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Begins: 30/1/89.
Ends: 9/5/89

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PART T

Chancellor's (Lawson) Papers:

THE NATIONAL HEALTH
SERVICE REVIEW

Disposal Directions: 25 Years

[signature]
14/8/95.

PO -CH /NL/0102
PART T

30.1.89.7

FROM: R B SAUNDERS

DATE: 30 January 1989

PS/CHIEF SECRETARY

cc PPS (without attachment)
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Gieve
Mr MacAuslan
Mr Parsonage
Mr Griffiths
Mr Sussex
Mr Kuczys - IR

PWP

NHS WHITE PAPER: WORKING FOR PATIENTS Cm 555

I attach a copy of this White Paper, which is being published tomorrow afternoon.

R B SAUNDERS

30.1.89.5

SECRET
until 31 January 1989

FROM: R B SAUNDERS
DATE: 30 January 1989

MR GIEVE

cc Chancellor
Chief Secretary
Financial Secretary
Paymaster General
Economic Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mr Culpin
Mrs Lomax
Miss Peirson
Mr MacAuslan
Mr Parsonage
Mr Pickford
Mr Richardson
Mr Griffiths
Mr Sussex
Mrs Chaplin
Mr Tyrie
Mr Call
Mr Kuczys) Inland
Mr Walker) Revenue

PWP

NHS WHITE PAPER: "WORKING FOR PATIENTS"

This is being published tomorrow afternoon. Obviously the main responsibility lies with Department of Health. But the White Paper raises a number of issues of direct interest to the Treasury. I therefore attach briefing as follows:

- A summary of the main points in the White Paper, together with a line to take on its public expenditure implications

- Defensive briefing on points of particular concern to the Treasury. Detailed enquiries on other issues should be referred to Department of Health.

2. Mr Walker's minute of 27 January enclosed briefing on the new tax relief for private medical insurance premiums for those over the age of 60.

R B SAUNDERS

30.1.89.3

SECRET
until 31 January 1989

"WORKING FOR PATIENTS": MAIN POINTS

Aim of reforms is to enable NHS to respond to pressures on it, by improving quality of care and value for money.

Key proposals:

- Greater delegation of power and responsibility to local level, from regions to districts and districts to hospitals. Resource management initiative to be accelerated.

- Major hospitals able to apply for new self-governing status within NHS as NHS Hospital Trusts. They will be free of health authority control and will be able to set pay rates. They will also have new financial freedoms, notably to borrow within annual financing limits.

- New arrangements for funding health authorities and hospitals, based on the concept of health authorities securing services for resident population from hospitals (whether self-governing, district-managed or private sector). RAWP abolished.

- Large GP practices (11,000 patients or more) to be able to apply to hold budgets for buying a range of hospital services. Other practices will have indicative drug budgets covering expenditure on medicines. Patients completely free to choose and change their GP.

- "Medical audit" (review of clinical effectiveness by a doctor's professional colleagues) extended. Consultants' distinction awards reformed; more active management of consultants' contracts of employment.

- Audit Commission to take over from DoH auditing of health authority etc accounts; will also undertake wider range of VFM studies. Role of NAO in auditing consolidated NHS accounts and in conducting VFM studies unchanged.

- NHS Management Board reconstituted as new NHS Management Executive, chaired by Chief Executive, Mr Duncan Nichol. Reports to Policy Board chaired by Secretary of State. Membership of regional and district health authorities, and of family practitioner committees, streamlined and made more management-oriented.

- Tax relief on private medical insurance premiums for those over 60, whether paid by themselves or, for example, by their families on their behalf.

- 100 new consultant posts over 3 years, over and above previously planned growth.

Costs of reforms

NHS expenditure plans for 1989-90 announced in Autumn Statement anticipated likely costs of these reforms.

Costs in future years will be considered as part of the annual public expenditure survey cycle.

IF PRESSED ON 1989-90: £43m included for Review-related expenditure, including acceleration of resource management initiative. If - which is not expected at this stage - actual costs turn out to be greater than anticipated, the necessary funding will be made available without detriment to patient services.

IF PRESSED ON COST OF NEW CONSULTANT POSTS: Costs will depend on a range of factors, eg specialty and location of new posts, and rate of build-up over 3 year period. New posts will be without detriment to other services: additional resources for 1989-90 will be considered if they turn out to be necessary.

SECRET
until 31 January 1989

"WORKING FOR PATIENTS" - DEFENSIVE POINTS

Drug prescribing costs

Will cash limits be imposed?

Not at the level of the individual GP practice. [Though drugs expenditure will form part of GP practice budgets, so that practices who opt for this system will meet their drugs expenditure out of a wider cash-limited budget.] The intention is that indicative budgets at GP level will operate with reasonable flexibility so that GPs will not be penalised for legitimate overspending.

But, as White Paper makes clear, budgets at regional and FPC level intended to be firm.

NOT FOR USE: White Paper talks about "firm budgets", and deliberately not "cash limits". Intention however is that they should operate similarly and eventually come under cash limits.

Sanctions against overspending?

Overspending in a region in one year will be taken into account in setting the budget for the following year. And GPs who persistently overspend without good cause may be called to account under existing disciplinary procedures.

Unconventional finance

Has the Treasury relaxed its previously unyielding line?

Our approach to "unconventionally financed" projects is based on two precepts: that any individual proposal must offer the best value for money for the taxpayer; and that such deals must not be used as a way round public expenditure controls. Those have not changed.

The application of these principles to health service projects has been reviewed and guidance will be issued to health authorities in due course.

SECRET
until 31 January 1989

Para 9.14 a green light for Bromley?

[There has been much comment about a proposal that a developer should build a new general hospital on a new site for Bromley DHA, taking possession of the existing city centre sites in part payment when they are vacated. This involves, in effect, selling the land forward to the developer who also provides bridging finance. DoH intend shortly to invite developers to tender, distinguishing from each other design/build costs, bridging finance and price offered for existing land. Options to be appraised in the light of responses.]

Individual cases have to be considered on their merits. No decisions yet on Bromley. Understand Department of Health likely shortly to invite contractors to submit informal tenders on a number of different bases. Options - including financing options - will be considered in the light of that.

Audit

Won't NAO and Audit Commission get in each other's way?

NAO and Audit Commission already have good working relations where they both have an interest - eg jointly financed health authority/ local authority projects. No reason to suppose that will not continue. Expect them to consult each other closely about VFM audit programmes.

Why did you not give the task to NAO?

"Statutory audit" of health authorities and FPCs (and in future self-governing hospitals and GP practice budgets) is on behalf of Secretary of State. NAO is responsible to Parliament and the PAC. In that capacity it audits the consolidated NHS accounts. But it cannot, as a Parliamentary body, report to the Secretary of State.

0671A

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~SXXXXXXXXXX~~ Health

CHIEF SECRETARY
REC. 30 JAN 1989
ACTION CX
COPIES TO

000086

COVERING SECRET

Paul Gray Esq
10 Downing Street
LONDON SW1

30 January 1989

PWP

Dear Paul

WHITE PAPER "WORKING FOR PATIENTS"

I attach a confidential final revise of the White Paper "Working for Patients" which is to be published at 3.30pm tomorrow. My Secretary of State will be making a Statement in the House at that time.

I am copying this letter and enclosure to the Private Secretaries, to members of the Cabinet, and also to Trevor Woolley at the Cabinet Office.

Yours

Andy

A J McKEON

0679A

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

CONFIDENTIAL

Paul Gray Esq
No 10 Downing Street
LONDON SW1

CHIEF SECRETARY
REC. 30 JAN 1989
ACTION CX
COPIES TO

30 January 1989

PWP

NHS REVIEW

I attach briefing on the Review White Paper for Cabinet Ministers as requested at last week's Cabinet meeting.

I am copying this letter and attachment to the Private Secretaries of other Cabinet Ministers and to Trevor Woolley.

Julie McLaughlin FOR

A J McKEON
Private Secretary

NHS REVIEW WHITE PAPER

Background and Summary

1. The Government's White Paper on the NHS, "Working for Patients", was published on 31 January 1989 following a year-long review of the NHS.

2. The White Paper concentrates on the hospital and family doctor service. It proposes a series of measures to improve the quality and efficiency of services. In particular:

- power and responsibility will be delegated much more to the local level, including greater flexibility in setting pay and conditions and over the use of capital;

- the role of the centre will be clarified by the establishment of a Management Executive with responsibility for NHS operations which will be accountable to a Policy Board chaired by the Secretary of State for Health;

- Regional and District Health Authorities (RHAs and DHAs) will be slimmed down and reconstituted. Local authorities will no longer have a right to appoint DHA members;

- hospitals will be able to apply for self-governing status, while remaining in the NHS. They will be known as NHS Hospital Trusts and will have considerable freedom over their use of resources;

- new funding arrangements will ensure that resources are channelled to those hospitals which attract most patients. Health authorities will be encouraged to buy the best service they can for their population whether from their own hospitals, other health authorities' hospitals, NHS Hospital Trusts or the private sector;

- hospital consultants will be expected to take more responsibility for their use of resources, and they will have fuller job descriptions. The system of distinction rewards will be revised;

- 100 new consultant posts will be created over the next 3 years in specialties with the longest waiting times;

- GPs in large practices will be able to opt to have their own budgets for buying a range of services direct from hospitals;

- indicative drug budgets for GPs will be introduced to put downward pressure on prescribing costs;

- the management of Family Practitioner Committees (FPCs) will be improved. They will become accountable to RHAs;

- what doctors call "medical audit" - quality control by peer review - will be extended to cover all hospitals and GP practices;

- the Audit Commission will assume responsibility for auditing the accounts of health authorities and other NHS bodies, and will undertake wide-ranging value for money studies;

- retired people will be able to claim tax relief on private health insurance.

Key facts on the NHS (UK base)

3. - the number of doctors and dentist increased from 42,000 in 1978 to 48,000 in 1987, an increase of over 14 per cent;

- the number of nursing and midwifery staff grew from 444,000 to 514,000 during the same period, an increase of 16 per cent;

- total gross expenditure on the NHS has increased from £8 billion in 1978-79 to £26 billion in 1989-90, an increase of 40 per cent after allowing for general inflation;

- the NHS now treats over one and a half million more inpatients a year than in 1978, bringing the total to nearly 8 million.

Points to make

4. - this is the most fundamental review of the NHS in its 40 year history. The Government is keeping all that is best in the NHS whilst strengthening it to meet the challenges of the 1990s;

- the Government remains committed to the underlying principles of the NHS that is open to all, regardless of income, and financed mainly funded out of general taxation;

- the Government has put patients first. More local flexibility and competition in the provision of services means more choice and better quality services. Hospitals will have major incentives to attract more patients by improving services;

- this will reduce waiting lists further. As a result of earlier Government initiatives, half of all waiting list patients are already admitted to hospital within five weeks or less;

- hospitals will be freer to respond to local needs. NHS Hospital Trusts are not a step on the road towards privatisation - they will remain an integral part of the NHS;

- the role of GPs will be enhanced and patients who are not satisfied with the service will be able to change GPs more easily;

- staff working in the NHS will have stronger incentives to improve performance, greater control over their resources and greater freedom to innovate and respond to patient preferences.

Points to watch

5. - Action on Griffiths' report on community care?

The NHS review has focused closely on the funding and management of health services - hospitals and family doctors in particular. The interaction of health and social care in the field of community care needs further study. That work is well in hand.

- Won't cash-limited drug budgets harm patients?

No. Patients will continue to get the drugs that they need but, by encouraging more effective and economic prescribing, the Government wants to release more resources for other areas of patient care.

- Will the introduction of contracts restrict GPs freedom of referral?

This is not the Government's intention. By improving the information that is available to GPs and encouraging more contact between GPs and hospitals, the Government wants to enhance the role of GPs as gatekeepers to the hospital service.

- NHS Review White Paper a bureaucrat's delight?

No. The Government's aim is to produce a more effective and responsive service, by redistributing staff to the hospital level where possible and strengthening key functions.

- Isn't the White Paper preparing the NHS for the Private Sector?

The White Paper makes it plain that the Government remains committed to a public sector service that is available to all, regardless of income, and financed mainly out of general taxation. NHS Hospital Trusts will remain an integral part of the NHS.

- Will higher regional costs still be reflected in the allocation of resources?

Yes. The Thames Regions will receive a slightly higher funding than the rest - some 3 per cent higher per head of population - to reflect the higher costs of and demands on services in the capital in particular.

0686A

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

CONFIDENTIAL

PWP

Paul Gray Esq
10 Downing Street
LONDON SW1

30 January 1989

Ch/ Dick's comments marked + passed to DH. I told them you may have some more. OK? DJS

Dear Paul

NHS REVIEW: STATEMENT TO HOUSE

I enclose a draft of the Statement which my Secretary of State proposes to give to the House tomorrow. I should be grateful to have any comments as early as possible tomorrow morning.

I am sending copies of this letter and attachment to Private Secretaries of other members of the Ministerial Group and to Richard Wilson (Cabinet Office).

Yours

Andy

A J McKEON
Private Secretary

CH/EXCHEQUER
REC. 31 JAN1989
ACTION MR SAUNDERS ✓31/1
COPIES TO CST
SIR P MIDDLETON
SIR T BURNS
MR ANSON, MR PHILLIPS
MR CULPIN, MRS LOMAX
MR KELLY, MISS PEIRSON
MR PARSONAGE, MR GRIFFITHS
MR CALL

I have made a number of points.

0642A

DRAFT PARLIAMENTARY STATEMENT

Britain enjoys high and rising levels of Health Care and, at its best, our Health Service is as good as any in the world. I believe that the principles underlying the NHS still hold as good today as they ever have and they will continue to guide it into the next century. The NHS is - and must remain - open to all, regardless of income, and financed mainly out of general taxation.

But if those principles remain unchanged, the Health Service itself - and the society in which it operates - are changing for the better We need constantly to improve and strengthen the NHS so that it can provide ever better care to those who rely on it. At the moment there are wide variations in performance across the country. We want to ~~take~~ maintain the best of the Health Service, and bring the rest of it up to that very high standard.

That is why the Government set out upon a fundamental review of the NHS last year. We have today published our conclusions in the White Paper entitled "Working for Patients". They build on and evolve from the improvements that the Government has already made to the Service in the last ten years. They reflect a change of pace rather than any fundamental change of direction. All of our proposals share a common purpose - to make the Health Service a place where patients come first and where decisions are increasingly taken at a local level by those most directly involved in delivering and managing care.

The main proposals apply to all the United Kingdom but there are separate chapters devoted to Wales, Scotland and Northern Ireland explaining how they will be applied in those countries. Implementation of the proposals will have to follow a process of discussion with many people in the serivce. We will be issuing in the course of the next week or two eight detailed working papers as the basis for those discussions.

Before I turn to the key proposals on management and the use of resources contained in the White Paper, I want to describe the kind of hospital service that I believe every patient has a right to expect. I intend to ensure that all hospitals will provide individual appointment times that can be relied upon. They should offer attractive waiting areas with proper facilities for patients and children. They should be able to provide proper counselling to those who need it and give clear and sensitive explanations of what is going on. In addition, patients should be able to pay for a number of optional extras such as a wider choice of meals, a bedside telephone, a television, or a single room. The best hospitals already provide this and I intend to ensure that the whole service treats patients properly as people.

We will also ensure that patients are freer to choose and change their GP. And we shall give more encouragement to those GPs who, by offering the kind of service that people want, succeed in attracting more patients. To achieve that, we are proposing to increase the proportion of GPs' pay which comes from the number of patients on their lists from 46% to at least 60%.

People look to their GPs to prescribe the medicines they need, and GPs must have the necessary flexibility to do so. But at present, drug costs in some places are nearly twice as high per head of population as in others. The drugs bill is the largest single element of all spending on the family practitioner services. At £1.9 billion in 1987-88, it was more than the cost of the doctors who wrote the prescriptions. In each of the last five years, spending has risen by an average of 4% above the rate of inflation. Unnecessarily expensive prescribing is wasteful and takes up resources that should be used in other ways. Over - prescribing is not in the best interests of patients. We shall therefore introduce a new budgeting scheme whereby GP practices will receive indicative budgets for their prescribing costs. The scheme will be operated in a way that ensures downward pressure on the cost of prescribing without inhibiting the ability of doctors to provide necessary medicines for their patients.

At present, because of the way that hospitals are funded, GPs are not always ableto offer their patients a full choice as to where they will be treated. We want to change this by giving GPs in large practices the opportunity to hold their own NHS budgets. They will be able to use these to purchase as they judge best certain types of hospital services for their patients. They will, in other words, be able to provide the hospitals they choose with the NHS funds required to finance ~~their work~~.

These GP practice budgets will cover in-patients, out-patients and day care treatments - for instance hip replacements and cataract removals. They will also cover prescribing costs and diagnostic tests - such as X-rays and pathology tests. Large practices will be free to decide whether to join the scheme or not. It will at first only be open to practices with at least 11,000 patients - that is twice the national average. Over 1,000 UK practices could join, covering about 1 in 4 of the population. All of those practices could have their own NHS budgets of about £1/2 million a year. Giving GPs the resources to finance services for their own patients will provide a real incentive to hospitals to improve the service they offer to those GP's. It will also enable GPs to provide a better service to patients for example by referring them to where waiting lists are shortest. And I am quite sure that GP's will want to judge the quality of service at least as much as the cost of services when they decide where to refer their patients. We have important proposals on the quality of medical service to which I shall turn later.

But it will not just be through GP practice budgets that money will follow the patient to where work is done best. The principle will apply throughout the Health Service as a whole. As part of this new way of getting resources to hospitals, the present elaborate system known as RAWP will come to an end. Over the last 12 years it has made an important contribution by helping to equalise the resources available to each Region, but that task has now very largely been achieved. Now we are in a position to replace it with an altogether more simple and fair system based on population numbers weighted for

age and health, and the relative costs of providing services. It will be much quicker to compensate those regions which treat large numbers of patients from elsewhere in the country. We will move to a system which finances Regions and Districts on exactly the same system with a 3% addition for the Thames Regions because of the inescapable extra problems of providing health care in the capital ~~in particular~~.

In future, the money required to treat patients will be able to cross administrative boundaries more freely, so that those hospitals which best meet patients' needs get the funds to do so. All NHS hospitals will be able to offer their services to different health authorities and the private sector. All District Health Authorities will be able to provide finance for health services to whatever hospitals they choose in other Districts or their own. As a result, we will not in future have the frustrating situation whereby a good, efficient hospital that attracts more patients runs out of money and has to slow down its work or close wards. This new system will start in 1990 for Regional Health Authorities, and 1991 for districts.

But improving the hospital service is not just a matter of changing the way in which hospitals receive their funds. We also want to change the way in which they are run and managed. We want all hospitals to have more responsibility for their own affairs so that they can make the most of local commitment, energy and skills, and can get on with what they are best at - providing care.

Management can be strengthened throughout the whole Health Service, The better the management the better the care it can deliver. Financial accountability and value for money will be improved by transferring audit of ~~the NHS~~ the health authorities & other NHS bodies to the independent Audit Commission. On management matters, it is a nonsense that the Ministers of any Government should be directly involved in the detail of the day-to-day running of the whole NHS. We shall therefore set up a new NHS Management Executive, chaired by the new Chief Executive, Mr Duncan Nicholl and responsible for all operational decisions. It will be accountable to an NHS Policy Board chaired by the Secretary of State for Health who will determine policy and strategy for the Service.

The prime responsibility of Health Authorities will be to ensure that the population for which they are answerable has access to a full range of high quality, good value services. Their job will be to judge the quality of services, to choose the best mix of services for their resident population and to finance those services. They will no longer provide and run all their local services which will be increasingly the role of the hospital and unit managers themselves. Authorities will need to be organised as more effective decision making and managerial bodies. We shall therefore be changing their composition to make them smaller and to include executive and non-executive members. The non-executive members will be appointed on the basis of the personal skills and expertise they can bring to the authority and not as representatives of interest groups. Although there will no doubt continue to be people who will combine being members of local health authorities with being local

The role of the NAO will not be affected by this change.

councillors, local authorities will lose their present right to appoint direct their own members. At the same time, we shall also be strengthening the management of FPCs along similar lines. We will also make them accountable for the first time to Regional Health Authorities so as to improve the links between planning for the hospital, community and family practitioner services.

We must devolve responsibility across the whole Health Service. But I believe that we can also go one stage further. The next logical step in the process of extending local responsibility is to allow individual hospitals to become self-governing. Let me make it absolutely clear that they will still be as much within the NHS as they are now. They will be no freer to leave the NHS than any unit has been throughout its forty year history. They will have far more freedom to take their own decisions on the matters that affect them most without detailed supervision by District, Region and my Department. Known as NHS Hospital Trusts, they will be free to negotiate with their own staff on rates of pay, and within limits to borrow capital. They will be able to offer agreed services for agreed resources throughout the NHS and the Private Sector. There will of course be safeguards to ensure that essential local services continue to be delivered locally. I believe that this new development will give patients more choice, produce a better quality service, build on the sense of pride in to local hospitals, and encourage other hospitals to do even better in order to compete. I expect the first NHS Hospital Trusts to set up in April 1991.

Mr Speaker, in all these reforms we intend to concentrate on the quality of care as much as quantity and cost. I admire the progress with which the medical profession is devising systems which doctors call "medical audit" to assess clinical performance and outcomes. We intend to work with the profession to ensure that good systems of medical audit are put in place in every hospital and GP practice as soon as is practicable. What matters for all patients, is that high standards of medical performance are maintained and where possible improved and such systems should secure that.

I turn finally to the area of perhaps greatest public concern - waiting times. All the measures I have so far outlined by making resources flow more directly to those parts of the service that deliver the best care, will help to cut the length of time that people sometimes have to wait for elective surgery. The Waiting List initiative will continue but we shall also introduce a number of other initiatives designed to have a more direct and immediate impact. First, we intend all GP practices to have the basic information systems they need to know where treatment is available quickest. Second, we shall introduce a new tax relief to make it easier for retired people to make private provision for health care. This will reduce the pressure on the NHS from the very age group most likely to require elective surgery, freeing up resources for those who need it most. Third, we shall manage consultants' contracts more effectively so that the very best use is made of their time and expertise. We will also introduce new incentives to reward those consultants who become more involved with the management of the NHS. And fourth, we shall increase the number

of consultants by 100 over the next three years. Those consultants will be appointed in those specialties and in those Districts where waiting times are most worrying. Extra finance will be available to cover the costs of the new appointments, and the supporting services for their workload. This will help us keep up the attack not only on waiting times, but also on long hours worked by junior doctors.

Taken together, these proposals add up to the most formidable programme of reform in the history of the NHS. They are the latest step in our drive to build a stronger, more modern, more efficient Health Service. For an NHS that is run better will be an NHS that can care better. They will of course mean change, but change of the kind we need if we are to have a service that is fit for the future. I trust that all those who - like me - truly believe in a Health Service which offers high quality care to all our people, will lend their support to these reforms, and I commend them to the House.

30.1.89.6

COVERING SECRET

cc all pm officers

FROM: R B SAUNDERS

DATE: 30 January 1989

MR GIEVE

cc Mr Phillips
Miss Peirson
Mr Griffiths

NHS WHITE PAPER

When we spoke on Friday about briefing for the publication of this White Paper tomorrow, you asked me to list the main reforms to which the Treasury would attach importance. I suggest the following.

a. Renewed emphasis on value for money: giving statutory audit to the Audit Commission; measures (eg more delegation of responsibility, more flexibility on pay and conditions of service) to improve management.

b. Better financial and management information systems for hospitals through the acceleration and extension of the resource management initiative.

c. Getting doctors to take greater responsibility for the resources they commit, partly as a result of RMI, partly through reform of the distinction award system and better enforcement of consultants' contracts.

d. Drug budgets hold out the prospect of better control of the burgeoning FPS drugs bill.

e. Treasury has a less direct interest in other proposals in the White Paper, eg self-governing hospitals and GP practice budgets, but they go with the grain of the above changes.

RB

R B SAUNDERS

18

30.1.89.5

SECRET
until 31 January 1989

FROM: R B SAUNDERS
DATE: 30 January 1989

MR GIEVE

cc Chancellor
Chief Secretary
Financial Secretary
Paymaster General
Economic Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mr Culpin
Mrs Lomax
Miss Peirson
Mr MacAuslan
Mr Parsonage
Mr Pickford
Mr Richardson
Mr Griffiths
Mr Sussex
Mrs Chaplin
Mr Tyrie
Mr Call
Mr Kuczys) Inland
Mr Walker) Revenue

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R B SAUNDERS

SECRET
until 31 January 1989

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Aim of reforms is to enable NHS to respond to pressures on it, by improving quality of care and value for money.

Key proposals:

- Greater delegation of power and responsibility to local level, from regions to districts and districts to hospitals. Resource management initiative to be accelerated.

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SECRET
until 31 January 1989

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SECRET
until 31 January 1989

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Overspending in a region in one year will be taken into account in setting the budget for the following year. And GPs who persistently overspend without good cause may be called to account under existing disciplinary procedures.

Unconventional finance

Has the Treasury relaxed its previously unyielding line?

Our approach to "unconventionally financed" projects is based on two precepts: that any individual proposal must offer the best value for money for the taxpayer; and that such deals must not be used as a way round public expenditure controls. Those have not changed.

The application of these principles to health service projects has been reviewed and guidance will be issued to health authorities in due course.

SECRET
until 31 January 1989

Para 9.14 a green light for Bromley?

[There has been much comment about a proposal that a developer should build a new general hospital on a new site for Bromley DHA, taking possession of the existing city centre sites in part payment when they are vacated. This involves, in effect, selling the land forward to the developer who also provides bridging finance. DoH intend shortly to invite developers to tender, distinguishing from each other design/build costs, bridging finance and price offered for existing land. Options to be appraised in the light of responses.]

Individual cases have to be considered on their merits. No decisions yet on Bromley. Understand Department of Health likely shortly to invite contractors to submit informal tenders on a number of different bases. Options - including financing options - will be considered in the light of that.

Audit

Won't NAO and Audit Commission get in each other's way?

NAO and Audit Commission already have good working relations where they both have an interest - eg jointly financed health authority/ local authority projects. No reason to suppose that will not continue. Expect them to consult each other closely about VFM audit programmes.

Why did you not give the task to NAO?

"Statutory audit" of health authorities and FPCs (and in future self-governing hospitals and GP practice budgets) is on behalf of Secretary of State. NAO is responsible to Parliament and the PAC. In that capacity it audits the consolidated NHS accounts. But it cannot, as a Parliamentary body, report to the Secretary of State.

chex.rm/ds/27 CONFIDENTIAL

FROM: D I SPARKES
DATE: 31 January 1989

MR CALL

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mr Culpin
Miss Peirson
Mr Saunders
Mr Gieve

PWP

NHS REVIEW PRESENTATION

The Chancellor was grateful for your minute of 27 January discussing the presentation of the review. He has commented that he is unsure that the "internal market" means very much to the man in the street. He found the Gallup surveys attached to your minute interesting and reasonably encouraging.

D.I.S.

DUNCAN SPARKES

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

PMP

Paul Gray Esq
No 10 Downing Street
LONDON SW1

CHIEF SECRETARY

REC.	31 JAN 1989
ACTION	CX
COPIES TO	

31 January 1989

Dear Paul

NHS REVIEW

I would be grateful if you and copy addressees could make a small amendment to the briefing for Cabinet Ministers which I circulated yesterday. The item on tax relief (the last point in para 2) should read:

- income tax relief on medical insurance premiums for those aged 60 and over, whether paid by then or, for example, by their families on their behalf.

I am copying this letter to the Private Secretaries of other Cabinet Ministers and to Trevor Woolley.

Yours

Andy

A J McKEON
Private Secretary

CHANCELLOR

PWP (NHS)

1. T. Grieve
2. Mr Burd

cc Minister
Advisers
Burd / Grieve
Anson / H Phillips / R Saunders

These summaries arrived 3.45pm, completely unsolicited. But we know the BMC is much more expensive than Tellex, to whom I shall be writing shortly about a 3 month contract.
John Fletcher 1/2

FAX TRANSMISSION SHEET

COVER SHEET

DATE: 1st February 1989

TOTAL NUMBER OF PAGES:

TO: John Fletton, H.M. Treasury.

FAX TELEPHONE NUMBER: 270-5244.

FROM: Donal Smith
The Broadcast Monitoring Company

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COVERING MESSAGE

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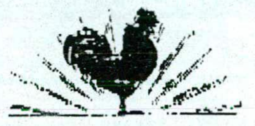
THE BROADCAST MONITORING COMPANY 8-20 Shorts Gardens, London WC2H 9HR Tel. 379 4445 Fa

NATIONAL HEALTH SERVICE
RADIO & TELEVISION BROADCASTS
WEDNESDAY 1 FEBRUARY 1989
0600 - 1400



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AM (LBC: 0600) interviewed Dr. Ken Grant, Hackney Health Authority, who said there were few who accepted the benefits of opting out and who foresaw a danger of unprofitable hospitals being ignored. (5 mins)
Later the programme interviewed Eric Moonman, Islington Health Authority, who was concerned for the future position of GPs but thought waiting lists would be reduced. (4 mins)
Later, interviewed Prof. McColl, Guy's, who emphasised the hospital would not leave the NHS and who regarded the proposals as giving more power to the customer. He said the PM was caring and compared Robin Cook to a football hooligan. (3 mins)

TV-am (ITV: 0600) reported 60 Conservatives as having signed a motion claiming Cook had received stolen property. (1 min)

Newsdesk (WOR: 0600) commented that after WW2 the NHS had been regarded as the jewel in the crown of the Labour movement, adding that Thatcher had claimed it was safe in her hands. (3 mins)

Today (RAD4: 0630) interviewed Dr. Michael Goldsmith, CPS, who said hospitals and GPs should welcolm increased management sufficiency; Kenneth Judge, Medical Research, who stressed greater accountability; and Dr. Jonathan Greffey, who said it was necessary to provide the best service, not the cheapest. (5 mins)
Later Brian Redhead interviewed Dr. Nicholas Barr, LSE, and Dr. Alan Maynard, York University. Maynard thought increased GP efficiency and hospital facilities would result while Barr said the NHS had been highly successful by international standards, adding that any alterations must be made carefully. (4 mins)
Later, interviewed Nicholas Winterton MP, who saw no benefit and feared for older patients; Sir Geoffrey Johnson-Smith MP, who desired the greater managerial efficiency; Robert McCrindle MP, who scorned tax relief for the elderly; Ray Whitney MP, who thought financial incentives to GPs would improve patient care; and Gerry Hayes MP, who stated the future of the Government depended on the White Paper. (5 mins)

Breakfast Time (BBC1: 0700) interviewed Kenneth Clarke, who expressed irritation at the leak; Robin Cook, who stated Labour had pre-empted the Government; and Gerry Hayes, who was concerned re. GP budgets. (3 mins)
Later, interviewed Derby GP Wilf Ali, who feared diminished care as a result of further trimming of the NHS, and Dr. Peter Ellis, who welcolmed increased efficiency consequent on GPs not being able to sign a blank cheque. (4 mins)
Separately, political correspondent John Harrison described the NHS review as critical for Thatcherism, stated there was anxiety on the Tory backbenches and said Labour would exploit every problem. (4 mins)

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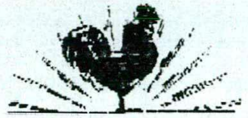

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Later, interviewed Dr. Maureen Dixon, IHSM, who expressed concern at the introduction of a two-tier system despite increased efficiency, who feared that GPs would have no incentive to care for the elderly and who considered a national system of accreditation would be necessary to ensure hospital standards. Rodney Bickerstaffe, NUPE, stated the Government was preparing for a private health service. (5 mins)

Good Morning Britain (ITV: 0700) reported from Tadworth Court childrens hospital, which has opted-out, and interviewed John Dunwoody, who was concerned at the development of a two-tier system. (9 mins)

The Parliament Programme (CH4: 1200) interviewed Sir Gerald Vaughan, who was in favour of increased choice and efficiency but keen that the NHS remain free. Sam Galbraith MP asserted that the Government was more concerned with a healthy balance sheet than a healthy patient, adding that choice could not be based on cheapness. (10 mins)

Newsbeat (RAD1: 1230) reported the forthcoming announcement as separating the funding from the provision of health care and interviewed Gerry Hayes, who said there was concern re. the proposal for GP budgetting. (4 mins)

The World at One (RAD4: 1300) quoted the PM stating she had no more intention of dismantling the NHS than of dismantling the nation's defences and stating the need to break-up the monolithic structure of the health service. Interviewed, Gerald Vaughan commented on the current low morale and appalling delays; Patrick Jenkin thought increased autonomy would lead to more community responsiveness; and Roy Griffiths commented on the need for greater management skills. (7 mins)

One O'Clock News (BBC1: 1300) interviewed Michael Wilson, BMA, who foresaw shorter waiting lists; Nicholas Winterton, who saw no benefits; Robert McCrindle, who expressed concern; and Robin Cook, who stated many hospitals would opt-out. Also interviewed, three GPs expressed concern at the potential conflict between the concerns of business and humanity. (8 mins)

IR News (LBC: 1300) commented that while the leak had put Clarke on the defensive it might limit backbench criticism. Interviewed, David Owen said Thatcher had no place for the NHS in her heart. (4 mins)

NATIONAL HEALTH SERVICE
RADIO & TELEVISION BROADCASTS
TUESDAY 31 JANUARY 1989

Verbatim transcripts and audio/visual compilations available.

This report comprises summaries of UK national, network and local London broadcasts between 0530 and 2400.

THE BROADCAST MONITORING COMPANY 8-20 Shorts Gardens, London WC2H 9JR Tel: 379 4445 Fax: 836 0596

AM (LBC: 0600) reported the Commons debate, with contributions from Nicholas Winterton, Kenneth Clarke and Robin Cook (4 mins)
In interview later, Roger Poole, NUPE, declared that patients would suffer as doctors strove to meet budgets and warned of NHS Americanisation (5 mins)
Separately, Mike Smith, BUPA, observed that tax relief for the elderly on private insurance would increase BUPA membership and pointed out insurance did not cover chronic illness (1 min)
Later, Arnold Elliot, GP, noted that Clarke had not answered when pressed on the re-opening of closed wards and warned that the application of market economy principles would be regressive. (7 mins)
Later, Roger Freeman commented in interview that the review meant more localisation of responsibility and more independence for hospitals. He highlighted more patient choice in changing GP's and the introduction of tax relief. (4 mins)
Philip Hunt, NAHA, expressed concern for community health, the contract-based relationship with hospitals, the GP budgets and the speed of the reforms (4 mins)
Also, Howard Davies, Audit Commission, was interviewed about the body's new role of auditing NHS expenditure. (5 mins)
Interviewed, Harriet Harman claimed patient care would suffer from monetary constraints and values and that, once understood, the proposals would meet public rejection (6 mins)

TV-am (ITV: 0600) interviewed Kenneth Clarke, who stated that those directly involved would work through the poroposals with the DoH. (1 min)
Later interviewed Ethel Buckles, long-serving nurse at Royal Preston Hospital, who thought the reforms deviated from the original NHS concept of free health care for all and who feared that hospitals would specialise, thereby causing hardship to poorer people forced to travel in order to get, for example, a hip replkacement. (5 mins)
Separately, the programme commented on the professionalism of the government campaign and noted Labour's belief that the issue was a vote winner for them (5 mins)

Today (RAD4: 0630) carried interviews with Guy's Hospital staff, including McColl, both for the reforms and concerned at the consequences of self-government. (4 mins)
Kenneth Clarke linked up with the programme throughout: he first discussed the review with David Bowden, IHSM, who supported the aims but wanted more representation for clinicians; Paddy Ross, BMA, who looked for clarification on appointments procedures; Becky Molby, ward sister, who voiced concern at fragmenting community care; and Sally Gooch, nurse, who welcomed the increased RCN consultative role but attacked the empahsis on illness rather than health promotion. Clarke stressed that

cont./

increased managerial roles would not out-weigh medical judgement, highlighted the extension of GP responsibility and patient choice, denied the break-up of community health and said there would be no pilot schemes as speed was necessary (15 mins)
Later, Clarke replied to comments by Dr. Michael Wilson, BMA, who expressed concern at assuring patients that treatment was not dependent on cash provision, and Whitley Bay GP George Rae, who favoured the budgetting plans, adding that cheaper drugs were not necessarily inferior. (7 mins)
The Health Secretary then reassured two National Heart Hospital patients, emphasising the patient's freedom of choice with regard to doctors, that there would be no change in exemption from paying for prescriptions and his desire to see shorter hours worked by junior doctors in general surgery with longer hours worked by consultants in specialist fields. (9 mins)
Finally, within Yesterday in Parliament, the programme quoted from the speeches of Clarke, Cook, Field, Kirkwood, Foot, Ashley, Hayes and Sillars. (10 mins)

Good Morning Britain (ITV:0700) interviewed Heather Bond, RCN, who thought patients would have less access to care, and David Mellor, who stressed government commitment to the service and accused health unions and Labour of cheapening the debate (10 mins)

Breakfast Time (BBC1:0700) interviewed a surgeon enthusiastic about the opportunities to offer speciality services to other districts; NHS patients who expressed doubts at the proposed changes; student nurses fearing a monetary ethos; a consultant who stated that more funding was the main need; and a consultant vascular surgeon worried at patient representation. (7 mins)
Separately, Sally Greengross, Age Concern, welcomed tax relief but warned that existing insurance was inadequate for the chronically ill and observed that two thirds of the elderly paid no tax anyway. (2 mins)
Later the programme reported on a hospital which had already implemented business-like methods and interviewed members of staff. In a studio discussion David Mellor denied economic viability would be an element in patient care, accused Cook of scare tactics and Labour of parroting NUPE. Cook replied that the paper encouraged doctors to think of patients in terms of their cost and complained that no mechanism existed to implement the proposal that waiting lists be cut by appointments. (9 mins)
Later, there were interviews with a hospital doctor, who commented that hospital medicine's nature and practice would change, and Barbara Young, IHSM, worried about fragmentation and implementation difficulties. (5 mins)

News at One (ITV: 1300) interviewed Clarke, who said sensible discussion on the actual rather than leaked detail was wanted, and Dr. Pirie, Adam Smith Institute, who considered the White Paper to add choice and cost-effectiveness to the achievments of the NHS. GP Arnold Eliot expressed concern at consequences of a budget running-out; Manchester general manager Michael Ruane said people found waiting-lists unacceptable, adding that there were no incentives at present to transfer resources where necessary; while St. Mary's Prof. Rodney Harris hoped that adequate provision would be made to safeguard preventative medicine and links with regional authorities. The programme also interviewed Robin Cook, who stated privatisation was the next step; Robert McCrindle, who thought the changes desirable but was disturbed at GPs running-out of money; and Edward Leigh MP, who favoured GPs being made aware practically of prescription costs. (14 mins)

Question Time (RAD4: 1530) was presented from the House of Commons. The Secretary of State's announcement was given as well as the speeches inter alia of Robin Cook, Jill Knight and Frank Field. (60 mins)

Update (LBC: 1700) quoted the Commons speeches of Clarke and Cook, on the prescription for a NHS run by accountants for civil servants. Interviewed, David Owen stated the proposals would gradually poison the NHS, adding that division of the service into separate accounting units was wrong. Michael Lowe, BMA, complained that the Government was prepared to go ahead without pilot studies, feared the consequences of GP budgets and of hospitals opting-out, but added that he did not believe the Government intended to privatise the NHS. (12 mins)
Later Trevor Clay, RCN, stated that constantly re-organising management was not the answer and saw the real problem as being care for the elderly. Kenneth Judge regarded the proposals as not being radical enough while Eamonn Butler, Adam Smith Institute, thought it would raise quality. Interviewed, Kenneth Clarke stressed commitment to the idea of the NHS but said it needed to become more responsive to patient needs. Robin Cook stated that the proposals were about balance sheets rather than patients. (12 mins)

PM (RAD4: 1700) detailed the proposals in the context of self-government and cost-consciousness. The speeches of Clarke, Cook Archie Kirkwood and Jill Knight were quoted in part. The programme interviewed Ian Donachie, general manager of St, James, Leeds, who foresaw being better able to balance services, and Ray Rowden, general manager West Lambeth mental health services, who was concerned at the lack of attention given to priority rather than acute areas. (13 mins)

cont./

Later the programme interviewed Kenneth Clarke, who stated that the reforms would place the patient in the driving-seat, adding that the NHS would become less bureaucratic and more responsive. Dr. John Marks, BMA, emphasised the desire of people to have care locally available; Martin Long, NAHA, thought the system would be strengthened; Rodney Bickerstaffe said the chronically ill would be left out in the cold; Hector MacKenzie, COHSE, feared for staff consequences and hence health care provision; and Trevor Clay, RCN, regarded the management organisations as disorientating. (9 mins)

GLR News (GLR: 1700) interviewed ruth Ashton, RCM, who queried the non-mention of maternity services and who regarded the Paper as being more concerned with accountancy than with health care. (8 mins)

Newsbeat (RAD1: 1730) quoted from the speeches of Clarke and Cook prior to repeating in part the PM statements of Marks, Long, Clay and MacKenzie. (5 mins)

ITN News (ITV: 1745) interviewed Marks, who was concerned that the proposals were piecemeal, and Clay, who feared for the NHS as such. Clarke stressed that hospitals would not be leaving the NHS; Cook said hospitals would become private companies; and Owen re-iterated his statement that the reforms were poisonous. The programme also repeated in part earlier interviews with GP Eliot and hospital manager Ruane. (7 mins)

Six O'Clock News (RAD4: 1800) detailed the proposals then quoted from the speeches of Clarke, Cook, Knight, Ashley, Field and Owen. The programme then repeated the interviews with Marks, Long, MacKenzie, , Clay and Bickerstaffe. (18 mins)

Six O'Clock News (BBC1: 1800) detailed the proposals then interviewed Michael Wilson, who said treatment would become chosen for cost reasons, and Toby Harris, ACHA, who thought patient care would become worse. Robin Cook stated that accountants and bureaucrats would have more power; Archie Kirkwood said the NHS was drifting into the free market; and Nicholas Winterton expressed deep concern. The programme also interviewed GPs Iona Heath and Mairi Scott, the former concerned at there being an incentive not to spend and the latter excited at being able to plan a budget. Interviewed, Kenneth Clarke said that most of the reservations expressed had been about Robin Cook's descriptions rather than the reality; he hoped the BMA would take-up the greater choice offered and stressed that GPs who over-spent would not be shut-down. (14 mins)

London Plus (BBC1: 1830) reported from Guy's, interviewing Prof. McColl, who desired to opt-out, and Stuart Barber, NUPE, who feared job losses. (7 mins)

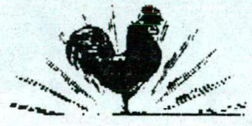
The Way It Is (CAP: 1900) interviewed David Mellor, who expressed anger at notions of the Government privatising the NHS and emphasised their desire to look after the elderly; Harriet Harman, who said the government was putting cash before care; and Rosie Barnes, who expressed anger at the restrictions on GPs and care for the elderly. (9 mins)

Channel Four News (CH4: 1900) interviewed Kenneth Judge, who welcolmed the proposals but desired further safeguards; John Marks, concerned at the consequences of GP budgets; Sally Greengross, Age Concern, afraid that some GPs would not take-on the elderly; Maureen Dixon, who said there was a danger in splitting services; and Roy Clarke, BUPA, who thought his company could cope with the insurance suggestions. The programme then interviewed John Redwood MP, who regarded the package as good and an attack on waiting-lists; Archie Kirkwood, who thought the proposals unsafe specifically as regarding GP budgets and insurance for the elderly; and Robert McCrindle, who similarly feared for the elderly. A studio discussion between David Mellor and Robin Cook ensued, with Mellor stating the proposals would enable patients to get better care from a more responsive system while Cook stated no local health authority would be able to plan and that some hospitals could collapse financially. (24 mins) Later the programme interviewed GPs Jim Milligan and Rowland Hopkinson, the former concerned with the application of the funding made available to doctors and the latter concerned that management needs would detract from clinical time. (7 mins)

Nine O'Clock News (BBC1: 2100) interviewed Dr. Mark Rowland, who said trust between doctor and patient would be destroyed, and Dr. Mairi Scott, who welcolmed the increased choice and responsibility. Hospital manager Chris West thought everyone would win while John Marks expressed concern that monetary considerations were being put first. Interviewed, Kenneth Clarke emphasised the incentives and support for GPs. (13 mins)

News at Ten (ITV: 2200) interviewed Clay, antagonistic to people having to travel for care; Greengross, on some GPs treating OAPs as a budget drain; and Marks, concerned at the lack of pilot studies. David Owen stated that the GP system would be eroded and Robert McCrindle said the money provided indirectly through tax relief should have gone directly to the service. The programme reported from the Freeman hospital in Newcastle, interviewing project resource manager Jeremy Loeb, who said resouces could be allocated more effectively, and general manager Len Fenwick, who said demand would always outstrip resources. (12 mins)

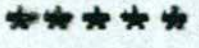
Newshour (WOR: 2200) quoted Cook, on accountants controlling the NHS for the benefit of civil servants, and Clarke, on the underlying principles of the NHS holding firm. (2 mins)



The World Tonight (RAD4: 2230) reported NAHA as welcolming the proposals, the BMA as having reservations, NUPE as regarding the White Paper as cynical, and the RCN as critical. The programme interviewed Clarke, who said talk of privatising the NHS was nonsense and who stressed that modern management practices would lead to improved public service. The programme then interviewed GPs Amir and Rea, the former stating that care and competition were not compatible and the latter stating that practices could becoma BUPA-like in desiring only fit, young non-smokers. Prof. McColl expressed delight, Prof. Bosanquet regretted that the Paper was more concerned with structure than with aims while Michelle Pullier said it would be hard on younger doctors in poorer areas. (23 mins)

Newsnight (BBC2: 2230) interviewed John Marks, BMA, who complained at the piece-meal nature of the proposals and the lack of pilot schemes, and Philip Hunt of NAHA, who said it would be necessary to ensure the full range of services was delivered. Alan Pike, Financial Times correspondent, considered John Moore's desire for better management and a greater private sector role to be behind the Paper; David Willetts, CPS, who stated the changes were available to those who wanted them and were not compulsory; while Gerry Hayes MP stated that the Select Committee had stressed its opposition to a US style system. Reporting from Bradford, the programme interviewed David Foggett, general manager of the Royal Infirmary, who welcolmed the chance to reward hard work, and Maureen Woods, RCN, who considered the proposals to be about a sickness rather than a health service. GP Dr. Hayward regarded budget control as exciting but feared that payment by number of patients was a retrograde step in terms of prevention. A studio discussion between Kenneth Clarke and Robin Cook then ensued; Clarke emphasised that quality of care remained as important as quantity, stressed the need to free hospitals from bureaucracy and union influence, averred that people desired modern management skills in a public service and stated that pilot schemes were unnecessary; Cook stated that free-standing hospitals would be effectively private, opined that accountants would hold power over consultants and added that GPs would have longer lists and less time for patients. (35 mins)

Today in Parliament (RAD4: 2230) quoted from the Commons speeches of Clarke, Cook, Kirkwood, Sillars, Barnes, Spearing and Nelson and also from the Lords speeches of Ennals, Winstanley, Hesketh, Stafford and Kilmarnock.



st2feb.2

FROM: D P GRIFFITHS
DATE: 2 February 1989

MR PHILLIPS

cc PS/Chancellor
PS/Chief Secretary
Mr Anson
Mrs Lomax
Miss Peirson
Mr Parsonage
Mr Saunders
Mr Sussex
Mr Walker IR

CENTRE FOR POLICY STUDIES SEMINAR ON THE OUTCOME OF THE NHS REVIEW

Mr Saunders and I attended this seminar today. I attach a copy of the programme.

2. The participants were all very enthusiastic about the reforms proposed in the White Paper. Indeed, some thought that the Government should have been bolder in respect of GP budgets and allowed all practices to be eligible. (It was argued that small practices were much more likely to be innovative than in large ones, which had to move at the pace of the slowest member). In the question and answer session Mr Mellor indicated that the Government was prepared to be flexible on this issue. However, the proposed tax relief for the elderly attracted criticism. Michael Goldsmith attacked it as an irrelevance while David Green (IEA) expressed concern that, if no limit was placed on the eligible premiums, there could be upward pressure on private health insurance prices as companies offered more luxurious and costly products. He suggested the Government use the relief to insist that insurers provided cover for pre-existing conditions.

3. The question of the future of community care was touched on by a number of speakers. There is clearly concern that the Government should come forward with proposals and end the uncertainty in this area. Another general issue which was mentioned was the importance of the NHS's continuing to develop its health promotion and preventative work.

4. Particular points worth noting are:

i. David Willetts thought that, at least in the early days of the internal market, it would be best for there to be standard nationwide prices for cold surgery on a DRG basis, building perhaps on the RAWP cross-boundary flows arrangements. This would be helpful to GPs and would also prevent hospitals, who were not currently geared up to set prices, from getting into difficulties.

ii. Ken Jarrold said that elective surgery represented a fairly small proportion of hospital activity. He had done some quick calculations which showed that core services accounted for 80% of Gloucestershire Health Authority's budget, while 54% of admissions to Gloucester DGH were emergencies. He thought that the White Paper proposals would transform the attitudes of NHS staff and the hospital working environment. However, he noted that hospitals' undertaking more work involved increased expenditure and pointed to the tensions between this and continuing cash limits.

iii. Michael Goldsmith mentioned the possibilities for GP budget holders to go into partnership with local employers in providing employee health care schemes. The GPs would provide the basic service for the workforce through the NHS with the employer paying for any top-up extras.

iv. Dr Donald Irvine thought that GP budgets would broaden patient choice and make for a more realistic discussion between GPs and patients about the options available. He noted that many patients were kept in the outpatient system long after there was any real need for them to make continued visits (the patients usually saw junior doctors doing their 6 month stint who did not have the authority or confidence to say that no further visits were necessary). Practice budgets would give GPs the incentive to tell consultants when patients were receiving unnecessary appointments.

v. Dr Meiri Scott took up this point. The waiting list could often be used as a 'dustbin': the patient did not really need a hospital visit but was referred simply to get him off the GP's back. She thought that cold medicine (outpatient appointments and hospital tests) was where the greatest waste was at present.

vi. Professor McColl said that self-governing hospitals would not focus on high technology elective surgery to the detriment of other services. For one thing market forces would prevent this: if too many hospitals specialised in the high-tec areas, prices would be driven down while reduction in the supply of the less glamorous services would increase prices here. He emphasised that self-government would not mean Guy's cutting itself off from the local community.

vii. Mr Mellor said that the White Paper proposals would involve a big investment in providing the NHS with an enhanced management capability. Over time the reforms would lead to savings which could be reallocated within the NHS. The Government wanted a better health service and was prepared to pay for it.

D P GRIFFITHS

CENTRE FOR POLICY STUDIES

8 Wilfred Street, London SW1E 6 PL. Tel: 01-828 1176

THE OUTCOME OF THE HEALTH REVIEW

WHITEHALL SUITE, ROYAL HORSEGUARDS HOTEL, WHITEHALL COURT, S W 1

Thursday 2nd February 1989

9.00 Coffee

9.30 Introduction - David Willetts.

9.40 **The Internal Market**
Ken Jarrold, District Manager, Gloucestershire Health Authority.

9.50 **A mixed economy for health care**
Dr Michael Goldsmith, CPS Research Fellow.

GP Budget holders

10.00 Dr Donald Irvine, GP, former Chairman of Royal College of General Practitioners.

10.10 Dr Meiri Scott, GP in Glasgow . 2 GP practice

Self-Governing Hospitals

10.20 Dr Gillian Todd, Unit Manager, Ransom Hospital, Notts.

10.30 Professor Ian McColl, Professor of Surgery, Guys Hospital.

10.40 **The Main Themes of the Review**
David Mellor, QC MP, Minister for Health.

11.00 Coffee

11.15 Questions and discussion

12.30 Drinks

BOARD OF DIRECTORS Lord Thomas of Swynnerton (Chairman) Sir Ronald Halstead (Hon Treasurer) Peter Bowring Jonathan Gestetner Professor Julius Gould Dr Richard Haas Professor R V Jones Oliver Knox (Director of Publications) Shirley Letwin Professor Kenneth Minogue Ferdinand Mount Sir Derek Palmar Cyril Taylor Charles Tidbury Dr George Urban Simon Webley David Willetts (Director of Studies)
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PUD

FROM: H PHILLIPS

DATE: 6 February 1989

COGPEC

cc PCC
Mr Saunders

NHS REVIEW

Now that the Government's White Paper, "Working for Patients" has been published (Cmnd 555) it may be worth drawing out for colleagues the main points of general interest to the Treasury. These are listed, with a brief commentary, below.

Value for Money

2. One of the main themes of the review was to improve systems for achieving better value for money. The new policy tackles this in a number of ways by

(a) pushing down delegated responsibilities and accountability;

(b) placing the weight of the new financing and management arrangements on new pricing mechanisms and service contracts, and therefore on budgetary control;

(c) engaging the professionals in resource management through their contracts and reward systems;

(d) better audit - the Audit Commission will replace the DoH's audit staff; and

(e) further developing market testing and contracting out.

3. These are obvious themes of Treasury policies, but some will break new ground in their practical application. They have a particular link with the development of Next Steps agencies, and

are especially relevant where expenditure programmes are driven in part by "professional" judgement into which it is difficult to probe.

Expenditure Control

4. Existing overall controls on NHS expenditure are retained. They are increased in relation to FPS drugs (hitherto treated as demand determined) by the adoption of cash limits - described as "firm budgets" in Cmnd 555 - at the regional level, and "indicative budgets" at the level of the GP. FPC's will be responsible for reining back overspending at local level, using peer review, and, where necessary financial penalties. Those large GP practices who opt to take direct budgetary responsibility for securing hospital services willhave their drugs expenditure included in the budget which will be cash limited at the local level.

Capital

5. The Government will introduce capital charges for the assets of hospitals managed by District Health authorities - this will be constructed on asset valuation and management accounts - and will have to be agreed with the Treasury. The general implications of this decision for other public services, and for central Government departments will be followed through in the work on capital assets (Sir Peter Middleton's minute to the Chancellor of 27 January).

6. The Government also propose to encourage self-governing Hospital Trusts within the NHS. They will begin life with an originating debt on which they will pay interest in the normal way. They will be outside the capital charging regime but will have to cover both interest and depreciation in pricing their services. They will be able to retain surpluses and to borrow from the Government or the private sector. Like public corporations (which they will be for statistical purposes) they will have EFL's. Their Government borrowing will be on vote, as the Treasury has proposed for Agency funds.

Private Sector Involvement

7. I mentioned market testing and contracting out in paragraph 2. Cmnd 555 also emphasises

(a) public/private sector sharing of facilities, and trading between them;

(b) a range of acceptable leasing arrangements; and

(c) the imaginative use of private sector skills - and sometimes financing - where the result is more cost-effective and quicker development of new and existing services.

The NHS Review has therefore helped to clarify areas where private sector and/or joint venture activity can take place without, so far, undermining the rules on private finance.

Pay and Conditions

8. A number of changes are envisaged in relation to pay regimes and conditions of service. They will be implemented progressively. All develop the Government's approach in the public sector of increasing flexibilities to deal with local labour market problems, and relating pay more closely to performance.

9. In addition to this general approach, self-governing Hospital Trusts will be free to settle the pay and conditions of their staff, including doctors, nurses and others covered by national pay review bodies. As far as most GPs are concerned basic practice allowances will form a much smaller proportion of remuneration than they do now in favour of pay more closely linked to numbers of patients.

Conclusion

10. Apart from any general Treasury interest there may be in these decisions it is conceivable that other departments will seize on some particular component of the Government's proposals and argue for similar treatment. Obviously we shall need to look at such arguments on their merits but you should bear in mind that the proposals for the NHS have been put together as part of a complete package - of controls and disciplines balanced with new delegated freedoms and flexibilities.

11. If arguments are presented by other departments praying in aid the proposals in Cmnd 555, please consult Mr Saunders about the detail and the context in which it is placed.

HP

HAYDEN PHILLIPS

week.6.2/m.7

FROM: H PHILLIPS
DATE: 7 February 1989

MR GRIFFITHS

cc PS/Chancellor - 2nd
PS/Chief Secretary
Mr Anson
Mrs Lomax
Miss Peirson
Mr Parsonage
Mr Saunders
Mr Sussex
Mr Walker - IR

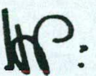
CENTRE FOR POLICY STUDIES SEMINAR ON THE OUTCOME OF THE NHS REVIEW

Thank you for your note of 2 February about this seminar which was obviously useful and reasonably well covered in the Press. It is clear that you and Mr Saunders managed to maintain an inscrutable silence.

2. Obviously there is going to be a build up of pressure for a Government announcement on community care but the Chief Secretary and Mr Clarke are well aware of this and work is in hand. (Incidentally I think I am right in saying that in some areas DHA's actually lead on community care. I wonder whether, on this subject, in addition to introducing a care-test to decide whether residential care is necessary in an individual case, we might allow, indeed encourage, a variety of arrangements for provision rather than a single blue-print for the country as a whole.)

3. The announcement about GP practice budgets has so far taken hold of public debate rather forcefully. The points made by Dr Irvine and Dr Scott are telling but without firm statistical backing are not going to be of much use to Ministers for the long haul of this debate.

4. Finally Professor McColl's reference to high technology surgery reminds me that we have yet to receive a reply to the Chancellor's letter on health technology assessment. Perhaps we could prompt DoH on this in a few days time.



HAYDEN PHILLIPS

7.2.89.2

CONFIDENTIAL

FROM: R B SAUNDERS

DATE: 7 February 1989

CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mrs Lomax
Miss Peirson
Mr Gieve
Mr MacAuslan
Mr Parsonage
Mr Richardson
Mr Griffiths
Mr Sussex
Mr Wellard
Mr Call

prop

NHS REVIEW WORKING PAPERS

We have now settled most of the outstanding points between us and Department of Health on these papers, save one, and they should be ready for publication next week (the latest report is that Mr Clarke will be holding a press conference on Monday). On some issues, we have agreed to defer final decisions. I attach (top copy only) my latest correspondence with the Department.

2. The greatest difficulties have been with the paper on the proposed capital charging system. The department have not made such good progress as we had hoped on working up the nuts and bolts of the scheme. There is likely to be an extended debate about the precise basis of valuation which, although technical, will significantly affect the sums of money involved. But of more immediate concern, the department have failed to come up with credible proposals on the implications of the scheme for the funding of health authorities. As a result, all references have been removed from the working paper, save for a promise to publish a further paper on funding later in the year.

3. The capital charges will be large in relation to health authority budgets - perhaps 15% or more. So mismatches between what an authority has to pay in respect of capital charges and how much extra money it is given will have significant effects on

CONFIDENTIAL

levels of service. In practice, the charges paid in different health authorities will vary quite widely, not least because new hospitals will have to pay significantly higher charges than old ones. So the transition to the new system will need to be very carefully worked out if unacceptable distortions are not to arise. (The response of the department to the emergence of such distortions will almost certainly be to bid for more money to buy them out.) Even in the longer term, this effect may give rise to difficulties - for example where a health authority has to face much higher charges because a new district general hospital has opened.

4. In working out ways of tackling these problems, we will need to ensure consistency with the approach which emerges from Mr Phillips' review of accounting for public sector assets more generally (Sir Peter Middleton's minute of 27 January to the Chancellor). We do not want decisions in relation to the NHS to pre-empt what we decide for the public sector more generally. And points may emerge in the course of our internal review which we want to see reflected in the system for the NHS.

5. Mr Freeman, who is the Department of Health Minister in the lead, is understandably anxious that the further working paper should not be too long delayed. He wants to promise it by the end of April. But, since Mr Phillips' review is not planned to finish until the middle of April, we think this is too tight, and we have suggested that a target date of end May would be more prudent. Mr Freeman or Mr Clarke may write to you on this timing issue.

6. No action is called for at this stage: this minute is simply to alert you to the problem should Department of Health Ministers seek to raise it with you informally beforehand.

Alex Reeves

pp R B SAUNDERS

pso.jt/Middleton/1.14.2

From: SIR PETER MIDDLETON

Date: 14 February 1989

CHANCELLOR

cc Chief Secretary
Financial Secretary
Paymaster General
Economic Secretary
Mr Anson
Sir T Burns
Mr Hardcastle
Mr Monck
Mr Phillips
Mr Byatt
Mrs Lomax
Mr Moore
Mr Riley
Mr Robson
Mr Spackman
Mr Grice
Mr Gieve

DISCOUNT RATES

You will remember that I submitted proposals on discount rates to you in August. You discussed these with us in October and you wrote to your colleagues with your conclusions on 23 November last.

2. Following your letter there has been concern in some departments that the use of a 6% discount rate for non-trading bodies, as opposed to an 8% RRR for trading bodies, would in some circumstances bias a choice unreasonably in favour of a public service rather than private sector proposal. I have discussed this matter at length with Permanent Secretaries and have persuaded them that, given our intention to ensure a rigorous risk analysis, and to secure higher benefits or lower costs when projects are relatively risky, they need have no fears on this account.

3. The way is now clear for the Government to announce the conclusions of the whole review. The most convenient way to do this would be in the form of an answer to an arranged Parliamentary Question. On past precedent this would fall to the Chief Secretary.

... 4. I enclose a draft answer to such a question. I do not think it will present any problems to your colleagues, since it has been cleared with Permanent Secretaries. There is, however, one point which we would like to raise with you. In the last sentence of the second paragraph the answer says that 8% would be a ceiling for public sector monopolies. This is a point to which you attached considerable significance. But there is a case for omitting this sentence in the Parliamentary Answer, although it would remain policy. The purpose of omitting it would be to avoid the risk that Ministers might be asked whether the 8% ceiling would apply to privatised monopolies. This would be an awkward fork. If the answer was no, it would fuel the criticism that privatisation will put prices up. If the answer was yes, it might damage privatisation proceeds and would be very difficult to enforce consistently.

5. There is in particular a problem in relation to the British Airports Authority which is currently earning a return of 9% in its CCA accounts. The American Government is proceeding against us on this on the grounds that the level of charges at British Airports, particularly Heathrow, where the rate of return is 10-11%, represent over charging. The current arbitration relates to the present and the past, possibly as far back as 1983. For much of it the RRR was set at 5% in real terms. To announce 8% as a ceiling could make the position more difficult.

P E MIDDLETON

DISCOUNT RATES

Draft Answer to Written PQ

The Government have reviewed the level and use of discount rates in the public sector. These were last reviewed in 1978. Since then the rate of return in the private sector has risen to over 11%.

2. In the light of this, the Government have decided to raise the required rate of return (RRR) for nationalised industries and public sector trading organisations from 5% to 8% in real terms before tax. The new RRR of 8% will be an important factor in setting new financial targets, but there will be no impact on pricing during the life of existing financial targets. [In the case of public sector monopolies, the 8% rate will be a ceiling.]

3. As at present, the choice of the discount rate to appraise individual projects is a matter for individual nationalised industries or trading bodies to decide in consultation with sponsor departments and the Treasury. The Government's main concern will continue to be that the industries approach should be compatible with achieving the RRR on the programme as a whole. In appraising whether or not new capital investment projects should be undertaken, proper attention will need to be paid to risk. The effect of full allowance for risk will often be implicitly equivalent to requiring a higher internal rate of return on riskier projects.

4. The Government have decided that the discount rate to be used in the non-trading part of the public sector should be based on the cost of capital for low risk purposes in the private sector. In current conditions this indicates a rate not less than 6% in real terms. Risk will be analysed separately and projects (and options) which are more risky will be required to demonstrate correspondingly lower costs or higher benefits.

5. These proposals will ensure that the appraisal of public projects will be no less demanding in the non-trading sector than

in the trading sector, both public and private. In particular, they will provide a comparable basis for the consideration of private participation in public sector activities by taking account of the full economic cost of the public sector option.

8 February 1989

DRAFT

FROM: Chief Secretary

TO: Foreign & Commonwealth Secretary

Copies: Ministers in charge of Departments

DISCOUNT RATES

The Chancellor minuted you on 23 November last following the Interdepartmental Review which has taken place on the level of discount rates in the public sector. I understand there have been discussions among Permanent Secretaries and our proposals are agreed.

2. I think we should announce our conclusions as soon as possible. I propose that we do this by way of an arranged Parliamentary Questions and Answer. I attach a draft. Can I assume you are content unless I hear from you by [Wednesday 22 February].

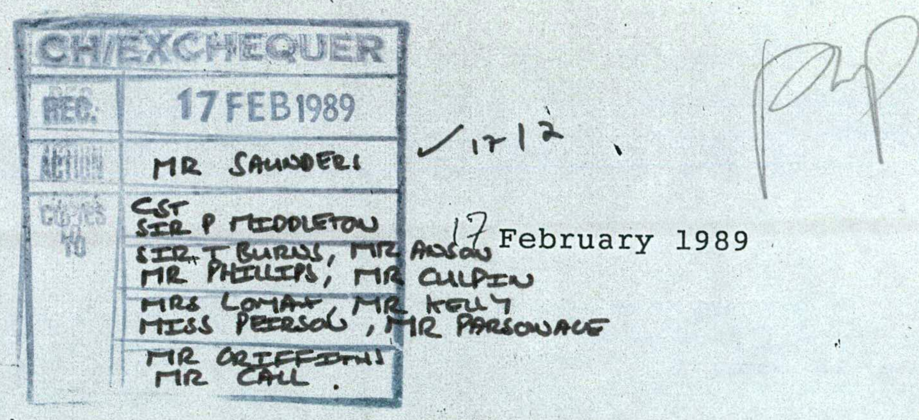
[3. I have omitted a sentence at the end of paragraph 2 of the version of the draft answer which was circulated to Permanent Secretaries. This stated that "in the case of public sector monopolies the 8% rate will be a ceiling". The Chancellor and I consider that this should indeed be the policy but that it is better to omit it from the answer. The aim of doing so is to avoid difficult questions about whether or not this ceiling applies to privatised monopolies, as well as damage to the UK case in the litigation by the US Government against charges at Heathrow and other BAA airports.]

4. My officials will be in touch with departments about the implementation of the new arrangements.

0845A

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health



CH/EXCHEQUER
REC. 17 FEB 1989
ACTION MR SAUNDERS
COPIES TO CST
SIR P MIDDLETON
SIR T BURNS, MR ANSON
MR PHILLIPS, MR CULPIN
MRS LOMAX, MR KELLY
MISS PEIRSON, MR PARSONAGE
MR GRIFFITHS
MR CALL

Mr Paul Gray
Private Secretary
10 Downing Street
LONDON SW1

17 February 1989

Dear Paul

NHS REVIEW: PUBLICATION OF THE WORKING PAPERS

I am writing to let you know that arrangements have now been made for the publication of the eight working papers setting out how the main proposals in the NHS Review White Paper will be implemented. The papers are:

Working Paper 1 - Self-Governing Hospitals
Working Paper 2 - Funding and Contracts for Hopsital Services
Working Paper 3 - Practice Budgets for General Medical Practitioners
Working Paper 4 - Indicative Prescribing Budgets for General Medical Practitioners
Working Paper 5 - Capital Charges
Working Paper 6 - Medical Audit
Working Paper 7 - NHS Consultants: Appointments, Contracts and Distinction Awards
Working Paper 8 - Implications for Family Practitioner Committees

The papers will be issued on Monday 20 February and the Secretary of State will hold a press conference at 11.30am on that day. Five sets of the papers are being sent to Regional, District and Family Practitioner Chairmen in England; copies of papers 2, 3 and 4 are being sent to every General Medical Practitioners in England. Arrangements have been made for copies of the papers to be placed in the Vote Office and the Printed Paper Office before the press announcement. Members of the Ministerial Group will receive a personal set of the papers on Monday.

E.R.

I am sending a copy of this letter to the Private Secretaries to the Chancellor of the Exchequer; to the Secretaries of State for Wales, Northern Ireland and Scotland; to the Lord President; to the Lord Privy Seal; to the Chief Secretary; to the Minister of State and Sir Roy Griffiths in this Department; and to Mr Whitehead at the No 10 Policy Unit and Mr Wilson at the Cabinet Office.

Yours

Andy

ANDY McKEON
Principal Private
Secretary

chex.ul/jt/17.2.7

FROM: J M G TAYLOR
DATE: 17 February 1989

PS/SIR PETER MIDDLETON

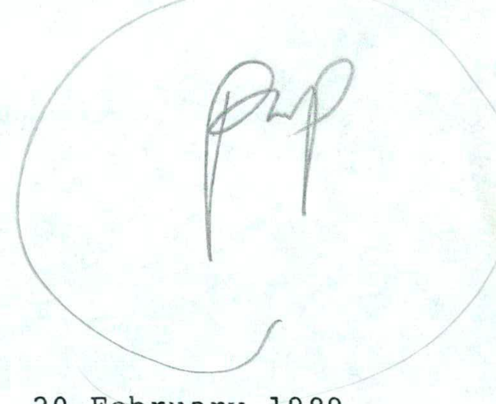
cc Chief Secretary
Financial Secretary
Paymaster General
Economic Secretary
Mr Anson
Sir Terence Burns
Mr Hardcastle
Mr Byatt
Mr Monck
Mr Phillips
Mrs Lomax
Mr Moore
Mr Riley
Mr Robson
Mr Spackman
Mr Grice
Mr Gieve

DISCOUNT RATES

The Chancellor was grateful for Sir Peter Middleton's note of 14 February.

2. He is content with the draft PQ (without the last sentence of the second paragraph, on the understanding that the policy remains that the 8 per cent rate will be a ceiling in the case of public sector monopolies).

J M G TAYLOR



10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

20 February 1989

Dear Andy,

NHS REVIEW: PUBLICATION OF THE WORKING PAPERS

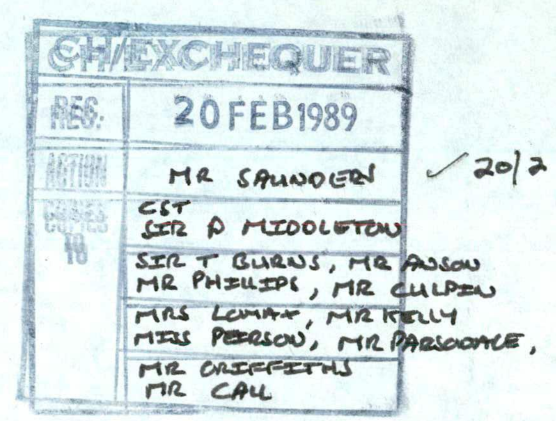
Thank you for your letter of 17 February, enclosing the final version of the eight working papers, which the Prime Minister has seen. She has commented that all concerned have clearly worked very hard in order to have the working papers ready for publication tomorrow.

I am copying this letter to the Alex Allan (HM Treasury), Stephen Leach (Northern Ireland Office), David Crawley (Scottish Office), Stephen Catling (Lord President's Office), Nick Gibbons (Lord Privy Seal's Office), Carys Evans (Chief Secretary's office), Malcolm Buckler (HM Treasury), Sir Roy Griffiths (DoH), and to Richard Wilson (Cabinet Office).

Yours,

Paul

Paul Gray



Andy McKeon Esq
Department of Health.

0868A

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

The Rt Hon John Major MP
Chief Secretary to the Treasury
HM Treasury
Parliament Street
LONDON SW1

CHIEF SECRETARY
REC. 21 FEB 1989
ACTION Mr Sanders
COPIES TO CX, Sir P Middleton, Mr Anson, Mr Phillips, Miss Peirson, Mr Lomax, Mr Griffiths, Mr Call

21 February 1989

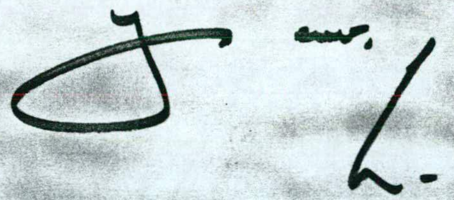
Dear John,

NHS REVIEW - WORKING PAPER ON CAPITAL CHARGES

I was concerned to hear that your officials asked for a very late amendment to the Capital Charges Working Paper to delete reference to the interest rate being that set for the non-trading part of the public sector. I understand that the policy previously agreed by officials - that the rate should be the non-trading rate for both the capital charging scheme in directly managed hospitals and for self-governing hospitals - is being reconsidered.

In order to get the paper out on time we reluctantly accepted the drafting point but this should not be taken to imply a change in our view on the substance. I will be pressed by authorities and others to give details of the rate as soon as possible and had earlier hoped that the Chancellor would have announced the new rates so that I could specify the rate itself (6%). I am anxious to avoid a further period of uncertainty for the NHS. I hope that you can now agree that the rate will be that for the non-trading public sector.

I believe that the 6% rate should apply both to capital charges and to self-governing hospitals. It is very important that we do not introduce distortions between the two sorts of hospitals. While self-governing hospitals may need to be classified as public corporations they will not be trading in any real sense as the majority of their transactions will continue to be within the NHS; it is clear to me that the rate of return earned by nationalised industries is not a relevant concept. The capital charging system will itself represent a major step towards greater comparability with private sector providers and I hope that we can settle the question of the rate of return accordingly.



KENNETH CLARKE

cst.ps/3jm23.2/lets

cc:
Chancellor
FST
PMG
EST
Sir Peter Middleton
Mr Anson
Sir Terence Burns
Mr Hardcastle
Mr Byatt
Mr Monck
Mr H Phillips
Mrs Lomax
Mr Moore
Mr Riley
Mr Robson
Mr Spackman
Mr Grice
Mr Gieve

Treasury Chambers, Parliament Street, SW1P

The Rt Hon Sir Geoffrey Howe QC MP
Secretary of State for Foreign Affairs
Foreign & Commonwealth Office
King Charles Street
London
SW1A 2AH

22nd February 1989

Dear Geoffrey,

DISCOUNT RATES

The Chancellor minuted you on 23 November last following the Interdepartmental Review which has taken place on the level of discount rates in the public sector. I understand there have been discussions among Permanent Secretaries and our proposals are agreed.

I think we should announce our conclusions as soon as possible. I propose that we do this by way of an arranged Parliamentary Question and Answer. I attach a draft. Can I assume you are content unless I hear from you by the end of the month?

I have omitted a sentence at the end of paragraph 2 of the version of the draft answer which was circulated to Permanent Secretaries. This stated that "in the case of public sector monopolies the 8 per cent rate will be a ceiling". The Chancellor and I consider that this should indeed be the policy but that it is better to omit it from the answer. The aim of doing so is to avoid difficult questions about whether or not this ceiling applies to privatised monopolies, as well as damage to the UK case in the litigation by the US Government against charges at Heathrow and other BAA airports.

My officials will be in touch with departments about the implementation of the new arrangements.

I am copying this letter to the Prime Minister, Ministers in charge of Departments and to Sir Robin Butler.

Yours Ever,
John

JOHN MAJOR

dcea.jh/Feb89/5.8

DISCOUNT RATES

Draft Answer to Written PQ

The Government have reviewed the level and use of discount rates in the public sector. These were last reviewed in 1978. Since then the rate of return in the private sector has risen to over 11%.

2. In the light of this, the Government have decided to raise the required rate of return (RRR) for nationalised industries and public sector trading organisations from 5% to 8% in real terms before tax. The new RRR of 8% will be an important factor in setting new financial targets, but there will be no impact on pricing during the life of existing financial targets.

3. As at present, the choice of the discount rate to appraise individual projects is a matter for individual nationalised industries or trading bodies to decide in consultation with sponsor departments and the Treasury. The Government's main concern will continue to be that the industries approach should be compatible with achieving the RRR on the programme as a whole. In appraising whether or not new capital investment projects should be undertaken, proper attention will need to be paid to risk. The effect of full allowance for risk will often be implicitly equivalent to requiring a higher internal rate of return on riskier projects.

4. The Government have decided that the discount rate to be used in the non-trading part of the public sector should be based on the cost of capital for low risk purposes in the private sector. In current conditions this indicates a rate not less than 6% in real terms. Risk will be analysed separately and projects (and options) which are more risky will be required to demonstrate correspondingly lower costs or higher benefits.

5. These proposals will ensure that the appraisal of public projects will be no less demanding in the non-trading sector than in the trading sector, both public and private. In particular,

they will provide a comparable basis for the consideration of private participation in public sector activities by taking account of the full economic cost of the public sector option.

21 February 1989

DEPARTMENT OF TRANSPORT
2 MARSHAM STREET LONDON SW1P 3EB
01 276 3000

My ref :

Your ref :

CH/EXCHEQUER
REC. - 1 MAR 1989
ACTION CST
COPIES TO

The Rt Hon John Major MP
Chief Secretary to the Treasury
HM Treasury
Treasury Chambers
Parliament Street
LONDON
SW1P 3AG

Dear John,

28 FEB 1989

DISCOUNT RATES

Your letter of 22 February to Sir Geoffrey Howe contained proposals for the announcement of the new public sector discount rates.

I am content with the draft Parliamentary Question and Answer which does not specify the discount rate for roads projects. To provide comparability of treatment between road and rail, I shall be changing the discount rate for roads projects from 7% to 8%; but I need to give consideration to the best timing for this, bearing in mind the effect the change would have on schemes at Public Inquiry, and other changes, such as revised traffic forecasts, which we expect to make soon. I shall aim to make an announcement as quickly as I can taking account of these considerations.

I am copying this letter to the Prime Minister, Ministers in charge of Departments and to Sir Robin Butler.

Yours,
Paul

PAUL CHANNON

0959A

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

The Rt Hon John Major MP
Chief Secretary to the Treasury
HM Treasury
Parliament Street
LONDON
SW1P 3AG

CHIEF SECRETARY	
REC.	-1 MAR 1989
ACTION	Mr Byatt
COPIES TO	CX, FST, PMG, EST, Sir P Middleton, Mr Anson, Sir T Burns, Mr Hardcastle, Mr Monck, Mr Phillips, Mrs Lomax, Mr Moore, Mr Riley, Mr Robson, Mr Spackman, Mr Greve, Mr Grice.

1 March 1989

Dear John,

DISCOUNT RATES

Your letter of 22 February on the above appears to have crossed with mine of 21 February on the question of the interest rates to be incorporated into the capital charging system to be introduced in the NHS. I understand that official discussion of the outcome of the Inter-Departmental Review of discount rates has been long and protracted and I do not wish to further delay a public announcement.

However, I am only willing to go along with the proposed public statement on two understandings. First that it is not inconsistent with the adoption of a 6% service charge for capital for both directly managed hospitals and for self-governing hospitals. Secondly that before the public statement is made we can agree on how the new regime is to be announced as applying to the NHS and especially the self-governing hospitals. The form of wording currently suggested by your officials is not satisfactory.

Yours ever,
Ken.

KENNETH CLARKE

mg2.cc/Sheath/91g6.3.1

CONFIDENTIAL

FROM: R L SHEATH
DATE: 2 March 1989

1. MR GRICE

2. ECONOMIC SECRETARY

cc PS/Chancellor
Sir P Middleton
Sir T Burns
Mr Wicks
Mr Scholar
Mr Odling-Smee
Mr Peretz
Mr Riley
Mr Sedgwick
Mr Gieve
Miss O'Mara
Mr Bush
Mr Brooks
Mr Pike
Ms Ryding

File: MAMC C9

Apart from postal strike effects, the abnormally low bankers' balances are also affecting the growth rates. The underlying increase in notes and coin - £23 mn - is a better guide and is unremarkable.

JWG 2.3.89

Please cc Mr Gray @ No 10 & pup

M0 FIGURES

The latest weekly figures, covering the first week in March are attached. They show that the 12 month rate of growth of M0 in the latest 4 week period was 6.5 per cent in both seasonally adjusted and unadjusted terms. The 12 month growth rate of increase of notes and coin over the same period was 6.5 per cent (also 6.5 per cent nsa).

2. The six month growth rates in March are seriously distorted downwards by September's postal strike.

R L SHEATH

TABLE 17 CONFIDENTIAL (Until Publication)

M0 : THE WIDE MONETARY BASE

Monthly data	Level £ million (Change in brackets)							% change on previous month		3 month % growth annualised		6 month % growth annualised		Percentage change on previous year			
	Notes and Coin (nsa)	Notes and Coin (sa)		Bankers' Deposits	M0 (nsa)	M0 (sa)		Notes & Coin (sa)	M0 (sa)	Notes & Coin (sa)	M0 (sa)	Notes & Coin (sa)	M0 (sa)	Notes and Coin (nsa)	Notes and Coin (sa)	M0 (nsa)	M0 (sa)
1988 January	15457	15615	(-37)	181	15638	15796	(-42)	-0.2	-0.3	4.0	3.4	6.0	5.2	4.7	4.5	4.8	4.6
February	15352	15660	(45)	124	15476	15783	(-13)	0.3	-0.1	3.6	2.1	5.3	4.4	5.7	5.7	5.3	5.3
March	15588	15756	(96)	163	15751	15919	(136)	0.6	0.9	2.7	2.0	5.0	4.7	6.9	6.3	6.4	5.8
April	15796	15801	(45)	229	16025	16030	(111)	0.3	0.7	4.9	6.1	4.4	4.7	5.9	6.0	5.9	6.1
May	15870	15969	(168)	178	16048	16147	(117)	1.1	0.7	8.1	9.5	5.8	5.7	6.0	6.6	5.7	6.4
June	16073	16140	(171)	174	16247	16314	(167)	1.1	1.0	10.1	10.3	6.3	6.1	7.5	7.1	7.7	7.3
July	16411	16273	(133)	188	16599	16461	(147)	0.8	0.9	12.5	11.2	8.6	8.6	7.5	7.3	7.0	6.9
August	16577	16462	(189)	156	16733	16618	(157)	1.2	1.0	12.9	12.2	10.5	10.9	8.1	7.9	7.8	7.6
September	16629	16711	(249)	164	16793	16874	(256)	1.5	1.5	14.9	14.5	12.5	12.4	8.3	8.7	8.1	8.5
October	16506	16677	(-34)	186	16691	16863	(-11)	-0.2	-0.1	10.3	10.1	11.4	10.7	7.9	7.9	7.7	7.7
November	16606	16739	(62)	166	16772	16905	(42)	0.4	0.2	6.9	7.1	9.9	9.6	8.1	7.8	7.9	7.7
December	17867	16893	(154)	173	18039	17066	(161)	0.9	0.9	4.4	4.6	9.5	9.4	8.6	7.9	8.5	7.7
1989 January	16746	16805	(-88)	155	16901	16960	(-106)	-0.5	-0.6	3.1	2.3	6.6	6.1	8.3	7.6	8.1	7.4
February	16354	16684	(-121)	152	16507	16836	(-124)	-0.7	-0.7	-1.3	-1.6	2.7	2.6	6.5	6.5	6.7	6.7
March (1/4) @	16410	16693	(9)	76	16486	16769	(-67)	0.1	-0.4	-4.7	-6.8	-0.2	-1.2	5.3	5.9	6.5	6.5
Latest 4 weeks @	16367	16689	(-79)	147	16514	16836	(-69)	-0.5	-0.4	-1.5	-1.9	2.5	2.6	6.5	6.5	6.5	6.5

Weekly data	Level £ million (Change in brackets)						Percentage change on previous week	Percentage change on previous year			
	Notes and Coin (u/a)	Notes and Coin (s/a)	(s/a)	Bankers' Deposits	M0 (sa)		M0 (sa)	Notes and Coin (nsa)	Notes and Coin (sa)	M0 (nsa)	M0 (sa)
January											
4th	17375	16819	(-133)	170	16989	(-193)	-1.1	10.1	7.9	9.4	7.3
11th	16697	16786	(-33)	178	16964	(-25)	-0.1	8.1	7.6	8.0	7.5
18th	16503	16843	(57)	124	16967	(3)	0.0	7.9	7.7	7.7	7.5
25th	16407	16771	(-72)	149	16920	(-47)	-0.3	7.2	7.3	7.2	7.2
February											
1st	16361	16672	(-99)	96	16768	(-152)	-0.9	6.7	6.7	7.0	7.0
8th	16353	16693	(21)	173	16866	(98)	0.6	6.6	6.6	6.5	6.5
15th	16359	16700	(7)	184	16884	(18)	0.1	6.6	6.5	6.8	6.7
22nd	16344	16670	(-30)	156	16826	(-58)	-0.3	6.3	6.3	6.4	6.5
March											
1st	16410	16693	(23)	76	16769	(-57)	-0.3	6.4	6.4	6.2	6.2

@ Weekly data for the current month so far include estimates for the unbacked note issue. The latest week also includes an estimate for coin.
The changes for the current month so far use as a base the previous full month a year ago.
The latest four week changes use as a base the four week averaged level four, thirteen, twenty-six and fifty-two weeks ago.

st.ln/dra/mh/1.3

CONFIDENTIAL

AWP

FROM: MISS M E PEIRSON

DATE: 3 MARCH 1989

CHIEF SECRETARY

cc Chancellor
Sir Peter Middleton
Mr Anson
Mr Phillips o/r
Mr Burgner
Mrs Case
Mrs Lomax
Mr Luce
Mr Moore
Mr Spackman
Mr Gieve
Mr Parsonage
Mr Saunders
Mr Welsh

opp
CST of 22/2

DISCOUNT RATE: NHS

1. Mr Clarke has written to you (1 March) saying he is only willing to go along with the proposed public statement on discount rates if he can say that 6 per cent is to be used both for the cost of capital in the new capital charging system for the NHS generally, and for the required rate of return on capital for the self-governing hospitals. (Taken by itself, his letter is not absolutely clear on what he is after. But taken with his earlier letter of 21 February, copy also attached, the message is clear.)

2. We have been considering within the Treasury the appropriate financial target for the self-governing hospitals, and are now ready to advise that 6 per cent should be adopted, at least initially (see below). If you agree, you may like to reply to Mr Clarke accordingly, and clear the way for the statement on discount rates. I attach a draft.

Discussion

3. When the NHS Capital Charges Working Paper was being prepared, we asked DH to omit certain words which would have prejudiced this decision. Hence Mr Clarke's letter of

21 February, and his further letter now. We simply wanted more time to consider the matter, which we have now done.

4. One of our concerns was that, if 6 per cent were announced as the cost of capital for the capital charging regime, and nothing were said about the financial target for the self-governing hospitals, the inference would be drawn that the latter would also be 6 per cent, and it would be extremely difficult to change that later. But if we accepted (explicitly or implicitly) a 6 per cent financial target for the self-governing hospitals, we thought that might prejudice the position on other activities within the public sector, notably "Next Steps" Agency funds.

5. We have now considered the arguments with others concerned in the Treasury, and have concluded as follows:-

i) 8 per cent is appropriate as an average rate of return required on the capital of a freely trading and marketing activity. But 6 per cent is appropriate where the aim is cost recovery.

ii) Agency funds are likely to cover a very wide spectrum of activities, and the appropriate financial targets for them will vary from 6 per cent to 8 per cent or more.

iii) Initially at least, cost recovery would be the appropriate concept for self-governing hospitals. We should therefore agree to 6 per cent now, but leave open the possibility that a higher rate of return would be required if and when the free market in hospital services becomes significant.

6. Examples of the variety of Agency funds are as follows. At one end of the spectrum there are real trading funds, such as HMSO and the Royal Mint, which have been given targets of 8 per cent and 10 per cent respectively. At the other end of the spectrum are licence-type operations, such as the Passport Office when that becomes an Agency, where charges must be constrained to costs to avoid the accusation that the charge is really a tax, and which

are likely therefore to be given a 6 per cent, cost recovery, regime.

7. In between there are operations such as the various Government research establishments. We are currently exploring ideas for the creation of an internal market in which the establishments would have to compete with one another and the private sector for Government work. But there are and would be constraints on the extent to which those establishments could freely market their activities in the private sector. This could point to a cost recovery target of 6 per cent (in line with the likely approach to market testing and contracting out) although 8 per cent may be appropriate in some cases.

8. The self-governing hospitals will at first be very largely monopolies. Pricing their services to earn a profit above cost does not seem appropriate at this stage, especially since the tax payer will be meeting almost all the bill. We would certainly want them to surrender any profit above the cost of actual borrowing. And the private sector analogues do not suggest that 8 per cent is necessary: the profit making private sector is not for the most part providing a comparable mix of services, and the charity sector is non-profit-making.

9. However, the freely trading market in hospital services could well develop significantly; and if and when it becomes big enough we might want to apply the same sort of financial target as for the public enterprises. We therefore recommend leaving the way open for that, especially so that we do not prejudice the position for Agency and other funds.

<u>Conclusion</u>

10. We recommend that you accept 6 per cent as the cost of capital for all NHS hospitals, and for the required rate of return for self-governing hospitals, and that you write to Mr Clarke to say so. Draft attached.

MEP

MISS M E PEIRSON

Encs.

st.ln/dra/mh/2.3

CONFIDENTIAL

DRAFT LETTER TO MR CLARKE

DISCOUNT RATES AND THE NHS

1. Thank you for your letters of 21 February and 1 March. In the very hasty preparation of the Working Paper on Capital Charges, my officials did not want to include words which might prejudice decisions which had not yet been taken. However, I have now considered the matter and am ready to agree that, when the statement on discount rates and required rates of return is made, you should announce that 6 per cent will be used as the discount rate for investment appraisal in the NHS, as the cost of capital in the new capital charging regime, and (initially at least) as the required rate of return for self-governing hospitals.

2. As regards the last point, I take the view that initially the financial target for self-governing hospitals should be based on cost recovery. The tax payer will continue to foot the bill for most of their services. It would therefore be inappropriate to require them to make a profit in excess of the cost of capital. But if as we hope the mixed market in hospital services develops significantly, we may well want to change the regime for these hospitals to bring them into line with other freely trading enterprises.

3. I hope you can agree to the above approach.

0959A
5/2/3

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~XXXXXXXXXX~~ Health

The Rt Hon John Major MP
Chief Secretary to the Treasury
HM Treasury
Parliament Street
LONDON
SW1P 3AG

CHIEF SECRETARY	
REC.	- 1 [illegible]
ACTION	Mr Byatt
COPIES TO	CX, FST, PMG, EST, Sir P Middleton, Mr Anson, Sir T Burns, Mr Hardcastle, Mr Monck, Mr Phillips, Mrs Lomax, Mr Moore, Mr Riley, Mr Robson, Mr Spackman, Mr Gieve, Mr Grice.

1 March 1989

Dear John,

2

DISCOUNT RATES

Your letter of 22 February on the above appears to have crossed with mine of 21 February on the question of the interest rates to be incorporated into the capital charging system to be introduced in the NHS. I understand that official discussion of the outcome of the Inter-Departmental Review of discount rates has been long and protracted and I do not wish to further delay a public announcement.

However, I am only willing to go along with the proposed public statement on two understandings. First that it is not inconsistent with the adoption of a 6% service charge for capital for both directly managed hospitals and for self-governing hospitals. Secondly that before the public statement is made we can agree on how the new regime is to be announced as applying to the NHS and especially the self-governing hospitals. The form of wording currently suggested by your officials is not satisfactory.

Yours ever,
K.

KENNETH CLARKE

Miss Pierson
Could we have a word about this pl?
RB
2 iii

65/3

1 MAR '89 19:47 FROM S OF S (HEALTH) PAGE.002

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~XXXXXXXXXX~~ Health

The Rt Hon John Major MP
Chief Secretary to the Treasury
HM Treasury
Parliament Street
LONDON SW1

CHIEF SECRETARY
REC. 21 FEB 1989
ACTION Mr Sanders
COPIES TO CX, Sir P Middleton, Mr Anson, Miss Peirson, Mr Phillips, Miss Pierson, Mrs Lomax, Mr Griffiths, Mr Call

21 February 1989

Dear John,

NHS REVIEW - WORKING PAPER ON CAPITAL CHARGES

I was concerned to hear that your officials asked for a very late amendment to the Capital Charges Working Paper to delete reference to the interest rate being that set for the non-trading part of the public sector. I understand that the policy previously agreed by officials - that the rate should be the non-trading rate for both the capital charging scheme in directly managed hospitals and for self-governing hospitals - is being reconsidered.

In order to get the paper out on time we reluctantly accepted the drafting point but this should not be taken to imply a change in our view on the substance. I will be pressed by authorities and others to give details of the rate as soon as possible and had earlier hoped that the Chancellor would have announced the new rates so that I could specify the rate itself (6%). I am anxious to avoid a further period of uncertainty for the NHS. I hope that you can now agree that the rate will be that for the non-trading public sector.

I believe that the 6% rate should apply both to capital charges and to self-governing hospitals. It is very important that we do not introduce distortions between the two sorts of hospitals. While self-governing hospitals may need to be classified as public corporations they will not be trading in any real sense as the majority of their transactions will continue to be within the NHS; it is clear to me that the rate of return earned by nationalised industries is not a relevant concept. The capital charging system will itself represent a major step towards greater comparability with private sector providers and I hope that we can settle the question of the rate of return accordingly.

Yours ever,

Ken

KENNETH CLARKE

cc Mr Parsonage, Mr Sussex
Mr Griffiths
Pl. prepare a draft reply in consultation with Mr Parsonage
RB 21/2

298/2

cst.ps/2jm6.3/drfts

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Treasury Chambers, Parliament Street, SW1

cc:
Chancellor
Sir Peter Middleton
Mr Anson
Mr Phillips
Mr Burgner
Mrs Case
Mrs Lomax
Miss Peirson
Mr Luce
Mr Moore
Mr Spackman
Mr Gieve
Mr Parsonage
Mr Saunders
Mr Welsh

The Rt Hon Kenneth Clarke QC MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

PWP

6 March 1989

Dear Secretary of State

DISCOUNT RATES AND THE NHS

Thank you for your letters of 21 February and 1 March. In the very hasty preparation of the Working Paper on Capital Charges, my officials did not want to include words which might prejudice decisions which had not yet been taken. However, I have now considered the matter and am ready to agree that, when the statement on discount rates and required rates of return is made, you should announce that 6 per cent will be used as the discount rate for investment appraisal in the NHS, as the cost of capital in the new capital charging regime, and (initially at least) as the required rate of return for self-governing hospitals.

As regards the last point, I take the view that initially the financial target for self-governing hospitals should be based on cost recovery. The tax payer will continue to foot the bill for most of their services. It would therefore be inappropriate to require them to make a profit in excess of the cost of capital. But if as we hope the mixed market in hospital services develops significantly, we may well want to change the regime for these hospitals to bring them into line with other freely trading enterprises.

I hope you can agree to the above approach.

Yours sincerely
Carys Evans

JOHN MAJOR

approved by the Chief Secretary
and signed in his absence

1047A

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

The Rt Hon John Major MP
Chief Secretary to the Treasury
HM Treasury
Parliament Street
LONDON
SW1P 3AG

13 March 1989

CHIEF SECRETARY
REC.
Miss Peirson,
Sir P Middleton, Mr Anson, Mr Phillips
Mr Burgner, Mrs Case, Mrs Lomax, Mr Luce,
Mr Moore, Mr Spackman, Mr Grieve
Mr Parsonage, Mr Saunders, Mr Welsh

Dear John,

DISCOUNT RATES AND THE NHS

Thank you for your letter of 6 March. I was pleased to note that you are able to agree the use of 6% as the discount rate for investment appraisal in the NHS, as the cost of capital in the new capital charging regime and as the required rate of return for self-governing hospitals.

I note your view that the financial target for self-governing hospitals should be based on cost recovery, including the cost of capital. My officials are awaiting from yours further details of the financial regime for self-governing hospitals and I think that we should settle the question of the financial target in that broader context.

Yours ever,

Ken

KENNETH CLARKE

Mike

Are you going to keep this or am I?

Jood

12/34 2.13.4.89

CONFIDENTIAL

FROM: R B SAUNDERS (ST2)

DATE: 13 April 1989
x 4800

I agree with these proposals, for which the DoH are pressing. They have already asked me for "flexibility" in our proposals; so I expect I shall need to take a meeting with them before Mr Clarke turns to you.

HP. 13/4

1. MR PHILLIPS

2. CHIEF SECRETARY

Copies attached for:

Chancellor
Financial Secretary
Paymaster General
Economic Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Dame A Mueller
Mr Wicks
Mrs Chaplin
Mr Tyrie
Mr Call

cc Mr Byatt
Mr Monck
Mr Scholar
Mr Beastall
Mr Harris
Mr Kelly
Mrs Lomax
Mr Luce
Miss Peirson
Mr Peretz
Mr Spackman
Mr P Rayner
Mr L Watts
Mr Houston
Mr Inglis
Mr Devereux
Mr Griffiths

NHS REVIEW: FINANCIAL REGIME FOR SELF-GOVERNING HOSPITALS

We have for some time now been working up a paper for Department of Health on the detailed financial framework for self-governing hospitals. I attach the result, which has been agreed within the Treasury. The next stage is to send it to Department of Health at official level.

2. The paper is intended to be a basis both for preparing instructions to Parliamentary Counsel and for offering further detailed advice to hospitals about what self-governing status means. It is based largely on the rules under which public corporations, including Government trading funds, now operate and the forthcoming Treasury legislation on agency funds. That legislation will be going through Parliament at the same time as the Health Services Bill, and it will be important to ensure that the two are kept consistent.

3. In a sense, therefore, the document is a technical one. But it can nonetheless be expected to create difficulties with Department of Health. Mr Clarke is likely to contest the restrictions on borrowing from, and depositing money with, the

private sector set out in paragraphs 10 and 11. Their effect in practice will be to restrict direct borrowing from the private sector to bank overdrafts only, since private sources will not be able to match the NLF-type interest rates which the hospitals will be able to secure under voted loans. These simply reflect the rules which are applied to nationalised industries, and self-governing hospitals will be better off than most public corporations (including trading funds) in having the power to borrow privately at all. Any argument by Mr Clarke that this goes back on the agreement reached in the discussions leading up to the White Paper should be firmly resisted.

4. Mr Clarke may also be unhappy with the extent of the reserve powers proposed in paragraphs 19-24. A general power of intervention (paragraph 21) is normal for any public body. Murphy's law indicates that if such powers are not taken they will become necessary in particular cases quite quickly. The existence of ultimate powers of control will underline that the hospitals are firmly in the public sector, notwithstanding the likely Opposition attack that they are being set up for privatisation. (The same argument applies, incidentally, to the restrictions proposed on the exercise of borrowing powers.)

5. The proposed powers over pay and prices (paragraphs 22 and 23) are necessary to respond to already perceived problems. Pay are particularly anxious that we should not be without a reserve power to control pay if self-governing status led to a pay bonanza without concomitant improvements in efficiency.

6. The initial capital structure of the hospitals is an important issue. We have opted in the end for a conventional solution for new public corporations: NLF-type debt fixed in nominal terms and equal to the value of the assets at the date of vesting, with the additional possibility (as with trading funds) of public dividend capital either initially or later. Paragraph 5 of the paper discusses the problem of front end loading: initially at least, interest on the commencing debt will exceed the public sector cost of capital, which we have agreed is the appropriate target rate of return for self-governing hospitals. Clearly we do

not want the hospitals to be loss-making initially, and two possible ways of dealing with this are suggested: deferring and rolling up some interest payments in the early years, or subscribing part of the capital initially or later in the form of PDC. So long as Department of Health follow the two legislative precedents cited, these will both be available in individual cases. Department of Health may however be reluctant to consider PDC initially, since setting the hospitals up with some equity capital may be interpreted as a precursor to privatisation. We can discuss this further with them.

7. I should be grateful for your approval for our sending this paper now to the Department.

R B SAUNDERS

FINANCIAL REGIME FOR SELF-GOVERNING HOSPITALS (NHS HOSPITAL TRUSTS)

Introduction

This paper sets out the detailed proposals for the financial framework for these hospitals and is intended to form the basis for Instructions to Counsel to draw up the necessary legislative provisions.

2. The most useful analogues for the legislation are the Government Trading Funds Act 1973 (GTFA) and the paper cites relevant precedents from this and other legislation. The 1989-90 legislative programme will contain a Bill to extend the GTFA to cover certain types of Next Steps Agency presently outside its scope. Many of the powers to be sought in this Bill will be similar to those proposed in respect of self-governing hospitals and close consultation should be maintained in drawing up the two sets of legislation.

Originating Debt

3. On establishment each self-governing hospital will have its assets vested in its Hospital Trust and be given an originating debt equal to the value of those assets. The basis of initial asset valuation will be the same as used in the capital charging scheme for health authority-managed hospitals.

4. The commencing capital debt will be in the form and on the terms laid down by the Secretary of State with the approval of the Treasury. The debt will be deemed to have been issued out of Voted loans but the terms would be expected to be in line with those for comparable loans from the National Loans Fund. As with Trading Funds, the Government would have the power to determine how and when the loans were repaid, including the power to require early repayment of loans in whole or part (pre-payments would involve premium or discount as appropriate) and to set the interest rate on the loan (see Section 2 of the GTFA). The Government will also have the power to subscribe public dividend capital (PDC) - see Section 2 of the GTFA - and to determine the dividend payable.

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5. In the early years it is possible that nominal interest on debt may exceed the return required to meet the financial target (paragraph 7 below), so that the hospitals would be in deficit. There are two possible ways of avoiding this. First, they could be allowed, with the approval of the Treasury, to defer interest payments on all or part of the loan, with deferred interest payments added to the principal. A power to this effect should be included in the legislation: see, for example, section 2 of the Coal Industry Act 1980. Second, some of the initial capital might take the form of PDC with a lower dividend payable in the early years. What arrangements to adopt in practice should be considered case-by-case; the legislation should allow both possibilities.

6. All dividend and debt interest payments will be made to the Consolidated Fund but repayments of principal will be appropriated in aid.

Financial Target

7. Each self-governing hospital will be legally required to achieve a specified return (before interest) on all the capital it employs. The Government will need powers to determine the financial target and to ensure that it is met. The fixed asset element of capital employed will be professionally revalued every third year and adjusted by appropriate indices in the intervening years. The reserves generated from these asset revaluations will be recapitalised. The target rate of return should be the same as the interest rate adopted in the capital charging regime for health authority-managed hospitals (6% real terms).

8. The return made by the hospital could be in the form of payments to the Government, such as interest payments, repayment of loan principal (including early repayment where appropriate) or dividend on PDC. The return may also be in the form of increased investment in new assets or working capital. The Government should have the power to extract surpluses (excess of revenue over outgoings) made in any accounting year and to direct that the whole or part of the reserves of a self-governing hospital are paid into the Consolidated Fund. There are precedents for these powers in the GTFA.

Treatment of subsequent loans

9. Self-governing hospitals will be allowed to borrow, subject to an annual financing limit, from voted funds and/or from the private sector. Short term loans for cash flow management would also be permissible. In either case the hospitals will repay the principal as well as meeting interest charges. Loans from voted funds shall be on such terms as the Government specify. (An appropriate form of words may be found in Clauses 24(1) and 24(3) of the Water Bill, although the context is not exactly the same.) As with the commencing capital debt, payments of interest on voted loans would be made to the Consolidated Fund with loan repayments appropriated in aid.

10. In conformity with normal policy concerning public bodies, all loans to self-governing hospitals from the private sector would be guaranteed by the Government so that the hospitals can obtain the finest possible terms. In particular, self-governing hospitals would be eligible for guaranteed overdraft facilities with commercial banks to meet their very short-term financing requirements. A specific power to issue such guarantees would have to be taken, as in, for example Clauses 78(2) and 170 of the Water Bill. As with every other public sector body, borrowing from the private sector would be allowed only where the hospital could obtain better terms than the Government obtains by borrowing in its own name. Equally, uncovered foreign currency borrowing should not normally be undertaken, unless there was an appropriate stream of foreign currency income with which to service the debt. These provisions would be enforced administratively rather than statutorily.

11. Self-governing hospitals should not be able to borrow from voted funds at preferential terms and place the monies on deposit with the private sector at a higher rate of interest. The hospitals should not therefore borrow in advance of need and all deposits will be required to be made with the public sector (see Section 4 GTFA), eg Government securities, local authority bonds, the National Loans Fund and other public sector bodies. The hospitals will be able to maintain current accounts with commercial banks but money should not be left on deposit as a matter of course. The legislation will have to include provision for specifying the ways in which liquid assets may be held.

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Borrowing Limits

12. As with other public corporations, the legislation establishing self-governing hospitals will need to specify a limit on the net borrowing of the sector as a whole (including the total originating debt). This limit could be raised by statutory instrument up to a maximum specified in the legislation. If it were necessary to raise the limit beyond this level, further primary legislation would be required. The statutory limit would be set in cash terms based on an estimate of the likely number of self-governing hospitals and their likely indebtedness.

Annual Financing Limits

13. Like any public corporation, each self-governing hospital will be subject to an annual external financing limit. (This would not necessarily constrain the level of a hospital's borrowing during the course of the year, although there would be separate limits on temporary borrowing.) The annual financing limit would cover any subsidy or grant to the hospitals (though these are not envisaged), net lending to them by government, and any market borrowing. Repayments of loan principal count as negative external finance, but payments of interest, dividends or surrenders of surplus do not form part of external finance. Market and overseas borrowing includes certain leases as well as movements in cash, bank balances and other liquid assets (though there is scope for treating some of these movements as part of their working capital rather than external finance). Payments to the hospitals by district health authorities would not score as external finance but as central government's own expenditure.

14. Each year as part of their rolling three year business plans presented to the Department of Health self-governing hospitals will submit bids for any external financing requirements - in broad terms, the difference between their capital requirements and the net funds generated by the business. The Department will examine the business plans and scrutinise the bids. As the number of self-governing hospitals grows, the Department would look increasingly to RHAs to undertake detailed scrutiny of proposals.

15. The Department would then determine what EFL it wished to seek in the Public Expenditure Survey for the self-governing hospital sector as a whole. In submitting their bid for the overall EFL the Department would have to specify its detailed make-up, and provide the necessary information on all major investment proposals. Copies of the business plans will be supplied to the Treasury. The EFL will then be settled in the normal manner in the Survey. It would then be for the Department to allocate an annual financing limit to each individual hospital, subject to any restrictions agreed with the Treasury.

Brokerage

16. Hospitals may find that they do not need to borrow up to their limit or may repay loans early. Equally, although the hospitals will be expected to keep within their annual financing limits, some may need more resources. The Department should therefore make in-year adjustment of these limits as appropriate and organise brokerage facilities to avoid there being any breach of the overall EFL. If a hospital does breach its annual financing limit, its limit for the following year will be reduced by the amount of the excess.

Leasing and Private Finance

17. Self-governing hospitals will be able to undertake leasing transactions. These will score against their annual financing limits (unless they are genuine operating leases) and will be capitalised for the purposes of calculating the current cost of assets employed. The usual rules will apply in respect of private finance projects with adjustments being made as required to individual annual financing limits and the overall EFL for the self-governing hospitals sector.

Financial and Other Targets

18. Powers should be taken to set other targets in addition to a financial return. One such target could be reductions in unit costs. It is important that there should be a common framework of targets covering the self-governing and health authority managed hospital sectors so that performance can be compared.

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Reserve Powers

19. The Secretary of State will have powers to withdraw self-governing status and to dismiss all or any of the board of directors. However, he will also require various 'intermediate' reserve powers to intervene to prevent or stop a hospital:

(i) acting outside its powers (eg entering into a contract which is ultra vires);

(ii) acting imprudently (eg embarking upon an over-ambitious capital expenditure scheme or disposing of assets below value or any other action which would jeopardise the financial viability of the hospital, involve an unacceptable liability to the taxpayer or otherwise run counter to the normal rules of propriety governing the actions of public bodies).

(iii) acting 'anti-competitively' or against the local interest (eg if it over-prices in relation to the rest of the NHS in circumstances where there is insufficient alternative capacity available within reasonably easy reach of the locality).

(iv) abusing its freedom to set the pay and conditions of its staff.

The Secretary of State must also have the power to ensure that a self-governing hospital continues to provide essential core services to the local population where no alternative provision exists. This would need to cover the power to prevent the disposal of an asset or withdrawal from the provision of a service where this would have a deleterious effect on the provision of health care within the locality.

20. As regards the first category, it has been suggested that the Audit Commission should have a general 'stop' power for the NHS as it has in relation to local authorities. However, the extent of this power is unclear. Nor is it the intention that the Audit Commission should act as the Secretary of State's agent in supervising the hospitals. Since the Secretary of State is answerable to Parliament for the activities of these hospitals, he will therefore require a power of his own.

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21. There would be a general power of direction, encompassing both (i) and (ii) above, to be exercised if the Secretary of State considered that a hospital was pursuing or intending to pursue a course of action which appeared to him to be outside its powers or to involve imprudent application of public funds or imprudent assumption of actual or contingent liabilities. The power would enable him to direct that a hospital to take a particular course of action or desist from any specified action. We clearly cannot prescribe all the circumstances in which this power might be used. It should therefore be widely drawn, bearing in mind that they will need to be enforceable. The usual 'Government Accounting' rules would apply in respect of asset disposals.

22. In the case of a hospital acting anti-competitively or against the local interest, the Secretary of State will need a power to direct what specific prices it should charge under particular contracts, allied if necessary with use of the power to direct what specific services it should supply to ensure a full range of services for local patients. In view of these powers of direction and since both the Audit Commission and the National Audit Office will have the right to carry out value for money studies of self-governing hospitals' activities, it is proposed that the sector should be excluded from competition legislation. [DTI will need to be consulted on this point.]

23. A separate power of direction is needed over pay and conditions since there may be cases where abuse of freedom does not entail a significant financial liability or over-pricing of services. The Secretary of State would need the power to direct that a hospital adjusted the pay and conditions of any or all of its staff as he specified. See also paragraph 27 below.

24. The Secretary of State's power to require the repayment of loans or commencing capital debt, plus any premium judged necessary, might need to be invoked to recover the proceeds of the disposal of assets.

Monitoring

25. Hospitals will produce business plans and annual accounts. There will be monthly monitoring on similar lines to the Nationalised Industries Financial Information System. In addition, hospitals would be required to report to the Department any transaction involving the acquisition or disposal of assets above a given figure. To this end there will need to be a statutory duty to supply the Secretary of State with such information as he may require - see for example section 17 of the Civil Aviation Act 1982.

Accounts and Audit

26. Each self-governing hospital will keep proper accounts and other financial records and will prepare an annual statement of accounts. The form, contents and principles of these accounts will be as laid down by the Government. The accounts will be audited by the Audit Commission and the audited statement of accounts will be transmitted to the Secretary of State for incorporation into the consolidated accounts for the NHS.

Pensions

27. The staff of self-governing hospitals will remain NHS staff and as such they will be eligible for NHS superannuation scheme membership. Given that self-governing hospitals have greater freedom in relation to rates of pay than the rest of the NHS, it is possible that the pay and pensions of their employees will different from elsewhere in the NHS. Equally, it is possible that a particular self-governing hospital might have a staffing structure which gave rise to pension liabilities which were different from the NHS average. There may therefore be a case for charging a separate rate of contribution to the NHS scheme for self-governing hospitals or any particular self-governing hospital to reflect the different liability. This is unlikely to require primary legislation because the existing NHS superannuation scheme regulations already allow the Secretary of State to specify an employing authority's contribution rate and it would seem that this need not be the same for all employing authorities. However, as a small technical step, it would be necessary to add self-governing hospitals to the list of employing authorities in the regulations.

Tax

28. The question of self-governing hospitals' liability to corporation tax/CGT and the implications for present arrangements regarding the payment and refund of VAT in the NHS are still under consideration.

H M TREASURY

April 1989

FROM: A G TYRIE

DATE: 13 April 1989

CHANCELLOR

cc: Chief Secretary
Mr Saunders
Mrs Chaplin
Mr Call

THE HEALTH REVIEW AND GPS' LISTS

Tony Favell would like to write a letter to the Times making the point discussed Prayers on Wednesday that the introduction of this scheme would not mean any diminution in the number of doctors.

2. Tony wanted to check that you were happy for him to do this.

Fine.

pp RJ
A G TYRIE

FROM: D I SPARKES
DATE: 14 April 1989

MR TYRIE

cc PS/Chief Secretary
Mr Saunders
Mrs Chaplin
Mr Call

THE HEALTH REVIEW AND GPS' LISTS

The Chancellor was grateful for your minute of 13 April concerning Tony Favell's proposal to write to The Times. The Chancellor is content for Mr Favell to go ahead with this.

DUNCAN SPARKES

014/2761

CONFIDENTIAL

FROM: **P T WANLESS**
DATE: **17 April 1989**
Ext 5086

MR SAUNDERS

cc:
PS/Chancellor
Sir Peter Middleton
Mr Anson
Mr Phillips
Mr Monck
Mr Scholar
Mr Beastall
Mrs Lomax
Miss Peirson
Mr Griffiths
Mr Call

pmp

NHS REVIEW: FINANCIAL REGIME FOR SELF-GOVERNING HOSPITALS

The Chief Secretary was grateful for your submission of 13 April and for sight of the attached paper on financial regimes for self-governing hospitals.

2 He commented that the contents looked daunting. The Chief Secretary's view is that we should be reasonably accommodating where possible; we do not want to stifle self-governing hospitals.

3 He is content for you to send the paper to the Department of Health and awaits their response with interest.

PW.

PETER WANLESS
Assistant Private Secretary

CONFIDENTIAL

FROM: D I SPARKES
DATE: 19 April 1989

MR PHILLIPS

cc PS/Chief Secretary
PS/Financial Secretary
PS/Paymaster General
PS/Economic Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Mr Kelly
Mrs Lomax
Miss Peirson
Mr Todd
Mr Griffiths
Mr Sussex
Mr D Rayner
Mrs Chaplin
Mr Tyrie
Mr Call

PWP

NHS REVIEW

The Chancellor was grateful for your minute of 18 April, covering one from Mr Saunders dated 17 April, reporting on the progress that has been made to implement the proposals in the NHS White Paper. He read these with interest and will wish to reflect further on the issues raised.

D.S.

DUNCAN SPARKES

SPARKES TO PHILLIPS 19 APR

 cc Mrs Thorpe

FROM: D I SPARKES
DATE: 19 April 1989

MR PHILLIPS

cc PS/Chief Secretary
Sir P Middleton
Sir T Burns
Mr Anson
Mr Saunders
Mr Call

NHS REVIEW

The Chancellor was grateful for your minute of 18 April offering some general reflections on the progress of the NHS Review. The Chancellor would like to hold a small meeting with you and copy recipients in the near future (preferably before the Chief Secretary attends the No.10 meeting on DH organisation next Tuesday) to discuss the issues you and Mr Saunders raised in your recent submissions. I should be grateful if you would supply an annotated agenda for this meeting. Mrs Thorpe will be in touch to arrange a suitable date.

Julie Done
See behind
Sarah

D.S.
DUNCAN SPARKES

cst.ps/lce20.4/mins

UNCLASSIFIED

FROM: MISS C EVANS
DATE: 20 April 1989
Ext 4339

MR SAUNDERS

cc: Chancellor
Mr Phillips

NHS REVIEW

The Chief Secretary would be grateful to know how many of the representations from the NAHA and the Royal Colleges were in fact incorporated in the NHS Review White Paper.

CE

MISS C EVANS
Private Secretary

UNCLASSIFIED

Mike: pls would you consult Hayden + get him the set he wants.

RESTRICTED

CH/EXCHEQUER

REC.	21 APR 1989
ACTION	
COPIES TO	

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

20 April 1989

Mr Spackes,
Please consult with Mr Phillips, and let him have a set of whatever documents he needs
AA 21/4

Dear Alex,

CLASSIFICATION OF NHS REVIEW PAPERS

You asked me whether the classification of the papers prepared during the NHS Review could be reduced. I would prefer not to make any general change to the classification at this stage. Perhaps the best approach would be for you to make a separate set of copies of the relevant papers and issue them to a single designated official, so that those needing to see them at divisional level have ready access to them.

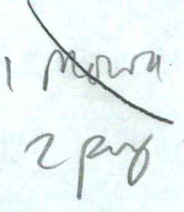
I am copying this letter to Richard Wilson (Cabinet Office).

Yours,
Paul

PAUL GRAY

Alex Allan, Esq.
H.M. Treasury

RESTRICTED



NATIONAL HEALTH SERVICE IN DANGER!

THE GOVERNMENT WANTS TO LIMIT THE NUMBER OF DOCTORS IN GENERAL PRACTICE. THEY WANT DOCTORS TO CARE FOR MORE PATIENTS, LESS TIME FOR YOU.

DOCTORS WILL HAVE AN ANNUAL DRUGS BUDGET. WHEN THE MONEY RUNS OUT, HOW WILL YOU GET A PRESCRIPTION?

WE WILL FACE NEW RESTRICTIONS ON WHICH HOSPITAL WE SEND YOU TO. DON'T YOU WANT A CHOICE?

DO WE GIVE YOU A GOOD SERVICE NOW? IF WE DO, WHY CHANGE THINGS?

IT IS YOUR HEALTH SERVICE

Your Doctor is already taking action. For the first time your Doctor is asking if you will join in and help.

Please write now to your local MP at:

HOUSE OF COMMONS, LONDON, SW1A 0AA

Saying you share your Doctor's opposition to the Government's Plans.

Ask for the plans to be reconsidered so we can make The N.H.S. into the kind of Health Service we all want to see.

THE GOVERNMENT'S PLANS ARE NOT THE WAY FORWARD

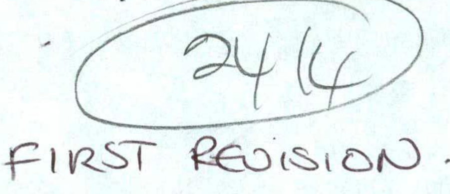
Signed:- Dr. J. CAUSTON, Dr. A. CAUSTON, Dr. R. MORRIS, Dr. M. WHALLETT, Dr. D. WHALLETT, Dr. M. WATTS, Dr. W. BURNHAM, Dr. M. BASIT, Dr. J. BIRCH, Dr. P. BURNEY, Dr. D. HOLLIDAY

Mr Phillips cc PS/CST
Mr Saunders

The Chancellor thought you should see this, if you have not already

[signature]
21/4

CONFIDENTIAL



FIRST REVISION.

CHANCELLOR OF THE EXCHEQUER'S OFFICE: MEETING

SUBJECT	NHS REVIEW
DATE	MONDAY 24 APRIL
TIME	4.45 pm
VENUE	Chancellor's Room, ~~Treasury~~/No.11/~~Conference Room/House of Commons~~ NO 11
PAPERS	H. PHILLIPS TO PROVIDE AGENDA
THOSE ATTENDING	CST SIR P MIDDLETON SIR T BURNS MR ANSON MR H PHILLIPS MR SAUNDERS MR CALL

SUBJECT: NHS REVIEW.

LOCATION: HMT

1½

CAST LIST.	PHONE NO.	DATE + TIME: 24/4 2:30	✓/✗ IF NO GIVE REASON	21/4 3.00PM	✓/✗ IF NO GIVE REASON	24/4 9.30am	✓/✗ IF NO GIVE REASON	21/4 11 00 am	✓/✗ IF NO GIVE REASON
CST		✓				✓			
PEM	5158	✗	MEETING	✗	NOT HERE	✓		✗	LEAVE
TB	5202	✓				✓			
J. Anson	5643					✓			
H Phillips	5261	✓	MEETING CST			✓			
D. Saunders	5033	✓	[illegible]			✓			
M. Call	5107	✓	CST.			✓			

pl recirculate.

Sarah – NHS meeting

We are now going for 4.45pm Monday – OK with CST/PEM pls check others and – if OK – confirm with everyone

PAPERS:

SUBJECT: NHS REVIEW

LOCATION: HMT

CAST LIST.	PHONE NO.	DATE + TIME. 24/4 4.45PM ✓	IF NO GIVE REASON	✓	IF NO GIVE REASON	✓	IF NO GIVE REASON	✓	IF NO GIVE REASON
CST		✓							
PEW		✓							
TB		X	Frank Cassell						
J ANSON		✓							
H PHILLIB		✓	✓						
D SAUNDERS		✓							
M CALL		✓	SCOTTISH OFFICE AT 6.00						

PAPERS:

cst.ps/8ce24.4/mins

FROM: MISS C EVANS
DATE: 24 April 1989

PS/CHANCELLOR - 14/2

Sir Peter Middleton
cc Mr Anson
Mr Phillips
Mrs Lomax
Mr Saunders
Mr MacAuslan
Mr Gieve
Mr Call

NHS REVIEW

... I attach a draft speech on the NHS reforms which the Chief Secretary proposes to make shortly. We have not yet found a suitable slot but he would like to clear with Mr Clarke this week. Could I therefore ask for comments by close tomorrow please

Ch/ one or two comments marked. A bit of a risk, but mainly safe, supportive stuff.
MPW. 25/4

CE

MISS C EVANS
Private Secretary

CHIEF SECRETARY'S SPEECH NHS REFORMS

DRAFT OF 24 APRIL

Today's Health Service gives us much to be proud of. It is bigger and better than ever before. Health spending up 40% between 1978 and 1989/90 in real terms. It treats 8 million patients a year, 1½ million more than in 1978. It employs 6,000 more hospital doctors and dentists than it did in 1978 and 70,000 more nursing and midwifery staff. It is undertaking complex and advanced treatments that were hardly thought possible not so long ago. There were 315 heart transplants in 1987. In 1975 there were just 3. Perinatal mortality has fallen by almost half in the last 10 years. In 1976, only 300 babies weighing less than 1,000 grams survived the first month. By 1986 this had grown to over 1,000 - 3 times as many lives saved. These impressive improvements are hardly the result of a Government hostile to the NHS, to its funding, to its principles, or to its future.

2. In the White Paper the Government has set out the direction it believes the Health Service needs to go to improve service to patients in the 1990s and beyond.

3. Many people have interpreted the White Paper on the NHS as a cost cutting exercise. That is wholly wrong. In the last PES the increase for the NHS was over £2 billion in the UK for the current year with a further £2½ billion being set aside for next year and nearly £3½ billion on top of that for the year after. These sums will be further reviewed in the Public Expenditure Surveys both this Autumn and next.

4. These increases show that cost cutting is not in prospect. Nor has it ever been in our mind. The NHS will continually need more resources to meet the demands of increasingly sophisticated treatments and an increasingly elderly population and we shall continue to provide the resources that are necessary. That should not be in doubt. Nor should there be any doubt about the commitment that its services will continue to be open to all, regardless of income, and paid for mainly out of general taxation. Indeed, no other principle would be acceptable. But we are determined to get the best value for money that is obtainable. Ultimately, that means more patient care for any given level of resources.

happy with this?

5. Through taxation the average family of 4 now pays some £35 a week for the NHS. As a result they have the right to expect - and the Government and the Health Service have a duty to ensure - that the money they contribute is put to the best use and achieves the maximum possible patient care. Value For Money is not penny pinching cost accountancy - it is essential to produce better health care.

What is wrong with the NHS?

6. In recent years the NHS has made great improvements in efficiency. But no organisation of 1 million people is without its problems. Some 40 years after the foundation of the NHS, it is becoming increasingly clear that the patient is not getting the

there is still room for further improvement in the interests of the patient

best service possible from the resources which are devoted to it. Efficiency can still be improved. The NHS has the opportunity to benefit from the latest management techniques and technology. Businesses have brought themselves up to date in the 1980s. So must the public services.

7. That efficiency could be improved in some areas is seen clearly from the fact that the average cost of treating acute hospital in-patients can vary by as much as 50% across the country, even after allowing for the complexity and mix of cases. In the same way, waiting times for operations varies sharply and there are great differences in referral rates and prescribing habits of GPs. The cost of drugs prescribed by family doctors in some places nearly twice as high per head of population as in others. Some GPs refer twenty times more patients to hospital than others.

8. The reasons behind these disparities [of performance] are many and complex. Some are justifiable; some are not. What is clear is that in many respects ~~those working in the organisation lack the~~ The present system does not give any incentives to improve service to patients. The existing financial framework gives hospitals only limited encouragement to improve their efficiency and increase the number of patients treated, because they are not rewarded with extra funding. The rigidity of the present financing system can positively work against the enthusiasm of

people in the NHS who want to improve the performance of their hospitals. The Government's reforms will remove these constraints, giving efficient hospitals the opportunity to provide still more and better services. This will improve the way the Health Service works, and will result in a better service to patients.

What solution is the Government proposing?

9. The main proposals are the following. First, a new funding mechanism which will ensure that money gets to where it is needed. There will be a fairer system for allocating money to different parts of the country. And a new system of contracts between health authorities and hospitals will ensure that the best are properly recompensed.

10. Second, hospitals will be able to choose to become self-governing NHS Hospital Trusts. This has been misinterpreted, sometimes deliberately, as opting out of the NHS. That is simply not the case. Self-governing hospitals will not opt out of the NHS. They will remain firmly within the NHS now and in the future. But they will bring back the community link which was so effective in the past.

11. Third, large group practices of GPs will be able to choose whether to operate a practice budget. I emphasise 'choose'. It is for them to decide. It is not compulsory. For those that choose to operate a

practice budget we believe it will give them greater control over the allocation of NHS funds, and allow them to improve the service they offer to their patients. But this judgement is for doctors to freely make. It will not be imposed on them.

12. Fourth, we will introduce a system of indicative drug budgets for those GPs who do not take up practice budgets. This proposal too has been misrepresented. It is not an attempt to get GPs to prescribe the cheapest available, no matter what the therapeutic benefits. No GP will be forced by budgetary constraints not to prescribe medicines for a patient who needs them. But we are concerned to ensure that expenditure on drugs - which will continue to grow as demand rises and new medicines become available - gives the best possible value for money. Many GPs are already cost-effective in their prescribing. We want to help all to come up to the standards of the best, and to encourage keenness in pharmaceutical pricing.

13. Fifth, medical audit will ensure that performance in providing patient care is monitored and discussed by the medical profession. In promoting medical audit generally we are building on the best practice that already exists. The profession has warmly welcomed this part of the White Paper.

14. Sixth, external financial audit of the NHS will be strengthened. This task will in future be taken on by the Audit Commission, who have done such a good job in auditing local authorities. They will expand the programme of value-for-money audit, so that differences in performance across the country can be assessed, and ways found of bringing poor performers up to the standard of the best. To do this the Audit Commission will develop information on comparative performance of the Health Service throughout the country. It will not simply be conducting ticks and crosses audits, but will be seeking to understand the reasons for differences in performance and efficiency, and then acting as a coach in achieving improvements. It has helped bring greater effectiveness to the services provided by Local Authorities. It will do the same for the National Health Service. It is there to help, and not to harass.

15. Finally, 100 additional consultants posts are to be created to reduce waiting times and improve the quality of service in hospitals. This will also help reduce the long hours worked by some junior doctors.

16. More detailed and more easily accessible information will play a great part in making the NHS more responsive to patients. It will be easier for them to choose and change their doctor and we are taking steps to help them make a more informed choice of GP.

In turn, their GP will have better information on waiting times, costs etc when deciding to which hospital they should be referred And hospital doctors too will have better information at their fingertips about the resources at their disposal.

17. Hospitals will be encouraged to introduce a more personal and flexible service. They will introduce appointment systems which give people individual and reliable appointment times. They will improve the quality of their waiting and other public areas. They will produce clear information leaflets about the facilities available and what patients need to do when they come into hospital. They will give patients clear and sensitive explanations of what is happening. [Patients are the paymasters and the consumers of the service. They are not supplicants.] They will improve procedures whereby patients and visitors can make suggestions for improvements and, if necessary, complaints. They will speed up the notification of the results of diagnostic tests. [Finally, they will expand the range of optional extras and amenities such as single rooms, televisions, and a wider choice of meals for those who want to pay for them.]

Don't like tone. prefer deleted

18. Overall, the reforms will extend patient choice; delegate responsibility to those best placed to respond to patients' needs; ensure that the NHS delivers a more effective service to patients; and get the best value out of the money the taxpayer puts in.

19. To achieve that, the NHS will need to introduce proper management techniques and systems, including computers and new technology wherever appropriate. These have transformed and brought benefits elsewhere in our lives and should do so in health. Today, you can go into your local travel agent and see whether there is a seat on a plane from New York to Tokyo. But neither you nor your GP can check which hospital has a vacant bed, or has the shortest day patient waiting time.

20. The White Paper is entitled "The NHS - Working for Patients", and the aim of the reforms is indeed ~~Indeed the reforms include a number of measures~~ to put patients first.

(risks being a bit repetitive of paras 9-18)

21. ~~Firstly, m~~Money will follow the patient, in what has been referred to as an internal market. This means that resources will go more directly to those hospitals which are most successful at attracting referrals. The GP will refer the patient to that hospital which offers the quickest and most effective treatment, and not

why say?

simply the cheapest. Rewarding the best will increase the quality of patient care, and encourage all hospitals to improve their standards.

22. Secondly, the proposals will increase the incentive for GPs to serve their patients well. A greater proportion of GP's income will be made up from capitation fees. Currently 47% of the average GP's income is related to the number of patients he looks after. This will be increased eventually to 60%. In addition, measures to make it easier for people to choose or change their GP will be introduced. So if patients are not satisfied with the service they get they can freely move without embarrassment or difficulty. Doctors will not be able simply to build up the number of patients on their lists without regard to their satisfaction.

23. As a result of the reforms, doctors will be accountable to their patients, in the same way that private sector producers are accountable to their customers. [Combined with the fall in the size of GP panels - from [2300] in 1978/79 to around [1800] today -] these proposals amount to a patient's charter for better service. And the practice budget will put in the doctor's hands the power to deliver better service by giving them responsibility for directing funds to hospitals which treat their patients.

patient lists

24. ~~But~~ These measures have been widely misunderstood by some in the medical profession who claim that GPs will have an incentive to increase their list at the expense of providing a good service to patients. I do not believe this will happen. If it did, the new, simpler arrangements for changing GPs would simply mean that patients moved to another practice. What the new system will do is reward GPs who attract more patients because of the good service they provide. And that is how it should be.

Conclusion

25. Some in the Health Service have misinterpreted these reforms as an attack on the very idea of the NHS. They are not. They are sensible reforms which recognise that the NHS must evolve if it is to give the best possible service into the 1990s and beyond. They will improve the NHS, not endanger it. And they embody the principles which have guided the NHS since it inception. These are far-reaching proposals which affect all of us. They deserve both rational and careful consideration and the support of everyone who wishes the NHS well. Now is the time for a constructive dialogue and not a rush to the barricades.

FROM: J MACAUSLAN (GEP1)
DATE: 25 APRIL 1989
x 4780

PS/CHIEF SECRETARY

cc: PS/Chancellor
Sir P Middleton
Mr Anson
Mr Phillips
Mrs Lomax
Mr Saunders
Mr Gieve
Mr Call

NHS REVIEW: DRAFT SPEECH

Thank you for sending me a copy of your minute of 24 April, covering a draft speech for the Chief Secretary on the NHS reforms. I thought it was splendid stuff! I had only a couple of small comments on paragraphs 3 and 4.

2. We do not normally make anything of the increases over baseline agreed for the last year covered by a Survey. The baselines for that year are not based on previous plans for that year (because none exist). They are instead derived mechanically from the plans for the year before, and deliberately set low. Increases over the baseline for the last year are therefore always spectacular - but also less than meaningful. So I would delete lines 5-6 of paragraph 3, and insert instead:

"further £2½ billion next year."

3. That also requires us to alter the last line to read:

"Expenditure Survey this Autumn."

(But I will come back to that sentence).

4. I would rewrite the opening of paragraph 4 as follows:

"These increases show that cuts are not in prospect. Provision has increased every year under this Government; and further increases are planned. Demands on the NHS are likely to grow as time goes by. Treatments are becoming increasingly sophisticated; and the population is becoming increasingly elderly. We shall continue to provide the resources that are necessary."

5. The redraft refers to cuts rather than cost-cutting, since the latter could be confused with measures to improve value for money. And it loosens the link between the needs (driven by technological and demographic change) and the resources. The existing draft gives the impression that the NHS budget will always show real increases after adjustment for technological and demographic change. It may well not actually do that.

6. I think it would then improve the flow of the argument, and make it more compelling, to move the sentence about future Surveys (now the last sentence of paragraph 3) up to this point. You could write:

" ... increasingly elderly. Provision for the NHS will be reviewed in each year's public expenditure Survey. We shall continue to provide the resources that are necessary."

deleting the last sentence of paragraph 3. Thus the "increases" at the beginning of paragraph 4 follow on directly from the £2 billion and £2½ billion in paragraph 3.

JM

J MACAUSLAN

MP

FROM: J. ANSON
25th April, 1989.
Ext. 4370

MISS C. EVANS

c.c. Chancellor
Sir P. Middleton
Mr. Phillips
Mrs. Lomax
Mr. Saunders
Mr. MacAuslan
Mr. Gieve
Mr. Call

Moira

NHS REVIEW: SPEECH

A few thoughts on this admirably punchy speech.

2. We are constantly telling others that they should look at outputs and not concentrate on inputs. I would therefore begin with the achievements rather than the extra money. This could be done by starting straight in at line 4:

> "The Health Service today is treating 8 million patients a year, 1½ million more than 10 years ago ..... etc."

The points in lines 1-3 could then be put at the end of that paragraph, so as to reinforce the present last sentence before going on to paragraph 2, eg:

> "..... or to its future. Quite the contrary. Today's Health Service gives us much to be proud of. And we are spending on it [40%] more in real terms than 10 years ago."

In paragraph 3, line 3, "Last autumn we increased" would sound better than "In the last PES".

3. In paragraph 5, you could link back to paragraph 1 by adding at the end of the paragraph: "It has already made an essential contribution to the improvements which I mentioned just now. But more must be done."

4. In paragraph 8, line 8, I am not sure whether "rewarded" strikes quite the right note: you could perhaps say "because these achievements are not recognised by".

5. In paragraph 11, you could perhaps nod in the direction of those who would prefer pilot projects, by adding at the end "The experience of those who make this voluntary choice will help others to decide whether they want to make it later on".

6. In paragraph 17, line 11, "They will improve" should read "Hospitals will also improve", to distinguish from the previous "They" which refers to patients. More generally, you may want to re-consider using the word "will" so many times in this paragraph, which gives it a rather military tone. The first sentence of the paragraph is nearer the tone of the White Paper on these matters, eg (see paragraph 1.13) that the Government "believes that each hospital should offer" these improvements, and that "every hospital in the NHS should offer what the best offer now". Paragraph 1.13 also had the thought that impersonal and inflexible regimes are not what those working in the Health Service themselves want to see.

7. In paragraph 21, lines 1-2, it might be more tactful in this presentation to omit "in what .... market". The point is adequately made by the words before and after.

J. ANSON

SECRET

000258

10 DOWNING STREET

LONDON SW1A 2AA

CHIEF SECRETARY
REC. - 2 MAY 1989
ACTION CX
COPIES TO

pup.

From the Private Secretary

28 April 1989

Dear Flora,

CENTRAL MANAGEMENT OF THE NATIONAL HEALTH SERVICE

I would be grateful if you would note the following amendment to the record of the meeting on 25 April which I circulated on that day.

The third sentence of the penultimate paragraph should read:

"This should in particular cover progress in separating the Management Executive from the policy functions of the Departments; turning some of the..."

I am copying this letter to the recipients of my letter of 25 April.

Yours,

Paul

(PAUL GRAY)

Mrs. Flora Goldhill,
Department of Health.

SECRET

2.28.4.89

CONFIDENTIAL

On balance, I agree that it is better to go for "one bite", provided that Mr Clarke signs up firmly to the formula in paragraph 9. A 2/5

FROM: R B SAUNDERS (ST2)

DATE: 2 May 1989
x 4800

1. MR ANSON

2. CHIEF SECRETARY

Copies attached for:
Chancellor
Mr Anson

cc Sir P Middleton
Mr Phillips
Mrs Lomax
Mr Luce
Miss Peirson
Mr Hansford
Mr MacAuslan
Mr Richardson
Mr A M White
Mr Griffiths
Mr D Rayner
Mr Call

NHS REVIEW IMPLEMENTATION: 1989-90 IN-YEAR BID

This submission, which has been agreed with Mr Phillips and GEP, seeks your views on how we should respond to the bids which Department of Health have put to us for the costs this year of implementing the White Paper proposals. They fall into four groups:

HCHS expenditure - £33m

Departmental running costs - £8.4m

New consultant posts - £5m

Information - £0.55m

The Annex to this minute describes the composition of these bids in more detail, and discusses their merits. In putting in these bids, DH gave no promise not to come back for more later in the year. (they wouldn't have done, would they?).

2. We have agreed to defer the last two. More precise costings of the bid for new consultants have to wait for DH to receive and assess health authority requests for specific new posts. That will not be ready before the autumn, but we shall probably have to

255

concede in large measure. And we understand that Mr Clarke wishes to discuss with you separately the information bid. We have so far said that this bid - £½m on top of a budget of £19½m (over 50% up on 1988-89) and much of which appears to be only tenuously related to the Review - is unacceptable. We will let you have separate briefing for your talk with Mr Clarke.

3. It has been clear from the beginning that we shall have to make significant concessions. Implementation of the Review will require more work, and to a tighter timetable, than envisaged at the time of the Survey settlement, and the White Paper commitment of "no detriment to patient services" makes it difficult to argue that extra costs should be absorbed within existing provision. After discussion with Department of Health officials at a meeting chaired by Mr Phillips, it is clear that Mr Clarke will press these bids very hard. Our view is that we should very largely concede them, in return for as firm an undertaking as we can get that they will not be reopened later in the year. The following paragraphs explain why.

4. <u>One bite or two</u>? There are powerful political and managerial arguments for settling global figures now, rather than coming back for a second bite after the summer holidays. The political argument is that the impact of the extra money is thereby maximised. The managerial argument is that health authorities will know exactly what cash envelopes they have to work within, and so can draw up firm implementation plans.

5. This approach is also likely to be in the Treasury's interests. If we say the Department can have some more money now for those items which are reasonably firm, with others to be reconsidered in early autumn, it is likely to end up costing us more: we would not reduce the bid now by as much as we hope (we might get the £33m down to £20m if we were lucky), and by the autumn the Department would no doubt have identified further expenditure pressures, including those items where they had nominally already settled. So in our view the arguments point clearly to trying to agree binding global sums now.

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6. **How much**? If we are to persuade the Department to accept a final settlement now, it probably has to be pitched higher than if the possibility of reopening later in the year was allowed. On the case that has so far been presented to us, we think no more than around £25m of the £33m non-running cost bid, and some £6m of the £8.9m running costs bid, is justified. But that would leave the Department very little margin for contingencies, and officials made it clear that Mr Clarke would not accept such settlements as anything more than interim.

7. DH officials indicated that they would be prepared to commend to Mr Clarke some shading down of the bids - say £1m off each of the running costs and non-running costs bids respectively. In return they would be prepared to agree only to reopen the settlement when firm estimates of the cost this year of the new consultant posts were available; or if genuinely new and unforeseen contingencies arose.

8. The resulting increase of £7.4m in running costs compares with £3.5m which you have already agreed. (In both cases, the running costs limit would be increased by a further £0.5m for reasons unconnected with the NHS Review.) The cash limit would be increased by £7.4m.

9. **How to limit reopening**? We think the best way to do this is by reference to the Department's own plans for implementing the White Paper. As you will recall from my minute of 17 April, they have broken the work down into a series of projects (now 34 separately identified ones) covering self-governing hospitals, funding, contracts, practice budgets, prescribing budgets, capital charges, medical audit, and so on. They are intended to form a comprehensive work programme for implementing the Review, and so it seems sensible to tie the concession to them, as follows:

> "These additional sums will cover all expenditure pressures as a result of implementing the NHS Review projects which could reasonably have been foreseen in May 1989. The Department undertakes not to submit any new in-year bid arising from changes in the estimated cost of the plans as

seen at that time, or from items of expenditure which were not included in its original bid by oversight. The Treasury for its part undertakes to consider on its merits any bid for expenditure which could not reasonably be expected to have been foreseen at the time."

10. Our conclusion therefore is that we should be prepared to accept cash limit increases and claims on the Reserve this year of £32m non-running costs and £7.4m running costs, so long as the Department agree to the formula in paragraph 9. This is probably more than they strictly need at the moment, but it gives them a margin to deal with, for example, more candidates for self-governing status coming forward than currently expected. It would certainly not be an ungenerous settlement. If you felt it was too much, we might go for an offer of around £20m non-running costs and £6m running costs. But we would have no hope of making this a final settlement and, for the reasons in paragraph 5, we would not recommend this approach.

11. If you are content, we will suggest to Department of Health officials that they advise Mr Clarke to write accordingly.

R B SAUNDERS

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NHS REVIEW IMPLEMENTATIONS: COMPOSITION OF IN-YEAR BID

HCHS non-running costs £33m

This bid has five main components. When originally submitted, it included also a provisional £5m for the first tranche of the 100 new consultant posts, but we have since agreed to drop it pending responses to the bidding letter sent to health authorities; a further increase in respect of this will almost certainly be needed later in the year.

i. Finance staff and training £12m

Mainly to strengthen finance staffing at unit (ie hospital) level. They are needed so that preparatory work may start on costing systems to underpin contract funding systems (between district health authorities and district-managed hospitals) from 1992. The bid would finance 2 extra man years per district: perhaps 1 per acute unit and ½ per non-acute (eg mental illness or community health services) unit. Any shortfall, eg because staff are employed for a smaller fraction of the year than budgeted for, could be used to divert extra resources to putative self-governing hospitals or to buy in extra consultancy support. About £1½m of the bid would be for training existing staff in the implications of the Review.

In general, we think this a well-founded bid. A heavy load will fall on finance staff locally, and a lot of strengthening will be required.

ii. Capital charging £12m

Mainly the costs of compiling and maintaining comprehensive asset registers. The principal initial task would be to record all assets possessed by health authorities. The work would be carried out by temporary or casual staff under supervision. At least one clerk per district is required to maintain registers thereafter - recording acquisitions and disposals, maintenance expenditure, etc.

Reasonably well-founded. Costs of drawing up asset registers well known from previous asset accounting pilot projects. Expenditure necessary even if a decision taken to slow down on the introduction of real capital charges, since we would in that event want to press ahead with comprehensive management accounts, including asset accounting.

iii. Personnel staff and training £6m

Short term aim of increasing personnel staff at unit level by 600, or about 10 per prospective self-governing hospital. Part of a longer term aim of increasing personnel strength from present 3,500 (0.4 per 100 staff, compared with private sector average of about 1 per 100) to 5-6000 (0.6 per 100). Range of their functions would include better manpower information systems, manpower planning and management training; operation of more devolved pay arrangements; and management of new consultant contracts, including drawing up and policing job descriptions. Also an element (£1m) for training.

This is a softer bid. Some of the items are not really Review-related, and a secular increase in personnel staff is a matter which should be considered in the Survey. Nevertheless, some expenditure justified, notably preparatory work in self-governing hospitals (although 10 new staff for each by March 1990 seems an unrealistic target) and consultants' contracts. Work on drawing up job descriptions, which is the most manpower-intensive part, is not however expected to start before January 1990. No more than £2m in total justified.

iv. Medical audit £2m

This is to finance the appointment of full-time co-ordinators at regional level and one half time doctor in each district to push forward medical audit at local level; research and development (eg development of a national Confidential Enquiry into Infant Deaths); and central support for local projects.

A reasonably well-justified bid. Some visible extra funding will be needed in order to maintain the momentum generated by the announcement in the White Paper.

v. Training in public health and health economics £1m

This is to invest in the longer term development of people with the professional skills to support an NHS "internal market". Studentships in health economics (at York University) are financed centrally by DH, and trainees in public health medicine are paid for by regions.

A laudable objective, though possibly more for the Survey than an in-year bid. Should be encouraged anyway by the department, and necessary funding ought to be capable of being found from existing resources.

Departmental running costs £8.4m

This has 3 elements. Following Miss Peirson's submission to you of 4 April, you have already agreed to an increase of £3½m (£4m including a £½m bid not related to the Review).

i. Staff £3.5m

A heavy burden will fall on the Department initially in drawing up legislation and central guidance within which health authorities and hospitals will work. They are bidding for some 130 posts. On close examination, we think an increase of around 100 is justified. £1m already conceded.

ii. Consultancy support £2.5m

A lot of expertise will have to be bought in, notably IT to help see through the resource management initiative, and the management consultants to help get first wave of hospitals ready for self-government from 1991. Difficult to judge what is the right sum here, but possibly up to £2m justified. £0.75m already conceded.

iii. Financial audit £2.4m

Preparation for handover to Audit Commission from 1991, including expanded VFM programme, buying in Audit Commission expertise, and purchase of computers. £1.75m already conceded.

Information £0.55m

This is for publicity expenditure on videos, exhibition material, training packs etc, aimed at doctors and others in the NHS covering the following items

- resource management (£200,000)
- FMI in the NHS (£150,000)
- Income generation (£150,000)
- VFM publicity (£30,000)
- Estate management (£20,000).

We have pointed out that none of these - with the possible exception of resource management - is a direct consequence of the Review and that in any case the expenditure should be capable of being absorbed within the information budget of £19.6m, which is already substantially increased over last year's provision of £12.75m, and in any case forms part of a cash limit of £670m. Against this background, the bid is little short of preposterous.

cst.ps/6ce24.4/lets

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CC - CX - 2
SIR P MIDDLETON
MR ANSON
MR PHILLIPS
MRS LOMAX
MR SAUNDERS
MR MACAUSLAN
MR GIEVE
MR CALL

Treasury Chambers, Parliament Street, SW1P 3AG

Andy McKeon Esq
Private Secretary to the
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1

Can I have pps back pl (Carys → PS/Ch) last wk.

2 May 1989

Dear Andy

NHS WHITE PAPER

I mentioned recently that the Chief Secretary is planning to make a speech defending the NHS reforms. I now attach a draft of his proposed speech which he would like to deliver shortly. He would be grateful to know whether your Secretary of State is content with the draft.

Yours

Carys

MISS C EVANS
Private Secretary

UNCLASSIFIED

cst.ps/1jm24.4/spch

CHIEF SECRETARY'S SPEECH ON NHS REFORMS

DRAFT OF 2 MAY

The Health Service today is treating 8 million patients a year, 1½ million more than in 1978. It employs 6,000 more hospital doctors and dentists than it did in 1978, and 70,000 more nursing and midwifery staff. It is undertaking complex and advanced treatments that were hardly thought possible not so long ago. There were 315 heart transplants in 1987. In 1975 there were just 3. Perinatal mortality has fallen by almost half in the last 10 years. In 1976, only 300 babies weighing less than 1,000 grams survived the first month. By 1986 this had grown to over 1,000 - 3 times as many lives saved.

2. These impressive improvements are hardly the result of a Government hostile to the NHS, to its funding, to its principles, or to its future. Quite the opposite. Today's Health Service gives us much to be proud of. And we are spending 40 per cent more in real terms than 10 years ago.

3. In the White Paper the Government has set out the direction it believes the Health Service needs to go to improve service to patients in the 1990s and beyond.

4. Many people have interpreted the White Paper on the NHS as a cost cutting exercise. That is wholly wrong. Last Autumn we increased provision for the NHS by over £2 billion in the UK for the current year, and by a further £2½ billion for next year.

5. These increases show that cuts are not in prospect. Provision has increased every year under this Government; and further increases are planned. Demands on the NHS are likely to grow as time goes by. Treatments are becoming increasingly sophisticated, and the population is becoming increasingly elderly. Provision for the NHS will be reviewed in each year's public expenditure Survey. We shall continue to provide the resources that are necessary. That should not be in doubt.

6. Nor should there be any doubt about the commitment that its services will continue to be open to all, regardless of income, and paid for mainly out of general taxation. No other principle would be acceptable. But we are determined to get the best value for money that is obtainable. Ultimately, that means more patient care for any given level of resources.

7. Through taxation the average family of 4 now pays some £35 a week for the NHS. As a result they have the right to expect - and the Government and the Health Service have a duty to ensure - that the money they contribute is put to the best use and achieves the maximum possible patient care. Getting value For Money is not penny pinching cost accountancy - it is essential to produce better health care. It has already made an essential contribution to the improvemments which I mentioned just now. But more must be done.

What is wrong with the NHS?

8. In recent years the NHS has made great improvements in efficiency. But there is room for further improvement in the interest of the patient. In spite of all that has been achieved, we are not providing as good a service as we could be, not only in the provision of treatment but also in smaller ways such as appointments queues and notifying people of the result of a test. This quality of service is very much a matter of the way resources are used. To improve performance the NHS needs to seize the opportunity to benefit from the latest management techniques and technology. Businesses have brought themselves up to date in the 1980s. So must the public services.

9. There is clear evidence of the scope to improve efficiency in a number of areas. The average cost of treating acute hospital in-patients can vary by as much as 50 per cent across the country, even after allowing for the complexity and mix of cases. In the same way, waiting times for operations vary sharply and there are great differences in referral rates and prescribing habits of GPs. The cost of drugs prescribed by family doctors in some places nearly twice as high per head of population as in others. Some GPs refer twenty times more patients to hospital than others.

10. The reasons behind these disparities of performance are many and complex. Some are justifiable, some are not. What is clear is that in many respects those working in the organisation do not have either the ability or the incentives to improve service to patients. The existing financial framework gives hospitals only limited encouragement to improve their efficiency and increase the number of patients treated, because these achievement are not recognised by extra funding. The rigidity of the present financing system can work directly against the enthusiasm of people in the NHS who want to improve the performance of their hospitals. The Government's reforms are intended to remove these constraints, giving efficient hospitals the opportunity to provide still more and better services. This will improve the way the Health Service works, and will result in a better service for patients.

What solution is the Government proposing?

11. First we are taking steps directly to make the NHS more responsive to patients. There will be more detailed and more easily accessible information about treatment and about services. This will be easier for them to choose and change their doctor and we are taking steps to help them make a more informed choice of GP. In turn, their GP will have better information on waiting times, costs etc when deciding to which hospital they should be referred And hospital doctors too will have better information at their fingertips about the resources at their disposal.

12. Hospitals will be encouraged to introduce a more personal and flexible service. For example, by introducing appointment systems which give people individual and reliable appointment times. By improving the quality of their waiting and other public areas. And by producing clear information leaflets about the facilities available and what patients need to do when they come into hospital. We want patients to be given clear and sensitive explanations of what is happening. Patients are the paymasters and the consumers of the service. They are not supplicants. Hospitals will also be encouraged to improve the procedures for patients and visitors to make suggestions for improvements and, if necessary, complaints. They should also speed up the notification of the results of diagnostic tests, and

expand the range of optional extras and amenities such as single rooms, televisions, and a wider choice of meals for those who want to pay for them. All these changes will help make the system more human and more flexible. But we also need to increase the opportunities and incentives for doctors and hospitals to provide better care and treatment. That is the objective of our main organisational proposals.

13. The main proposals are the following. First, a new funding mechanism which will ensure that money gets to where it is needed. There will be a fairer system for allocating money to different parts of the country. And a new system of contracts between health authorities and hospitals will ensure that the best are properly recompensed.

14. Second, hospitals will be able to choose to become self-governing NHS Hospital Trusts. This has been misinterpreted, sometimes deliberately, as opting out of the NHS. That is simply not the case. Self-governing hospitals will not opt out of the NHS. They will remain firmly within the NHS now and in the future. But they will bring back the community link which was so effective in the past.

15. Third, large group practices of GPs will be able to choose whether to operate a practice budget. I emphasise 'choose'. It is for them to decide. It is not compulsory. For those that choose to operate a practice budget we believe it will give them greater control over the allocation of NHS funds, and allow them to improve the service they offer to their patients. But this judgement is for doctors to freely make. It will not be imposed on them. And the experience of those who make this voluntary choice will help others to decide whether they want to make it later on.

16. Fourth, we will introduce new arrangements for monitoring drugs expenditure by those GPs who do not take up practice budgets. This proposal too has been misrepresented. It is not an attempt to get GPs to prescribe the cheapest available, no matter what the therapeutic benefits. No GP will be forced by budgetary constraints not to prescribe medicines for a patient who needs them. There are bound to be fluctuations in demand locally, and regional health authorities will be able to respond by switching resources within their budgets. The total sums made available will have to reflect both the increasing demands for drugs and the rate at which new medicines are becoming available. The intention of the new system will be to encourage GPs to be as cost effective as possible in their prescribing, and to encourage pharmaceutical companies to price their products keenly.

17. Fifth, we propose to strengthen and extend medical audit in order to ensure that performance in providing patient care is monitored by the medical profession. Here we are building on the best practice that already exists, in order to improve standards throughout the NHS. The profession has warmly welcomed this part of the White Paper.

18. Sixth, external financial audit of the NHS will be strengthened. This task will in future be taken on by the Audit Commission, who have done such a good job in auditing local authorities. They will expand the programme of value-for-money audit, so that differences in performance across the country can be assessed, and ways found of bringing poor performers up to the standard of the best. To do this the Audit Commission will develop information on comparative performance of the Health Service throughout the country. It will not simply be conducting ticks and crosses audits, but will be seeking to understand the reasons for differences in performance and efficiency, and then acting as a coach in achieving improvements. It has helped bring greater effectiveness to the services provided by Local Authorities. It will do the same for the National Health Service. It is there to help, and not to harass.

19. Finally, we have provided funding for 100 additional consultants posts, to reduce waiting times and improve the quality of service in hospitals. This will also help reduce the long hours worked by some junior doctors.

20. Overall, the reforms are designed to extend patient choice; delegate responsibility to those best placed to respond to patients' needs; ensure that the NHS delivers a more effective service to patients; and get the best value out of the money the taxpayer puts in.

21. To achieve that, the NHS will need to introduce proper management techniques and systems, including computers and new technology wherever appropriate. These have transformed and brought benefits elsewhere in our lives and should do so in health. Today, you can go into your local travel agent and see whether there is a seat on a plane from New York to Tokyo. But neither you nor your GP can check which hospital has a vacant bed, or has the shortest day patient waiting time.

22. The White Paper is entitled "The NHS - Working for Patients". Indeed the reforms include a number of measures to put patients first.

23. Firstly, money will follow the patient, so that resources go more directly to those hospitals which are most successful at attracting referrals. The GP will refer the patient to that hospital which offers the quickest and most effective treatment, and not simply the cheapest. Rewarding the best will increase the quality of patient care, and encourage all hospitals to improve their standards.

24. Secondly, the proposals will increase the incentive for GPs to serve their patients well. A greater proportion of GP's income will be made up from capitation fees. Currently 47% of the average GP's income is related to the number of patients he looks after. This will be increased eventually to 60%. In addition, measures to make it easier for people to choose or change their GP will be introduced. So if patients are not satisfied with the service they get they can freely move without embarrassmnet or difficulty. Doctors will not be able simply to build up the number of patients on their lists without regard to their satisfaction.

25. As a result of the reforms, doctors will be accountable to their patients, [in the same way that private sector producers are accountable to their customers.] Combined with the fall in the size of GP (panels) - from [2300] in 1978-79 to around [1800] today

- these proposals amount to a patient's charter for better service. And the practice budget will put in the doctor's hands the power to deliver a better service by giving them responsibility for directing funds to hospitals which treat their patients.

26. These measures have been misunderstood by some in the medical profession who claim that GPs will have an incentive to increase their list at the expense of providing a good service to patients. I do not believe this will happen. If it did, the new, simpler arrangements for changing GPs would simply mean that patients moved to another practice. What the new system will do is reward GPs who attract more patients because of the good service they provide. And that is how it should be.

Conclusion

27. Some in the Health Service have misinterpreted these reforms as an attack on the very idea of the NHS. They are not. They are sensible reforms which recognise that the NHS must evolve if it is to give the best possible service into the 1990s and beyond. They will improve the NHS, not endanger it. And they embody the principles which have guided the NHS since it inception. These are far-reaching proposals which affect all of us. They deserve both rational and careful consideration and the support of everyone who wishes the NHS well. Now is the time for a constructive dialogue and not a rush to the barricades.

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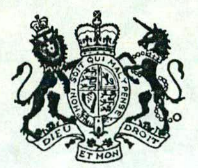


DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Secretary of State for ~~XXXXXXXXXX~~ Health

Andrew Turnbull Esq
Principal Private Secretary
10 Downing Street
LONDON SW1A

4 May 1989

PWP

Dear Andrew

At last week's meeting of Cabinet, it was suggested that my Secretary of State might find simple examples drawn from the health service of wasteful and restrictive practices which show the need for change if patient care is to be improved. These are set out in the attached annex.

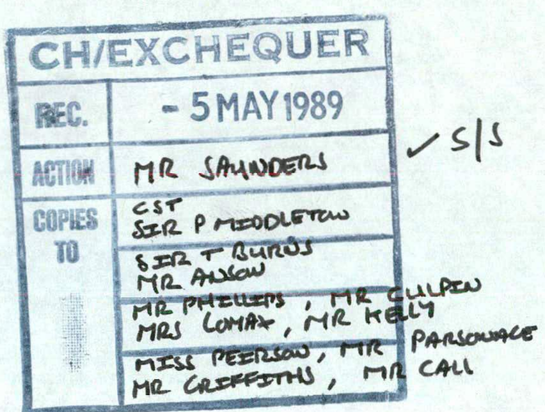
I should stress that these are some examples which have come to our attention and of course action has been taken to put things right in these cases. But it is clear that changes to the NHS are needed to tackle the underlying problems which allow such situations to develop.

I am copying this letter and attachment to the private secretaries to other members of the Cabinet and to Sir Robin Butler.

Yours sincerely

Flora Goldhill

FLORA GOLDHILL
Private Secretary



✓ S/S

RESTRICTIVE PRACTICES ADVERSLY AFFECTING PATIENT CARE

1. <u>Immunisation</u> - Lancashire

   Specialist in community medicine refuses to allow GPs to do childhood immunisation.

   Result: unacceptably low uptake rates achieved, putting children at risk of disease.

2. <u>Ambulance Service</u> - North West

   Drivers and attendants insisting on eating sandwich lunch at home station.

   Result: life saving vehicle involved in unnecessary journies away from DGH.

3. <u>Discharge of In Patients</u> - London

   Consultant ophthalmologist decides to keep discharge decision to himself despite fact that he only does one word round per week.

   Result: patients stay in hospital up to 6 days longer than necessary.

4. <u>Waiting List/Times</u> - Manchester

   Consultant claims waiting list is his personal property and allows no management access to it.

   Result: management cannot take action to reduce list - one patient on it for 13 years.

5. <u>Cancellation of Operations</u> - Preston Health Authority

   Consultant anaesthetist refuses to work with anyone other than consultant-level surgeon.

   Result: Operating list cancelled for 6 weeks of anaesthetists leave <u>and</u> 6 weeks of surgeons leave.

6. <u>Lack of Registrar Cover</u> - Manchester

   Local Medical Manpower Committee decides not to allocate registrar to key specialty because of emphasis on training priority, disregarding service implications.

   Result: Operating lists cancelled unnecessarily during annual leave absence of consultant surgeon.

7. <u>Past Use of Qualified Nurses</u> - Manchester

   Nurse manager insists that qualified nurses (3) are needed by one doctor in dermatology in case any patient requires examination.

   Result: Qualified nurses in short supply are used for most of their time on receptionist duties.

8. <u>GP Prescribing</u> - Bournemouth

GP visited sick holidaymaker and issued every person in hotel with same prescription 'just in case' of illness.

Result: Unnecessary prescribing with high cost to drugs bill and fees to GP

9 <u>Domiciliary Visits</u> - Dorset

GP sets half mile radius for practice boundary.

Result: collects large number of higher fees for home visits near to surgery.

10. <u>Short Surgery Hours</u> - Manchester

GP only does 1 hour surgery each day.

Result: gets high basic practice allowance for poor service to patients.

11. <u>Excessive Prescribing</u> - Manchester

GP prescribes £30,000 worth of drugs to patient with short life expectancy.

Result: High drug cost and suspected financial incentive from pharmacist.

12. <u>Abuse of Cost Rent Scheme</u> - Dorset

GP claims exceptional site costs eg antique furniture, building work which can easily be converted back to family residence

Result: Personal gain from money intended for patient benefit.

13. <u>Admission of In Patients</u> - London

Consultant who does operating list on Tuesdays admits patients on previous Friday so that junior doctors can do paperwork.

Result: Low bed through put and patients in hospital longer than necessary.

14. <u>High Drug Costs</u> - East Anglia

Consultant cuts use of high cost drug by 90 per cent per patient but because drug is produced in one size capsule staff are throwing away remainder of capsule.

Result: Drug bill kept artificially high despite economy initiative.

002/2981

CONFIDENTIAL

FROM: **P T WANLESS**
DATE: **8 May 1989**
EXNT: 5086

MR SAUNDERS (ST2)

cc:
Chancellor
Sir Peter Middleton
Mr Anson
Mr Phillips
Mrs Lomax
Mr Luce
Miss Peirson
Mr Hansford
Mr MacAuslan
Mr Richardson
Mr A M White
Mr Griffiths
M D Rayner
Mr Call

PMP

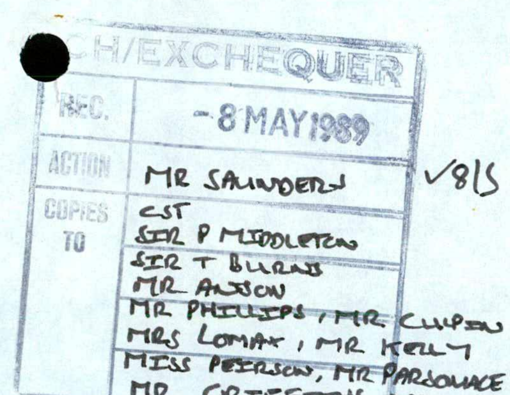
NHS REVIEW IMPLEMENTATION: 1989-90 IN-YEAR BID

The Chief Secretary was grateful for your submission of 2 May.

2 The Chief Secretary is content for you to accept cash limit increases and claims on the Reserve this year of £32 million non-running costs and £7.4 million running costs, so long as the Department of Health are willing to agree the terms which you quote in your paragraph 9.

PW.

PETER WANLESS
Assistant Private Secretary



10 DOWNING STREET
LONDON SW1A 2AA

From the Principal Private Secretary

8 May 1989

Dear Flora

WASTEFUL AND RESTRICTIVE PRACTICES

The Prime Minister has seen your letter to me of 4 May and the annex attached to it listing a number of restrictive and wasteful practices adversely affecting patient care. She was very grateful for this material but has asked for advice on whether these examples could be used in the House.

I am copying this letter to the Private Secretaries to the other members of the Cabinet and to Sir Robin Butler.

Yours sincerely

Andrew Turnbull

(ANDREW TURNBULL)

Mrs. Flora Goldhill,
Department of Health.

7.8.5.89

Thanks – happy to do this

FROM: R B SAUNDERS (ST2)

DATE: 9 May 1989
x 4800

CHANCELLOR

Ch/ OK for us to write to DM, or are we merely stating the obvious?

cc Chief Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mrs Lomax
Miss Peirson
Mr Gieve
Mr Todd
Mr Griffiths
Mr D Rayner
Mr Call

NHS REVIEW: WASTEFUL AND RESTRICTIVE PRACTICES

Mr Clarke's office circulated on 4 May a list of simple examples intended to demonstrate why reform was needed in the NHS.

2. The Prime Minister has now asked whether this material could be used in the House. I attach a commentary on it. My general conclusion is that, while the examples demonstrate appalling waste and inefficiency, they are a bit anecdotal and it is unclear what the reforms in the White Paper or the new GP contract will do to tackle them.

3. Many are examples of bad management locally, or failure to stand up to trade union or professional vested interest. The reforms will introduce new incentives to improve management generally: the internal market will force managers to look at their costs more critically; medical audit will make it more difficult for individual doctors to hide behind professional mystique; and the reforms to the distinction award system will make doctors think more clearly about management. But, as the attached note shows, the links between these cases and specific White Paper proposals are much more tenuous. (It is interesting, incidentally, that the only White Paper reform which tackles any of these problems directly is indicative prescribing budgets for GPs - which underlines the importance of keeping this proposal.)

4. I would not suggest circulating the detailed critique. (When I spoke to them, the DH policy division were unaware of Mr Clarke's note, which may have been prepared by his special adviser without consulting officials.) But it might be worth sending in some cautionary comments, as in the attached draft. Alternatively, you could wait and see how Mr Clarke responds before intervening yourself.

typical!

R B SAUNDERS

8.8.5.89

RESTRICTIVE PRACTICES ADVERSELY AFFECTING PATIENT CARE

1. Specialist refuses GPs permission to do childhood immunisation.

Comment: Unclear what power a community specialist has to do this. New contract includes incentives for GPs to ensure that children are immunised.

2. Restrictive practices by ambulance drivers.

Comment: Matter for local management, not White Paper.

3. Consultant refuses to delegate discharge decisions.

Comment: Poor management locally. Medical audit may help.

4. Consultant keeps waiting list from management.

Comment: Unclear what this means. May just be a problem of poor management.

5. Operations cancelled because anaesthetist will only work with consultants.

Comment: As 3.

6. Registrars wrongly allocated by LMMC.

Comment: Not tackled in White Paper, which specifically reserves medical manpower decisions to Royal Colleges.

7. Inefficient use of nurses.

Comment: Not tackled at all in White Paper.

8. GP writes prescriptions "just in case".

Comment: Will be tackled by indicative prescribing budgets.

9. GP sets half mile radius for practice boundary.

Comment: Not affected by new contract; home visiting requirements unchanged; increased capitation proportion a disincentive to this.

10. GP does only 1 hour surgery per day.

Comment: Dealt with by new contract, which requires at least 20 hours per week direct consultations.

11. High drug expenditure on terminally ill patients.

Comment: Problems will be tackled by indicative prescribing budgets.

12. GP gets antique furniture, renovation of house, etc at public expense.

Comment: Cash limits introduced by Health and Medicines Act will help; but practice budgets may make this problem worse.

13. Patients admitted unnecessarily long before operation.

Comment: Result of poor local management.

14. Drug wastage.

Comment: Straightforward problem with supplier; not addressed by White Paper proposals.

4.9.5.89

DRAFT LETTER FROM MR SPARKES TO:

Flora Goldhill
Department of Health

pls type as final. copy list as cover minute.

NHS REVIEW: WASTEFUL AND RESTRICTIVE PRACTICES

The Chancellor has seen your letter of 4 May to Andrew Turnbull, and his reply of 8 May and your subsequent letter of 11 May.

He thinks these anecdotes are striking illustrations of the waste and inefficiency to be found in the NHS. The White Paper and the new contract for GPs are intended to improve efficiency and can therefore be expected to help tackle such problems generally. But if these examples are to be used publicly, it will be necessary to point to specific ways in which the Government's proposals will tackle each individually. This will be possible for some, but more difficult for others. He suggests that Mr Clarke's response to the Prime Minister should indicate what specific solutions are in the White Paper proposals.

I am sending copies of this letter to recipients of yours.

He feels that [illegible] [illegible] specific [illegible] the [illegible] [illegible] point @ X in Mr Clarke's letter of 14 May to [illegible].