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PRIME MINISTER 6 June 1988

REVIEWING THE NHS REVIEW

At the end of the last meeting, we had reached three somewhat uncertain and confused decisions:

(i) By rejecting the buyer/provider distinction, we decided among other things not to extend the cost control to GPs. This was an important decision even if not everyone realised it was being made. For since 1979 primary care costs have risen by 42% whereas hospital costs have risen by only 27%. Yet this decision was supported by the Treasury and opposed by the DHSS.

(ii) We rejected the idea of buying units on the grounds that, as proposed, they would be merely resurrected district health authorities. Our reason was a dislike of excessive bureaucracy. Yet we seemed to end the meeting by sticking to the existing bureaucratic structure of regional and district health authorities. Indeed, we will be exploring at our next meeting a new method of financing for elective surgery, proposed by Mr Major, which could mean an additional layer of bureaucracy to administer and monitor the scheme. In the name of less bureaucracy, we look like ending up with more of it - although the Treasury's ambition to extend its detailed centralised control of NHS financing might also be advanced.

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(iii) We ended up with an incoherent idea of moving towards independent hospitals alongside existing district health authorities rather than the proposed "buyers". This would presumably mean that DHAs would continue to control some hospitals as now, and only a minority of hospitals would decide to "opt out".

The likely consequences are, of course, that DHAs would continue to direct GPs and patients away from independent hospitals and towards those in whose success they had a direct interest. They would be even more likely to starve the private sector of NHS patients. The net result would be that independent hospitals would be either stillborn or limited to a small number of teaching hospitals and hospitals of great prestige. That would achieve no more than the status quo ante 1974 when the teaching hospitals were independent.

Little by Little

Having taken these decisions, we commissioned a number of papers which would advance by a series of modest steps towards a mixed economy in health care. Two of them - the Chancellor's paper and the paper from Mr Moore - are before us today. In general, they offer useful proposals in that direction. But many of the reforms proposed in the DHSS paper are already being carried out (largely from the stimulus that the mere existence of the NHS review has given the NHS bureaucracy). And Mr Moore makes plain that his other proposals for encouraging public/private sector co-operation are likely to be of only minor value in the absence of more dramatic structural reforms or a major fiscal stimulus.

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He clearly believes that the Chancellor's paper, supporting tax relief for the elderly, is right but inadequate. And as it stands, that is probably correct. However, the Chancellor may have been more radical than he intended. By fixing tax relief for the elderly at the basic rate, and making it payable to the insurance company, he is in effect proposing something like a voucher. I have no objection to this; indeed I welcome it. But the political effect may be to weaken slightly the ring-fencing which he hopes will confine this tax relief to those over 65.

Is that a good thing? The Chancellor's objections to wider relief, notably the benefit-in-kind exemption, are not wholly convincing: in particular, that relief to the employee would not be an incentive to the employer. Surely it would increase the value to the employee of a benefit provided by the employer and so enable the employer to reward his workforce at less cost to himself.

What we must decide politically is whether we actually want to ring-fence the scheme for the over 65s effectively? Or would we prefer to create conditions in which other groups would naturally demand tax relief for private health care for themselves? If we are relying principally on fiscal incentives to expand private health care - which is the burden of Mr Moore's covering note for his own paper of modest reforms - then presumably we want a gradual drift in the direction of general fiscal relief for the health care.

The risks of caution

This brings us back to the question of whether we need to be bolder in our proposed structural reforms. The political risks of radicalism are too evident to need spelling out. But there are also risks in presenting a "mouse" of a reform.

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It would dispirit your own supporters in and outside Parliament and even perhaps cause a minor rebellion among your more committed back-benchers. It would be presented in the media as a defeat for you. It would postpone any

further health reform for a decade. And it might even put into reverse the encouraging progress within the Health Service itself.

In these circumstances we should use the next two meetings to examine critically the proposals of gradual reform before the review. We should apply the same criteria - do they reduce bureaucracy? do they encourage the private sector? do they produce greater efficiency within the NHS? do they increase patient choice while also controlling costs? - as we have applied to the earlier and more radical papers. If at the end of that period, we have a set of proposals which would seem timid and inadequate after a review which has been widely advertised as searching and fundamental, then we should be prepared to reopen some of the structural proposals - though in a less bureaucratic form.

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