PO-CH/NL/0102

PART 4

Part. U.

SECRET

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Begins: 10/5/89.
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PART U

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PART U

Chancellor's (Lawson) Papers:

THE NATIONAL HEALTH SERVICE REVIEW

Disposal Directions: 25 Years

14/8/95

cst.rj/docs/8.5.1

RESTRICTED

FROM: A G TYRIE
DATE: 10 May 1989
cc: Chief Secretary
Mr Anson
Mr Phillips
Mr Saunders
Mrs Chaplin
Mr Call

CHANCELLOR

HEALTH REVIEW

When we come forward with legislation, hopefully at the beginning of the next Session, we will get another opportunity to sell the package. We still have to convince people on a couple of big points:

- A Health Review really is needed. We need to show that the health service is wasteful. Treatment costs twice as much in one area as another with no improvement in care etc. The health service is also badly managed: bad working habits and restrictive practices must go.

- This Review will benefit patients.

A. On the need for a review we are finally getting hold of some good information to prove the case. There are now some fairly good examples of identical treatment costing wildly different amounts. We must give these more prominence and explain why the Review will help tackle it.

There are also many examples of bad management and restrictive practices. The list of examples sent from DoH to Andrew Turnbull on restrictive practices adversely affecting patient care, are appalling. Some of them are hangovers from a public sector mentality which is being eroded in privatised industries. We could give those an airing.

Of course, telling people that all is not well with the health service may convince a few that our Review was necessary. It may convince just as many that it's all our fault, probably because of underfunding. But now we have gone ahead with this Review we have no alternative but to explain why it was really necessary. That job is half done.

B. <u>Something for patients</u>. Here we haven't taken much ground. People think we are up to no good in the Health Review simply because it is so difficult to explain to anybody what is in it for patients. Accounting, auditing, GP budgets and the like are at best are an instant turn off. At worst all this Treasury-led stuff can be construed as sinister meddling with the NHS prior to dismantlement.

The introduction to the first chapter talks about a better health service for patients but, apart from paragraph 1:13, there are few tangible suggestions.

What about producing "A Charter for Patients"? It should be possible to put something together that is more or less cost free, but not content free. Of course this idea isn't new; it's well trodden ground, but for reasons I can't fathom DoH still aren't getting on with it.

Here are some preliminary suggestions on content. Nick True, a former adviser at DHSS, gave me some ideas. Dick Saunders tells me that this stuff won't provoke a spending bid.

(i) A right to know. Except in exceptional and very narrowly defined circumstances patients should have a right to know what is wrong with them. GPs and clinicians should have a duty to tell them, in plain English.

At least one relative should also be given the right to the same information, except where the patient has expressly forbidden it.

At present clinicians are under no obligation to tell patients, relatives, nor even the patients' GPs anything about their patients' illness or treatment. I understand that a clinician's only obligation is, on discharge of the patient, to notify the GP. This is antiquated paternalism of a highly developed order. It should go.

Patients should also have a right to know who is treating them, perhaps with a note explaining hospital hierarchy and with the name of someone whose responsibility it is

to make sure they know when the visiting hours are, and other basic information about the hospital.

(ii) Admission. Many patients find that they have to go through the admission bureaucracy twice. Hospitals must organise themselves so that this does not happen.

(iii) Casualty. Administrative incompetence sometimes results in casualty patients being shuffled from hospital to hospital or lying around on tables for hours without knowing what's going on. On arrival they should be told roughly how long they have to wait and why they are waiting. [To be cynical – the wait in casualty is often a v. necessary rationing device and gets rid of all the people who only have a cold and shouldn't be there in the first place as they can see their GP in the morning – MPW]

(iv) Appointments. Paragraph 1.13 of the White Paper says that appointment systems should be developed on which people can rely. That's true. Furthermore, appointment systems for out patient treatment should be organised by 'phone. [Four years ago I was referred to Barts, and given an appointment time by post. I was unable to change this by 'phone. On arrival I found that 19 others had also been summoned at exactly the same time, to one doctor. This, apparently, is standard practice.]

(v) Basic facilities. It should not be too difficult or costly to provide some basic things and to announce publicly that these are going to be available:

- two chairs for every hospital bed;

Could rebound.

No doubt v. necessary, but if I were G Brown, a doctor, or anyone on a waiting list, the easy jibe is: "how about a bed for everyone who's waiting for an operation."

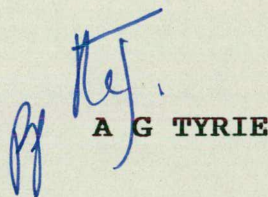
m.

- some flexibility about sleeping arrangements for relations etc;

- standard arrangements to enable relatives to buy meals and to eat surplus food free;

- access to a telephone. (Could we make the same demands on BT over public 'phones for hospital 'phones? At certain times it should be possible to permit calls direct into patient wards. There should also be facilities to leave messages at hospitals.)

"A Right to Know" may require legislation but the rest does not. These ideas (and there must be many more) are largely cost free and common sense.



A G TYRIE

FROM: D I SPARKES
DATE: 10 May 1989

MR SAUNDERS (ST2)

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

BF 15/5

NHS REVIEW: WASTEFUL AND RESTRICTIVE PRACTICES

The Chancellor was grateful for your minute of 9 May concerning Mr Clarke's list of wasteful and restrictive practices in the NHS. The Chancellor would prefer to wait and see how Mr Clarke responds to the Prime Minister's request before intervening.

D.C.S.

DUNCAN SPARKES

FROM: MISS M E PEIRSON (ST)
DATE: 11 MAY 1989
X 4500

PS/CHIEF SECRETARY

cc PPS — 2nd.
Mr Anson
Mr Phillips
Mrs Lomax (GEP)
Mr Richardson (GEP)
Mr Saunders o/r (ST2)
Mr Griffiths (ST2)

NHS REVIEW IMPLEMENTATION: 1989-90 IN-YEAR BID

1. Mr Griffiths has already told you that Mr Clarke wishes to make a statement in the debate today about the extra resources you have agreed. (DH have confirmed that Mr Clarke does want to make a statement. See below.)

2. The draft being put to him at the moment is as follows:-

i) To be included in Mr Clarke's statement (ie Mr Clarke does not want to wait to be pressed):

> "I shall be making available some extra resources in the current financial year to cover the additional work in the NHS and in my department to begin implementing the review."

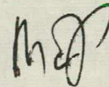
ii) To add if pressed:

> "This brings the total available for implementation this year to over £82 million which will be used to provide financial information for doctors, to fund pilot projects, and to provide the resources both in staff and consultancy in my department for the implementation of our proposals."

3. This wording is acceptable. It avoids the original reference to "the amounts which we at present estimate are necessary"; and the reference to £82 million is all right because it takes in the £43 million for the implementation of the review which was included in the Autumn Statement settlement.

4. The question remains whether Mr Clarke should say anything at all. His officials will make the point to him that, in the context of complaints from the NAHA about £400 million under funding, the £82 million might look a little small. But Mr Clarke is keen to make an announcement and probably will disregard the argument.

5. His private office will be in touch with you after he has looked at the above drafting. I suggest that if Mr Clarke wishes to make a statement on the above lines we should leave it to him.



MISS M E PEIRSON

FROM: MISS M P WALLACE
DATE: 11 May 1989

MP

MR A G TYRIE

cc PS/Chief Secretary
Mr Anson
Mr Phillips
Mr Saunders
Mrs Chaplin
Mr Call

HEALTH REVIEW

The Chancellor was grateful for your minute of 10 May.

2. He agrees that there is a risk that a campaign to convince people that all is not well with the NHS could rebound - all the Government's fault, under-funding etc. So the Chancellor thinks there is a need to tread carefully here.

3. On your suggestions for a "Charter for Patients", he is attracted by making a priority of Items (ii) and (iv) — improving the admission and appointments systems.

MOIRA WALLACE

1381A

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

Andrew Turnbull Esq
10 Downing Street
LONDON
SW1A 2AA

11 May 1989

CH/EXCHEQUER
REC. 12 MAY 1989
ACTION MR SAUNDERS 12/5
COPIES TO C&T, SIR P MIDDLETON, SIR T BURNS, MR ANSON, MR PHILLIPS, MR CULPIN, MRS LOMAX, MR KELLY, MISS PEIRSON, MR PARSONAGE, MR GRIFFITHS, MR CALL.

Dear Andrew

WASTEFUL AND RESTRICTIVE PRACTICES

Your letter of 8 May asked about the use of the examples annexed to my letter of 4 May.

The cases could be quoted publicly as examples of the inefficient use of resources that we need to tackle if the NHS is to give better services to patients and provide value for money. The White Paper proposals will lead to better management of the NHS and in particular will enable doctors to play a fuller and more responsible role in that management.

There is a risk, however, that a Minister quoting these examples could be asked to identify the individuals concerned. The examples should, therefore, be used with care so as not to identify individuals or, indeed, blacken the profession as a whole. In all cases, local managers have taken action to put things right.

A further point is that the GPs' contract has now been settled. We therefore advise against drawing attention to examples 9, 10 and 12 in my original letter since the issues have been covered in the contract. Finally, we have now learned that the case in question at example 11 may be investigated by the police. An alternative example is therefore attached.

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

Yours sincerely

Flora Goldhill

FLORA GOLDHILL
Private Secretary

GP PRESCRIBING

General Practitioners have prescribed such items as margarine, soft drinks, toothpaste, coffee whitener and soap powder. Many products of this type which have been prescribed in the past have now been added to the list of products which may not be prescribed at NHS expense. These include:

- Flora margarine
- Boots Orange drink
- Carnation Coffeemate
- Cadburys Coffee Compliment
- Badedas Bath Gelee
- Simple Hair Conditioner
- Farleys rusks

Treasury Chambers, Parliament Street, SW1P 3AG
01-270 3000

15 May 1989

Mrs Flora Goldhill
PS/Secretary of State for Health
Dept of Health
Richmond House
79 Whitehall
LONDON
SW1A 2NS

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

pmp

Dear Flora,

NHS REVIEW: WASTEFUL AND RESTRICTIVE PRACTICES

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

The Chancellor thinks that if these examples are to be used publicly, it should also be explained how the Government's proposals will tackle them. This will certainly be possible for some, but may be more difficult for others. In particular, he feels that something more specific than the general point you make in the last sentence of the second paragraph of your latest letter is needed.

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

Yours sincerely

Duncan Sparkes

DUNCAN SPARKES
Assistant Private
Secretary

dg11.5.2

CONFIDENTIAL

FROM: D P GRIFFITHS (ST2)
DATE: 16 May 1989
Ext 5216

There are conflicting considerations. You may like to discuss the issues first with us and then perhaps with the Chief Secretary. MEP 16.5

1. MISS PEIRSON

2. MR ANSON

3. ECONOMIC SECRETARY

Copies attached for:
Mr Anson
PPS
PS/Chief Secretary
PS/Paymaster General

cc Mr Phillips
Mrs Lomax
Mr Luce
Mr Willacy
Mr Gilhooly
Mr Hansford
Mr Richardson GE
Mr Saunders
Mr Todd PSE
Mr Binns
Mr Dow
Mr Michie
Ms Harris RC
Mr Call

PS/C&E }
Mr Ruston } C&E
Mr McIntyre } (Sols)

VAT AND CONTRACTING OUT IN THE HEALTH SERVICE

Introduction

1. We have been considering at your request whether any change should be made to the rules governing refunds of VAT on work contracted out by Health Authorities. This follows correspondence from MPs and others concerned with the Health Service (including letters from the Scottish Minister for Education and Health). The changes these letters have suggested for the NHS would involve a significant shift in policy and have implications for the rules for Government Departments as well as health authorities. There might also be some distortion of competition between the public and private sectors which might contravene EC law.

2. This submission discusses the issues and presents four options for consideration.

Background - Section 11 of Finance Act 1984

3. Government Departments and health authorities do not have to pay VAT on services provided in-house; but they do on those contracted out. In theory all that is needed to ensure that

Departmental and health authority managers do not take distorted decisions is to require them to compare costs on a VAT-exclusive basis. But managers will be influenced by the cash costs they have to bear. Therefore, in order to remove a disincentive to the use of outside contractors, powers were taken in Section 11 of the Finance Act 1984 to refund to Government Departments payments of VAT on certain services acquired for non-business purposes from private contractors. For this purpose "Government Department" is defined in Section 27(4) of the Value Added Tax Act 1983. Because it includes "any body of persons exercising functions on behalf of a Minister of the Crown", the term covers Health Authorities (as well as many other bodies for the purpose of the 1983 VAT Act). (Local authorities are able to reclaim the VAT attributable to their non-business activity under Section 20 of the VAT Act 1983. Under Section 49 of the VAT Act 1983 there is also a separate scheme for the Northern Ireland Civil Service, under which they get more or less all their VAT refunded.)

4. VAT is not refundable on contracted out services in connection with business activities such as paybeds. However, it is not really practicable to ensure that no VAT is reclaimed in any such area. For example, where a cleaning contract covers a whole hospital, it would not be feasible to identify and disallow refunds for all elements supporting paybed-related work. But the position will need to be kept under review and we are considering whether health authorities should make an explicit adjustment to their paybed prices to take into account the benefit of being able to reclaim VAT on contracts which cover business activities.

5. Government policy regarding Section 11 was set out in the speaking notes prepared to guide the legislation through Parliament (copy at Annex A), although they were not read out in full in Committee. The notes stated explicitly that it was not intended to give Government departments (and thus also the NHS) any automatic right to reclaim the tax incurred on non-business expenditure. The powers were to be discretionary, applied only in cases where the Treasury is satisfied that VAT acts as a disincentive to contracting out services which have traditionally been performed in-house or where an in-house capability exists. The policy has consistently been that a disincentive exists

only in those marginal cases where, without a refund, the contracted out service would cost more but, with a refund, it would cost less. The types of services involved are identified by Department in a Treasury Direction which is revised annually and published in the relevant Gazettes.

6. In the latest year for which figures are available (1987-88) VAT refunds claimed under Section 11 were £85 million for Government Departments and £152 million for Health Authorities. These large amounts result - at least as far as the NHS is concerned - because the disincentive criterion has not been applied (see paragraph 7 below). The amount of VAT refunded has been steadily increasing both for departments and the NHS and so a requirement for requalification at least every five years was introduced recently to weed out cases that no longer meet the criteria.

Health authority procedures

7. Due to the lack of clarity in the original Treasury Direction and uncertain guidance from DHSS, until last year health authorities had been operating on the mistaken impression that VAT could be reclaimed on any contracted out service listed in the Direction for which they had an actual or potential in-house capability. The result was that health authorities were reclaiming VAT on more or less all the services they were contracting out instead of only on those which met the Section 11 disincentive criterion.

8. However, following further Treasury guidance to departments, the Department of Health issued fresh guidance last August (copy attached at Annex B) to explain how the Section 11 scheme should be operated. Unfortunately the Department did not consult us about the terms of the guidance which was misleading in two respects. First, it suggested that the policy had changed, whereas the 1 April 1988 Treasury Direction had (as you will recall) done no more than clarify the legal position in fresh language supplied by the Treasury Solicitor's Department. Second, it made the scheme out to be more restrictive than it really is by stating that a necessary condition for a refund was that the service in question

must have actually been already performed in-house by the particular Authority. In fact both the Treasury and Customs and Excise have always interpreted the rules as relating to services of a type traditionally performed in-house by the type of body in question (ie the body did not need to create the in-house capability before copying parallel bodies by contracting the work out).

9. However, the guidance was correct in stating that, as the Section 11 rules stand at present, VAT can only be reclaimed if the price of the external tender including tax is higher than the cost of performing the service in-house. It is this disincentive condition which causes concern, given the latitude which health authorities have in practice regarding their choice of contractor. (Like other parts of Government service, health authorities are not obliged to accept the lowest bid they receive but must, in accordance with general guidance, take into account factors such as the ability of the contractor to perform the work to the required standard and the likelihood of any cost overrun.)

Potential problem with the Section 11 disincentive criterion

10. The problem has two aspects. First, despite the intention of the Section 11 scheme, VAT may still act as a disincentive to contracting out in some cases. If the price difference between the in-house bid and the outside contractor (including VAT) favours the latter by a narrow margin and hence no VAT refund is available, the Authority might decide that the cash advantage is too marginal when compared against the risk and upheaval of contracting out. (Any redundancy costs associated with contracting out have to be reflected in the cost comparisons, and are cash costs for health authorities - though it might well be possible for the Department of Health or Regional Health Authorities to make provision centrally.) This situation could, of course, arise equally with a VAT - exclusive price; (and anyway, if the cost advantages are so slight relative to the risks, re-tendering at a later stage may indeed represent the best course). But in this case the value for money comparison would be more straightforward and not complicated by the uneven application of VAT.

11. Second, a health authority could be tempted to accept an outside tender above the one offering best value for money because VAT refunds would make it more attractive in cash terms. This would be outside the rules and a distortion of prudent budgetary decisions, in that the Health Authority pays a higher price than it should and the Exchequer loses the VAT revenue. But we suspect that some will see it as a device to maximise their own savings as shown below:

	£
In-house price	116,000
Tender A £100,000 + VAT	115,000
Tender B £110,000 + VAT	126,500

If Tender A is accepted, VAT is not refundable and the authority saves £1,000 pa but if it ignores Tender A and accepts Tender B, VAT is refundable - offering a cash saving of £6,000 to the Authority but with the Exchequer forfeiting £16,500 in VAT. In the worst case, suppliers and managers could connive, so that the suppliers obtained a higher price and the managers a VAT refund.

12. The correct course is for the purchasing organisation to assess all the outside tenders first and to select the one offering best value for money. This should then be compared (including VAT) against the in-house cost and, if it is higher as a result of the VAT but otherwise preferable, the VAT can be reclaimed. This encourages genuine competition between tenderers and rewards those offering best value for taxpayer's money. But in practice this is difficult to enforce. Indeed, as far as DH are aware, no checks are made by health authority auditors - internal or external - to establish whether all the sums claimed fall legitimately within the Section 11 arrangements. We have notified the department that we shall want to examine what should be done to remedy this when we have settled the Section 11 policy. As far as the rest of Government is concerned, internal audit would be expected to verify the VAT refund claim system as part of their regular 5-7 year cycle of investigations in their department, and no abuses have been reported so far. There may be scope for tightening up procedures even more in departments, but the NHS situation is more difficult.

13. Neither we nor Department of Health know how prevalent serious confusion on the correct application of the Section 11 arrangements is within the NHS, but the guidance recently promulgated by the Department of Health caused a number of complaints from Health Authorities who feel the regime (correctly applied) discourages contracting out, at least by comparison with their earlier non-application of the disincentive criterion. It is too early to know what effect the new guidance has had in reducing the level of VAT refunds to health authorities: about £45 million was claimed in the final quarter of 1988 as against some £40 million in the equivalent period of 1987. However, the higher figure could reflect factors such as inflation, increased contracting out or simply contracts in the pipeline before the Department's guidance had issued.

New Construction

14. We are facing further problems now that VAT is being applied to new construction. Following the ECJ judgement Treasury Ministers decided to compensate health authorities for the application of tax by adding new construction to the schedule of Section 11 services rather than increasing voted provision. The rationale was that this would be no more than the extension of the already existing arrangements in respect of VAT on building alterations and extensions and that it would be anomalous and inefficient to deal with different bits of health authorities construction in different ways. The intention was to give full relief for the VAT costs. Your announcement in the Commons stated that " full refunds of VAT on non-domestic construction will be available to both health authorities and local authorities ".

15. However, to obtain refunds under the existing regulations health authorities must have carried out cost comparisons which show that VAT makes the external tender higher than an actual or potential in-house bid. But we are now clear that, although most health authorities have some direct labour organisation and have been claiming VAT on major refurbishments for some time, none has the capability to build a big new hospital. Legal advice is that it would be placing the Section 11 legislation under great strain to permit health authorities to receive refunds for either

their larger new construction projects or for major refurbishment work. It would be difficult to justify a distinction between new construction and major refurbishment contracts on the basis of the in-house capability, and excluding these from VAT refunds will lead the Department of Health to seek compensation through increased public expenditure provision.

Options

16. There are four possible options:

(i) maintaining the present Section 11 policy, making no VAT refunds for new construction/major refurbishment work by health authorities but compensating them by increasing public expenditure;

(ii) issuing a new Treasury Direction allowing the NHS (but not departments) refunds for new construction/major refurbishment work but maintaining the rules as now for other contracts;

(iii) replacing the rules via a new Direction granting more automatic refunds of VAT on all NHS contracts, but leaving the rules for Government departments unchanged;

(iv) abolishing the disincentive criterion for both health authorities and Government departments.

Discussion

Option 1

17. This option would involve amending the announcement you made at the time of the decision to apply VAT to new construction and would increase public expenditure by at least £100 million a year. It would involve a claim on the Reserve in the current year, but this should be offset by reduced VAT refunds and so should prove neutral in terms of the PSDR. The availability of refunds for new

construction work and major refurbishment is inconsistent with the existing Section 11 rules and this option would correct this anomaly.

18. More generally, however, the incentive for contracting out in the NHS may still not be strong enough to overcome the negative perception of health authority management; and the scope for distorted decisions as outlined in paragraph 11 above would still remain. On the other hand, this option would avoid NHS hospitals having a potentially significant comparative advantage over private hospitals by being able to obtain VAT refunds when the latter cannot deduct tax on similar supplies (health care is an exempt supply so private hospitals cannot offset input tax on construction by charging their customers VAT). Such a comparative advantage could be held to lead to a "significant distortion of competition" in contravention of EC law. This issue is discussed in more detail in paragraphs 23 - 26 below.

Option 2

19. Legal advice suggests that the present legislation would permit adaptation of the Section 11 rules to ensure that VAT could be reclaimed on all new construction/major refurbishment work contracted out by health authorities. This would avoid the need for a claim on the Reserve and an increase in public expenditure, but since the amount of VAT reclaimed would increase with the provision of full refunds on new construction, the effect on the PSDR should still be neutral. But the general considerations outlined in paragraph 18 above would remain the same (with health authorities having a competitive advantage over private sector hospitals through their ability to reclaim VAT on new construction/major refurbishment when the latter could not).

Option 3

20. Under option 3 refunds would be available on any external NHS contract where there was an actual or potential in-house capability, irrespective of VAT being a disincentive but subject to the application of all the other existing rules. A pragmatic interpretation of potential capability would be needed to provide

the health authorities with the promised full refund of VAT on new construction. This could be achieved via a new Direction but VAT refunds to health authorities would continue to increase each year, and it would not be practicable to reduce this through periodic requalification.

21. The greater automaticity introduced into the scheme for health authorities should remove any potential problems implied by the existing rules as outlined in paragraphs 10 and 11 above. It should help to combat inertia and hostility to contracting out when the competitive tendering initiative is extended beyond non-clinical support services, as announced in the NHS White Paper. Health authorities would gain a greater cash advantage on contracting out, and would no longer see some of the savings going to the Exchequer in VAT payments. It would also make the VAT refund rules easier to operate in the NHS.

22. But there would be a cost to the PSDR which would grow with the extension of competitive tendering in the NHS. The Exchequer would be forgoing VAT revenue it otherwise would have received with no offsetting reduction in public expenditure. It is unlikely that we could make an appropriate reduction to the hospital service baseline in the Public Expenditure Survey to compensate for the refunds or ensure that no unplanned increase in public sector activity resulted (though our hand would be strengthened in pressing for a higher level of cost improvement savings by health authorities). Moreover, such a change in the rules would mean that we would be making refunds in probably a large number of cases where VAT could not be described as a disincentive to contracting out. However, it is impossible to say how much additional VAT revenue would be forgone.

23. The risk of contravening EC law on competitive advantage applies more keenly here, given the changes to be introduced in the health service following the NHS Review. There is already a drive for NHS hospitals to raise extra income through their own efforts, including expanding their paybed activities (and they are now free to charge commercial rates). They will thus be competing with independent hospitals for private patients. Insofar as the

NHS Review reforms make the public health care sector more efficient and businesslike, this competition will intensify.

24. More importantly, in the post NHS Review world there will also be greater competition between public and private sectors for NHS patients (ie non-business activity). The reforms envisage that health authorities become primarily purchasers rather than providers of health care for their resident populations, entering into contracts for the supply of given services. Health authorities will continue to manage some hospitals (though it is expected that as time goes on increasing numbers of hospitals will opt for self-governing status) but they will not be expected to favour these over other providers - public or private. The White Paper makes it clear that health authorities will be expected to consider opportunities to buy in services from the private sector in carrying out their new role.

25. Hence the Section 11 arrangements could give NHS providers (whether self-governing or health authority-run hospitals) an advantage over the private sector. The former would at least in some circumstances be receiving VAT refunds on contracted out services whereas the latter would be paying VAT on all theirs (and, as noted above, unable to charge VAT on the supply of health care). This could place the public hospitals at a competitive advantage in bidding for contracts for NHS work such as the provision of elective surgery (eg hip operations) as well as in competing for private patients. The wider the Section 11 arrangements are, potentially the less level the playing field is likely to be.

26. Article 4(5) of the Sixth EC Directive provides that Government authorities are not to be considered taxable persons unless, in respect of activities carried on by them, their non-taxable status would lead to significant distortion of competition. We have not yet taken legal advice on what would constitute "significant distortion of competition". There is of course no prospect of creating absolutely equal competitive conditions between the public and private sectors. And, to a large extent, it is a matter of deciding where adjustments are most needed to ensure that fair competition is maintained and promoted.

Relaxing the Section 11 rules for health authorities is likely to benefit the private sector as providers of ancillary services (whether clinical or non-clinical) to NHS hospitals but to disadvantage them over construction/refurbishment and as health care contractors carrying out full-scale surgical and medical care for NHS patients. It is a matter for consideration whether the overall effect would be to give such an advantage to NHS hospitals over the private sector that there would be a significant distortion of competition in contravention of EC law. We would need to take further legal advice on this if you were minded to pursue this option.

Option 4

27. Government Departments have not been affected by the confused guidance issued to health authorities. But introducing a more generous system for the NHS could lead to growing pressure by Departments for parallel treatment for parallel services.

28. If the disincentive criterion were abolished for Government departments as well as the NHS, this would decrease the PSDR by the extent to which VAT refunds were granted where no disincentive to contracting out applies. The latest CUP report on contracting out shows savings at over 25%, so large numbers of contracts could be affected, but neither we nor Customs are able to estimate the cost. The present policy of requiring departments to re-qualify through fresh tendering at least every 5 years would become impracticable, and the PSDR cost would therefore increase each year.

29. Where Government departments are providing services in competition with the private sector (eg PSA, HMSO, etc) the question of possible contravention of EC law could arise again - but across a much broader and less defined range of activities.

Conclusion

30. The issues involved have turned out to be much more complex than we first thought and appear to involve matters of legal and

political judgement. There is arguably a case for treating the NHS in future on a rather different basis from Government Departments (as was originally decided in the case of new construction), given that there is greater delegation and central controls are more diffuse. But the question of incentives for managers referred to in paragraph 11 above could equally apply within Government departments. Increasingly managers are being held responsible for achieving budgetary targets in cash terms. There may therefore be a case for relaxing the existing procedures in respect of both health authorities and Government departments (this is the option favoured by the Central Unit on Purchasing), but there will be a PSDR cost involved (and the size of the refunds seems certain to grow with every passing year). Moreover, we could be placing the public sector at an unfair advantage and distorting competition to an extent which contravened EC law.

31. We recommend that you discuss the options with officials.

32. This submission has been agreed with RC, FP, the Central Unit on Purchasing and Customs and Excise.

D P Griffiths

D P GRIFFITHS

ANNEX H

CUSTOMS AND EXCISE

FINANCE BILL 1984

Clause 11

REFUND OF TAX TO GOVERNMENT DEPARTMENTS ETC IN CERTAIN CASES

SUMMARY

1. Clause 11 enables Government departments and Health Authorities to receive refunds of the VAT that they incur on services and goods which are acquired for non-business purposes. The provision will operate in respect of such individual departments and such contracted-out activities as the Treasury may direct. The provision has been operating extra-statutorily since 1 September 1983.

THE CLAUSE IN DETAIL

2. The clause adds two subsections to section 27 of the Value Added Tax Act 1983 which deals with the application of VAT to the Crown.

3. Subsection (2A) empowers Customs and Excise to refund VAT to government departments subject to certain conditions being met. These are:
(a) the goods and services are acquired for non-business purposes;
(b) the Treasury directs that the tax chargeable shall be refunded;
and (c) the claim meets any conditions which may be laid down regarding timing, form and manner.

4. Subsection (2B) empowers Customs and Excise to make refunds conditional upon the claimant keeping, preserving and producing relevant records.

5. "Government Department" is defined for this purpose in Section 27(4) of the VAT Act 1983. Because it includes "any body of persons exercising functions on behalf of a Minister of the Crown", the term covers Health Authorities.

PART II: SPEAKING NOTES (NOT FOR CIRCULATION)

GENERAL NOTE

Clause removes disincentive to contracting out.

6. It is Government policy to encourage public bodies to contract-out services to the private sector when it is cost effective to do so. The clause is intended to stop VAT from distorting the cost comparison.

7. For Government departments and Health Authorities, services such as catering, laundry and cleaning provided in-house attract only negligible amounts of VAT on the materials used. When contracted-out, VAT at the standard rate of 15 per cent applies to the full amount charged for the service and this cannot be recovered under the normal VAT credit mechanism when the services are acquired for non-business purposes. So VAT can distort the comparison and is a disincentive to contract out. The purpose of Clause 11 is to provide a permanent statutory basis for the removal of this disincentive to the use of outside contractors, by allowing Government departments and Health Authorities to reclaim VAT paid on contracted-out services for their non-business activities.

Relief will be discretionary

8. The clause is an enabling one and the refund mechanism will be brought into operation only in respect of such individual departments and such contracted-out activities as the Treasury may direct.

9. The provision is discretionary because it is not intended to give Government departments any automatic right to reclaim the tax they incur on their non-business expenditure. It will be applied only in cases where the Treasury is satisfied that VAT acts as a disincentive to contracting-out services which have traditionally been performed in-house, which can be performed more effectively by outside contraction.

What supplies will be relieved

10. The types of contracted-out activity to be covered by the provision will be similar to those which Treasury has already approved as suitable for refunds under the extra-statutory arrangements. This list of approved activities is not closed: Departments have been told that they may make bids for the addition of further activities and that these will be considered by Treasury.

11. The scheme will apply to supplies received by a Government department from other Government departments as well as from the private sector so that Government departments (especially Trading Funds) can compete on an even basis with outside contractors.

What Supplies will not be relieved

12. It is not proposed to bring existing contracted-out activities within the scope of the scheme if they are traditionally done by outside contractors. The provision will not not be applied to the supply of goods on their own since there is no distortion of choice caused by the application of VAT in these circumstances.

Supplies for Taxable Business Activities already relieved

13. Almost all Government departments and Health Authorities are currently registered for VAT and can already recover tax on their expenditure on taxable activities (input tax) under the normal credit mechanism. The refund provision need therefore only apply to supplies acquired for non-business purposes.

Who gets relief

14. The legislation will apply to "Government departments" as defined in the existing section 27 (4) of the VAT Act 1983. This covers:

a. mainstream Government departments, including a few borderline bodies such as the Manpower Services Commission, all of which are Vote funded; and

b. Health authorities. These are "any body of persons exercising functions on behalf of a Minister of the Crown", a term which is included in the definition of Government department in section 27 (4).

15. The provision will not apply to non-departmental public bodies which are outside the scope of the definition of Government department.

Local Authorities relieved by other means

16. The clause does not apply to Local Authorities, which can already claim VAT incurred on expenditure for their non-business activities under the special provisions of section 20 of the Value Added Tax Act 1983.

Extra-Statutory Operation from 1 September 1983

17. This provision originally appeared in the first Finance Bill 1983, but was abandoned for lack of time before dissolution. Customs and Excise introduced the provision on an extra-statutory basis with effect from 1 September 1983 and the Chancellor announced in the House on 25 July that he proposed to include provision for it in the 1984 Finance Bill (OR 25 July 1983 WA Cols 306-308.)

Treasury Direction

18. It is intended that the Treasury direction will be made shortly after the Finance Bill 1984 receives Royal Assent.

Refund Mechanism - Staffing Cost

19. As the refund mechanism is closely dovetailed with existing procedures Customs and Excise anticipate that the work arising from the provision can be contained within existing resources.

Revenue Cost

20. It is too early to give an accurate estimate of the amount of VAT likely to be refunded annually. (Details of refunds made under the extra-statutory arrangement are summarised in paragraph 26).

Alternative Method of Relief - PSBR Effects

21. A similar effect to the refund provision could have been achieved by increasing the Votes of the bodies concerned, but this was considered undesirable and, in any case, under a refund procedure, the amounts concerned can be determined more easily and precisely. In themselves, the changes have a neutral effect on the PSBR by reducing VAT revenue and public expenditure by equal amounts, but they should in practice lead to a lower level of PSBR by encouraging departments to find genuine savings through contracting-out services.

Extension of Relief to Charities (Defensive)

22. The refund mechanism is designed to lead to genuine savings by removing a disincentive to seek economies through contracting-out. To extend the provision to bodies outside Government would add to the PSBR. Very careful thought has been given to the tax treatment of charities in recent years. This is an entirely separate issue which is not germane to the refund provision.

EC Position (Defensive)

23. The refund mechanism is not part of the VAT system as such, and it is therefore outside the scope of the EC Sixth Directive on VAT. It is simply a means by which one element in the costs of Government financed bodies is precisely reimbursed from central funds.

24. Ministers have accepted that any contracting-out of services currently performed by public bodies in-house in the course of their non-business activities will lead to an increase in the UK Own Resources payment to the EC. Were the NHS to achieve full contracting-out of services it is estimated that this would add a total of some £2½ million a year permanently to our present Own Resources contributions. Additionally, because of the way in which Own Resources are calculated there would be an extra charge of a total of up to £20 million in the first two years after full contracting-out took place.

BACKGROUND

Services Covered by the Extra-Statutory Arrangement

25. The following services have so far been approved for refunds when contracted-out.

ADP-DATA preparation and processing
Catering
Cleaning
Debt Collection
Domestic Services (including all cleaning services and ancillary non-nursing ward support duties.)
Laboratory Services
Laundry Services (including linen)
Maintenance - building
 grounds
 vehicles
Maintenance and repair - plants, equipment and furniture
 - vehicles
Pest Control
Photographic work
Portering and messenger services
Press cuttings
Professional services - ADP (including software development and consultancy)
 - design
 - legal
 - management consultancy
 - planning
 - sales of property
 - specialist advice, consultancy or management
Security guarding
Storage and distribution
Telephonist Services (other than British Telecom)
Training
Translation
Transport - Passengers
Transport services
Typing, printing and reprographics
Waste disposal services

Refunds

26. At the latest date on which information is available (31 March) the VAT reclaimed on contracted-out services during the period 1 September to 31 December 1983 is as follows:

21	Government Departments have made claims for a total sum of	£ 653,890
15	Regional Health Authorities have made claims for a total sum of	£ 4,628,948
		£ 5,282,838

27. It is expected that about 50 Government Departments and 23 Regional or other Health Authorities will make claims under the refund mechanism.

ANNEX B

Financial Matters
August 1988

VAT REFUNDS: Contracted Out Services

1. The list of eligible services provided in Appendix 4 of FM 4/87 has been updated by HM Customs and Excise and a new list is attached. The new list is very similar to last year's with some clarification of Item 5.

2. Questions on individual cases should be resolved in the light of available guidance and in consultation with the Regional Health Authority. If necessary Division H2 of the VAT Administration Directorate, HM Customs and Excise, 4th Floor, East Wing, New King's Beam House, 22 Upper Ground, London SE1 9PJ will consider queries raised through Regional Health Authorities.

Revised Conditions for Refund

3. Treasury have recently made the point that VAT on contracted-out services can only be refunded in cases where, if there was no refund, payment of VAT would be a disincentive to contracting out.

4. To bring this policy into sharper focus, Treasury guidelines now provide that:

a) VAT cannot be refunded on services which have not been traditionally performed in-house;

b) when an in-house service is put out to tender (either for the first time or at contract renewal) and is subsequently contracted out, VAT cannot be refunded if the successful bid, plus VAT, was less than the in-house bid;

c) VAT can still be refunded on existing contracted out services, provided they were at some time performed in-house.

5. Any queries on this Appendix should be addressed to Mr P Brunning on Ext 4440 at Room 631 Friars House (01-703-6380).

PPP (have we had advice?)

2 MARSHAM STREET
LONDON SW1P 3EB
01-276 3000

My ref:

Your ref:

CHIEF SECRETARY
REC. 18 ... 1989

Miss Lenson, CX, Sir P Middleton, Mr Anson, Mr Phillips, Mr Edwards, Mr Saunders, Mr Call.

The Rt Hon Kenneth Clarke QC MP
Department of Health
Richmond House
79 Whitehall
LONDON
SW1A 2NS

16 May 1989

Dear Secretary of State,

When I wrote to you in January following my visit to the Audit Commission I said that it would be for you and your Department to take matters forward with the Commission on Health Service audit but that we should need to consult one another further on certain issues concerning the structure of the Commission and appointments procedures. I am now writing to set out my proposals on these matters and to seek your views and those of colleagues.

Under the present legislation the Commission is bound to comprise not less than thirteen and not more than seventeen members. I appoint the members, chairman and deputy chairman jointly with Peter Walker after statutory consultation with the local authority associations, the accountancy bodies, the CBI and the TUC. At present the Commission has the maximum complement of 17 members of whom 8 including the chairman and deputy chairman are generalists drawn from industry, commerce and the profession, with the other having local government experience.

David Cooksey is keen to retain the independent/generalist flavour to the Commission. He would also favour minimising the increase in the size of the Commission for the sake of manageability and to ensure a workable team. I have a great deal of sympathy with his views. I also believe that one of the strengths of the Commission has been that its membership has never been made up of people who see themselves as representing a single interest. I would like to preserve this and to appoint as many good people as we can find with experience in more than one field. However, within those objectives, it may be helpful to us to have an understanding about the broad composition we are aiming for. I also need to ensure a level of local authority experience which will retain the confidence of local government who will continue to fund the greater part of the Commission's work.

I therefore propose an increase in the size of the Commission to a statutory range of 15-20 members. Within this total we might aim to include broadly 6-7 with some local government experience, 4-5 health people and 5 - 8 generalists, though of course some

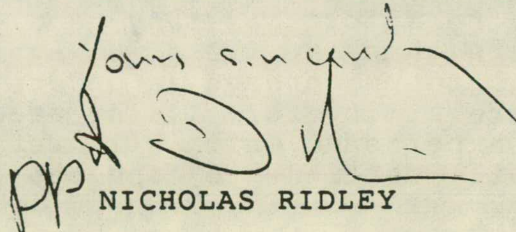
individuals may be found who cover more than one of these areas, which would be all to the good. I would be grateful for your views on whether this seems about the right balance.

We shall need to consult one another about all appointments. I am sure you will wish to take the lead in making health appointments and you may also wish to do so for perhaps one or two of the generalists, as Peter has done in the recent appointment of a Welsh member. This can be agreed each year in the light of particulars of appointees and the then balance of the Commission. Irrespective of who is in the lead, I believe all appointments should formally be made jointly by you, Peter, and me, continuing the present approach Peter and I have followed, and which would serve to emphasise that no one is appointed to represent some particular interest. I also believe it would be helpful if my officials continued to provide the secretariat for the appointments round, and clearly our officials will need to keep closely in touch on all appointments.

Unless the legislation distinguishes different classes of appointments - such as health, local government, and generalist - which would be directly contrary to the aim of building a unified Commission, the same statutory consultation requirements must apply to all appointments. I understand that you do not wish to be bound to consult health bodies. But it would be very difficult for me to withdraw existing consultation rights without arousing strong opposition and mistrust in local government. It is essential we maintain local government's support for the Commission if we are not to diminish its effectiveness. Accordingly, I propose we should amend the existing legislation so as to provide a general consultation duty requiring us to consult those whom we think fit, and I would give an undertaking that we would continue to consult existing consultees on all appointments, although I doubt if they would have much to say about health people. And we could, if you wished, extend the range of consultees for some or all appointments.

I understand that officials have now resolved most of the outstanding issues concerning the Commission's involvement in Health Service. Provided you are content with my proposals on these remaining matters I believe that you now have all you need to proceed with the legislation on the audit of the Health Service next session as part of the Health Service Bill.

I am copying this letter to Peter Walker and John Major.



pp NICHOLAS RIDLEY

(Approved by the Secretary of State
and Signed in his Absence)

min.fv/docs/Contract

CONFIDENTIAL

FROM: J. ANSON
18th May, 1989.
Ext. 4370

ECONOMIC SECRETARY

c.c. Chancellor
Chief Secretary
Financial Secretary
Paymaster General
Mr. Phillips
Mrs. Lomax
Mr. Luce
Mr. Willacy
Miss Peirson
Mr. Gilhooly
Mr. Hansford
Mr. Richardson
Mr. Saunders
Mr. Todd
Mr. Griffiths
Mr. Binns
Mr. Dow
Mr. Michie
Ms Harris
Mr. Call

PS/C&E
Mr. Ruston, C&E
Mr. McIntyre, C&E Sols

VAT AND CONTRACTING OUT IN THE HEALTH SERVICE

You will want to discuss the problem considered in Mr. Griffiths' submission below, and the Chief Secretary may also want to comment. My own personal reactions are as follows.

2. None of the options offers a perfect solution. We are trying to balance two objectives. One is to avoid discriminating against contracting out. That is the purpose for which Section 11 was set up in the first place. The other is to avoid discrimination between public and private sector providers when health authorities are buying health care services, which is one of the main planks in the NHS reforms. But the steps which can be taken under Section 11 to remove the first kind of discrimination are likely to aggravate the second. Mixing the usual metaphor, we are trying to create a "level playing field", but on sloping ground; levelling at one end makes the other worse.

CONFIDENTIAL

3. You will want to consider, therefore, which of these two objectives will do more to bring in the stimulus of the market. From the standpoint of the NHS, the first probably remains more significant in the short term as competitive tendering has already generated substantial savings and is hoped to generate more. The second will become increasingly more important in the long term as a greater market builds up in health care services, and it also seems less likely to fall foul of EC law.

4. Of the four options in paragraph 16, option 1 has some obvious drawbacks, requiring a withdrawal of what you said last summer, and an addition of at least £100 million a year to the public expenditure planning total. It does not deal conclusively with the contracting out problem, although it does most to level the playing field at the other end, and hence to minimise difficulties with the EC.

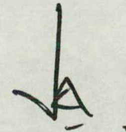
5. Option 2 would enable us to deal with the immediate problem of giving guidance to health authorities on the handling of refunds for new construction and major refurbishment. Apart from that area, it avoids enlarging the present concession and leaves open the possibility of a move to option 3 or 4 later on. But it does not deal with the problems of administering the present concession in paragraphs 10-12 of the submission; and the different treatment of new construction and other services may prove awkward to defend.

6. Options 3 and 4 are those which give primacy to encouraging contracting out and dealing with the problems in paragraphs 10-12 of the submission. Option 3 would deal with the NHS and leave departments where they are, on the principle that it is more difficult to apply a complex test in the NHS where we are operating at more than one remove from the people who are actually taking the decisions. But for the most part the arguments run for departments as they do for the NHS, and option 4 would appear the more coherent solution of the two.

7. Both 3 and 4 would however enlarge the present concession, and might make it more difficult to draw back later if more weight needed to be given to levelling the health care market. They are also the options most at risk from the EC, and their likely cost is still unclear (the evidence quoted in paragraph 13 is inconclusive and we will not get any further useful evidence before we need to give guidance to the health authorities). If you are inclined to favour either of these options we might therefore get further legal advice on the EC point.

8. Opinions in the office are divided. RC would prefer option 2, on the basis that it would avoid enlarging the present concession, and leave the way clear to review the VAT concessions for the NHS (and perhaps also for local authorities) in a couple of years when we can see how the NHS reform is working out. Option 2 is also favoured by Miss Peirson and (marginally) by FP. On the other side, CUP feel that the present rules for Section 11 are not being properly operated by departments and that the problems in paragraphs 10-12 need to be tackled; and they therefore favour option 4. PSE's provisional view is that the economic arguments also point in that direction. I myself also feel that the present rule is over-complicated and that if Section 11 continues we would have to move towards 3 or 4; if option 2 is adopted to keep the matter open for the time being, it ought to be on the basis that the matter is reviewed again fairly soon as RC suggest.

9. Whichever option is chosen, we need to tighten up the system of administering claims - mentioned in the second half of paragraph 12. RC are already pursuing this with Customs and the others concerned.



J. ANSON

CONFIDENTIAL

This request may have been overtaken a bit by events now. But this is an interesting table

FROM: HUGH C BURNS
DATE: 23 May 1989
EXT: 5213

1. MR SAUNDERS (ST2)
2. PS/CHIEF SECRETARY

RS 23/5

cc. PS/Chancellor
Mr Phillips
Miss Peirson
Mr Griffiths o/r
Mrs Chaplin
Mr Call

NHS REVIEW: REPRESENTATIONS FROM MEDICAL ASSOCIATIONS

You asked for information on the extent to which the NHS Review White Paper incorporated prior representations received from various medical and NHS associations. I attach a short summary.

2. You will note that in general their representations did not anticipate many of the Government's proposals. Indeed they tended to concentrate on the issues of funding; alleged under-funding, insurance-based funding systems and individuals opting-out of the NHS.

3. Some organisations which did submit representations are not included in the table because they did not really anticipate any of the Government's proposals (eg the Society of Family Practitioner Committees), but many of the notable ommissions just did not submit any representations at all (eg the Royal Colleges of General Practitioners and of Physicians).

4. You will also wish to note that during the review both the Prime Minister and the Department of Health declined to give any information about the number, source or nature of the representations received, partly because most of the correspondence was regarded as being in confidence (the BMA are an exception in this respect - they published theirs).

Hugh Burns

HUGH C BURNS

4/15/5

CONFIDENTIAL

NHS REVIEW: SUPPORT FOR WHITE PAPER PROPOSALS IN REPRESENTATIONS FROM MEDICAL ASSOCIATIONS SUBMITTED DURING THE REVIEW

Review Proposal	Organisations FOR	Organisations AGAINST
The Internal Market	NAHA (1), IHSM (1) RCS, RCN, KFI (1) HCSA, CMS, TG	BMA, SFPC, COHSE RC of Midwives
Self-Governing Hospitals	HCSA	
An increased role for Clinicians in Management	NAHA, BMA, JCC, KFI TG, RC of Radiologists	
Medical/Clinical Audit	JCC, RCS, CMS, TG British Geriatric Soc.	
Increased Management Flexibility (inc. Pay)	NAHA, IHSM	
Revised role for the NHS Management Board	NAHA, IHSM, KFI, TG	
Acceleration of introduction of RMI	NAHA, IHSM, BMA KFI, TG	JCC
Increased co-operation with private sector	NAHA, BMA, RCN, KFI CMS, TG	
Audit Commission to audit health authorities	CMS	
Revised contracts for Consultants	KFI, TG	
Tax Relief for the elderly	CMS (2)	
100 extra Consultants	JCC, RCS	
Streamline Regional Health Authorities (3)	NAHA, KFI	

Notes: (1) supported experimentation only
(2) suggested 65 as the cut-off
(3) RC of Nursing proposed complete abolition

BMA = British Medical Association
CMS = Conservative Medical Society
HCSA = Hospital Consultants & Specialists Association
IHSM = Institute of Health Service Managers
JCC = Joint Consultants Committee
KFI = Kings Fund Institute (semi-charitable organisation)
NAHA = National Association of Health Authorities
RCN = Royal College of Nursing
RCS = Royal College of Surgeons
SFPC = Society of Family Practitioner Committees
TG = "Trafford Group"

3.24.5.89

FROM: R B SAUNDERS (ST2)
DATE: 24 May 1989
x 4800

CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Anson
Mr Hardcastle
Mr Phillips
Mr A J C Edwards
Miss Peirson
Mr Wellard
Mr Griffiths
Mr Call

pmp

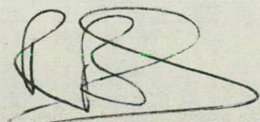
NHS REVIEW: FINANCIAL AUDIT

The letter of 16 May from Mr Ridley to Mr Clarke sets out proposals for expanded membership of the Audit Commission, and revised appointment procedures, when it takes over full responsibility for NHS statutory audit.

2. He proposes increasing the maximum membership of the Commission from 17 to 20, of whom some 6-7 would have local government experience and 4-5 experience of the NHS. The existing duty to consult the local authority associations would be replaced by a general duty for the Secretary of State to consult whoever he saw fit. This would enable Mr Ridley to continue his present practice in relation to the local government appointments, while leaving Mr Clarke a free hand over consultation about the health appointments, in particular not committing him to consult particular bodies. I understand that Department of Health officials will be advising Mr Clarke to accept these proposals.

3. The letter concludes by noting that officials have now sorted out what detailed provisions should be included in the legislation transferring statutory audit to the Audit Commission. I can confirm that this is so, and that the Treasury have been fully consulted.

4. The proposals in the letter are primarily for DoE and DH. You need do no more than note them, and ask Mr Ridley and Mr Clarke to consult the Treasury as necessary about appointments. I attach a draft.



R B SAUNDERS

4.24.5.89

DRAFT LETTER FROM THE CHIEF SECRETARY TO:

Secretary of State for the Environment

NHS REVIEW: FINANCIAL AUDIT

Thank you for sending me a copy of your letter of 16 May to Ken Clarke. So long as he is content I have no objection to any of the proposals you make. No doubt you and he will continue to ensure that the Treasury are consulted as necessary about future appointments to the Audit Commission.

2. I am copying this letter to Peter Walker and Ken Clarke.

cst.ps/3jm26.5/lets

cc:
2 – Chancellor
Sir Peter Middleton
Mr Anson
Mr Hardcastle
Mr Phillips
Mr A J C Edwards
Miss Peirson
Mr Saunders
Mr Wellard
Mr Griffiths
Mr Call

Treasury Chambers, Parliament Street, SW1P

The Rt Hon Nicholas Ridley AMICE MP
Secretary of State for the Environment
Department of the Environment
2 Marsham Street
London
SW1P 3EB

26 May 1989

Dear Secretary of State,

NHS REVIEW: FINANCIAL AUDIT

Thank you for sending me a copy of your letter of 16 May to Ken Clarke. So long as he is content I have no objection to any of the proposals you make. No doubt you and he will continue to ensure that the Treasury are consulted as necessary about future appointments to the Audit Commission.

I am copying this letter to Peter Walker and Ken Clarke.

Yours sincerely,

P. Wallace

pp JOHN MAJOR
(Approved by the Chief Secretary
and signed in his absence)

DEPARTMENT OF HEALTH

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Secretary of State for Health

CHIEF SECRETARY

REC. - 1 JUN 1989

ACTION Mr Sanders

COPIES TO cx, Sir P Middleton, Mr Anson, Mr Phillips, Miss Peirson, Mr Griffiths, Mr Call.

POH(1)2338/36

John Maples Esq MP

30 MAY 1989

Dear John,

Thank you for your letter of 4 April setting out your suggestions on capital charging.

You are quite right in saying that my objectives include cost comparisons, both within the NHS and with the private sector. Equally important, however, is making health service managers fully responsible for the costs of capital so that they are encouraged to use capital efficiently.

I am aware of private sector accounting practices and the near universal rejection of current cost accounting for external financial reporting purposes. There is, however, a distinction between what companies report to their shareholders and what information they use to run their businesses. A business which ignores the rising cost of replacing assets in setting prices (and very modest rates of inflation can have a major impact on even a 10 to 20 year asset life) does so at its peril. Evidence of what private sector businesses, including private sector health care providers, actually do in relation to pricing is not widely available. Such intelligence as we have does indicate that these businesses take account of rising replacement costs and rising land and buildings values.

You have raised many other interesting points in your letter. My officials are already working on some; for example, we are alert to the problems of the central London teaching hospitals which, on the one hand, need to be managerially aware of the high costs of the land they are using yet, on the other hand, represent valuable health care facilities which must not be penalised by simple cost comparisons.

I can assure you that my officials will carefully consider all the points you have made when designing the detail of the capital charging system.

I am copying this letter to John Major.

Yours ever,

Ken

KENNETH CLARKE

CONFIDENTIAL

CHIEF SECRETARY

Miss Peirson
cc. Sir P Middleton
Mr Anson, Mr Phillips
Mr Saunders, Mr A M White
Mr Griffiths, Mr Call.

31/5/89.

Prime Minister

MANAGEMENT ARRANGEMENTS FOR THE NHS IN SCOTLAND

At its meeting on 24 January, the Ministerial Group indicated that "a clear statement of responsibilities would [also] be needed for Scotland". At our meeting on 25 April, I indicated that the arrangements I propose to put in place in Scotland are broadly on the same lines as those now agreed for England. This note outlines my proposals in more detail.

Background

The White Paper referred to Scottish arrangements at paragraph 10.16 - 10.18. The key features were that:-

a. The responsibility for Health Service policy would continue to rest with the Scottish Home and Health Department (SHHD), reporting to Ministers;

b. A Chief Executive would be appointed for the NHS in Scotland responsible for the efficiency and performance of the Health Service and for the overall supervision of the execution of policy; and

c. The Scottish Health Service Policy Board would be abolished: Ministers would instead consult directly with Health Boards and others as necessary, obtaining advice also from a new Advisory Council which would replace the Scottish Health Service Planning Council.

The Chief Executive post has now been advertised with the aim of making an appointment by 1 October. The Policy Board has been wound up; the Planning Council will shortly have had its final meeting; and

arrangements are in hand to convene a first meeting of the new Advisory Council in the autumn.

The Chief Executive

After examining the way in which current tasks performed by the Scottish Home and Health Department could be separated out, I have concluded that the Chief Executive post should be established within the Department on a five-year contract basis. The important underlying concept is that policy and management must inform and influence each other: policy will not be effective if it takes no account of management considerations; and at the same time, management issues must be set in a clear policy framework, established by Ministers and provided to the Chief Executive for him to implement through the Health Boards and the Common Services Agency.

The Chief Professional Officers of the Department will give advice to both the Chief Executive and the policy side of the Department. The Chief Professional Officers will also retain their present right of independent access to me as appropriate. The Chief Executive will be designated Accounting Officer for the bulk of the Hospital and Community Health Services Vote and for the Health (Family Practitioner Services) Vote. Limited Health Service Accounting Officer responsibilities will remain with the Secretary, Scottish Home and Health Department, for example in relation to research.

The Chief Executive will serve as an Assessor to the new Advisory Council in order to strengthen the management input to its work of promoting good practice. He will be invited to undertake the role of Vice Chairman of the Common Services Agency, which provides a wide range of operational and support services on a national basis; and I will consider whether he should assume the role of Chairman in April 1991, when the present Chairman (formerly Chairman of our largest Health Board) demits office, whether to retain the present arrangement in order to avoid overloading the Chief Executive.

Transitional Arrangements

It will be important that the Chief Executive should have time to consider how best to discharge the responsibilities of the post, looking to the staff of SHHD to provide his main support. To facilitate this, he will have an initial three-month period in which to assess the situation and to decide what pattern of support staff is necessary. He should be free to propose adjustments or supplementation to the existing arrangements at senior level before formally assuming full management and Accounting Officer responsibilities. In consequence and as agreed with the Treasury the existing NHS Finance and Management Grade 3 post in SHHD will be given up by the end of the current financial year.

Management Arrangements

I do not intend initially to replicate the Department of Health's arrangement for a Policy Board to which the Chief Executive would report. Instead he will report directly to Ministers. Supporting this arrangement will be two groups:-

1. The Department's existing **Health Service Policy Group**, normally chaired by the Secretary SHHD. This comprises senior Civil Servants, the Chief Professional Officers, and (now) the Chief Executive. The key element of its role will be to consider major issues of policy arising in relation to the operation and development of the Health Service, including questions of priorities in the allocation of resources, and to formulate policy proposals for consideration by Ministers;

2. A **Management Executive Group** to be chaired by the Chief Executive. The internal membership will be similar to the **Policy Group**; but it will be augmented by key NHS personnel and any additional appointees made on the Chief Executive's recommendation. The Group's function will be to oversee the management of the NHS in accordance with the policies established by Ministers, and to secure the necessary coordination in the implementation of policy decisions.

The Chief Executive will operate in accordance with an annual business plan of NHS policies and priorities, which will be an amplification of the 10 objectives for the Scottish Health Service published in November 1988. He will produce an annual report on the achievement of his objectives; and by the second year of his appointment he will be expected to produce a corporate management programme for the Health Service in Scotland.

Role of Ministers

Ministers will continue their regular meetings with Health Board Chairmen whose role must not be or appear to be diminished. Within the policy framework established by Ministers, the working dialogue will generally be between the Chief Executive and Board General Managers.

General Managers who are now full members of their Boards, will continue to be employed by Boards; but I expect the Chief Executive to foster a sense of corporate identity among General Managers so that they will, in due course, come to regard him as their "head of profession". He will countersign the annual reports on General Managers prepared by Board Chairmen.

Conclusion

Once established and once next Session's Bill is enacted, these arrangements will secure the clearer distinction between the policy responsibilities of Ministers and the operational responsibilities of the Chief Executive and Health Boards that we want to achieve, making it possible for Ministers to disengage from operational detail.

I am copying this minute to Kenneth Clarke, Peter Walker, Tom King, John Major, Sir Roy Griffiths, Sir Robin Butler and Mr Wilson (Cabinet Office) and Mr Whitehead (Policy Unit).

M R

Scottish Office
31 May 1989

2.2.6.89

FROM: R B SAUNDERS (ST2)

DATE: 2 June 1989
x 4800

CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Anson
Mr Hardcastle
Mr Phillips
Mrs Lomax
Miss Peirson
Mr Spackman
Mr Richardson
Mr Todd
Mr Wellard
Mr Griffiths
Mr Sussex
Mr Call

NHS REVIEW: CAPITAL CHARGES AND FUNDING ISSUES

You will recall that when the 8 working papers were published in February, that on capital charges omitted any reference to how health authorities would be funded to pay the new cash charges. A further working paper was promised on this for the end of May.

2. I now attach a draft which Mr Clarke wishes to publish next week. We have been consulted throughout its preparation and I recommend that you agree to it.

Background

3. This is a matter of importance because capital charges will represent a large slice of current expenditure, and so failure to get the funding right would mean that net gains or losses could be significant. On average, we think current expenditure budgets at district level will have to rise by some 20% in gross terms in order to meet capital charges of typically around £15m.

4. This will not however result in an increase in measured public expenditure, since the charges will be paid back to regions and will hence represent internal transactions within the Vote. The cash which passes between regions and districts will thus be net: uplifted to enable payment of capital charges to be made, less payment of charges back to regions.

5. The intention is that the introduction of the system should be neutral in the first year: the uplift in funding of individual districts should equal the charges to be paid by its hospitals (with some adjustment as necessary for cross-boundary flows). But over time, as district funding moves towards weighted capitation payments to buyers, this will change. Ultimately district funding will incorporate an element for capital charges on a standard formula, which may be greater or less than the charges actually paid by individual districts. In this way, there will be real incentives for districts and hospitals to use their assets more efficiently and get their capital charges down, since they will be able to keep the resulting savings. The transition will however take several years, since the shifts implied may be very large for some districts, particularly those saddled with older hospitals where inefficient use of capital assets is inherent in the design. The transition will be managed as part of the move to weighted capitation payments at district level, which is expected to take at least until the mid-1990s.

6. Our concerns have primarily been to ensure that, first, the system does not have impact on Votes which leads to an increase in measured public expenditure and, second, that it does not introduce such distortions into the funding of districts that we get faced with calls for the losers to be bought out. I am satisfied that the proposals in the attached draft achieve this.

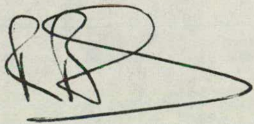
Valuation basis

7. A further issue which we have been discussing with the Department - although it is not covered in this working paper - is the basis of valuation of land and buildings. This is tricky and potentially very important.

8. Land can be valued either on the basis of full opportunity cost - ie if developed for commercial or residential use - or just at its value in existing use as an NHS hospital. The first basis is the theoretically correct one but would in practice lead to such high values in certain cases - eg St Thomas's and Guy's - as

to impose quite crippling capital charges on them. The second basis is the normal one employed for commercial accounts, but is difficult to determine for NHS hospitals (unlike, say, commercial buildings where there is a well-established market).

9. We have now agreed with Department of Health and the Valuation Office a methodology by which land would be valued on the basis of "prevailing use in the locality" - roughly speaking, what a competitor would be expected to pay for the provision of equivalent facilities locally, but not necessarily on the same site - and depreciated replacement cost for buildings. We believe this will ensure that the capital charging system sends the right signals to managers, but without imposing unduly heavy burdens on particular hospitals. You are invited to note this agreement.



R B SAUNDERS

CAPITAL CHARGES

FUNDING ISSUES

1. This working paper deals with the funding issues related to the introduction of capital charges. Capital charges are dealt with in Working Paper No 5.

2. In the long term capital charges will be fully absorbed into NHS funding mechanisms as explained in paragraphs 3 to 13. There is likely, however, to be a long transitional period during which existing disparities in terms of capital stock are dealt with. The precise nature of the transitional issues will not become clear until authorities have completed the valuation of the assets and calculated capital charges. Paragraphs 14 to 20 outline the way in which transitional issues are expected to be tackled. The main part of this paper (paragraphs 3 to 20) does not deal with self-governing hospitals; these are briefly referred to in paragraphs 21 and 22.

Long term funding

3. As explained in Working Paper No 2 on Contracts and Funding there is to be a gradual move towards weighted capitation funding of authorities' recurrent expenditure. Regions are expected to be funded on this basis by 1992/93 and districts after that. Provided that the transitional issues dealt with later in this working paper are not more complex than those associated with moving the NHS as a whole

to weighted capitation funding by the same times, the Government expects to move capitation funding of Regions and Districts so as fully to reflect capital costs. Hence weighted capitation funding of Districts (and GP practice budgets) will be set at a figure which includes recurrent costs and capital charges. There will continue to be separate allocations for capital to Regions.

4. The scheme at sub-regional level will work as follows:

a. capital charges will be payable, principally by hospitals (taken to include all directly managed units) but also by multi-district or regionally managed services, to the Region in which they are located organisationally;

b. hospitals (etc.) will take these costs of capital into account in setting their prices for services;

c. Regions will be due to pay to districts and GP practice budget holders weighted capitation funding;

d. the cash actually passing between Regions and Districts will be the net amount due to each district. A series of inter-authority etc accounts will be maintained so as to ensure that actual cash flows will be minimised. Transactions will need to be settled within each year as at present so as to comply with the annuality requirements.

5. In order for Regions to be in a position to pay to Districts and GP budget holders the net amounts that each needs (ie capitation funding less, in the case of Districts, local capital charges flows), each Region will itself need to be funded for its own net cash flows. The Department's cash allocation to Regions will thus be calculated by reference to the capitation funding amounts less intra-regional capital charges receipts. In this way Regions' funding will fully reflect their estimated cash flows arising from the new systems irrespective of the actual location of assets and hence capital charges payments. Annex A illustrates these concepts.

6. The annual weighted capitation funding will not be regarded, even notionally, as split between capital charges and revenue costs. The level of expenditure provision will be considered by Ministers in the usual way as part of the public expenditure survey. These discussions will focus on the changes in the net cash flows of the NHS and will thus encompass all relevant aspects of NHS finances. Once the amount of the vote has been determined the Department will allocate the amount received to Regions based upon the estimates of the capital charges payments to regions and upon Regions' weighted populations as described above.

7. It will be necessary for regions and districts to estimate the capital charges payable by each hospital etc for the forthcoming year. Payments to Regions and by Regions to

Districts during the year will be based on these estimates with corrections to the estimates being made to subsequent years' charges. The timing is expected to be as follows:

Year 0-1 Districts/Regions obtain from hospitals etc estimates of capital charges payable in Year 0.

Department sets allocations to Regions and Regions set allocations to Districts based on these estimates.

Year - 0 Department and Regions make net allocations taking into account the estimated capital charges.

Hospitals etc pay to Region (via the inter-authority accounts) the estimated capital charges.

Hospitals etc update estimates of capital charges in Year 0. Differences are added to or subtracted from the estimates being prepared for Year 0+1.

Year 0+1 Final accounts prepared and final capital charges are calculated (and audited) for Year 0. Differences between the updated estimates used for the purposes of calculating capital charges for Year 0+1 are added to/subtracted from the estimates produced for Year 0+2.

8. The arrangements outlined in paragraph 6 require capital planning and budgeting to be as accurate as possible. Regions will need to satisfy themselves as to the reasonableness of the estimates produced by hospitals etc. in order to ensure that hospitals or authorities do not benefit from misestimation.

9. The proceeds of sales of land assets will be payable to Regions (probably via the inter-authority accounts but significant disposal proceeds should be remitted direct to Regions). These proceeds will continue to be appropriated in aid of the Vote and should be allocated for capital purposes (or vired, see paragraph 12) within the Region. Regions will want to ensure that Districts have sufficient incentives to make sales, including the cessation of capital charges on sold assets. The presumption in favour of the District initiating a sale being allowed to reinvest the proceeds will continue. The reinvestment of proceeds will, however, have to be considered in the context of, inter alia, Districts' own needs following the establishment of self governing hospitals, the Region's strategic plan for capital investment and the incidence of capital charges on the reinvested proceeds.

10. The proceeds of sale of non-land assets will also be payable to Regions. As noted in paragraph 3.6 of Working Paper No 5 a system of final adjustments will apply to these assets. This in effect allows hospitals/authorities to retain any surplus over book value via capital charges that

are made. Such disposals and final adjustments will be dealt with through the estimating and adjustment to actual procedures outlined in paragraph 7.

11. The capital charging scheme will apply to all capital assets acquired out of public funds. The source of the public funds (for example whether from capital or revenue allocations) is irrelevant in determining whether or not the capital charging scheme will apply; the important factor is whether or not a capital asset, as defined for the capital charging scheme, has been acquired. As noted in paragraph 2.21 of Working Paper No 5 many donated assets will not be within the capital charges scheme but hospitals will need to take account of their eventual need to replace such assets when making their financial plans.

12. Virement powers will continue as at present in order to give authorities in year funding flexibility. The current limits are 10 per cent from capital to recurrent and 0.5 per cent from revenue to capital. These limits will be kept under review. The ability of authorities to vire from capital to recurrent should not be used to allow hospitals etc to subsidise pricing and, broadly as at present, each hospital and authority will need to satisfy a requirement that taking one year with another there is a balance between income and expenditure on revenue account.

13. A number of detailed changes to authorities' accounts will be needed in order to reflect the new capital charging scheme and the need to demonstrate the balance between

recurrent income and expenditure as referred to in the previous paragraph. Details of these will be circulated at a later stage.

Short term funding

14. In the first year that capital charges are introduced (1991/92), allocations will be adjusted throughout the system precisely in line with the estimated capital charges for that year. In this way the introduction of the capital charges system will be neutral. It will be necessary for Regions to identify the capital element of cross-boundary flows between Regions for including in the cross-charges between Regions envisaged in Working Paper No 2 in 1991/92. While it will be for Regions to determine between themselves how best to handle this, it is likely to be convenient for Regions to calculate the charge by uplifting the agreed recurrent cross-charges by a percentage which reflects the overall level of capital charges within the Region or relevant Districts. Similar arrangements might apply to cross-charges between Districts. The overall effect will be neutral. Each Region's allocation from the Department plus its own capital charge receivables plus the net cross boundary flow payment (including the capital charges element) will equal the amounts handed down to Districts or GP practice budget holders to pay for contracted services which will be priced to include both recurrent and capital charge costs. Annex B illustrates how this will work.

15. When authorities have completed the valuation of their capital assets and calculated the capital charges payable, the Department will examine with authorities the reasons for high or low capital charges relative to population served or to recurrent costs. The Department expects to find that the source of these differences will include:

a. a concentration of high technology, capital intensive services;

b. old hospitals or facilities which have low capital charges;

c. new hospitals which offer quality advantages over older hospitals but with a correspondingly higher capital charge;

d. efficiency of use including utilisation rates;

e. design efficiency;

f. geographical differences in building costs and land values;

g. differences in availability of hospital services;

h. the effect of teaching and/or research facilities.

16. Some of these differences will be coped with by the contract system. A hospital which runs a capital intensive speciality and which attracts patients from neighbouring districts will be able to recover its apparently high costs in its contract charges to its own and other districts. Other differences, for example geographical differences in costs, will be among the factors considered in determining the capitation formula for funding Districts.

17. Some efficiency differences may be controllable by management in the shorter term. If, for example, bed utilisation rates result in high capital costs per patient it will be up to the hospital's management to increase efficiency to reduce the cost. Transitional funding arrangements should not support the continuance of under utilisation of resources.

18. By far the most difficult category of difference will relate to those factors which are not now within management's control. For example, a poor management decision 10 years ago to build a particularly inefficient design may well show up in higher than expected capital charges now (though the extent of this will depend on the precise valuation bases applied to older building designs). The optimum economic decision may be to retain the building for several more years or, even if the optimum decision were to rebuild immediately, there may be insufficient capital funds available to support the project. The Department will pay particular attention to these issues and, in conjunction with Regions and Districts,

phase the movement towards weighted capitation funding to coincide with the pace at which authorities can act to bring capital charges back to the average level expected for the facilities concerned. This will not be an easy process and will result in some Districts and GP practice budget holders being funded at a higher level than others in order to allow them to purchase from these transitionally higher cost providers.

19. As with contracts generally, Regions will have an overall supervisory role to ensure that contracts are placed by Districts in a way which reinforces efficient service delivery. Included within this will be the monitoring of the transition to ensure that facilities are available locally where necessary or appropriate despite higher cost contracts. If Districts are funded for higher levels of costs in their providers, they will not then be allowed immediately to place all contracts elsewhere. There will thus be a close link between contracts and transitional funding.

20. Some of the apparently high costs of certain providers may also be dealt with by the funding arrangements for teaching costs, research or for supra regional specialities. Similarly Regions may deal with the higher costs of providers of multi-district specialities by direct funding for a part of the costs.

Self governing hospitals

21. Self governing hospitals do not pay capital charges but instead have their assets vested in NHS Hospital Trusts matched by initial debt; details of this are contained in Working Paper No 1. The main impact that a self-governing hospital will have on the capital charging system is that when a self governing hospital is set up its capital charges will cease to be payable to its Region. Instead, self governing hospitals will make interest and capital payments in respect of their debt direct to the Department. The Region's own funding of its Districts will, ceteris paribus, be unchanged (as Districts will continue to buy from self governing hospitals) and hence the Region's cash requirements will be higher than they would otherwise have been. This will be dealt with in setting the Vote.

22. Self governing hospitals will meet their capital needs out of their own cash flows, including the additional borrowing allowed within their annual financing limits.

CCFI

Annex A

CAPITAL CHARGES - CASH FLOWS AND SETTLEMENT

1. This annex explains how it is expected that the cash flows from capital charges will actually be settled by Regions, Districts and Units.

2. Assume that there are three Regions as follows:

	A	B	C	Total
Revenue Costs (£m)	5,600	4,900	3,500	14,000
Capital charges receipts from own hospitals	1,120	980	700	2,800
Resident population	25m	15m	10m	50m

3. There are no weighting differences in population and no disparities in levels of recurrent or capital charges. The total amount of the DH Vote for recurrent expenditure is £14,000 million. This will be allocated as follows:

	£m
Recurrent expenditure	14,000
Capital charges	2,800
Gross allocations	16,800
Less: Regions' capital charges receipts	2,800
Cash allocation	14,000

4. As shared between Regions, the calculations are as follows:

	A £m	B £m	C £m	Total £m
Gross allocation (proportional to population)	8,400	5,040	3,360	16,800
Less: internal cash flows for capital charges	(1,120)	(980)	(700)	(2,800)
Cash allocation	7,280	4,060	2,660	14,000

5. This allocation allows Regions to allocate to their Districts to buy from Units within each Region and outside. Assume that Region A has two Districts one with two units and one with one unit. 20 per cent of Region A's patients are treated in Region B as follows:

	District X	District Y	Total
Resident population	10m	15m	25m
Expected patients treated based on population	400,000	600,000	1m
Actually treated			
Unit X 1	200,000	100,000	300,000
Unit X 2	200,000		200,000
Unit Y 1		300,000	300,000
Region B		200,000	200,000
	400,000	600,000	1m

6. Capital charges payable by each unit are as follows:

	£000
Unit X 1	420
Unit X 2	280
Unit Y 1	420
	1,120

7. Region A will allocate £8,400 million (gross) to its Districts and Districts will enter into contracts with Units as follows:

	District X £m	District Y £m	Total £m
Allocations from Region A	3,360	5,040	8,400
Contracts with			
Unit X 1	1,680	840	2,520
Unit X 2	1,680		1,680
Unit Y 1		2,520	2,520
Region B		1,680	1,680
	3,360	5,040	8,400

8. Cash will be settled via a series of inter-authority/ unit accounts, offsetting capital charges within Districts, as follows:

	Gross	Capital Charges Offset	Cash Settlement
	£m	£m	£m
Region/District			
A/X*	3,360	(700)	2,660
A/Y	5,040	(420)	4,620
	8,400	(1,120)	7,280
	=====	=====	=====
Districts/Units			
X/X1*	1,680	(420)	1,260
X/X2	1,680	(280)	1,400
Y/X1	840	-	840
Y/Y1	2,520	(420)	2,100
Y/Region B	1,680	-	1,680
	8,400	1,120	7,280
	=====	=====	=====

* ie Account between Region A and District X, District X and Unit X 1 etc.

memo327

CAPITAL CHARGES - THE TRANSITION

1. This annex explains how adjustments will be made beween Regions for capital charges in respect of cross boundry flows.

2. Assume that there are only three Regions with costs/resident populations etc. as follows:

	A	B	C	Total
Revenue Costs (£m)	5,600	4,900	3,500	14,000
Capital charges for own hospitals (£m)	1,120 (20%)	1,225 (25%)	770 (22%)	3,115 (22.25%)
Resident population (no weighting differences)	25m	15m	10m	50m
Expected patients treated based on population	1m	600,000	400,000	2m
Patients actually treated	800,000	700,000	500,000	2m

3. As there are no weighting differences each Region would receive a revenue allocation of £280 per resident so that contracts/cross charging can take effect as follows:

	A	B	C	Total
Assume cross-boundary flows	000	000	000	000
To/from region A	(200)	150	50	-
To/from region B	-	(50)	50	-
Net	(200)	100	100	
	£m	£m	£m	£m
Allocation to Regions	7,000	4,200	2,800	14,000
Cross charged (actual flows x average cost per patient)	(1,400)	700	700	-
Net available to Region	5,600	4,900	3,500	14,000

4. Capital charges will need to be built into cross boundary flow charging as soon as possible. Before any levelling of capital charges takes place allocations to regions need to reflect the capital charges payable for their resident population. We would calculate this in the first year (1991/92) as follows:

	A	B	C	Total
Own capital charges per patient	£1,400	£1,750	£1,540	£1,558
	£m	£m	£m	£m
Treatment of own population at own average rate of capital charges	1,120.0	962.5	616.0	2698.5
A's population treated:				
by B (150,000 x £1,750)	262.5	-	-	262.5
by C (50,000 x £1,540)	77.0	-	-	77.0
B's population treated by C (50,000 x £1,540)	-	77.0	-	77.0
	1,459.5	1,039.5	616.0	3,115.0

5. This would allow each region to fund its districts to pay for cross boundary flows at their actual cost. In later years there will be a move towards funding each region (and ultimately each district) at the average rate.

memo328

037/3294

UNCLASSIFIED

FROM: S I M KOSKY
DATE: 5 June 1989
EXTN: 5088

MR SAUNDERS

cc:
Chancellor -2
Sir Peter Middleton
Mr Anson
Mr Hardcastle
Mr Phillips
Mrs Lomax
Miss Peirson
Mr Spackman
Mr Richardson
Mr Todd
Mr Wellard
Mr Griffiths
Mr Sussex
Mr Call

pmp

NHS REVIEW: CAPITAL CHARGES AND FUNDING ISSUES

The Chief Secretary is content with your submission of 2 June.

2 He has commented that he hopes we are right about meeting the concerns set out in paragraph 6 of your submission.

Sheldon Kosky

S I M KOSKY

FROM: D P GRIFFITHS (ST2)
DATE: 7 June 1989
Ext: 5216

CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Anson
Mr Phillips
Mr Beastall
Miss Peirson o/r
Mr A M White
Mr Saunders
Mr Call

pmp

MANAGEMENT ARRANGEMENTS FOR THE NHS IN SCOTLAND

1. In his minute of 31 May to the Prime Minister Mr Rifkind sets out his proposals for the new NHS management arrangements in Scotland. The proposals look generally acceptable, subject to keeping one or two points under review, and there is no need to intervene in the correspondence.

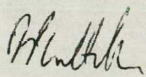
2. To a large extent Mr Rifkind is following the English model. Policy and management will be separated albeit with overlapping personnel. The Scottish Home and Health Department will remain responsible for the former with a Health Service Policy Group of senior civil servants advising Ministers on major issues. The NHS in Scotland will have a Chief Executive (on a five year contract) supported by a management executive of composed of civil servants, the chief medical and nursing officers etc and top NHS personnel. However, unlike his English counterpart, he will report directly to Ministers rather than a Policy Board, although he will be a member of the Health Service Policy Group. He will also become Accounting Officer for most HCHS and all FPS expenditure. (Some restructuring of the Scottish health votes will be required.)

3. There will be no downgrading of the role of Health Board chairmen but operational matters will generally be dealt with by the Chief Executive and the Board general managers.

4. There is no reason to insist that Scotland set up an NHS Policy Board on English lines. The Scots did have such a Board but found that policy issues could be dealt with more effectively by Ministers directly and it has now been abolished. Mr Rifkind's

proposals do mean that there will be no formal policy input by non-civil servants - there will be no Tartan equivalents of Sir Graham Day et al. However, it is envisaged that the Chief Executive might recommend appointments to the Management Executive and this could be used to bring in any business or other expertise thought desirable.

5. Once appointed, the Chief Executive will have a three month period to assess his new responsibilities and make any proposals for changes in the level of support staff. We would obviously need to be consulted and give our consent if any significant changes were to be made.



D P GRIFFITHS

1585A

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

David Crawley Esq
Principal Private Secretary to the
Secretary of State for Scotland
Dover House
Whitehall
LONDON SW1

9 June 1989

PMP

Dear David

MANAGEMENT ARRANGEMENTS FOR THE NHS IN SCOTLAND

This is to confirm that my Secretary of State has no comments on the paper put forward by your Secretary of State to the Prime Minister on 31 May.

I am sending a copy of this letter to Paul Gray, Stephen Williams, Stephen Leach, Carys Evans, Trevor Woolley, Richard Wilson and Ian Whitehead.

CHIEF SECRETARY	
REC.	-9 JUN 1989
ACTION	Mr Griffiths
COPIES TO	CX, Sir P Middleton
	Mr Anson, Mr Phillips
	Miss Peirson

Yours

Andy

A J McKEON
Private Secretary

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

12 June, 1989.

CHIEF SECRETARY
REC. 17 JUN 1989

Mr Griffiths
CX, Sir P Middleton, Mr Anson,
Mr Phillips, Mr Beastall, Miss Peirson,
Mr RIC White, Mr Sanders, Mr Call

PMP

MANAGEMENT ARRANGEMENTS FOR NHS IN SCOTLAND

The Prime Minister was grateful for your Secretary of State's minute of 31 May.

The Prime Minister is concerned that the proposals do not go far enough to ensure effective management of the NHS in Scotland. She has the following specific comments and queries:

- She notes that in England there will be a written statement of the Chief Executive's responsibilities, and she wonders if your Secretary of State has anything similar in mind for Scotland so that the Chief Executive's specific powers are made clear.

- She notes that in England the Chief Executive will make his own senior appointments subject to clearance with the Permanent Secretary and the Secretary of State in the most senior cases; does your Secretary of State plan a similar arrangement for Scotland? Similarly, the Prime Minister wonders whether it will be made clear that, in his relations with the Health Boards, the Chief Executive will speak with the Secretary of State's authority on management matters.

- She would be grateful for more precise details of the proposed membership of the Management Executive.

- She has asked for information about the number of support staff in SHHD on the policy and management sides, and whether your Secretary of State will consider the possibility of reducing numbers, for example through an elimination of double banking.

- She would be grateful for material on the proposed Accounting Officer responsibilities, especially as regards administration expenditure.

- She has noted the proposal to decide how the responsibilities of the Chief Executive's post should best be discharged some time after his appointment; she wonders why it is not intended to do this before his appointment.

- She has asked whether the Chief Executive will have the final say in fixing the level of remuneration of general managers based on the relative performance of the Health Boards.

I am sending a copy of this letter to the Private Secretaries to the Secretary of State for Health, the Secretary of State for Wales, the Secretary of State for Northern Ireland, the Chief Secretary, the Deputy Chairman of the NHS Management Board, and to Richard Wilson (Cabinet Office) and Sir Robin Butler.

Paul Gray

David Crawley, Esq.,
Scottish Office.

pwp

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

CHIEF SECRETARY
REC 20 JUN 1989
Mr Griffiths
CC, Sir P Middleton, Mr Anson, Mr Phillips, Mr Bagstall, Mrs Lesson, Mr Whitehead, Mr Saunders,

CONFIDENTIAL

Paul Gray Esq
10 Downing Street
LONDON
SW1A 2AA

19 June 1989

Dear Paul,

MANAGEMENT ARRANGEMENTS FOR THE NHS IN SCOTLAND

Thank you for your letter of 12 June giving the Prime Minister's reactions to the minute from my Secretary of State of 31 May and setting out some specific comments and questions.

Mr Rifkind is very grateful for the Prime Minister's comments and appreciates that some clarification of his minute of 31 May would be helpful. He fully shares the objectives of ensuring effective management of the NHS in Scotland and he believes that the proposals he has put forward - which are closely modelled on the Department of Health's proposals - will meet that objective. Obviously, in order to do so they must take into account certain differences of structure as between Scotland and England, notably the fact that in Scotland the regional and national roles are combined in the Scottish Office.

Mr Rifkind has asked me to comment as follows on the particular points in your letter:

(a) There will indeed be a job description for the Chief Executive and Scottish Ministers will establish a clear policy framework and provide it to the Chief Executive for him to implement;

(b) The answers to both the questions in your second indent are affirmative. On page 3 of his minute Mr Rifkind said that the Chief Executive would have an initial period to decide what pattern of support staff was necessary and to propose adjustments or supplementation at senior level. That is consistent with the Chief Executive's ability to make his own senior appointments subject to the clearances indicated in your letter. On management matters the Chief Executive will certainly speak with the authority of the Secretary of State to the Health Boards and the Common Services Agency.

(c) The composition of the Management Executive Group will be decided finally when the Chief Executive is in post. It will include the senior staff responsible for Finance, Personnel, Information Technology and Strategic Planning. It would be

wider than those key areas but Mr Rifkind would want to discuss what other elements should be in it with the Chief Executive. He would be guided by the pattern adopted for the Department of Health but would want to settle its exact composition in the light of particular Scottish circumstances.

(d) The Secretary of State is most anxious that there should be no double banking of staff as between the Department and the Chief Executive. And he has decided that the professional staff should give advice to both sides. The total number of administration group staff on the Health side is 200, though, in parallel with the increase agreed between the Treasury and the Department of Health to meet the extra demands of implementing the White Paper, a small increase of 18 for the current year has been sought. The expectation is that the Chief Executive would have 130 and the remaining 70 would stay with the policy side. There will be no overlap. The Department is at full stretch in order to match the efforts of the Department of Health and also to discharge the responsibilities for the separate Scottish system as well as the responsibilities of a regional organisation.

(e) In the Scottish Office the Permanent Secretary has Accounting Officer responsibility for the single administration Vote covering all the Departments, while the Heads of those Departments are Accounting Officers for the programme Votes. Mr Rifkind proposes to retain that arrangement. There would be a substantial transfer of Accounting Officer responsibility from the Head of the Scottish Home and Health Department to the Chief Executive; and the latter would also have, within the Administration Vote, a clear budget allocated to him for his staff and other administrative costs.

(f) The responsibilities of the Chief Executive's post have been set out in the public advertisement and the Civil Service Commission's literature so that those who are applying for the post know what is expected of them. However, Mr Rifkind believes that it is right to settle the fine detail once the new incumbent is in post and has had time to express a considered view. Given that the post has not existed in Scotland until now, Mr Rifkind considers that it is simply a matter of good sense to give the new Chief Executive the opportunity of shaping the organisation in a way that will best suit his or her approach to tackling this formidable task.

(g) The Chief Executive will have the task of determining the performance related element of the remuneration of individual General Managers.

Mr Rifkind is fully committed to ensuring that the Chief Executive has the remit, the powers, the authority and the staff required to allow him to be an effective and dynamic force for better management in the health service in Scotland.

I am sending a copy of this letter to the Private Secretaries to the Secretary of State for Health, the Secretary of State for Wales, the Secretary of State for Northern Ireland, the Chief Secretary to the Treasury, the Deputy Chairman of the NHS Management Board, and to Sir Robin Butler and Richard Wilson (Cabinet Office)

Yours sincerely,

David

DAVID CRAWLEY
Private Secretary

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

26 June 1989

PMP

Dear David,

MANAGEMENT ARRANGEMENTS FOR THE NHS IN SCOTLAND

The Prime Minister has seen your letter of 19 June.

She is grateful for your Secretary of State's assurance that there will be effective management arrangements for the NHS in Scotland with clear lines of responsibility. She notes that the Chief Executive will be given a statement of responsibilities which will set out his specific powers - which she assumes will be made public - and that these will include the power to make his own senior appointments subject to clearance in the most senior cases and to decide the performance pay of individual general managers. She would be interested to see the statement when it is available together with the proposed membership of the Management Executive Group.

As with the NHS in England she would be grateful for a progress report in three months' time.

I am sending a copy of this letter to the Private Secretaries to the Secretary of State for Health, the Secretary of State for Wales, the Secretary of State for Northern Ireland, the Chief Secretary, the Deputy Chairman of the NHS Management Board, and to Sir Robin Butler and Richard Wilson (Cabinet Office).

CHIEF SECRETARY

REC.

ACTION

COPIES TO

Mr Griffiths
cx, Sir P Middleton Mr Anson,
Mr Phillips, Mr Beastall, Miss Pearson
Mr AM White, Mr Saunders.

Yours,
Paul

(PAUL GRAY)

David Crawley, Esq.,
Scottish Office.

SECRET pse.jf/JAF10/JAF10.4M

MP

FROM: M A PARSONAGE
DATE: 29 JUNE 1989

CHANCELLOR

cc: PS/Chief Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mr Culpin
Miss Peirson
Mr Saunders
Mr Call

NHS REVIEW: SUPPLY AND DEMAND

I have discussed with Mr Phillips the revised draft of the above paper which was circulated by your office earlier today.

2. Our comments and drafting suggestions are marked on the attached. I hope these are self-explanatory.

3. Three points which require some amplification are as follows:

(i) the third paragraph on page 2 threatens the own goal which you mentioned this morning. One possibility would be to omit it. Another would be to add the qualifying point that a substantial proportion - about 40% - of private hospital treatment is financed not by insurance but by direct payment by the patient. Where this is the case, the price mechanism works more or less in the usual way;

(ii) we suggest adding a new paragraph in the middle of page 3, to illustrate the growth in private insurance, on the following lines: "PPP report that their subscriptions grew by 20% in the first few months of this year, which was the whole of their earlier planned growth expectation for the two years 1988 and 1989. BUPA say that they are planning on the basis of a doubling in the number of subscriptions over the next two years."

(iii) finally, you mentioned this morning that it would be helpful for the paper to include one or two practical examples. Page 5 looks the most suitable place for this, and we have two suggestions. One is to add the following at the end of the first complete paragraph on this page: "There are already difficulties in recruiting and retaining operating theatre nurses in some parts of the country, and the gaps are having to be filled by the use of expensive agency staff." The other is to move your example of consultants' restrictive practices from page 3 to the end of the second paragraph on page 5.

MP

M A PARSONAGE

ps/ 5A

This version incorporates Chancellor's initial comments. He wants to look at it again later, with any comments from copy recipients. Can we have comments by 3.30 today please? MPW 29/6

cc: PS/FST
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Mr Culpin
Miss Peirson
Mr Saunders
Mr Parsonage
Mr Call

NHS REVIEW: SUPPLY AND DEMAND

In the work we are doing on the review, it is vital that we do not lose sight of some of the basic features of the economics of health care.

Put simply, the demand for health care exceeds the supply. In the public sector, that is inevitable: with a "free" service financed out of general taxation, demand will always be virtually unlimited; it is regulated partly by waiting lists, and partly by the safety valve of private sector care. Our objective for the public sector must clearly be to ensure that it provides health care as efficiently and effectively as possible, so that we get the best possible output for the money we put in.

In the private sector, there <u>is</u> a price mechanism. The problem there is to a large extent that the price is so high, because of constraints and inefficiencies in supply and restrictive practices by the medical profession. We need to improve the supply performance and hence bring down prices and encourage growth. If we simply boost demand without improving supply, the inevitable result will be higher prices and little real growth in private health care.

This prescription is exactly the one we have successfully followed in many other areas of policy, where we have shown decisively that the route to improved performance is to concentrate on the supply side. There is no reason why health should be any different. Indeed, there are features of the supply and demand for health care which make it especially important that we should not look simply at demand in isolation.

First, as I have already indicated, we must recognise the almost complete absence of the price mechanism as a means of regulating the level of output in the NHS. Prices and charges play a negligible role, particularly in the hospital service. Indeed, charges now raise only X per cent of the costs of the NHS, compared to X per cent in 1947. It follows that patients (and their doctors too) will always tend to press for high-cost options.

There is a danger of this in the private sector too. Private treatment is mainly financed out of insurance. This means that once someone needs treatment, there is little reason for the patient to limit his demands.

These problems are reinforced by a lack of cost-consciousness among doctors and others. As we have noted many times in the course of the review, budgeting and information systems in the NHS are ill-designed for the purpose of encouraging cost-effectiveness and economy. Those who commit resources are not financially

accountable for their decisions, nor are they yet given adequate information on the costs of what they are doing. The position is somewhat better in the private sector, but most doctors cling to the outmoded belief that they should not be involved in the management of resources. Under present arrangements, the demands from patients are more likely to be amplified than constrained by the decisions of doctors.

The result has been a chronic tendency towards excess demand. In the NHS, some of this demand is suppressed, for example by controls on expenditure, and remains latent only because patients are put off by lengthy waiting times. Some of it has been channelled into growing use of private health care - a trend we all wish to see continue. Indeed, there is some evidence that growth in the take-up of private insurance is now extremely rapid. [new para - see covering minute]

[see bottom of page 5]

Some of the steps we are considering would give a further boost to that demand. As with any other product, a demand for health care can have one of two effects: it can bring forth extra output, or it can push up costs. It goes

without saying that the split between these two effects is of crucial importance. There is nothing to be said for boosting demand if supply does not respond and if it simply leads to a bidding-up of pay and prices.

Without fundamental changes to the incentives faced by hospitals and other suppliers, the supply of health output will adjust only slowly to increases in demand, at least in the short to medium-term.

The starting point is the availability of skilled manpower - doctors, nurses, therapists, technicians etc. The supply of skilled manpower cannot be increased over-night: there are inevitably lags as a result of the need to recruit and train specialist staff.

In addition, there are numerous institutional and other rigidities stemming from the way in which health care in this country is currently organised. The problems here are well known and have been discussed in earlier papers. Particularly important in my view are the inflexibilities on the manpower side: the restrictive practices, over-specialisation, promotion blockages, reward systems unrelated to performance, national pay rates, and so on.

[we suggest retaining this para.]

[Even within the limits imposed by these constraints, there are failures to use resources efficiently and to direct them towards the uses where they will have the maximum effect. The scope for improving supply

performance is amply demonstrated by the evidence of substantial variations in efficiency and output between different units within the NHS.]

It is clear, therefore, that there is little to be said for measures which simply affect the demand for health care and have little impact on supply behaviour. The likely effect would be higher costs, not higher output. This is true whether the extra demand is directed towards the public or the private sectors. One part of the market cannot be isolated from the rest; for example, a large increase in the demand for specialist staff in the private sector would inevitably have repercussive effects in the NHS, not least on wage levels. [see covering minute.]

Shortage of demand is certainly not limiting the expansion of the private sector. As I indicated earlier, there is healthy growth in the numbers taking out private insurance, particularly in company schemes, and all the expectations are that this growth will continue. The companies themselves recognise that the key constraints are on the supply side: ~~they are~~ private providers already fully stretched in meeting the existing rate of growth~~, which has greatly exceeded their plans~~. There are shortages of several groups of specialist staff, such as anaesthetists and radiologists. And the attitude of the ~~consultant~~ medical establishment remains unhelpful, ~~for example towards joint public/private ventures.~~ particularly in maintaining restrictive practices: the insistence that all operations must be carried out by consultants, for example.

It follows that our strategy for reform must focus much more directly on the supply side, with the aim of promoting a more flexible and responsive supply capability. There is much we can do to tackle the problems I have mentioned of manpower and other inflexibilities. Only then can we be sure that additional demand will be translated into additional provision, rather than simply dissipated in higher costs.

In putting together a credible and coherent package of reforms, what we need to do is to test each individual proposal against the analysis I have set out in the paper, working through the supply and demand consequences. There is no need to underline the crucial importance of getting this right.

I am copying this minute to John Moore, John Major, Tony Newton, Sir Roy Griffiths and Sir Robin Butler.

[N.L.]

28 June 1988

3/7/89.

This looks
authoritative.
I sh like to
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from the Phillips
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N.

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You can enter if you've ever owned a Volkswagen or if you're due to take delivery of one before the end of August.

The car is actually blue but also, in a way, green.

It comes complete with a catalytic converter.

Because we still cleave stubbornly to that old hippie notion that the world is a beautiful place.

In fact, very soon we hope to be able to offer a ready-converted version of every model in our range.

Could any yogi bear to be without one?

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WILL BE CONSIDERED. 5. PROOF OF POSTING WILL NOT BE PROOF OF RECEIPT. 6. ENTRIES WILL BE THE PROPERTY OF V.A.G. (U.K.) LIMITED. 7. JU
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Whitehall Watch: **Peter Hennessy** on caring for the nation

Welfare state founded on figures that never add up

Sir Kenneth Stowe spent nearly 40 years wrestling with one or other arm of the post-war welfare state. His was a career which took him from cycling round Romford for the National Assistance Board, carrying blankets to the cold and old in Mr Attlee's England, to the permanent secretaryship of the Department of Health and Social Security (DHSS), dealing with a budget of £70bn-plus in Mrs Thatcher's Britain.

If anyone is well-placed to compile an assessment of the changes flowing from the Beveridge Report of 1942 — the social underpinning of the famed post-war consensus — it is Sir Kenneth. Tomorrow evening, at the Royal College of Physicians in London, he will offer a set of thoughts which a Rock Carling Fellowship from the Nuffield Provincial Hospitals Trust has enabled him to put in place since retiring from the civil service two years ago.

Its theme, "On Caring for the National Health", will, given the man, his experience and the ink still drying on the Government's review of the NHS, command attention. He will have much to say on managing and funding the Leviathan he once accounted for to Parliament — plus observations on health education and the "indispensable" voluntary sector.

He will be specially eloquent on the difficulties of managing a million-strong workforce, more than half of which belongs to self-regulating professions whose members profess an ethic which puts the patient first and the employer some way behind.

Sir Kenneth is not one of nature's defeatists. Quite apart from the DHSS, his senior experience saw him in No 10 as Principal Private Secretary to three prime ministers during the relentless economic and industrial crises of the Seventies. The frustration is tangible, however, when he admits: "I have spent much of my life in government engaged in either confronting the intractable or re-organising something."

But the big theme lurking in the interstices of what he calls the "little essays" comprising his Rock Carling Lecture is the question of whether "the 'Welfare State', so-called, was viable in the form in which it was established" after the war.

Attempting the impossible, he says, invariably means some things will be done badly. You almost feel he wishes he were back in 1942 (he was an East London grammar schoolboy then) and able to take Sir William Beveridge by the arm and say: "Listen, it simply won't work even if we get full employment after the war."

When I put this to him, Sir Kenneth said he would want a word not just in Beveridge's ear, but in the ears of the post-war Labour ministers who put together the statutory scaffolding of the Welfare State.

He would tackle Beveridge first on demography. The problem of an ageing population stems from the enormous increase in children surviving birth and early life in the 1900s. It was predictable by the early 1940s and becoming urgent by the 1950s. Why didn't Beveridge think more about it?

Next, finance and some questions for both Beveridge and Attlee's ministers. What was to be gained by combining health and income insurance into a single national scheme which was sure to be unmanageable? By 1942, some 20 million adults (out of a population of 46 million) were already covered by extensions of Lloyd George's 1911 National Insurance Act.

"Wouldn't it have been better to build on that base? How did you get the costings so wrong? Didn't anyone listen to the Treasury? Prescription charges had to be applied within three years of the NHS coming into existence. (To be fair to Beveridge, he did contemplate "hotel" charges for hospital patients.)

"Wouldn't it have been better to go for viability, rather than having everything free when, in fact, nothing is for free?"

By combining health and income insurance, Sir Kenneth added, it increased the chance of health being hijacked as, indeed, it was with only a tiny proportion of national insurance being fed into the health budget.

Nationalising welfare through the National Insurance and NHS Acts of 1946, was, Sir Kenneth believes, a mistake that would not be made today. Running the NHS might have been more manageable if Herbert Morrison had won his fight in the Cabinet in 1945 to keep local authority hospitals locally owned and managed.

"In the act of nationalising all hospital provision, the state took over assets and liabilities on a vastly larger scale than any of the other nationalisations, the difference being that there was no central management authority to give direction and leadership."

There is scope here for a series of lectures if not a book. Is Sir Kenneth tempted? "No. It should be done but by someone of the new generation," he says.

■ *On Caring for the National Health*, The Nuffield Provincial Hospitals Trust, 3 Prince Albert Road, London NW1; £9.

FROM: D I SPARKES
DATE: 3 JULY 1989

MR PHILLIPS

cc Sir P Middleton
Mr Anson
Miss Peirson
Mr Saunders
Mr Griffiths
Mrs Chaplin
Mr Tyrie

'ON CARING FOR THE NATIONAL HEALTH'

The Chancellor has seen the attached article from the Independent which reports that Sir Kenneth Stowe is launching his book 'On Caring for the National Health' with a lecture at the Royal College of Physicians tomorrow evening. He thought this looked interesting and, once you have obtained a copy of the book, the Chancellor would be grateful for any observations you may have.

DUNCAN SPARKES

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DATE: 3 JULY 1989

MR PHILLIPS

cc Sir P Middleton
Mr Anson
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[Given up hoping for response]

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Mike (o/R)
Is Mr ~~Saunders~~ Griffiths yet ready to comment?
Mr Griffiths s216
Duncan
Should get something by middle of next week
BF 28/9

~~Mike pls chase~~ x S261
Mr Saunders is on leave until 29/8
Pls see whether HP has had time to obtain + comment on this book.
Thanks
Mr Saunders is taking this in hand but various other tasks have bigger priority. He will write although it ASAP.

Whitehall Watch: Peter Hennessy on caring for the nation

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1714A

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

CHIEF SECRETARY
... 1989

Mr Saunders
CX Mr Anson
Mr H Phillips
Mrs Pearson
Mr Griffiths

MP

The Rt Hon John Wakeham MP
Lord President of the Council
Privy Council Office
Whitehall
LONDON SW1

10 July 1989

Dear John.

IMPLEMENTATION OF THE NHS WHITE PAPER: CROWN IMMUNITY

One of the key proposals in the White Paper "Working for Patients" is that hospitals and other NHS units should be able to apply for self-governing status whilst remaining fully within the NHS. Self-governing hospitals - or NHS Hospital Trusts as they will become - will have considerably more freedom than health authority managed hospitals. They will be largely autonomous, deriving their income from contracts for health services, which may be with a number of different District Health Authorities, with individual budget-holding GPs, with other SGHs or with the private sector. Unlike health authorities they will own their assets, decide their own management arrangements and determine the pay and conditions of service of their own employees.

As part of the process of preparing the instructions for the NHS Reform Bill, which will give effect to the White Paper proposals, we have considered whether NHS Hospital Trusts would be regarded, if this were tested in the Courts, as having Crown status. That is, would they or could they and their employees be regarded as servants or agents of the Crown and would or could their property be regarded as property owned or occupied by the Crown?

The conclusion that we have reached is that, given the degree of freedom intended for NHS Hospital Trusts, it is unlikely that they would be regarded by the Courts as having Crown status. In other words, unless the Bill contains provisions which positively confer immunities or privileges on Hospital Trusts, they are unlikely to find themselves entitled to any such immunities or privileges.

E.R.

Bearing in mind (a) the long and contentious history of health authorities' Crown immunities, which we ourselves cut back significantly in the 1986 NHS (Amendment) Act and which we are publicly committed to further reducing in respect of Nicholas Ridley's forthcoming new emission controls, and (b) that Crown immunity is normally restricted to bodies which are under the executive control of a Secretary of State I feel that it would be inappropriate and provocative to try to provide in the Bill any general immunities for the new Hospital Trusts. We shall however be considering with the Treasury how to deal with the consequential implications for the tax treatment of Hospital Trusts.

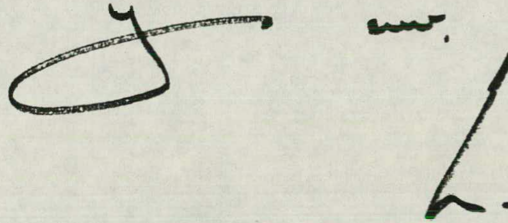
Consideration of the status of Hospital Trusts has led me to re-examine the case of retaining health authorities' Crown immunities. As explained, these have already been significantly reduced in recent years, and another major immunity is scheduled to go in the very near future. My conclusion is that there are strong grounds for using the present legislative opportunity to remove all remaining Crown immunities from health authorities, thereby putting them on the same footing as the new Hospital Trusts. My officials are making an effort to cost this change but do not suggest that there would be one-off capital cost of more than £60 million (most of which is already committed in respect of the upgrading of hospital incinerators to comply with the forthcoming emissions controls) and additional recurring costs of about £8 million a year.

I am particularly anxious, given that we are introducing real competition, to ensure that Hospital Trusts, health authority managed hospitals and the private health care sector are so far as possible treated alike. In particular, I want to avoid creating any disincentive to hospitals seeking self-governing status. Nor do I want to do anything that can be represented as putting self-governing hospitals "outside the NHS". By treating both sectors alike any such risk is minimised.

The removal of NHS Crown immunities should be a popular move. It can be presented positively in terms of demonstrating our commitment to maintaining standards of terms of safety and concern for the environment. So far as costs are concerned, I see no significant direct consequences for other Departments, but we need to consider whether there are any knock-on consequences or any unwelcome precedent which we might be creating for them. My hope is that there will be none: in this matter I think the NHS is more or less self-contained. It is alone in having already dismantled part of our Crown immunity structure and is already committed to removing more. In effect we would simply be taking a natural opportunity to complete the process. Indeed, by removing Crown immunity from an area where (one must privately concede) it has sometimes been abused in the past, I hope that it will in future be easier for colleagues to defend the continuance of Crown immunity in areas where there is no problem of abuse and where immunity remains operationally necessary.

E.R.

I am copying this letter to members of H Committee who will, I hope feel able to agree that I should proceed as outlined. It would be helpful if I could have any comments or views by 21 July to enable me to keep to the timetable for the drafting of the NHS Reform Bill. A copy of the letter also goes to Patrick Mayhew and Richard Luce, and to Sir Robin Butler.



KENNETH CLARKE

1764A

CONFIDENTIAL

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 Malcolm Rifkind QC MP
Secretary of State for Scotland
Scottish Office
Dover House
Whitehall
LONDON SW1

19 July 1989

PMP

Dear Malcolm,

GPs' NEW CONTRACT

As you know the results of the ballot of all GPs will be announced by the GMSC on 20 July. My expectation is that the package agreed with their leaders on 4 May will be rejected.

In that event I believe that we should press ahead with introducing the "4 May" package without changes. I hope you agree.

We will be pressed for a reaction to the ballot result as soon as it is announced. I envisage a fairly low key response. A press release seems the best course and I enclose a draft which I think covers all the points we need to make at this stage. I shall be glad to know if you are content.

I am copying this letter to the Prime Minister, Peter Walker and Tom King.

Yours ever,
Ken

KENNETH CLARKE

CH/EXCHEQUER
REC. 26 JUL 1989
ACTION MR SAUNDERS
COPIES TO CST, SIR P MIDDLETON, SIR T BURNS, MR ANSON, MR PHILLIPS, MR CULPIN, MRS LOMAX, MISS PEIRSON, MR KELLY / MR TODD, MR GRIFFITHS

/26/7

CONFIDENTIAL

DRAFT DRAFT DRAFT

89/368 20 July 1989

KENNETH CLARKE PRESSES AHEAD WITH CHANGES TO THE GP CONTRACT

Speaking after the ballot of GPs rejected the new contract which had been agreed with GPs' leaders of 4 May, Mr Clarke said today:

" I regret the GPs' lack of support for their own Negotiators and their vote to reject the contract which I agreed with Michael Wilson and his colleagues on 4 May. Those negotiations were hard fought. Both sides made concessions which they might not otherwise have done in order to secure a fair deal which was commended to the profession by their leaders. I see no sensible basis for re-opening those negotiations now.

" I do not think anyone seriously expects us to go back on our desire to improve the family doctor service with a new and fairer contract which will reward those who work hardest and provide the good quality services which we all wish to see.

" I have already been consulting the GMSC leaders on the detailed Regulations which will be required to implement the contract which was agreed on 4 May. Once the consultation process has ended I propose to place those Regulations before Parliament in the Autumn. Subject to Parliamentary approval the reforms to the GPs' contract will be introduced on 1 April 1990.

[MORE]

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" The new contract will help to tackle the variations in the service people get from their doctor. A recent study of GP practices by economists at York University showed wide differences across the country, for example in the range of services on offer. This has happened because there are so few incentives in the present contract to encourage doctors to improve their services to patients.

" Good GPs have nothing to fear from the new contract. It will reward those doctors who provide the kind of service that patients want and need. In future it will be a contractual requirement to provide extra care for elderly patients and GPs will be paid more for doing so. GPs who make night visits themselves or arrange for them to be made by a doctor the patient knows, will be paid more than those who use deputising services. GPs who perform minor surgery themselves, who specialise in the care and development of children and who run health promotion clinics will gain.

" In addition, there will be a new allowance for GPs who work in areas of deprivation in recognition of the additional work they are faced with. New bonus payments will be introduced for doctors who ensure that maximum numbers of their women patients are screened for cancer of the cervix and of their child patients are immunised against childhood diseases. The new contract will also mean that all doctors are more available at times convenient to patients.

" It is totally illogical to suggest that the new contract will increase average list sizes. There are only so many patients in the country and so many doctors. It doesn't take a degree in Mathematics to realise that the average list size will not rise. In fact, it will no doubt continue to go down as the number of general practitioners rises faster than the population.

" I will be writing to all GPs in due course to explain how the changes to their contract will affect them. I am sure that all GPs share my aim which is to raise standards and reward good practice."

[END]

CONFIDENTIAL

FROM: R B SAUNDERS (ST2)

DATE: 8 SEPTEMBER 1989
x 4800

1. MR PHILLIPS
2. CHANCELLOR

Copies attached for:	cc
Chief Secretary	Mr Kelly
Sir P Middleton	Mrs Lomax
Mr Anson	Miss Peirson
Sir T Burns	Mr O'Donnell
Mr Phillips	Mr Todd
Mrs Chaplin	Mr Griffiths
Mr Tyrie	Mr D Rayner

NHS REVIEW

The Prime Minister has now cancelled the meeting arranged for next Thursday. We have been told this was because she was broadly satisfied with Mr Clarke's progress so far. We think however that his present course carries significant risks for the Government, which you may wish to raise in some way with Mr Clarke and/or the Prime Minister. We are to discuss this with you on Tuesday.

2. The general background continues to be one of acute controversy. GPs have voted decisively to reject the new contract. Mr Clarke will now impose it, and the majority of GPs can be expected to acquiesce reluctantly. The BMA meanwhile have stepped up their campaign against the White Paper proposals, including the now notorious personalisation against Mr Clarke ("What do you call a man who ignores medical advice?"). We do not know yet what, if any, response Mr Clarke now proposes.

3. The Social Services Committee published last month their report on the White Paper, from which a number of Conservative Members dissented. While it welcomed some of the reforms, like medical audit and improved information and financial systems, it expressed scepticism about the timetable proposed for the reforms, and urged the Government to proceed more cautiously and by way of pilot experiments.

Progress with Implementation

4. A first draft of the Bill is now in existence, and it should be ready for introduction at the start of the Session. We have been kept reasonably well in touch with the drafting. It will cover community care as well as the NHS Review.

5. In some areas, progress on the ground is good. Work will soon start on upgrading the information supplied to GPs about their prescribing, in preparation for the introduction of indicative budgets. DH are also steadily working up "contract funding" - the contracts between buyers (health authorities) and providers (directly managed, self-governing and private hospitals). They have embarked on a major exercise, in consultation with the NHS and involving several pilot projects, to identify the practical implications and potential pitfalls in this system. Nevertheless there remain many tricky problems, not least how to ensure that budget holders retain financial control.

6. As this process has gone on, some of the ideas have become less radical. For example, we have discussed before the problems if GPs want to refer patients to hospitals where there are not contracts, or if the total of individual referrals makes the pattern different from that implied by district contracts. The Department have now concluded that the pattern of contracts must follow, and not lead, the pattern of GP referrals. While it may be possible to bring about changes over time, this will have to be by a process of consultation and persuasion, not by the mechanical operation of a contract system. This sort of realism is a welcome development. Even so, a fully satisfactory way of dealing with extra-contractual referrals has not yet been devised.

7. But there are other areas where this purposeful and pragmatic approach to implementation is not so evident. One has been information technology, where, although the Department's plans have already been scaled down once, they remain very ambitious, and it must be doubtful whether they are achievable on the present timetable. Secondly, the White Paper implies a wholesale change

in the role of FPCs (or Family Practitioner Services Authorities as it is now intended the Bill should rename them), with a quite fundamental change in their character. Up till now, they have been relatively low-grade clerical operations, recording patients accepted on a GP's list and payments to him in accordance with set formulae. But in future they will have to show active leadership and supervise the activities of GPs in a way they have not done before. They will become quite different organisations, and yet the Department's plans for managing such a dramatic change within a very short period of time seem non-existent.

The Risks

8. There are three main risks to which the Government is exposed.

9. The <u>first</u> is that the <u>changes will not be ready</u> for introduction from 1 April 1991. This is a real worry, and one which Robin Cook has picked up. While it will never be possible to introduce such far-reaching changes without some hitches, it will be important to avoid any suggestion that patient services are suffering or any impression of incompetence. This requires clear and active leadership from the Department, which is why their passive approach to, for example, the management of FPCs is so worrying.

10. <u>Second</u>, even if the changes are introduced relatively smoothly, <u>their impact in some cases may be unpredictable</u>. They depend heavily on the goodwill of the participants in the system. Some GPs may be only too happy to publicise individual cases where the reforms have allegedly worked to the detriment of patients. For example, the contract funding system will certainly tend to reduce freedom of referral. There may be temptations to lay problems at the door of indicative drug budgets. And volunteers for practice budget status may be thin on the ground. The medical profession has the capacity to damage the implementation of the reforms, and a more conciliatory approach by DH Ministers might bear fruit.

11. Third, there are the costs. Mr Clarke has entered Survey bids of £350/570/520 million, even after reducing them by £150-200 million a year by trimming back computerisation. He also wants to reduce the target efficiency savings set for health authorities. We believe some reductions for realism are possible, and, after deferring some of the later year bids, we think we can get the outcome down to £240/315/365 million. But this is still nearly £1 billion over the Survey period, with few foreseeable signs of a return on this investment.

?

Assessment

12. The third risk - costs - can be diminished only by tough scrutiny in the Survey. The bids imply an additional 5,000 administrative jobs in hospitals, and we shall be pressing for a reduction. We do not at this stage see scope for reducing the costs by deferring any of the White Paper proposals or otherwise modifying the package. Most is for extra administrative staff to strengthen the finance and personnel functions at local level, and to support medical audit. But I doubt if these bids will be Mr Clarke's last word. New bids may well be expected in next year's public expenditure survey, and it is reasonable to expect that the more self-governing hospitals are in the pipeline, say, the higher they will be.

13. As to the first and second risks, Department of Health Ministers have to a considerable extent already committed themselves to a high risk course of action. The GPs are already alienated. And Ministers have invested a good deal of credibility in implementation from 1991, without a formal series of pilot projects. This makes it virtually impossible to modify the main proposals without serious loss of face.

the PBs & SGHs are pilots

14. But it is possible to carry the reforms forward at a controlled pace without dropping any points of principle from the package. Essentially this means not gratuitously accelerating the process. The dangers of this were illustrated by the conference of potential self-governing hospitals in June. By announcing that 178 "expressions of interest" had been received, the Department

ensured that expectations about the number of hospital trusts in the early years were raised to wholly unrealistic levels. Their present views are that around 50 will be established in 1991, with a further 50 in 1992. This has not yet been made public, and I think it still looks dangerously optimistic. It will be a major task to set up the first wave of self-governing hospitals, which are a completely new concept, and the resources available to support them are strictly limited. It would be prudent to plan for an even more limited number - say 20 - in the first year. Ideas could thus be tested and management allowed to feel their way initially without formally designating them as "pilots".

15. There are similar dangers in respect of practice budgets. Mr Clarke is planning a practice budget "launch" in November, following which expressions of interest will be invited from GP practices. His Survey bid is based on the assumption that 800 of the 1,000 eligible practices will opt for practice budget status from 1991. This is an absurd proposition, particularly given the soreness among GPs about the new contract. Rather than open up a fresh area of controversy and of unrealistic expectations, Mr Clarke should keep the practice budget launch as low-key as possible. Since practice budgets are very much Mr Clarke's pet idea, it is perhaps unrealistic to expect him to postpone or cancel the launch altogether. He argues that there are many GP practices who are keen to explore practice budgets, although we are not sure what basis he has for this.

The Medical Profession

16. Thus far, the GPs have been making much more noise than hospital doctors, largely because of the furore about their new contract. As noted above, there are a number of ways in which they could disrupt the reforms. But the same is potentially true of consultants. Department of Health have been talking to the JCC over the summer about disciplinary procedures, consultants' contracts and distinction awards, and little progress has so far been made. They tell me the JCC appear to be going slow, and if agreement has not been reached by December or January they may be obliged to impose the new terms.

17. There are obvious and worrying parallels with the row about GP contracts. The JCC will find it more difficult than the GMSC to get public support for their case - it is difficult to argue that consultants should not have proper job descriptions or that there should not be some involvement of NHS management in making distinction awards. But a fresh row with the consultants may of itself be damaging to the Government's case.

18. The consultants moreover may be able to hinder the introduction of self-governing hospitals. At Guy's they have won a formal undertaking that self-government will not be pursued without a majority of consultants being in favour. And DH officials privately accept that no hospital could go self-governing in the teeth of opposition from the majority of senior medical staff.

19. It may therefore be important for Mr Clarke to devise some concessions that he could offer, both on terms and conditions and on self-governing hospitals, which might secure their support.

Central Management of the NHS

20. Mr Clarke's office wrote to No 10 about this on 20 July, and this was also due to be discussed at the Prime Minister's meeting. There were points we were going to advise you and the Chief Secretary to make, and we think the Chief Secretary should still do so in writing. Miss Peirson is preparing a separate submission on this.

Conclusions

21. We are now moving into the second and more difficult phase of the White Paper proposals - preparing on the ground for implementation in 1991. This is a critical phase, and we need to be sure we get it right. Our concerns may be summarised as follows.

(a) That there needs to be clear and active central management of the main areas of reform (paragraph 7). While

the Department are getting ahead well in some areas, they are less impressive in others. The reforms will not happen if the managers on the ground are not given clear guidance.

(b) The heavy costs implied by Mr Clarke's Survey bids and the risk of further bids next year (paragraph 12).

(c) That present ambitions for numbers of self-governing hospitals from 1991 should be scaled down (paragraph 14).

(d) That the planned November launch of the practice budget scheme should be as low-key as possible (paragraph 15).

(e) That a new row with hospital consultants may be looming in the new year and could further damage the Government's proposals (paragraphs 16-19).

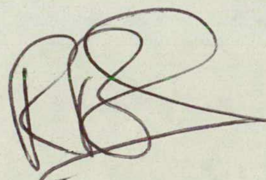
22. If you think these concerns are well-founded, the question is whether, and if so how, to raise them. The cancellation of the Prime Minister's meeting makes this more difficult. The choices would seem to be the following:

i. a minute to the Prime Minister or letter to Mr Clarke;

ii. a meeting between you, the Chief Secretary and Mr Clarke; or

iii. a private word first with the Prime Minister, possibly as a prelude to i. or ii.

In any event, the Chief Secretary is being advised to comment on Mr Clarke's proposals for the central management of the NHS.



R B SAUNDERS

ps.ay8.9nhs

CONFIDENTIAL

FROM: G H PHILLIPS
DATE: 8 SEPTEMBER 1989
Ext: 4390

CHANCELLOR

cc: Chief Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mr Kelly
Mrs Lomax
Miss Peirson
Mr O'Donnell
Mr Saunders
Mr Todd
Mr Griffiths
Mr Rayner
Mrs Chaplin
Mr Tyrie

NHS REVIEW

1. I attach a minute from Mr Saunders which sets out the concerns which we think we should bring to your attention, and that of the Chief Secretary, for discussion at your planned meeting on 12 September. Now that the Prime Minister's meeting has been cancelled, and the Chief Secretary is engaged in bilateral discussion with Mr Clarke on the Survey, the main issue is whether, in the light of our discussion, you wish to take any further initiative, either with Mr Clarke or with the Prime Minister, or both, about the Review's implementation.

2. The rest of this note sets out a possible agenda for your meeting. In addition to Mr Saunders' minute below of 8 September you might like to have in your folder Mr Clarke's progress report to the Prime Minister which we received on 21 July. There are three key areas - **implementation progress, the future pace of reform, and presentational issues.**

3. You might like first to consider any questions about implementation of the Review so far. Comments on where DoH have got to are set out in paragraphs 4 to 7 of Mr Saunders' note. Mr Clarke's progress report dealt with implementation more in terms of its process than its substance. But since that came

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round we have a good deal more information from the Department and, although the effectiveness of implementation is patchy, it does seem to be better than it appeared in July. Mr Saunders identifies information technology and the reforms to Family Practitioner Committees as the two areas where we have the greatest worries. We shall be looking at those in the Survey.

4. Second, you might like to discuss the difficult question of the pace of reform. The issues here are exposed in paragraphs 8 to 15 of Mr Saunders' note. The trick is to get a sensible balance between maintaining firmly the policy of reform and progress on it, while ensuring that what is done is done effectively on the ground and is within the limits of affordability. We have already come up against this issue directly in the Survey. Mr Clarke has helpfully indicated to the Chief Secretary that he is prepared to reconsider his target of 800 GP practice budgets out of an eligible 1,000 (paragraph 15 of Mr Saunders' note) but he shows no sign of any movement at all on the number of self-governing hospitals. He has however agreed to the Chief Secretary's request that he cost an NHS Review implementation package at half the cost of the Survey bids he has on the table. This will give us the opportunity to consider what a less comprehensive approach and a slower timetable might look like. This will not of course be acceptable to Mr Clarke as a basis for provision. But the question is do we need to do any more at this stage?

5. Third, there is the issue of the presentation of the NHS Review White Paper. Mr Clarke's report to the Prime Minister was largely about this and its tone was generally upbeat and optimistic. However, I am sure that he recognises that this is not yet a fully realistic assessment given the likely continued opposition of the medical profession, and general public scepticism. Mr Saunders refers in paragraphs 16 and 17 of his minute to a potential looming problem with consultants as well as with most of the rest of the medical profession. The depressing conclusion in Mr Clarke's report to the Prime Minister was that "it would be a serious mistake to imagine that any (ie Presidents of the Royal Colleges, academics, and opinion formers) will, or

could, be persuaded to offer vigorous public support for the Government against the BMA". Is this inevitable? Is there more that could be done? Should we press Mr Clarke to have as low key as possible a launch in November of the practice budget scheme?

6. Finally, you will want to consider handling. In my judgement, many of the problems of managing the change, and the costs of change, and to some extent its pace, are bound to come up in the Survey. I see no immediate advantage in your taking up either the same issues or one or two of them now directly with Mr Clarke but you may wish to hold in reserve the opportunity, in the light of Survey developments, of talking to him about the politics and presentation of the reforms.

HP.

HAYDEN PHILLIPS

MINUTES OF A MEETING HELD IN CHANCELLOR'S ROOM AT HM TREASURY ON TUESDAY 12 SEPTEMBER 1989

Present:

Chancellor
Chief Secretary
Sir T Burns
Mr Anson
Mr Phillips
Mrs Lomax
Miss Peirson
Mr O'Donnell
Mr Saunders
Mr Griffiths
Mrs Chaplin

MP

....

NHS REVIEW

Papers: Mr Phillips of 8 September; Mr Saunders of 8 September.

Mr Phillips said that he and Mr Saunders shared worries that the Department of Health had over-extended themselves in implementing the NHS Review and that the situation carried risks, financial and other, for the Government. The cancellation of the Prime Minister's forthcoming meeting on the progress of the NHS Review had limited Treasury Ministers' room for manoeuvre outside the Survey discussions.

2. Mr Phillips remarked that, in some areas, the progress of implementation had been good. But important areas remained vulnerable, notably the Department's plans for information technology and the new role for reconstituted Family Practitioner Committees. As regards the latter, Mr Saunders stressed that what was lacking was clearly defined management objectives; it was no good just leaving it to FPCs themselves to adjust to their new responsibilities.

3. On information technology, the Chancellor agreed that Department of Health's information technology effort should be concentrated on contract funding and drug budgets. This need not delay implementation of the main reforms by April 1991 and was a matter for the Chief Secretary to pursue in the course of the Survey. On FPCs, the Chancellor thought that there was a case for bolstering the medical representation on FPCs by asking retired doctors to serve; their experience could be helpful as they might well take the "poacher turned gamekeeper" attitude. He also asked Mr Phillips to see whether Mr Roy Griffiths could be involved to a greater extent in this aspect of the reforms.

4. As regards the pace of future reform, the Chancellor noted that the impact of the changes could in some cases be unpredictable. He felt sure that some GPs would be only too happy to draw attention to individual cases where the reforms had allegedly worked to the detriment of patients and would be tempted to blame the introduction of drug budgets. He thought more should be done to involve individual doctors in the implementation of the reforms so that they did not seem to be entirely management driven.

5. It was noted that Mr Clarke had tabled huge Survey bids which officials thought they could trim to £240/315/365 million. These figures were still worryingly large but even more concerning was the lack of evidence of a return on an investment of this magnitude. The Chief Secretary said that he had asked Mr Clarke to cost an NHS Review implementation package at half the cost of his Survey bids; this would enable the Treasury to consider the implications of a slower timetable.

6. As for self-governing hospitals and practice budgets, the Chancellor emphasised that their introduction was to be on the basis of "pilot" schemes. Again these were matters for the

Chief Secretary to address in the context of the Survey, but the Chancellor felt that it would be easier to temper the Department of Health's ambitions for practice budgets than for self-governing hospitals because the latter were seen as the flagships of the NHS Review. Nonetheless, it would be important to convince Mr Clarke that what was required was not a large number of self-governing hospitals in the first wave but a few well-known and conspicuously successful pilot operations.

7. The Chancellor noted that Mr Clarke might have to devise some concessions to secure the support of consultants, who might be able to hinder the introduction of self-governing hospitals. Mr Saunders suggested Mr Clarke might seek to involve consultants more formally in hospital management and in decisions on whether to apply for self-governing status. The Chancellor agreed but said he was less convinced by the arguments for concessions on terms and conditions; after all, consultants enjoyed less public support than GPs.

8. Summing up, the Chancellor observed that on the ground, among opponents of the NHS Review, there was a strong feeling of inevitability that the reforms would be implemented and that resistance was futile. It was important not to undermine this momentum.

9. The Chancellor asked the Chief Secretary to pursue in the context of the Survey the Treasury's main concerns: the need for clear and active management of the main areas of reform, the heavy costs implied by Mr Clarke's bids and the risk of further bids next year, and a scaling down both of the number and the high-profile launch planned for pilot practice budgets and self-governing hospitals. He asked Mr Phillips to take forward the management points that had been made about the composition of FPCs and the involvement of Mr Roy Griffiths.

10. Finally, the Chancellor said he would be considering, in the light of progress made at the Chief Secretary's second bilateral with Mr Clarke on 25 September, whether to see Mr Clarke himself.

D.C.S.

DUNCAN SPARKES
13 September 1989

Circulation

Those present
Sir P Middleton
Mr Tyrie