22

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PRIME MINISTER 15th January 1988

FOOTSTEPS IN THE FOG : THE DHSS VIEW

The DHSS view of reforming the NHS is, on first reading, a reasonable but somewhat unimaginative document. It sees the defects of the present system, which are outlined very clearly on pages seven and eight. But the schemes it proposes to remedy them are either not very convincing or unlikely to have much impact. It misunderstands some aspects of more ambitious proposals for reform. And it does not offer a sufficiently clear sense of direction.

The document opens well with an account of improvements that have been achieved within the existing structure. It proposes to continue this with improvements like the resource management initiative making doctors and other professionals more responsible for managing the relevant health resources. It promises to launch an enquiry into consultants' contracts (though the Department's aims in such an enquiry are stated only in general terms.) And it calls for a modest development of the "internal market" by producing better information about comparative costs and encouraging a "trading culture" between authorities (though this should be only a half-way house to a system in which resources follow the patient at will.)

These are sensible, if tentative, steps. It is when the document examines longer-term and more fundamental reform that it falters.

(1) The first proposal is charges for GP consultations and hospital stays. I have supported these myself in the past. But they run into a real difficulty, quite apart from

political unpopularity. If the usual exemptions for retired and low-income patients apply, they will raise little revenue and be costly to administer (as means-tested benefits are.) If, on the other hand, the exemptions are to be cut, then political unpopularity would be maximised and we would be open to the accusation of abandoning unhindered access to medical care.

In view of these points, I have to conclude that charges are politically out of court. To argue that more money is needed but that it must come from charges then becomes a disguised bid for increased public spending.

(2) A fiscal incentive for private health is discussed as the only other stimulus available to expand private care. This is not, in fact, the case. Waiting lists and a system of priorities can also be used to encourage 'topping up' insurance as I argue in the accompanying paper. There is anyway a further objection to private health insurance unpoliced by institutions like HMOs. Namely, American experience until the 1980s shows the controls neither costs nor producer- monopolies in health.

(3) National insurance is also examined and the continental model is rejected. This is doubtless because it also is demand-led and so cannot control costs. Instead, the document favours increasing the contribution of national insurance contributions to NHS finance and linking it specifically with the hospital service on pay slips etc. The object is to bring home the real costs of health care.

Again, this is something that I have supported. But I have had to concede that there are two strong objections to it. Since the NHS will continue to be financed by a cash-limited block budget, all that is really achieved is to make financing health slightly more regressive. And unless the National Health Service has visibly improved, drawing

attention to its exorbitant cost is bound to be double-edged. The public may complain that the Government is not giving value for money.

(4) Finally, Mr Moore proposes a major new initiative - the strategy for health. He intends to develop a portfolio of 'agreed and affordable indicators of good health' to set a new health agenda until the end of the century. This is a nice imaginative touch, but it falls below what is required. If he is to transform opinion effectively, he will have to advance a dramatic set of proposals for radical reform.

What is required can be found in Annexes 3 and 5 where more radical proposals are examined - health maintenance organisations on the American model, vouchers, an independent NHS corporation, etc. It is unfortunate that the document never really examines combinations of these ideas - although some of the most practical and imaginative schemes now in the public arena are exactly that. In this regard, it also under-rates the possibilities of HMOs, based upon district health authorities. These offer the best prospect of major reform - in combination with vouchers and an expansion of 'buying-in' private sector services.

Yet, at several points, the document argues that HMOs would actually restrict patient choice. It assumes that district based HMOs, (which it admits would control costs) would also be a system in which the patient is geographically assigned to a particular set of doctors, hospitals or medical services without the possibility of change. This is not so. Almost all the schemes on an HMO-based service assume that the patient (or GP) can choose between competing HMOs - whether another DHA or a commercial insurer. There is no good reason for assuming otherwise.

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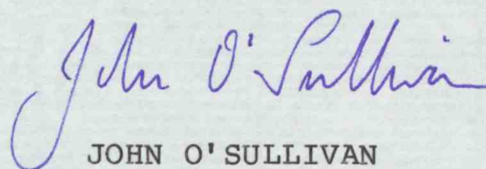
I am enclosing with this a paper on a possible combination of proposals that is consonent with your own principles on health care. I suggest that in Tuesday's discussion you should press strongly for the DHSS to make a study of other such combinations designed to realise free and equal access to health care, cost control, patient choice, and additional private finance. I shall re-read the document over the weekend with a view to more detailed observations.



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