SECRET

SUBJECT cc MASTER

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

1 March 1988

Dear Geoffrey,

NHS REVIEW

The Prime Minister held a meeting of the Review Group on the National Health Service yesterday, the third meeting in the present series. Those present were the Chancellor of the Exchequer, the Secretary of State for Social Services, the Minister for Health, Sir Robin Butler and Mr. Wilson (Cabinet Office), Professor Brian Griffiths and Mr. John O'Sullivan (No.10 Policy Unit).

The meeting had before it a note by the Cabinet Office covering twelve background papers prepared by the Department of Health and Social Security (HC1 to HC8) and the Treasury (HC9 to HC12). In discussion of these papers the following main points were made:

a. More work needed to be done on practical ways of shortening <u>waiting times</u> (paper HC3). It was, for instance, striking that nearly half the total waiting list was thought to be accounted for by only seven operations: it would be helpful to know how far these could be done by the private sector. It would also be helpful to know whether it would be possible to lay down maximum waiting times for particular operations. The possibility of introducing a nationwide computer system should also be examined: this would enable patients and their GPs to find out where else a particular operation could be performed with a shorter wait. For such a system to be able to work, the authority which carried out the operation would need to benefit financially: the money would have to follow the patient. Another possibility which needed to be examined was activity-funding: that is, specific grants aimed at particular illnesses, operations or other areas of activity. This would involve more central control but it too would have the advantage of the money following the patient.

b. The information about <u>comparative costs</u> in the private and public sectors (paper HC4) was thin. It would be helpful to have more detailed information about the costs of particular operations, perhaps from AMI or

Blue Cross, although it was recognised that this might not be available.

c. On manpower inflexibilities (paper HC5), it was agreed that there should be no approach to consultants about their contracts until the Group had considered the issues further. A head-on approach was not necessarily the right one. Subject to this, the Group would need to inform itself more fully about the problem of these and other restrictive practices so that it could decide how to handle them. A paper should be prepared which should include consideration of short-term contracts and making District Health Authorities the contracting party.

d. It was important that ways should be found of speeding up the availability of cost information so that it could be used for pricing and control purposes by, say, 1 April 1989 and of making more use of clinical (or medical) audits (paper HC6). The scope for more competitive tendering should be explored. Further papers on these matters should be brought forward.

e. Further information should also be brought forward on overseas practice in selected countries (paper HC8).

f. On independent audit of efficiency (paper HC11), the case for greater involvement of the Audit Commission appeared to be strong but it needed more thought. Your Secretary of State would be discussing this further with the Chancellor of the Exchequer.

g. The case for extending charges (paper HC12) rested on the desirability of introducing greater financial discipline into the present structure of the NHS. It was not however the only means to this end, nor necessarily the best. The question of introducing financial disciplines should be considered in the context of a structure for the NHS for the longer term. In the meantime no further papers should be prepared about extending charges.

In more general discussion about the longer-term reform of the NHS it was pointed out that although some Health Authorities were having difficulty living within their budgets, other Authorities were managing very well. It would be important to identify the latter and to study and learn from the reasons for their success. To the extent that the present system was working well it would not necessarily be right to change it.

Looking ahead, it was agreed that the short-term issues thrown up by the papers before the meeting would need to be resolved in a way which was consistent with whatever long-term reforms were decided for the NHS. The Group would therefore wish to start considering options for the longer term. In this context, it would be important to bear in mind the distinction between the financing and the provision of health

care. There were some categories of treatment which, it could be argued, were always reasonably likely to be financed by the taxpayer: for instance, accident and genuine emergency cases, geriatric care and the treatment of chronic diseases which the patient could not insure against or be expected to afford. At the other extreme there were some forms of treatment which individuals were in no circumstances entitled to expect from the NHS. And in between there were a variety of conditions requiring treatment which people might wish to choose to provide for themselves. In this last category it was for instance for consideration whether individuals should be able to opt out of part of the NHS in favour of private insurance, and perhaps be encouraged to do so through some form of incentive (eg tax relief, vouchers, no-claims bonuses). This change in fundamental financing was an example of the sort of longer-term option which now needed to be explored. Health Maintenance Organisations (which needed to be given another name) were another possible model.

Summing up the discussion, the Prime Minister said that at its next meeting the Group would wish to consider a paper on longer-term options for the NHS on the lines suggested in the attachment to the Cabinet Office paper, taking account of the points made in the discussion. This paper should be co-ordinated by the Cabinet Office which should also arrange for further work to be set in hand on waiting times and the other detailed issues which had been identified in the background papers which were before the meeting. The Department of Health and Social Security should be asked to identify the ten District Health Authorities which in its view were the most successful and explain what it knew about their success. The Prime Minister said she would be arranging separately for a programme of informal discussions to be held with individuals - in particular doctors, health administrators and nurses - who could contribute to the Group's work.

I am sending a copy of this letter to Alex Allan (HM Treasury), Jenny Harper (Department of Health and Social Security), Trevor Woolley and Mr. Wilson (Cabinet Office), and to Professor Griffiths and John O'Sullivan (No.10 Policy Unit).

Yours,
Paul

(PAUL GRAY)

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

SECRET

DRAFT LETTER FROM PAUL GRAY TO GEOFFREY PODGER

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The meeting had before it a note by the Cabinet Office covering twelve background papers prepared by the Department of Health and Social Security (HC1 to HC8) and the Treasury (HC9 to HC12). In discussion of these papers the following main points were made:

a. More work needed to be done on practical ways of shortening <u>waiting times</u> (paper HC3). It was, for instance, striking that nearly half the total waiting list was thought to be accounted for by only seven operations: it would be helpful to know how far these could be done by the private sector. It would also be helpful to know whether it would be possible to lay down maximum waiting times for particular operations. The possibility of introducing a nationwide computer system should also be examined: this would enable patients and their GPs to find out where else a particular operation could be performed with a shorter wait. For such a system to be able to work, the authority which carried out the operation would need to benefit financially: the money would have to follow the patient. Another possibility which needed to be examined was activity-funding: that is, specific grants aimed at particular illnesses or operations. This would involve more central control but it too would have the advantage of the money following the patient.

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c. On manpower inflexibilitis (paper HC5), it was agreed that there should be no approach to consultants about their contracts until the Group had considered the issues further. A head-on approach was not necessarily the right one. Subject to this, the Group would need to inform itself more fully about the problem of these and other restrictive practices so that it could decide how to handle them ~~in the final package of measures.~~ A paper should be prepared which should include consideration of short-term contracts and making District Health Authorities the contracting party.

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Looking ahead, it was agreed that the short-term issues thrown up by the papers before the meeting would need to be resolved in a way which was consistent with whatever long-term reforms were decided for the NHS. The Group would therefore wish to start considering options for the longer term. In this context, it would be important to bear in mind the distinction between the financing ~~of health care, in which the State would always be substantially involved,~~ and the provision of health care~~, which was not necessarily something which had to be done by the State.~~ There were some categories of treatment which, it could be argued, were always reasonably likely to be financed by the taxpayer: for instance, accident and genuine emergency cases, geriatric care and the treatment of chronic diseases which the patient could not insure against or be expected to afford. At the other extreme there were some forms of treatment which individuals were in no circumstances entitled to expect from the NHS. And in between there were a variety of conditions requiring treatment which people might wish to choose to provide for themselves. In this last category it was for instance for consideration whether ~~the~~ individuals should be able to opt out of part of the NHS in favour of private insurance, and perhaps be encouraged to do so through

some form of incentive (eg tax-relief, vouchers, no-claims bonuses). This change in fundamental financing was an example of the sort of longer-term option which now needed to be explored. Health Maintenance Organisations (which needed to be given another name) were another possible model.

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The Prime Minister said

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

Mr Gray

I agree with the ~~prop~~ course of action proposed by the Secretary of State to deal with the Griffiths Report.

John O'Sullivan

B/F with the other pps.

RREG
1/3

PART 10 (TEN) ends:-

SS/DHSS to PM 29.2.88

PART 11 begins:-

JOHN O'SULLIVAN to PG 1.3.88