was to merge FPCs and DHAs, as the Group had discussed earlier. The merits and practicability of the two approaches needed to be weighed up carefully.

Summing up this part of the discussion, the Prime Minister said that the Group were in favour of allowing large GP practices to opt to hold their own budgets, and agreed that these budgets should include the categories of

treatment set out in paragraph 3 of the Secretary of State's paper.

There were however a number of aspects which needed further work. In particular, there were strong arguments for including expenditure on drugs in all GP practice budgets, with arrangements to publish management information where appropriate. It also appeared that there was scope for experimenting with the inclusion of expenditure on accidents and emergencies. These points needed to be considered further. There were strong arguments for introducing restrictions on the number of GPs: more work was needed on this. It was not clear how the arrangements for 'top-slicing' would take account of GP practice budgets: this needed clarification. More generally, it was essential to devise a system which worked in practice and was not needlessly complicated: the proposals in the paper on overspending and underspending, for instance, needed to be developed in the light of this. It would also be important to prepare the ground carefully for public presentation of the proposals and to mobilise support for them. The Secretary of State should arrange for his proposals to be revised and developed in the light of the discussion.

On Family Practitioner Committees, the proposals gave FPCs a much bigger and more important role than they had had hitherto. They would be responsible for allocating funds to those GP practices which did not opt to have their own budget, monitoring them and calling to account those which were inefficient. The Group were not yet satisfied that the proposals would achieve this. A paper was needed for the next meeting which explained in more detail how the FPCs would be strengthened and would exercise effective control over those GP practices which did not opt out; and which also set out the alternative option of merging FPCs and DHAs.

In further discussion the Group considered what other issues were still outstanding on which decisions were needed. The main areas were as follows:

(a) Medical audit. The importance of medical audit had been a consistent theme of the Group's discussion. A paper was needed on who would carry it out and how it would work. It would also need to deal with the problem that at present consultants could refuse to take part in medical audit.

(b) A package to improve the treatment of patients. The Group had agreed on 8 July that the White Paper should include such a package.

(c) Organisational issues, in particular reconstituting District Health Authorities, Regional Health Authorities and the role of the NHS Management Board. It had already been agreed

that DHAs and RHAs should cease to have political representation; and there were attractions in using Community Health Councils as a channel for local politicians if the latter no longer held a place on DHAs. The aim was to make the Authorities executive bodies. Amendment of the Public Bodies (Access to Meetings) Act 1960 would probably not be necessary.

(d) A greater role for the private sector. Another theme of the Group's work had been the need to encourage the private sector and blur the distinction between public and private. Competitive tendering (e.g. for clinical services such as pathology and radiology) was one example.

(e) Restrictive Practices. There were many ways in which the NHS was fettered with restrictive practices. The introduction of short-term contracts for consultants in order to reduce waiting lists was one possibility with considerable attraction, as discussed earlier: it needed to be worked up. More generally, there were many areas where changes were needed: for instance, the training of nurses and their working patterns.

(f) Remaining funding issues. The details of 'top-slicing' needed to be worked out. Cross-boundary flows was another important topic.

Summarising this part of the discussion, the Prime Minister asked that papers on these subjects should be prepared for the next meeting of the Group, in addition to the papers on treatment of capital and on Family Practitioner Committees mentioned above.

The next meeting would take place in early November, and the papers for it should be circulated by Wednesday 2 November. The aim thereafter would be to draft the White Paper and submit it to E(A), followed by the Cabinet, before Christmas with a view to publication in mid to late January. The White Paper would need to be a document of some detail which would do justice to the thoroughness of the Review. The treatment of Scotland, Wales and Northern Ireland could only be decided when a draft of the text was available.

I am sending copies of this letter to the Private Secretaries of the Ministers attending the meeting, and to the others present.

Yours ever,
Paul Gray

PAUL GRAY

Andy McKeon, Esq.,
Department of Health.

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

25 November 1988

Dear Andy,

NOTE OF MTG 23/24 NOV

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister held the fifteenth and sixteenth meetings of the group reviewing the National Health Service on 23 and 24 November. The group considered papers HC 57, 58, 51, 53, 56, 54 and 55.

I should be grateful if you and copy recipients would ensure that the record of the discussion is handled strictly in accordance with the CMO arrangements.

Those present at the first of these two meetings were the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Scotland, the Secretary of State for Health, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. Whitehead (No.10 Policy Unit).

Those present at the second meeting were the Chancellor of the Exchequer, the Secretary of State for Northern Ireland, the Secretary of State for Scotland, the Secretary of State for Health, the Chief Secretary to the Treasury, Sir Robin Butler, Mr. Wilson and Mr. Monger and Mr. Whitehead.

Decisions so far

The first meeting began by considering the Cabinet Office note, 'Decisions So Far', HC 57.

The Prime Minister, summing up the discussion of this item, said that the group had agreed the note as a statement of decisions made and outstanding, subject to the following points:

a. The case for providing incentives to GPs tended largely to be ignored. It was nonetheless an important area. The Secretary of State for Health would consider what could be done.

b. The group had agreed that the timetable for the establishment of self-governing hospitals was important. Some progress might be made without

legislation through use of the existing power to set up Special Health Authorities. This was worth considering as a first step. But it would not by itself get very far since such Authorities lacked the power to charge for their services or to decide the pay of their staff.

c. A number of detailed points on the practical working of self-governing hospitals remained to be settled. One of these was how end-year flexibility would apply to them: there was a strong case for the view that a measure of such flexibility was essential to the running of the hospitals.

d. The group had considered whether to legislate in the forthcoming Housing and Local Government Bill for the Audit Commission to take over the external audit of the NHS. The group, while they wanted to press ahead with this change, would not want to import general discussion of the NHS review into the debates on the Bill. Whether this would happen would depend partly on whether the Long Title had to be drafted so as to refer to the NHS. The suggestion had been made in discussion that the Secretary of State could be given power, subject to affirmative resolution, to extend the Commission's powers. This might avoid any explicit reference to the NHS, and looked a promising possibility. The Secretary of State for Health should circulate a short note to the group on the whole question.

e. The group had also considered the case for Ministerial Chairmanship of the National Health Service Management Board. They believed that it was right for management, led by the Chief Executive, to operate the service within a framework of policy aims and objectives and of finance set by Government but without Ministerial interference in day-to-day management matters. The Chief Executive ought to be the person responsible for presenting and defending management decisions in public. The Group had therefore decided to return to the concept of a supervisory board under Ministerial Chairmanship to decide strategy, and a Management Committee which would be left the maximum freedom to manage the service, within the parameters set by Government.

Funding the Hospital Service

The group then considered the note 'Funding the Hospital Service', HC 58.

The Secretary of State for Health, introducing the paper, said that it had been agreed between himself and the Chief Secretary. It made detailed proposals for abolishing RAWP and moving over three years to a system of allocation to regions based on weighted capitation. The Chief Secretary and he had given particular attention to the distributional effects of the new system, especially the

effects on the Thames Regions which stood to lose from the continued operation of RAWP. As a solution to this problem, they recommended Option C, which involved setting funding at a higher level for those regions than for the others. This could be readily justified by pointing to the special health problems of London.

In discussion the following were the main points made:

a. The new system also had major advantages of simplicity and transparency. The RAWP targets, which had caused endless trouble, would be abolished. Cross-boundary flows would be effected by simple payment in cash rather than by obscure and imperfect adjustments to the RAWP formula. The same principles would be applied to allocations to districts, although in their case the period of transition would have to be longer, perhaps five years.

b. The redistribution of resources away from the Thames regions had been one of the most controversial effects of the RAWP system. It resulted in part from the fact that, for historical reasons and perhaps because of proximity to hospitals, people in London made greater use of hospital services than those elsewhere. The new system went as far as was practical in correcting the RAWP bias against the Thames regions. The other options which had been examined were less favourable to those regions.

c. Even under the new system, there would, as the table attached to the paper showed, be some movement of resources away from the northern Thames regions. But these figures were highly artificial. They did not allow for the ability of London hospitals to attract patients from other parts of the country and receive payment for them under the new and improved arrangements for cross-boundary flows. Above all, they were based only on 1988-89 allocations, and did not allow for future increases in the total provision for the NHS. In practice these increases over the period of transition would mean that the resulting gains for the northern Thames regions would more than outweigh the losses they suffered from redistribution. The new arrangements for performance funding would also be relevant.

d. It was argued that the timetable in paragraph 24 of the paper was not sufficiently ambitious, especially as regards the development of self-governing hospitals. On the other hand, it was argued that this timetable was consistent with rapid progress to self-governing status of a large number of hospitals. It was expected that when the first candidates for this status were identified in April 1989 there might be as many as twenty.

The Prime Minister, summing up this part of the discussion, said that the group accepted Option C in the

paper on the basis that it was the best that could be done. The criteria for the allocation of money for performance funding would not be stated in advance. The group agreed with the timetable in paragraph 24 on the understanding that it was consistent with the rapid progress to self-governing status of a large number of hospitals.

Managing the Family Practitioner Services

The group then considered the note, HC 51, 'Managing the Family Practitioner Services', by the Secretary of State for Health.

In discussion the following were the main points made:

a. It was argued that the proposal for GP practice budgets as it now stood contained a major flaw. Payments would be made to GPs according to their number of patients, some of whom might have private hospital insurance and not require NHS hospital treatment. Payments could therefore be excessive, to an extent varying from practice to practice, and likely to depend on the areas in which the practices were based. There was also a risk that, where GPs were known to refer to private providers, their patients would no longer think it necessary to take out private insurance, thus increasing public expenditure. The cost to public funds could be £50million at first, and would probably rise as behaviour changed. It was argued on the other hand that the risk that allocations would be excessive was already in principle present in allocations to regions and districts, which also made no allowance for the number of private patients. Moreover, the new arrangement for GPs should give them an incentive to encourage their patients to take out private insurance, and that was highly desirable. For their part, patients were unlikely to give up private hospital insurance - which gave them control over the timing and location of treatment - for the possibility of GP referrals to private providers, which gave them neither. If there was a problem the best solution might be partially to adjust the size of budgets for opted out GPs to take any necessary account of this effect after a period of experience in operating the budgets.

b. The group discussed how best to get effective control over FPS expenditure. On the one hand, it was argued that the right way was through proper management of GPs' contracts. Considerable progress in this direction had already been achieved but it was necessary to move with care. The two biggest determinants of GPs' expenditure were prescribing habits and referral patterns. On neither was the information yet available to say what the right level of expenditure was. Once this information had been collected, the contract could be managed, if necessary with the help of penalties, to prevent excessive spending. Cash limits could not by themselves overcome

the problem of lack of sufficient information and control. Indeed they would be justifiably criticised by the profession for being based on inadequate information about the desirable level of spending.

c. On the other hand, it was argued that the right solution was to combine DHAs and FPCs and then cash limit the merged body. This would provide the maximum opportunity for viring between different types of expenditure and make it unnecessary to take a view on the right level for individual items. There were broadly similar arrangements already in operation in Scotland and Northern Ireland. Such a change would also eliminate the distortions now arising from the fact that hospital services were cash limited while the FPS were not.

d. There was a very strong case for giving GP practices with their own budgets the further option of holding a budget for drugs.

e. The expansion of the Audit Commission's role should cover the FPS as well as hospitals. This would probably be achieved by the arrangements already agreed, but that would need to be checked.

f. It was a serious weakness of the present system that there was no control over the number of GPs, since each GP was able to call on public money. It had already been suggested that downward pressure would be exerted on GP numbers if their system of remuneration were changed to give a greater weighting to the element of capitation. As it stood, this proposal was subject to the difficulty that, under present arrangements, the Review Body would compensate automatically for any such change if that were necessary to achieve what they regarded as a reasonable level of net remuneration. Further work was needed on this.

The Prime Minister, summing up this part of the discussion, said that on control of FPS expenditure most members of the group agreed that the right solution was to merge the DHAs and FPCs and set reasonable budgets for the merged bodies. The White Paper would have to set out the case for making this the aim. But it could not be achieved at once. It had been pointed out in discussion that there was not at present enough information to reach a proper view on the level of expenditure on drugs and hospital referrals. There would therefore have to be a transition. The Secretary of State for Health should now prepare a note setting out his view of the timetable within which such information could be obtained and budgets could be based on it.

On the other matters discussed, the group had considered the argument that GP practice budgets as so far envisaged would lead to excessive allocations to those practices which had privately insured patients. They believed that the best solution to this difficulty would be

to adjust the size of the budgets for opted-out GPs to take account of this effect where this proved to be necessary after a period of experience in operating the budgets. An adjustment might take the form of allowing the GP to retain at least part of the excess allocation for some approved purpose such as investment in the practice. The Secretary of State for Health should circulate a note about this to the group.

The group had agreed that GP practices with their own budgets should have the further option of a budget for drugs.

The group had also agreed that the Audit Commission should provide the external audit of the FPS as well as the hospitals. The Secretary of State would check that this would be achieved by the arrangements now being developed following the previous discussions.

Finally, the group were agreed that some control over GP numbers was necesssary. The Secretary of State for Health should circulate a further note on the possible options. This should in particular consider the option of increasing the capitation element in total remuneration, and whether there was a way of ensuring that the Review Body's recommendations did not offset the effects of any such change.

A Better Service to Patients

The first meeting of the group then concluded. The second meeting began by considering the note by the Secretary of State for Health, 'A Better Service to Patients', HC 53.

The Prime Minister, summing up the discussion, said that the group had agreed as follows:

a. It was crucial to get the support of the public generally for the reforms to offset the possible criticism from professional vested interests. The public would judge the success of the review largely by the improvements it made in the treatment of patients. The importance the Government attached to such improvements should be a theme running right through the White Paper. There should be an appropriate reference in the foreword and a chapter setting out the list of specific improvements should come at the beginning of the White Paper.

b. For this purpose, what mattered most were specific practical improvements in the service received by patients rather than initiatives which would seem remote from the ordinary patient. A reduction in waiting lists for operations would seem of major importance to the public and more detail should be provided on how it would be achieved. Other desirable improvements which should be listed in the White Paper were: an appointments system that worked properly;

rapid notification of the results of tests; better information about availability of beds; shorter waiting times for appointments; an easier procedure for changing doctors; proper facilities for mothers and children in emergency departments; a better complaints procedure; and more information about optional extras and amenities.

c. The emphasis throughout should be on the responsibility of management to secure the necessary changes. Management would be supported by financial audit and medical audit. It must have effective control over professionals, including the power to hire and fire, and professionals should themselves accept more management responsibility.

d. One important task for management would be to ensure that best practice was applied more generally. The White Paper should give convincing examples of best practice in areas of practical importance to patients.

e. The White Paper should not propose the establishment of Quality Assurance Programmes or an Acute Sector Advisory Service. If management wished to set up multi disciplinary terms to advise it on any aspects of care it was of course free to do so, but the decision was its responsibility.

f. There should be no reference to health indicators. Standards of health depended on factors such as life style and diet more than on NHS treatment. Health indicators could however have a useful role for strictly internal purposes, to help the Department of Health to monitor the performance of the Health Authorities. It would also be wrong to give too much prominence to health education and promotion. The maintenance of a healthy way of living was a matter for individual decision, not Government interference.

Management of Capital

The group then considered the note by the Secretary of State for Health and the Chief Secretary to the Treasury, 'Management of Capital', HC 56.

The Prime Minister, summing up this part of the discussion, said that the group had agreed as follows.

a. A system of charges for the use of NHS capital assets was highly desirable.

b. Paragraph 4 of the paper suggested that disposals of more than 5 per cent of a self-governing hospital's total capital stock would require regional approval. This was much too restrictive and should be reconsidered by the Secretary of State for Health and the Chief Secretary.

c. Paragraph 5 of the paper proposed three stages in the

introduction of the system of real charges. The second stage involved the use of management accounts to enable the NHS to go through a process of familiarisation using notional figures. The group believed that notional accounts would carry little conviction and that it should be possible with use of proper accounting expertise to move quickly to the use of real charges. It should be made clear that the notional stage was only transitional and a clear timetable should be set for achieving the final stage. A period of two years seemed reasonable, so that the system could be in place by early 1991.

d. On access to private sector capital, it had been argued that this could take many forms and that more analysis was necessary to distinguish between them and establish sensible guidelines for each variant. The group agreed that more work was necessary, and that this should be undertaken by the Secretary of State and the Chief Secretary. But this further work should be firmly based on the general objective, to which the group attached importance, of giving self-governing hospitals the maximum possible freedom to run their own affairs and in particular to get access to private capital. The framework within which they operated should be enabling, not restrictive. Otherwise, they would not develop a proper business approach, and would fail to attract the best managers.

The Public and Private Sectors

The group then discussed the note by the Secretary of State for Health, 'The Public and Private Sectors', HC 54.

The Prime Minister, summing up this part of the discussion, said that the group broadly endorsed the proposals in the paper, subject to two points, which should be reflected in the White Paper. First, they thought it important that the NHS should provide more optional extras such as amenity beds, better food and television sets. Good progress had already been made in this direction, but more was desirable. Second, they believed that there was much more scope for competitive tendering. A recent CBI study had suggested that it was applied to only a comparatively small proportion of NHS purchasing. Areas to which it did not apply were said to be administration, portering, security, research, building and garden maintenance and estate management. There was also considerable scope for extending competitive tendering to clinical as well as non-clinical services. Good examples were pathology and blood tests; retired doctors might want to set up independent services in these areas. A major extension of competitive tendering ought to be achieved by the new pressures on management to be efficient that would follow from the reform proposals as a whole.

Professional and Employment Practices

The group then considered the note by the Secretary of

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MR. WHITEHEAD

Policy Unit

State for Health, 'Professional and Employment Practices', HC 55.

Summing up this part of the discussion, the Prime Minister said that the group had rejected the idea of a new inquiry into professional boundaries. It ran the risk that the inquiry would respond to professional opinion and entrench some demarcations even more deeply. Progress could best be achieved by good management, supported by financial and medical audit, applying the lessons of best practice, including practice abroad. The White Paper should give examples of best practice in this respect. Flexi-nursing was an obvious possibility.

The group had briefly discussed the question of consultants' contracts. They broadly endorsed the proposals in the letter of 21 November from the Secretary of State for Health to the Chancellor of the Exchequer. They attached special importance to the participation of management in decisions about consultants' merit awards. This could be achieved by the proposal by the Secretary of State for Health in HC 43 that the 'C' awards should be replaced by performance-related pay, eligibility for which would be determined by general managers and senior doctors jointly. The group also attached importance to the proposal in the letter of 21 November that merit awards should be reviewable after five years and subject to completion of at least three years further service.

Timetable

Finally, the group discussed timetable and next steps.

The Prime Minister, summing up the discussion, said that another meeting of the group had been arranged for 16 December. This would consider:

a. The further work commissioned at the meetings on 23 and 24 November.

b. The paper on pay being prepared by the Secretary of State for Health and the Chief Secretary jointly. On this subject, the group believed that the NHS must move away from national pay bargaining, and that there was a very strong case for leaving self-governing hospitals free to decide the pay of their own staff, and to hire and fire them.

c. A first draft of at least part of the White Paper, including especially the chapter on self-governing hospitals. Work on drafting should start straightaway.

A further meeting would be arranged in the week of 19 December to consider a full draft of the White Paper.

It was essential that the White Paper should be published before the first anniversary of the announcement of the review. There would be further meetings as necessary in the week beginning on 2 January to consider drafts of the

White Paper, and it would go to E(A) and Cabinet in the week of 9 January. The White Paper must be crisp and readable and a special effort must be made to ensure that it had an attractive presentation with good illustrations.

The group had noted that decisions would be needed at some point about the future of community care. Further work was needed on this, but it was probably right to take the necessary decisions on health first, and set them out in the White Paper, before settling the question of community care.

I am sending copies of this letter to the Private Secretaries of the other Ministers at the meetings, and to the others present.

Yours,
Paul

(PAUL GRAY)

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From the Private Secretary

16 December 1988

Dear Andy

NOTE OF MTG 16 DEC

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister this morning held the seventeenth meeting of the group reviewing the National Health Service. The group considered papers HC 64, 65, 66 and 63.

I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with CMO arrangements.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Northern Ireland, the Secretary of State for Health, the Chief Secretary to the Treasury, Sir Roy Griffiths, Sir Robin Butler, Mr Wilson and Mr Monger (Cabinet Office) and Mr Whitehead (No.10 Policy Unit).

Pay conditions of NHS staff

The group began by considering the joint paper by the Secretary of State for Health and the Chief Secretary to the Treasury. 'Pay and conditions of NHS staff', HC 64.

In discussion the main points made were as follows:

a. Individual health authorities at present had only relatively limited freedom to vary pay and conditions without central approval. This meant that they were unable to exercise one of the most important functions of management. It was highly desirable that the arrangements for determining pay in the NHS should become much more flexible and decentralised. Quite apart from the review, some progress had already been made in this direction and considerably more was planned, along the lines set out in the paper. It should be an especially high priority of policy to ensure that the national Whitley arrangements could not stand in the way of the necessary flexibility at local levels.

b. One important part of the policy of flexibility was the introduction of more regional pay. Proposals had been put to the Nurses Review Body for a sum of £5m. to be set aside in 1989/90 for a pilot exercise in supplementing national rates of basic pay where this was appropriate on recruitment and retention grounds. The sum involved was modest but if this approach was successful it would imply acceptance by the Review Body of the principle of regional pay and could pave the way for much greater use of it.

c. It was not realistic to suppose that Review Body staff in self-governing hospitals could be paid below the rates resulting from Review Body awards, and the proposals in HC 64 assumed that the Review Bodies would continue. Nevertheless, it was desirable to give these hospitals, for all staff, the freedom recommended by the paper to decide their arrangements for pay determination. They might want to pay at rates higher than those recommended by the Review Bodies, for example to get agreement to the introduction of improved working practices. The pay costs of self-governing hospitals would in practice be reduced by cutting numbers rather than pay rates but the scope for cutting numbers and improving efficiency was likely to be substantial.

d. It was also highly desirable to ensure that Ministers would no longer be answerable for detailed decisions on pay. The drafting of the White Paper must take account of this. Some progress in this direction had already been made, in particular by telling the new Chief Executive that he would be responsible, outside Parliament, for presentation of NHS decisions in this area. But a more formal shift of responsibility from Ministers to management would require legislation, and might meet with some resistance in Parliament where there would be opposition to any reduction in accountability.

e. The standard of financial management in the NHS was generally low, and the Government's reforms could not be carried through successfully unless it was raised. Success in achieving the reforms would also need more managers who could stand up to professionals. Improvement in NHS management would indeed be a major task for the Government. But many top managers were good. The weakness was more at lower levels and the other changes proposed by the government should force a more commercial approach throughout the organisation. Recruitment of better managers would cost money but it would be money well spent.

The Prime Minister, summing up this part of the discussion, said that the group endorsed the proposals of HC 64. They thought it important to achieve much greater flexibility in pay arrangements in the NHS and they supported the moves already underway to achieve it.

Financial arrangements for self-governing hospitals

The group then discussed the paper by the Secretary of State for Health and the Chief Secretary to the Treasury, 'Financial arrangements for self-governing hospitals', HC 65.

The following were the main points made in discussion:

a. The proposals in the paper were agreed by the Secretary of State and the Chief Secretary, except on the important question of whether there should be an annual limit on total borrowing by self-governing hospitals.

b. It was argued against having such a limit that the Government's objective was that the hospitals should behave commercially, and should attract good local businessmen to sit on their boards. These objectives would not be achieved if the boards did not enjoy the fundamental freedom to decide for themselves how much they should borrow. Universities and polytechnics already had much greater freedom in this respect. The proposal that there should be a separate External Financing Limit for each such hospital, fixed in the PES round, seemed especially bureaucratic.

c. On the other hand, it was argued that borrowing by the self-governing hospitals, which would be within the public sector, would be public expenditure. It would be effectively backed by the Government's credit since, whether or not there were a formal guarantee, the Government could never let such a hospital go bankrupt. Failure to fix an annual limit on borrowing by self-governing hospitals would therefore mean an unacceptable weakening of public expenditure control. The proposal was only that a limit should be fixed in PES on borrowing by those hospitals as a whole. It was primarily for the Secretary of State for Health to decide how this limit should be translated into controls for individual hospitals, for instance by hospitals bidding for their share of the borrowing allowed in a Region in a particular year.

d. As the paper noted, further work was required on some secondary aspects of the proposals. Some clarification was needed of the reference in paragraph 15 to monitoring arrangements to protect the position of the Accounting Officer. Another point, not mentioned in the paper, which needed further thought was the treatment of professional indemnity insurance by self-governing hospitals.

The Prime Minister, summing up this part of the discussion, said that the group endorsed the proposals in HC 65. On the one point of disagreement, they had decided that

there must be an annual limit on self-governing hospitals' borrowing since it was public expenditure and effectively underwritten by the Government. The limit would apply to all self-governing hospitals taken together. It was for the Secretary of State to decide how this limit should be translated into controls for each hospital individually, but some flexibility would be desirable. Finally, the group noted that further work was needed on some secondary aspects of the proposals, as set out in the paper. This should cover the position on professional indemnity insurance.

Access to private capital

The group then discussed the note by the Secretary of State for Health and the Chief Secretary to the Treasury, 'Access to private capital', HC 66.

The Prime Minister, summing up this part of the discussion, said that the group had noted that work was still underway and no decisions were required now. They endorsed the conclusions in paragraph 14 of the paper. They were attracted by the scheme for Bromley described in paragraph 9(c), and it should be pursued in the further work now underway.

Managing the FPS

Finally, the group considered the note by the Secretary of State for Health, 'Managing the FPS: outstanding issues', HC 63.

The Secretary of State for Health, introducing the paper, said that at an earlier meeting the group had provisionally decided that that part of the White Paper dealing with the future of the FPCs and in particular the case for merger with the DHAs should be green in character. He thought that this would get the worst of all worlds. The consultation that would then have to take place would produce nothing new, since opinions would not have changed since the last such consultation a few years ago. But it would distract the attention of all those concerned and hold up the implementation of the review. He was therefore sure that it was much better to take and announce in the White Paper a definite decision one way or the other. As to what this decision should be, he still believed very strongly that merger of the FPCs and DHAs would be a mistake. It would mean another administrative reorganisation, especially since there were many more DHAs than FPCs. All those concerned would in practice concentrate their attention on it for some time to come instead of getting on with their jobs and implementing the other reforms. He understood that merger had been proposed mainly as a way of getting control over FPS expenditure and he had therefore put forward in HC 63 a scheme for achieving this without merger. He recommended this as the way forward. There would be a major conflict with the professions whatever was done, but this should be in relation to a change which was effective and sensible.

In discussion it was argued that the scheme for controlling FPS expenditure put forward in HC 63 would not be effective. It contained no sanction against overspending, it did not provide enough scope for viring, and it was too bureaucratic. If the White Paper were to announce a definite decision, it should be in favour of a merger between the FPCs and DHAs.

On another matter, it was argued that further thought had demonstrated that there were major difficulties with the proposals for GP practice budgets. The decision to include them in the Government's proposals should be reconsidered.

The Prime Minister, summing up this part of the discussion, said that the judgment of the Secretary of State for Health on the future of the FPCs had to be accepted. But the whole group agreed that proper control over FPS expenditure was necessary. The Secretary of State's proposals in HC 63 for indicative budgets for drugs represented a big step forward, but the discussion had shown that other members had doubts about their practical effectiveness. In particular, the most appropriate means for achieving some viring between FPS expenditure and DHA expenditure should be considered further. As to GP practice budgets, the group had already decided in principle that they should be included in the White Paper. But if there were particular problems with the present proposals these should be addressed. The Secretary of State should now hold urgent discussions with Treasury Ministers to try to meet the concerns which had been expressed in the discussion. She would be prepared to chair a further meeting in the following week if necessary.

I am sending copies of this letter to the Private Secretaries of the Ministers at the meeting, and of the Secretary of State for Scotland, and to the others present.

Yours ever

Andy

pp Paul Gray

Andy McKeon, Esq.,
Department of Health.