SECRET

PRIME MINISTER 31 March 1988

THE HEALTH REVIEW: LOOKING AHEAD

We are now at a halfway stage in the health review.

After the last Ministerial meeting and the Chequers symposium, we seem to have reached a number of tentative conclusions. But there are significant points on which we have yet to make up our minds. And because certain proposals have been ruled out of court, gaps have suddenly appeared in our thinking. You may like to suggest some general directions for policy in which the review might proceed.

Received Ideas

Briefly, we seem provisionally to have accepted such ideas as:

Money following the patient; ✓

Opting out by hospitals; Possible

The greater involvement of doctors in managerial decision-making; Yes

Some sort of "overt" payment for health care (perhaps through national insurance); Not necessarily ?

The separation of 'caring' from 'curing'; Not necessarily ?

The clear location of medical responsibility (eg GPs treating diabetics rather than referring them automatically for hospital treatment); If possible

And a reduction in the role of NHS committees composed of political activists and medical vested interests, notably the District Health Authorities. ✓

Proposals which have been rejected include charges and health maintenance organisations (except perhaps as evolutionary developments in the private sector). HMO not rejected but not favoured for NHS.

And a number of choices have been left for later decision - for instance, how private health might be encouraged? By health tax plus opting out? By voucher? By tax relief?

Medicaid credit

Three Choices in Health Provision

Taken together, these decisions would introduce considerably greater competition, pressure for efficiency and cost-control in the supply and financing of health care. In particular, opting out of hospitals would bring a useful set of incentives to bear on hospitals, nurses, doctors and other health workers. And any method of health finance that allowed a wider exit into the private sector would act as a general competitive stimulus to the NHS.

But it is in the provision of health -- namely the NHS management board, regional health authorities, district health authorities and family practitioner committees -- that we have yet to reach conclusions that would bring about major improvements. The above reforms would, of course, ensure that health authorities would increasingly be purchasing agencies rather than direct providers of health care as now. But what sort of authority should we hope to shape in other respects? I would like to suggest that there are three broad options available to you:

(a) A Health Service based on local health authorities (district?) which are not in competition with each other (i.e. neither

No

patients nor GPs can move voluntarily between them.) No. This lack of competition, of course, would be modified, to a greater or lesser extent, by the existence of self-governing hospitals, by the patient's right to "contract out" into the private sector, and by various internal market reforms in which money follows the patient.

The advantage of such an approach is that it promises the least disruption.

The disadvantages are:

that it places no pressure on the health bureaucracies to improve service to the patient (other than the increased opportunity for the patient to go private) and therefore that they would not fully exploit the competitive situation offered by self-governing hospitals;

that under this system the "internal market" would mean trading between districts so that considerable restrictions would be placed on patient choice and GP referrals;

and, finally, that the Government would continue to be answerable for every error and omission of the health service.

(b) An HMO-based health service (i.e. one in which health authorities are in competition with each other and with private sector health insurance bodies.) Since you have ruled this out, I do not propose to deal with it except to point out that this is the one system which unambiguously exposes local health bureaucracies to the pressure of competition. We need to replicate this pressure in whatever system we finally choose.

(c) The National Health Service as statutory corporation. Under this model, the various political committees would no longer exist. RHAs and DHAs would become merely regional and branch offices of a nationalised industry.

This model would make the NHS one vast HMO. Its advantages would include the elimination of "political" committees and a greater ability by Ministers to achieve reforms and carry out experiments from the centre. It would also mean that cash-limited authorities would no longer exist to erect boundaries obstructing GPs from referring their patients around the country to the shortest waiting list, etc. Indeed, it is the structure most compatible with the a "computer hotel booking" system for reducing waiting lists, and in general with the money following.

But serious disadvantages must be taken into account:

Such a large organisation would be extremely difficult to manage efficiently (quite apart from the initial presentational problem of abandoning "local democracy" in favour of a centralised system);

It would inevitably keep producer monopolies in being to negotiate wages, training, conditions of service, etc;

It would mean, if anything, an intensification of centralised responsibility with the Prime Minister answering questions on NHS treatments twice a week at question time.

It does not seem likely to evolve naturally towards a "mixed economy" in health care.

And it would risk runaway costs since there is no very clear system of cost-control.

Competition Under A Nationalised Umbrella

Some of these flaws might be remedied by your suggestion after the Chequers seminar that the GP might be the budget-holder under this system. There is no objection in theory to this - it is, in fact, the GP-based HMO system advocated by Professor Alan Maynard - and it would certainly eliminate several layers of bureaucracy. But the practical objection to it is that not all GPs have the entrepreneurial mentality or the administrative skills to enable such a system to run efficiently.

A more gradualist version of this idea would be to keep DHAs in being for the moment but to allow GPs to "opt out" like hospitals and to become the budget-holders for their patients, dealing directly with hospitals, clinics, etc. In time, the DHAs would wither away as GPs grasped through the example of their more enterprising fellows that they could increase their income by cutting out the DHA.) This would control costs, increase competition, lead to greater patient choice and evolve over time into a mixed economy of health.

Without some such provision, however, the only pressure on health authorities to provide improved service to the patient under both options (a) and (c) would be the patient's right of exit to the private sector. And the problem with "contracting out" being the only right of redress to the patient is that it does not assist the 80-plus per cent who will continue to use the NHS and so leaves us open to the powerful political objection of "two standards of care".

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