Po-CH/NL/0223

PART D

Alex Lawson

PART D

SECRET

(Circulate under cover and notify REGISTRY of movement)

PO -CH /NL/0223

PART D

CHANCELLOR'S PAPERS ON HEALTH AND SOCIAL SECURITY SERVICES

Begins: 1/11/88

Ends: 10/11/88 (CONTINUED)

DD: 25 years

15/9/95

PO -CH /NL/0223 PART D

26.10.3

SECRET

FROM: R B SAUNDERS

DATE: 1 NOVEMBER 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mr Culpin
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Sussex
Mr Call

NHS REVIEW: STOCKTAKING

You are holding a meeting on Thursday to take stock of what the Review has now got to, and where it might be going.

2. I attach a note prepared by Mr Griffiths which sets out, from the Treasury's point of view, which of the conclusions of the Review so far can be regarded as beneficial and which not. Overall, we have done quite well in fending off expensive bad ideas (save perhaps the concession we had to make on benefits in kind), but we must suspend judgement as to how far we have succeeded in ensuring that effective financial control is not undermined.

3. The main themes of the Review as it has evolved are now:

a. improving accountability within hospitals by, for example, better management and financial information systems, improved VFM audit, medical audit and reforming consultants' conditions, notably the merit award system;

b. freeing up the controls within the system by introducing self-governing hospitals, delegating more decisions to hospital level, and improving public/private sector co-operation;

c. making the system more responsive - hence the "package for patients", GP budgets for elective surgery, and performance funding.

4. We need to think about how some of these proposals will turn out in practice. Some look on the complicated side, while others still need a lot more work done on them before they can be unveiled as part of the outcome of the Review. We must look at the potential pitfalls, before we start getting into drafting a White Paper.

Accountability within hospitals

5. This is making good progress. The resource management initiative is being accelerated, and we are in touch to ensure that DoH drive it through properly. We have agreement that the Audit Commission will take over statutory audit of health authorities and FPCs. So long as DoH come up with positive proposals on medical audit and consultants, we have the makings of an attractive package here.

Self-governing hospitals

6. This too is coming along quite well. There may be political problems in pressing self-government in particular cases against opposition from at least some local groups. But the proposals now stand up reasonably well in procedural terms. The main problems are likely to be about pay. Clearly, if self-government is to have any meaning, the hospitals must have more freedom than at present over terms and conditions. But the political and possibly legal difficulties of taking some people out of national pay bargaining systems and review bodies, but not others, should not be underestimated.

7. Rather than treating the staff of self-governing hospitals differently from the rest, we need to try and reform the pay system more generally so that it offers employers the sort of freedom that self-governing hospitals would expect in terms of, eg geographical and performance-related pay. Abolition of the review bodies would be the ideal, though probably an unattainable

meaning what?

one. Instead, we might look at the relationship between review bodies and collective bargaining, particularly for nurses. We shall be having an initial discussion about this with DoH officials shortly.

Public/private sector co-operation

8. This is to be the subject of another DoH paper, on how to encourage the private sector and, as the record of the last meeting put it, blur the distinction between public and private. In considering this, we must keep in mind the distinction you made at an earlier stage between finance and supply. It is on the supply of health services that we want to blur the public/private distinction - eg by competitive tendering in clinical services. We most certainly do not want to blur it on finance. We have sought to maintain this distinction clearly and have resisted schemes for health vouchers or "opting out of the NHS", which involve new and expensive subsidies to those who pay for their own private health care. This will be the essential point to bear in mind when the DoH paper appears.

9. A specific instance in which it could arise is GP practice budgets. If GPs are to be allowed to refer patients directly to private hospitals, there is a danger of public finance substituting for private finance - in effect a new subsidy for private treatment. If your GP can refer you privately using public funds, you do not need insurance, so the net private funds going into health are reduced. This is quite different from a district buying bulk from a private hospital in order to reduce waiting lists: that is substituting private provision for public provision, a completely different kettle of fish.

10. The DoH proposals for more private finance for capital projects are also relevant here. The Chief Secretary will have held his meeting with Mr Clarke earlier on Thursday.

SECRET

GPs and family practitioner committees

11. This however is a rather unclear tangle of three quite distinct themes: GP budgets, management control of GPs, and cost control.

12. The first is mainly about giving GPs new powers to try and make the hospital system work better. It has little to do with management of the FPS (so talk of "opting out" is misleading). It is looking for a mechanism to get waiting lists down, either by discouraging unnecessary referrals or by targeting resources on those hospitals who deal with patients most expeditiously. The link made with top-sliced performance budgets at the last meeting is quite right: these two proposals, both aimed at waiting lists, need to be knitted together in some way. Tackling waiting lists must be a big objective for the Review. The proposals should be designed with this clearly in view. But beware the point about referrals to private hospitals (paragraph 9 above).

13. The minutes of the last meeting are muddled on the second theme: management control. DoH have been asked to produce a paper on how the capacity of FPCs to enforce their contracts with GPs should be strengthened. But the minutes talk about this in terms of those GPs who have not "opted out", completely ignoring the fact that GPs with practice budgets will have an identical relationship with their local FPC. It is through their contracts with FPCs that GPs are remunerated and enabled to provide primary health care. The practice budget proposal is simply an add-on. If GPs with practice budgets are to come under some new remuneration system - as the minutes seem to imply - then the issue needs to be addressed explicitly and quickly. The present system is much more complicated than simple capitation fees, which account for less than half of GPs' remuneration. In my view, we do not want to propose a new remuneration system for GPs with practice budgets. We want the stronger FPC management to apply to them as well as to other GPs.

14. The third - cost control - is the important one for the Treasury. We have got proposals for drug budgets, cash limits (including DHA/FPC merger) and controlling GP numbers in play, but are still some way from achieving any of them. Indeed the proposal to allow GPs to retain underspends on practice budgets will tend to ratchet FPS costs upwards: those who opt for practice budgets will tend to be those whose costs are below the average on which the budgets will be based. We should keep it a high priority to get something worthwhile in this area out of the Review.

15. We should be looking for an acceptable result on all three of these, to form a coherent package. We should not accept GP budgets without better cost control and management of the FPS generally.

Funding

16. The Department have a remit to produce a paper for the next meeting, including the "abolition" of RAWP and its replacement by a capitation-based system. We need to be clear what this means. There will need to be some system for allocating resources according to population, adjusted for differences in age structure and morbidity (ie how sick the local population are). In practice this will be little different from the present calculation of RAWP targets, the formula for which is not all that complicated. In a fully-fledged system of buyers and providers, these allocations would go to the buyers who would use them to purchase appropriate health services. But, initially at least, the two roles will continue to be closely intertwined in health authorities. So the money going to health authorities would be very much like allocations according to RAWP targets (with the possible exception that it would allocate to district rather than regional level, which would require a more finely-tuned formula). In other words, the effect would be to speed up the process of moving to RAWP targets, since it would be done at once rather than over a period of years. It will be interesting to see how DoH address this in their forthcoming paper, but they

might make a bid to buy out regions who are at present below target. We should not let them get away with the impression that RAWP is being "abolished" in return.

17. The changes so far proposed will make the system more complicated than it is now. It is now a fairly simple top-down process through regions and districts to hospitals. The new system, in contrast, would fund hospitals by a combination of at least three different methods ("core", "contract" and "performance"), have different arrangements for financing district-managed and self-governing hospitals respectively, and partially fund some services through GP practice budgets. It is hoped to simplify the treatment of one aspect of the present arrangements - cross-boundary flows - but even here it may not be possible to get rid of the present adjustment entirely (eg for "core" services).

18. Still on the theme of complexity, the objective was once to slim down, if not abolish, regional health authorities. The net effect of the proposals so far, however, is to beef them up considerably. No proposals are yet on the table which would take functions away from regions sufficient to compensate for the following additions so far proposed to their terms of reference:

- overseeing the transition of hospitals to self-governing status

- some controls over acquisition and disposal of assets by self-governing hospitals, a responsibility which now resides primarily with districts.

- oversight of FPCs, whether or not merged with districts

- allocation of budgets for elective surgery etc to GP practices who so opt

- running the performance-based element of hospital/district funding

- responsibility for the proposed new system of capital charges

- approving voluntary capital raising schemes which will attract pound-for-pound public funding.

19. Greater complexity is not in itself an argument against change. If we are to break up the present monolithic arrangements, and introduce new incentives to improve performance and efficiency, a more complicated funding system is inevitable. We were aware of this when we proposed the idea of performance funding, reasoning that the new incentives would have benefits outweighing the administrative costs. A stronger role for regions is also inevitable, since the alternative is to centralise these functions into the Department of Health and the NHS Management Board. But the Group should be aware of the extent to which the proposals complicate rather than simplify, and therefore seek assurances about the capacity of the people in charge to absorb and manage these changes. You will wish therefore to ask Mr Clarke whether he thinks that the regions, in particular, have strong enough managements to tackle the changes which he has proposed. We shall feed this thought in to DoH officials, who are preparing a paper on the reconstitution of regional and district health authorities for the next meeting.

Direct effects on patients

20. Finally, we must not lose sight of this. Insofar as the other proposals will improve the efficiency and effectiveness of the NHS, patients can be expected to benefit in the longer term. But the White Paper will need to contain some convincing ideas for tackling the worst waiting list black spots and for getting hospitals to raise the non-clinical treatment of patients from its present unacceptable standard. Mr Clarke is to put a paper on this to the next meeting.

R B SAUNDERS

ANNEX A

NHS REVIEW: STOCKTAKING

Treasury Objectives

1. Better value for money in the NHS through reforms to improve efficiency and enhance services to patients without a significant increase in public expenditure.

2. Ensure maintenance and, where necessary, development of effective public expenditure control over NHS.

3. Introduce more of a price mechanism into the NHS eg

- more patient charges [what's happened to optional extras as a form of income generation?]
- internal markets

Achievements

1. Acceptance of principle of introducing performance-related financing eg creation of funding mechanism more attuned to rewarding performance and use of top-slicing of resources to help efficient hospitals through practice budgets for certain GPs or waiting list funds for GPs. [But methods still not quite agreed.]

2. Agreement on importance of measures to provide better service to NHS customers (reforms to appointment systems, visiting hours, improving waiting rooms etc).

3. Some progress on promoting greater use of price mechanism eg commitment to extend the Resource Management Initiative throughout the NHS acute sector, introduction of capital charging.

4. Agreement to transfer responsibility for NHS audit to Audit Commission. [but still practical problems to sort out, eg relationship w. the NAO]

5. Rejection of opting out and health voucher concepts. ↖ hope so, but is it dead?

6. No significant diminution (so far) of public expenditure control in the HCHS.

Failures

1. No progress on extending charges.

2. Concession of private medical insurance tax relief for pensioners and all employee company schemes.

Still to play for

1. Better public expenditure control over the FPS. Ideal would be to merge DHAs and FPCs and impose cash limits. If cannot achieve this, seek to secure as many as possible of the necessary conditions for application of cash limits - implementation of controls over numbers of GPs entering the FPS, establishment of drug budgets for GPs. Minimum objective is to ensure that GP practice budgets do not lead to reduced financial control over and unnecessary increase in FPS expenditure.

2. Maintain effective control over capital expenditure with minimum derogation from the private finance guidelines.

3. Action to reform consultants' conditions. Agreement that this should be done but not on the measures necessary.

4. Competitive tendering for clinical services.

5. Pay in relation to self-governing hospitals and its impact on the rest of the NHS.

6. Accountability and the structures to support it (NHS organisation)

NHS REVIEW: FUNDING HOSPITALS

1. This paper sets out how a new approach to funding hospitals might work in practice, and how the present funding system might be changed over time. It does not cover the funding of family practitioner services or capital.

Funding Districts

2. Once fully in place, the new arrangements envisaged by Ministers for self-governing hospitals and greater competition imply a new basis for funding Districts. Each District will need a budget with which it is expected to provide or secure a comprehensive range of services for the population it serves. That budget will come ultimately from Government, and there will need to be agreed mechanisms:

* for deciding within the PES how much in total needs to be spent from public funds.

* for distribution between Districts. To the extent that Districts are charged with securing services for all the patients they serve, funding should in the main be related to population (subject to any necessary allowance for extra costs, such as for the number of elderly people). Whilst they remain directly responsible for the delivery of services, the money they get should also reflect performance. The level of privately funded expenditure might also be a consideration. Most, if not all, cross-boundary flows will be paid for directly.

* for reflecting unavoidable variations in the cost of providing services, notably the excess costs in London and the South East (which may well grow if Regional pay variation increases.)

* for any remaining central initiatives to reward performance, reduce waiting times or encourage new developments.

3. The present financial allocation system (briefly described at Appendix A) would require substantial change. To move overnight would mean that the majority of Districts would get significantly more or significantly less than at present. Without the new system in place there would be chaos, leading almost certainly to the need for substantial extra expenditure. We shall therefore need to manage carefully the process of change, working primarily through a regional tier which will need to co-ordinate each year's "normal" allocations to Districts with

* new developments in the funding of services to patients, of the kind discussed later in this paper, and

* the development of self-governing hospitals.

4. These charges will need to be managed carefully and, at least in part, experimentally. A number of possible experiments are summarised in Appendix B, all of which - including those concerned with the phasing in of self-governing hospitals (experiments (4) and (5)) - would both inform and progress the changes needed. Legislation will be necessary to enable much of that experimental work to take place as well as to make some of the changes to the funding system which will be required. The outcome will be a system based essentially on

* primarily capitation-based allocations from the Department to Regions (or regional arms of the Department) and from Regions to Districts.

* performance-related contracts or management budgets between Districts on the one hand and their management units or self-governing hospitals on the other.

5. Ministers may wish to consider making two immediate changes during the interim period:

i. identifying specific sums (which to be effective would have to be seen as additional) to be allocated by Regions on the basis of a proven track record of efficiency or, as with the existing waiting list initiative, in order to encourage targeted improvements in efficiency or output. This approach would not necessarily form part of the longer-term system, and could be phased out as the new arrangements began to bite on efficiency and waiting times. If interim, specific funding is to be introduced as early as 1989-90 the recipients would have to be Districts, but the aim could be to move to including hospitals among the recipients as they become self-governing. In addition all health authorities would need sufficient additional resources to meet the costs of inflation and of general service pressures, notably from the elderly.

ii. dealing more expeditiously with cross-boundary flows. The evolution of the new funding arrangements proposed in this paper will itself steadily increase the proportion of cross-boundary flows which are paid for directly. For example, one of the experiments outlined in Appendix B would provide for every Region to move in this direction, specialty by specialty, in the field of elective surgery - where progress on cross-boundary flows is particularly important. In the meantime, it may be possible for neighbouring Regions to reach agreement to move immediately to direct payment for patient flows. As a first step the DHSS are examining now how quickly they can move to using patient flow data one rather than two years late.

Funding services to patients

6. Where the new funding arrangements will really "bite" is below District level, at the point of funding services to patients. For convenience, future funding arrangements at this level can be divided into three categories:

i. "core" funding for services which must be available locally because, for example, immediate accessibility is essential for emergency treatment.

ii. "contract" funding for services which could be subject to competition: these services could be provided locally but could instead be bought in partly or wholly from elsewhere (including the private sector).

iii. "tertiary" funding for services which are too specialised to be affordable in more than a few locations.

The services covered by these categories are described more fully in Appendix C.

Core" funding

7. The funding of "core" services will need to be arranged in a way which

* guarantees immediate availability, so that treatment is provided when it is needed without any question as to where the money is coming from.

* secures acceptable standards of performance in terms of quality and efficiency.

For the most part "core" services are not subject to waiting lists. There is therefore no need for their funding to provide incentives to greater activity.

8. The best approach at the start might therefore be

* budgets allocated by DHAs to each management unit, backed in each case by

* agreed performance targets which recognise past performance or aim to achieve significant future improvements.

The practical application of this approach would need to be tested by experiment.

9. For hospitals which became self-governing, these performance-related budgets would be turned into formal contracts. Some self-governing hospitals would need to hold such contracts with more than one District "buyer", replacing the present retrospective arrangements for funding cross-boundary flows.

10. The services which need to be provided locally and therefore funded in this way can be divided into five broad categories:

i. accident and emergency (A and E) departments.

ii. services for patients who need immediate admission to hospital from an A and E department, for example a significant proportion of general surgery and injury services.

iii. services for other patients who need immediate admission, such as most general medicine and a substantial proportion of hospital geriatric and psychiatric services.

iv. out-patient and other support services which are needed in support of (i)-(iii), either on site or immediately available.

v. public health, community-based and other hospital services which need to be provided on a local basis as a matter of either policy (e.g. services for elderly and mentally ill people) or practicality (e.g. district nursing and health visiting).

"Contract" funding

11. "Contract" funding will apply to services which could be subject to competition and provided either locally or elsewhere. The funding of these services will need to be arranged in a way which

* offers patients and their GPs the maximum possible choice, including where relevant the possibility of trading off ease of access against length of waiting times.

* enables DHAs to look for the best "deals", for example in terms of cost and waiting times.

* frees hospitals to do more work as they become more efficient, but without risk to expenditure control.

* gives local GPs a significant voice in decisions by Districts as to where, and on what basis, Districts will fund treatment; and at the same time helps Districts to influence GP referral patterns where these are not necessarily making for the best use of hospital resources.

* preserves GPs' freedom of referral to their chosen specialist.

12. These objectives will not be easy to achieve, or to reconcile, in practice. It is not advisable to draw up a detailed national blueprint without experiment, and we cannot confidently predict how any particular solution will work in practice until we have tried it out.

13. Some of the experiments in Appendix B would be designed to assist this process, and these - or some equivalents - would be essential first steps. It would also be important to leave Districts with enough flexibility to adapt the outcome to their own circumstances. Subject to the outcome of pilot schemes, the main elements in "contract" funding will be:

* Districts would be free to enter into contracts with other Districts, with the private sector and, in due course, with self-governing hospitals for the provision of contract-funded services. These contracts would supplant current arrangements for funding cross-boundary flows in respect of those services.

* Each District would agree with its management units a performance-related budget for each of the relevant services. These budgets would secure the capacity needed

  a. for the District's own residents, to the extent that their treatment was not provided for in contracts with other Districts or the private sector; and

  b. to discharge the terms of any contracts to provide services to other Districts' residents.

  Self-governing hospitals would determine these budgets themselves. The aim of the budgets would be to anticipate future demand, including cross boundary flows, on the basis of past experience.

* Contracts and budgets would be reviewed annually. As "buyers", Districts would need to ensure that the hospitals concerned had fulfilled the performance targets in their contracts, were still offering better value for money than any alternative hospital, and were still providing the services required by their GPs (see below). In respect of non self governing hospitals, Districts would hold their hospitals to account for their performance and determine the following year's budgets in the light of their success. Budgets for each of a self-governing hospital's contract-funded services would be determined by their success in competition with other hospitals.

* Each "buying" District's contract or contracts for each service would be based on the referral patterns of each District's GPs and after consultation with them. The desirability of changing those patterns, on cost or quality grounds, would be subject to regular discussion with GPs. GPs - on behalf of their patients - would be able in this way to influence which consultants received bigger, or smaller, budgets. Districts would be able to ensure that GPs were fully informed about the relative cost-effectiveness, including waiting time, of alternative services; and would be free to try to persuade GPs to change their referral patterns in the interests of greater cost-effectiveness.

* Each District - again as "buyer" - would have a budget for in-year referrals which were not covered either by the budgets for its own hospitals or by a contract with other Districts and hospitals. This "GP budget", too, would be reviewed annually in the light of GPs' preferences, and could be either increased or decreased in the light of the performance of the hospitals with whom there were established contracts. The demands made by GPs on this budget would be subject to peer review, on an exception basis, to ensure that the money was not spent unnecessarily.

14. Taken as a whole, the approach in paragraph 13 would enable budgets to be set in a way that reflects the past pattern of referrals whilst maintaining future GP freedom of referral. The system of annual budget review in particular would enable budgets to reflect what has happened to patients in the previous year and so take account of patient choice. Equally, it would mean that budgets were increasingly set on the basis of performance and practice, and not simply allocated from above.

15. The services which would need to be funded in this way can be divided into three broad categories:

i. those procedures or treatments which are currently provided in every District as part of the "core" services but which do not necessarily have to be carried out locally. These are in the main acute surgical operations such as varicose veins, hernias and hip operations which make up the bulk of waiting lists.

ii. services which are currently provided on a supra district basis, such as ear, nose and throat (ENT), ophthalmology and oral surgery, which some Districts will need to buy in.

iii. other services for which patients may wish to be able to exercise choice as to location and/or timing, for example some long-stay care for elderly people. (These services however raise some additional issues which are not addressed in this paper.)

16. The DHSS estimate that at any one time up to a third of all patients awaiting or receiving treatment could in principle be treated in another District. Many of these would be people needing elective surgery. These are typically routine - and relatively inexpensive - operations and would therefore represent a rather smaller proportion of an acute hospital's budget.

"Tertiary" funding

17. "Tertiary" care is that which follows referral from one hospital - whose facilities are inadequate to care for a particular patient - to a specialist hospital or unit for more complex diagnosis and treatment - for example cardiothoracic or neurosurgery. Admission may or may not be required immediately. "Tertiary" services account for a small proportion of the average district's revenue budget, but are distributed very unevenly and are resource-intensive.

18. The funding of "tertiary" services will need to be arranged in a way which

* secures the availability of treatment for those who need it.

* maintains excellence and rewards efficiency.

* gives the referring consultant some choice where choice is practicable.

* avoids unnecessary duplication of these services.

19. The ideal solution, and the one most consistent with Ministers' overall approach to funding, might be to have protected funding for the fixed costs of these specialist services, with marginal costs being met by the Districts or hospitals from which the referrals were made. In theory at least this would give specialist hospitals or units reasonable security of funding whilst injecting a degree of pricing into their use. But it would be important to be sure that the viability of such units was not undermined, and it may be that some at least would in practice need to be 100% funded by Regions or the Department. These are important and sensitive services, and it will be particularly important to test and explore the funding options fully.

Training and research

20. Funding arrangements along the lines suggested above will not of themselves meet the needs of

i. medical teaching (undergraduate and post-graduate), which involves both direct costs and significant indirect costs and might be squeezed out if not protected;

ii. nurse training and training for the paramedical professions - although the latter is split with further education sector and might be moved further in that direction;

iii. future development and research; or

iv. overseas visitors.

Separate arrangements will be needed to meet the service costs of these activities.

Promoting efficiency

21. The new funding arrangements outlined in paragraphs 7-19 above will have built-in incentives to greater efficiency. Both before and after they become self-governing, hospitals which are efficient and successful will be able to attract more income from their contract-based services - attracting money as they attract additional patients - and to expand. The less successful will lose business accordingly. Districts and self-governing hospitals will also be competing with each other and with the private sector for business from the private insurance market. Self-government for hospitals will maximise both the competitive pressures themselves and each hospital's ability to respond in an imaginative way.

22. In the short term Districts will need to give their management units increasingly performance-related budgets and, through the resource management initiative and other developments, to build up the capacity of each unit to run its business effectively. Specific, performance-related funding of the kind discussed in paragraph 5(i) would act as a further stimulus to improved efficiency during this period.

APPENDIX A

PRESENT ARRANGEMENTS FOR FUNDING

1. Under the present system:

   1. agreement is reached in the Survey on the total cash that is to be made available to health authorities, as well as on target levels for cost improvement programmes, income generation or income from private patient charges.

   2. the Department distribute the whole sum to Regions, who in turn make allocations to Districts.

   3. Districts give budgets to hospitals and units.

2. Allocations from the Department to Regions make use of the RAWP formula. The formula identifies target shares for each Region, taking account of population structure and morbidity, and allowing for cross-boundary flows. Because historically most Regions were significantly above or below their targets, a decision is needed annually on how far it is possible to distribute the available additional resources in favour of below target Regions. That decision is taken by Ministers, and turns crucially on the total amount of growth money available, and a view as to the minimum required by above target Regions. In 1988-89 that minimum was set at 0.7% compared to a growth figure of 1.2%. In cash terms the difference between Regions' shares is much less because provision for inflation and Review Body additions are distributed pro rata to baseline allocations. Specific sums are earmarked.

3. Regions' arrangements for distribution to Districts vary. Reliance on sub-Regional RAWP formulae has diminished in recent years, giving ground to the practice of allocating specific sums to enable planned service developments to go ahead. Again, the cash differences between District shares are much less.

4. Cross-boundary flows between Regions are taken into account in the RAWP formula, but the information is at least a year out of date. Regions may by agreement replace cross-country flows by a specific funded service contract. Arrangements within Regions for dealing with inter District flows are more varied, but in general are more likely to involve specific funding in order to provide for planned flows.

APPENDIX B

THE FUNDING AND ORGANISATION OF HOSPITAL SERVICES: EVOLUTION AND EXPERIMENT

Introduction

1. There is much to be done to assess as we go along what works and what does not, to identify the information and other requirements needed to make the funding system work, and to create a band of enthusiasts to encourage the wider process of change. At least three Regions have expressed interest in conducting pilots.

2. This note sketches out five possible experiments which might contribute to an evolutionary path from devolved management within the present organisational structure to a position in which hospitals are (a) self-governing and (b) operating within increasingly contractual and competitive disciplines. A specification for each experiment would need to be worked up in more detail before we could be sure of its viability.

3. The purpose of the experiments would be to test out, either separately or in combination:

(i) the operation of new funding arrangements;

(ii) the nature of self-government, and its impact on the hospital itself; and

(iii) the working of a competitive environment (in effect, (i) and (ii) in combination).

The experiments are themselves set out in a broadly evolutionary sequence, although they would not necessarily have to be mounted sequentially.

Possible experiments

Experiment (1): elective surgery, specialty by specialty : all Regions, each at its own pace.

4. This experiment would develop and test trading in elective surgery, both between Districts and with the private sector. There need be no changes in the present organisational framework, and no self-governing hospitals. But close collaboration with FPCs and GPs would be essential, legislation would be needed to facilitate direct contractual relationships across District boundaries, and some adjustments to sub-Regional and perhaps Regional funding would be needed as cross-boundary flows were financed increasingly directly and at the

time. Each Region would select its own sequence of specialties. The aim would be to develop contractual relationships, exchange experience, and build District and unit expertise in the management of contracts.

Experiment (2): tertiary services
: all Regions, each at its own pace
: all postgraduate SHAs.

5. This experiment would develop and test alternative ways of funding specialist units, including postgraduate SHAs and tertiary referrals. It might explore the impact on specialist units of a shift in the balance between direct and contract-based funding. The conditions for this experiment would be similar to those for experiment (1). The aims would also be similar, but in more specialised areas and with an opportunity to explore the impact of a contract-based approach on already "self-governing" SHAs.

Experiment (3): a Region-wide "mixed economy"
: one Region (or possibly two contrasting Regions)

6. This experiment would also retain the present organisational framework, but would develop and test

* performance-based management budgets set by each DHA for its management units to cover "core" services.

* contracts between Districts and with the private sector for "contract-funded" services.

* GP budgets for "out of contract" referrals.

The conditions of the experiment would be similar to those for experiment (1), but with sub-Regional funding taking no account of cross-boundary flows except, perhaps, for "tertiary" services. Although there would be no "self-governing" hospitals, it would be important for the "provider" end of contracts to be managed as far as possible at unit level. The aim would be to establish a comprehensive "mixed economy" of devolved management and inter-District trading within one Region. The change in funding arrangements would force management to question whether services should be provided direct or bought in, and the impact of this would be assessed.

Experiment (4): self-governing hospitals.
: one Region or part-Region.

7. This experiment would establish "self-government" for a geographically-related group of hospitals. Legislation would be needed to set up boards of management which were able to employ staff, enter into contracts, and so on. The hospitals covered by the experiment would be accorded the full range of responsibilities envisaged for

self-governing hospitals, but would remain accountable to their "home" DHA on a limited, strategic basis and might have only limited freedom to sell their services to other Districts. The aim would be to test the internal consequences for the hospitals themselves, for example the management and other resources needed to make self-government "work"; the scope for self-government between and within current management units; and perhaps some of the implications for the functions of Districts and Regions.

Experiment (5): competitive self-governing hospitals.
: one Region (or possibly a large conurbation, eg London).

8. This experiment would establish a competitive market for self-governing hospitals, making the full range of funding and organisational changes over a sufficiently large geographical area for competition to work and be tested realistically. If the private sector were prepared to co-operate, the impact of competition with and among private hospitals might also be evaluated. Districts would continue either to provide direct or to buy in from elsewhere those services not provided by self-governing hospitals, and would hold substantial "core" contracts with self-governing DGHs. The aim would be to test the operation of all three of the elements in paragraph 3 above when working in combination.

Some general points

9. Important general points include:

(i) all five experiments assume that significant devolution from Districts to units - if not necessarily, say, the full implementation of the resource management initiative - will already have taken place.

(ii) all five experiments require at least some legislative cover (because legislation is needed for all three purposes summarised in paragraph 3).

(iii) there is nonetheless a quantum leap between experiments (1) -(3) on the one hand and (4)-(5) on the other, partly because more legislative cover is needed but mainly because experiments (4) and (5) might be effectively irreversible (for example because of the major changes required in conditions of employment). The Government would therefore need to be ready to commit itself to the main features of self-governing hospitals and the new funding arrangements before embarking on experiments (4) or (5).

(iv) experiments (1)-(3) would offer practical experience of the effects of trading on cross-boundary flow adjustments to

revenue allocations; but would not test the comprehensive changes implicit in a competitive "market".

(v) experiments (1)-(3) would nonetheless have a cost. All would need a reserve of money to ensure that they did not run out of steam or have unintended short term effects such as unwanted closures.

(vi) all five experiments would need very careful management by Regions, for example to ensure that experimental changes and sub-regional funding remained in step and that the experiments were adequately structured, managed, monitored and evaluated.

(vii) the choice of experiments assumes that it is not sensible to proceed on the basis that hospitals can simply "opt" into the new approach. (The funding arrangements imply a geographical market. Self-government implies privileges which could unnecessarily damage non-self governing, and therefore less advantaged, neighbours).

(viii) an experiment confined to teaching hospitals is not suggested, partly because of the reasons given at (vii) and partly because it would be resented by non-teaching hospitals who regard teaching hospitals as sufficiently privileged already.

APPENDIX C

"CORE" AND "CONTRACT-FUNDED" SERVICES

1. Under any revised funding arrangements district health authorities will need to ensure that their resident population continues to have access to a comprehensive range of "core" services. These are briefly summarised in paragraph 10 of the main paper. Within these core services there will however be some scope for health authorities to buy in certain procedures or treatments from another district if this offers a more effective or efficient use of resources. In addition, there are other acute services which are provided at present on a supra-district basis. Together these make up the services described in the main paper as "contract-funded".

2. This appendix concentrates on the "core" acute specialties; assesses the potential for buying in from outside the district some treatments covered by these specialties; and gives an indication of what proportion of an acute hospital's workload this might represent. By definition, there are no core acute services which can be wholly bought in from outside because all general acute hospitals will need the range of core services to support their central emergency functions. The scope for buying in specific treatments will vary from hospital to hospital and specialty to specialty. The greatest potential lies in the area of surgical specialties where the longest waiting times exist at present.

CORE DISTRICT SERVICES

Accident and emergency (A and E) services

3. By their very nature, A and E these services provide the "core" of a general acute hospital. They most commonly consist of an accident and emergency department supported by a range of general medical, surgical and diagnostic facilities. In any revised funding arrangement, an accident and emergency service will need to form an integral part of a package of local acute services. Depending on the nature and proximity of alternative facilities, there may however be scope for contracting out part of the service to a neighbouring hospital, particularly where a health authority finds it difficult to staff its "local" accident and emergency department round the clock. In practice this already happens in large conurbations where groups of hospitals in neighbouring districts pool their resources to provide a comprehensive emergency bed service.

Medical services

4. Medical services most commonly deal with conditions such as strokes, heart attacks, heart failure and pneumonia, often occurring in the elderly. The great bulk of treatment provided under this specialty is of an urgent nature requiring immediate attention as well as local

follow-up, including referral back to the patient's general practitioner. The scope for buying in part of the service from outside the district is therefore limited. In 1985, general medicine accounted for 17% of all acute admissions of which over 80% were admitted as emergency cases.

Surgical services

5. Surgical services cover a wide range of acute specialties and operative procedures, some of which do not require immediate treatment and could in principle be undertaken at a distance from home. Six surgical specialties (in order of magnitude: general surgery, orthopaedic, ear, nose and throat (ENT), gynaecology, ophthalmology and oral surgery) account for some 85% of all waiting lists. Of these, ENT, ophthalmology and oral surgery are not in fact core services and are already provided on a supra-district basis. A study of long waiting lists in West Midlands and Wales suggests that 46% of total waiting lists is accounted for by seven operations (varicose veins, hernia, hip replacements, arthroscopies, (operating on a joint), tonsils and adenoids, sterilisations and cataracts), none of which need necessarily be done in the "home" district. In practice, however, all surgical units would need to balance their emergency and elective services so as to maximise cost-effectiveness to meet teaching requirements, and to attract good quality staff. In 1985, surgical acute specialties as a whole accounted for 57% of all acute admissions.

Paediatrics

6. Like general medicine, the vast majority of paediatric admissions require urgent attention. In 1985, nearly 90% of all paediatric cases were admitted to hospital immediately. Paediatrics account for nearly 7% of acute hospital admissions. It needs to be provided locally not only because it is effectively an emergency service but also because of the need for parental access and support.

Maternity services

7. Maternity services need to be provided in association with acute medical, surgical and paediatric facilities to cover circumstances in which complications arise. Admission is normally immediate, but treatment is usually planned which makes maternity services more susceptible to contract-funding than other emergency services. Maternity services account for 6% of all health authority expenditure.

Priority care groups

8. Nearly a third of all health authority expenditure is accounted for by the priority care groups (the elderly, mentally ill, mentally handicapped and the physically disabled). This excludes the proportion of acute expenditure that is accounted for by elderly people. Current

policy is that districts should become self-sufficient in the provision of long-stay and acute support services for these groups. The creation of larger district health authorities should however encourage more competition in the provision of services, particularly for the long-stay population. There may also be greater scope for more private sector provision.

OTHER CONTRACT-FUNDED SERVICES

9. As indicated above, within the core district services there will be some scope for buying in certain treatments or procedures from other districts. In addition, there is a range of acute services which are currently provided on a supra-district basis and which, by definition, would be "contract-funded" under the proposed funding arrangements. These include cancer services, ENT, ophthalmology and oral surgery.

CONCLUSION

10. Any assessment of how much of an average district health authority's budget could be "contract-funded" is necessarily imprecise. Based on 1985 acute hospital admission figures, a quarter of all patients needing treatment had not been given a date for admission. In addition, 17% of the patients were on the "booked and planned" list, i.e. had been given a firm date but had not yet been admitted, and some of these patients will have been "non-urgent" in terms of representing an immediate call on local core services. On this basis, at any one time up to a third of all acute patients could in principle - if resources and alternative facilities were available - be treated elsewhere. These patients would be likely to represent rather less than a third of a district's acute service budget (some 46% of all HCHS spending) because the treatments they require are, in the main, relatively cheap.

chex.rm/mw/33 **CONFIDENTIAL**

FROM: MISS M P WALLACE
DATE: 1 November 1988

MR RAMSDEN

cc Chief Secretary
Financial Secretary
Sir P Middleton
Mr Anson
Mr Phillips
Mr Scholar
Mr Culpin
Miss Peirson
Mr Odling-Smee
Mr Gilhooly
Mr Riley
Mr McIntyre
Miss Simpson
Mr Speedy
Mr Tyrie
Mr Call

Mr Mace - IR

ANNUAL REVIEW OF NICS: ANNOUNCEMENT BY MR MOORE

The Chancellor was grateful for your minute of 31 October. He is content with the proposed written PQ Answer.

MOIRA WALLACE

fp.pk/rc/1.11.02 **SECRET**

FROM: ROBERT CULPIN

DATE: 1 NOVEMBER 1988

CHANCELLOR

cc Sir Peter Middleton
Sir Terence Burns
Mr Scholar
Mr Gilhooly
Mr Riley
Mr Macpherson

NATIONAL INSURANCE AND THE BUDGET

You have announced today a routine indexing of the various National Insurance limits. Suppose that, when it comes to the Budget, you want similarly to index the income tax system, leaving rates unchanged. You might suppose, as I did, that since both will be indexed, the National Insurance and tax changes will all come out in the wash. But they won't. A single person on the basic rate could be £1 a week worse off in cash. Here's why:

- the UEL goes up by £20 a week, or 6½ per cent;

- that means that anyone earning more than £305 a week (the present UEL) will lose £1.80 a week if contracted in;

- if the single allowance is indexed by 6¼ per cent, rounded up - the figure in the Autumn Statement ready reckoner - it will go up by £170 a year or £3.27 a week;

- the basic rate payer will gain 25 per cent of that, which is 82p a week;

- so he will lose £1.80 on NICs and only gain 82p on income tax, leaving him 98p a week worse off.

2. This is easily the worst case. The range runs from this 98p loss to a gain of 56p a week for the married man who is both contracted out and a higher rate tax payer. In slightly more detail, it looks like this:

GAIN/LOSS IN PENCE PER WEEK

(Approximate numbers affected in thousands)

	25%	40%
SINGLE		
Contracted in	- 98	- 49
	(170)	(70)
Contracted out	- 62	- 13
	(320)	(140)
MARRIED		
Contracted in	- 55	+ 20
	(420)	(180)
Contracted out	- 19	+ 56
	(840)	(360)

3. On past precedent, the cash gains and losses would be revealed in Budget day press notices.

4. I stress that there is nothing new about the result: it is a structural feature of the system. If the UEL and the income tax allowances both rise in line with prices, and both National Insurance and income tax rates are constant, those above the

UEL will always lose more on NICs than they gain on income tax. That is briefly because the UEL is about six times the single allowance, and the NIC rate is much more than a sixth of the basic rate.

5. In recent years, the effect has been unobtrusive for two reasons. Inflation has been lower. And you have been reducing income tax. In the next Budget, it could be more noticeable.

6. With the benefit of hindsight, it is a pity none of us noticed it before you announced the increase in the UEL. I am sorry, but we just didn't. I imagine everyone assumed, as I did, that there should be no problem with straight indexation. (One moral is that there should have been a take home pay table in the submission on the NIC uprating.)

7. However, even if we had spotted the point, I doubt if we should have urged you to go back on indexing the UEL:

- that's the way the system works;
- you consistently set the maximum UEL allowed;
- £1 a week is small beer for people earning over £300 a week;
- no-one will lose in real terms, assuming their earnings increase;
- the extra National Insurance Contributions buy extra benefits;
- the potential cash losers gained this year.

All that could be said in public if there is indeed a net cash loss to explain when it comes to the Budget. And the UEL increase will be old hat by then.

8. The loss would of course be removed if you were to take a penny off the basic rate or to double-index allowances. But it would be increased by any rise in the car scales.

9. This is my only real concern. The last thing we want is to let a perfectly normal increase in the UEL become a constraint on your ability to raise car scales in the Budget. The UEL increase can be readily justified on merits. Every extra 10 per cent real on cars could cost the basic rate payer just over another £1 a week in cash; but that too could be amply justified on merits.

10. There is nothing whatever to do about this note at the moment; and in an ideal world, I would not choose to inflict it on you just when you have launched the Autumn Statement. But having picked up the point, I thought it best to tell you straight away, if only because it occurs to me that there may be a bit of public comment this time on the quite large cash increase in the UEL.

ROBERT CULPIN

chex.rm/jmt/45 **SECRET**

FROM: J M G TAYLOR
DATE: 2 November 1988

1
2

MR CULPIN

cc Sir P Middleton
Sir T Burns
Mr Scholar
Mr Gilhooly
Mr Riley
Mr Macpherson

NATIONAL INSURANCE AND THE BUDGET

The Chancellor was grateful for your minute of 1 November.

2. He has commented that he was, in fact, aware of this problem, but felt that we should go ahead just the same. There will - on past form - be little or no adverse comment now: it is after the Budget when we will be vulnerable. He had not, however, thought about the car benefit angle.

J M G TAYLOR

pxe.mo/docs/2.11.4

RESTRICTED

FROM: M J SPACKMAN
DATE: 2 November 1988

PS/CHANCELLOR cc: Mr Anson

SOCIAL TRENDS 1989: ARTICLE ON SOCIAL ATTITUDES

I have passed on to the CSO the Chancellor's comments, in your minute of 27 October to Mr Anson, about the appallingly late consultation, the deletion from the article of tables A7 and A8, the consequential changes to the text, the need for a strong disclaimer and the ending of the practice of including invited articles.

2. The text I have discussed via the CSO with the authors.

3. To meet the Chancellor's suggestion on the text above the now deleted Table A8, the authors have sought from us a form of words which gets across the table's message of strong popular concern about taxation while also fitting precisely with the figures. They would be content to change the end of that sentence so that, with the previous sentence, it reads:

> "On the other hand almost nobody felt that they were currently undertaxed. People divided broadly into those who feel that tax levels are acceptable and the* majority who feel that they are too high or much too high."

I believe this meets both objectives. (This majority in fact was 61%).

4. The authors accept the Chancellor's amendment to page 16, with its deletion of "the trends are clear". They are concerned however to include some hint that the change from 1983 to 1985 was not a sudden jump. They would be content to add just the words "each year", so that the sentence would read:

> "Although attitudes are slightly ambivalent, the proportion of respondents favouring rises in taxes to pay for increased social provision has increased each year from just under a third in 1983 to one half in 1987."

This looks a fair proposal which meets the authors' professional concerns without restoring the previous flavour of certainty.

M J SPACKMAN

0009A

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

SECRET

Paul Gray Esq
No 10 Downing Street
LONDON SW1

3 November 1988

Dear Paul

NHS REVIEW

I attach seven of the papers commissioned for next Tuesday's meeting of the Ministerial Group. The paper on capital, which reports the outcome of this morning's meeting between the Chief Secretary and the Secretary of State, will follow tomorrow.

The Secretary of State has been considering how the papers might be handled in a way that is most helpful to his colleagues. His conclusion is that it would not be possible to do justice to each of the eight papers if they were all put down for discussion at next Tuesday's meeting. Mr Clarke suggests therefore, if the Prime Minister is agreeable, that the following four papers are put on the agenda for discussion in the order given:

Medical Audit
Funding
Reconstituting Health Authorities
Managing the FPS

The other four papers cover:

Capital (not attached)
A better service
Public and private sector
Professional and employment practices

Mr Clarke suggests that colleagues might like to let him have any comments on these papers so that if there are any major issues arising they can be discussed at a later meeting.

I am copying this letter and enclosures to the Private Secretaries to the Chancellor of the Exchequer, to the Secretaries of State for Scotland, Wales and Northern Ireland, to the Chief Secretary and to the Minister of State and to Sir Roy Griffiths in this Department, and also to Professor Griffiths and Mr Whitehead in the No. 10 Policy Unit and to Mr Wilson in the Cabinet Office.

Yours ever

Andy

ANDY McKEON

CH/EXCHEQUER
REC. -3 NOV 1988
Mr Saunders - 3/11
CST, Sir P Middleton, Sir T Burns,
Mr Anson, Mr Phillips, Mr Culpin, Ms Perrin, Mr Turnbull,
Mr Parsonage, Mr Griffiths,
Mr Call

week.31.10/m.12

SECRET

FROM: H PHILLIPS

DATE: 3 November 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Miss Peirson
Mr Turnbull
Mr Saunders
Mr Parsonage
Mr Griffiths
Mr Sussex
Mr Call

NHS REVIEW: STOCKTAKING

Before your meeting this afternoon I should record where we are on the papers for the next Ministerial meeting.

2. First, the Chief Secretary and I had a brief discussion yesterday about the number of papers for 8 November, ie 8 . Such a large number is not a sensible plan and I have agreed with the Cabinet Office and DoH to reduce the list to 5, namely:

Funding
Capital
The Family Practitioner Services
Structures - districts, regions, the NHS Management Board
Medical Audit

[I can't remember which 3 ones have been dropped - you have pps]

As the Medical Audit paper should not be difficult the result will be a halving of the agenda. At close of play yesterday it was agreed that Mr Clarke would write round to propose this reduction.

3. Second, I endorse the points covered on Mr Saunders's note of 1 November but would add the following comments:

(a) on funding of the NHS (paragraphs 16 and 17 of Mr Saunders's note) the problem is less likely to be increased complexity in itself but lack of clarity about the new complexity, and how the programme of change to a new

system will occur eg is RAWP being abolished or simply re-named;

(b) on capital, the Chief Secretary's discussion with Mr Clarke is today;

(c) on the FPS (paragraphs 11-15 of Mr Saunders's note) I have told DoH that we would only be prepared to go along with the move proposed towards GP practice budgets on the condition of agreement to effective controls on drugs and numbers of GPs (as near I think as we are likely to get to cash limits); and

(d) on structure there is a distinction between the power of regions and their bureaucratic size. Which is it we want to curtail? The list in paragraph 18 of Mr Saunders's note increases their influence. I expect Mr Clarke will aim to reduce their size. Is this acceptable?

pp Maria Reader.

HAYDEN PHILLIPS

3.11.1

CONFIDENTIAL

FROM: R B SAUNDERS
DATE: 3 November 1988

CHIEF SECRETARY

cc Chancellor
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr MacAuslan
Mr Parsonage
Mr Richardson
Mr Griffiths
Mr Sussex
Mr Call

NHS REVIEW: CAPITAL

I attach for your approval a draft joint paper for the Prime Minister's meeting on Tuesday. It has been prepared largely by DoH officials, but incorporates comments from us. We are now content with it.

2. I would only make a couple of points about this draft.

a. It does not mention the political point which you raised with Mr Clarke - that health authorities would say that they were being required to pay back to Government for bureaucratic reasons money which could otherwise be spent on patient services. We felt that to include this point would run the risk of opening up discussion on the paper, which we want to avoid.

b. The position of opted-out schools came up this morning in relation to the disposal of assets. In fact, opted-out schools may dispose of assets only with the written permission of the Secretary of State, so we are in fact proposing a more liberal regime for self-governing hospitals.

R B SAUNDERS

NHS REVIEW

MANAGEMENT OF CAPITAL

Note by the Secretary of State for Health and the Chief Secretary to the Treasury

Introduction

1. This note records that we have reached agreement on the introduction of capital charges in the NHS; and on a programme of work on the scope for access to private capital. We invite colleagues to note this progress and the next steps which we have put in hand. We believe that the issues do not now need to be discussed within the Group meetings, but we will keep colleagues in touch with further work.

Charging for the use of capital assets

2. We consider that capital should not in future be regarded as a free good by the NHS. We believe that a system of charges can and should be introduced so that the users of capital assets are required to meet the cost of those assets, as reflected (subject to normal depreciation) in their current valuation. The introduction of such a system will enable:

- effective management information on the use and value for money of assets

- more cost-effective allocation of future investment

- clear signals on the need for replacement of assets

- a proper basis for charging between hospitals and between the public and private sectors.

3. The introduction of charges is intended to provide clear incentives for authorities and self governing hospitals to rationalise capital holdings, and to invest most effectively. These market disciplines need to apply equally to all public sector hospitals, whether run by health authorities, or self governing.

4. The capital assets used by the NHS are, and will remain, primarily public ones financed by public sector funds. As was recognised at the last meeting of the Group, no impression should be given that elements of the NHS may be alienated from this essentially public ownership. Health authorities need to have freedom to manage their assets - and we envisage self governing hospitals having greater freedom - but we must retain a broad lien on the major assets they use. A minimum requirement might be that disposals of more than 5% of a self governing hospital's total capital stock would require Regional approval.

5. We see three stages in the introduction of a system of real charges. First, valuation upon an agreed basis. Secondly the introduction of a system of management accounts to enable the NHS to go through a process of familiarisation using notional accounts. Thirdly, and in the light of that experience, to move towards a fully effective system of real charges as soon as reasonably practicable.

6. Officials are working out the practical details of the system such as the definition of interest levels and depreciation schedules, the treatment of charges in the public expenditure context, and ways of achieving a smooth transition. We are confident that these are soluble, and invite colleagues to agree that we should continue to work these up, reporting back in due course. In the meantime, our White Paper should refer to the principles and objectives we have set out in this note.

Access to private sector capital

7. The issues here are more complex. We need to look at ways of enabling the NHS to work more closely with the private sector, ~~and of increasing~~ the scope for access to private capital, without losing expenditure control or being exposed to unacceptable risks with public money. A great variety of schemes may be possible, and the key issues can only sensibly be considered in relation to particular types of project. We have therefore asked our officials to prepare for us a series of key examples of schemes which have arisen in the past, and which might arise in the future, so that we can identify both the fundamental difficulties, and the scope for a more flexible approach. We shall report the results of this work to colleagues as soon as possible with the objective of making a general statement of our policy in the White Paper.

NHS REVIEW: CAPITAL CHARGING AND PRIVATE FINANCE

Note of a meeting in the Chief Secretary's office; 3 November 1988

Those present:

H M Treasury

Chief Secretary
Mr Anson
Mr Phillips
Mr Parsonage
Mr Richardson
Mr Saunders
Mr Sussex
Miss Evans

Department of Health

Secretary of State
Mr France
Mr Heppell
Mr James
Mr Smee
Mr Stopes-Roe

The Chief Secretary said that he and the Secretary of State had a remit to put a joint paper on capital charging and private finance to colleagues on Tuesday 8 November. He was grateful for the agenda contained in the Secretary of State's letter of 24 October and proposed that charging for capital be considered first, followed by private finance.

Charging for Capital

2. The Secretary of State commented that the Department of Health and the Treasury were agreed on the need to correct the mistaken view prevalent in the NHS that capital was a free good. He accepted that this should not be done in a way which created apparent increases in public expenditure or other presentational problems. The Chief Secretary suggested that Review Group colleagues were yet to be convinced of the advantages of charging for capital and that the paper put to them should set out these advantages as being to enable: a proper basis for setting charges both for internal trading and trading with the private sector; effective management information on the use and value for money of assets; better allocation of capital and revenue resources; and

better planning of equipment replacement. There remained, however, areas not yet clearly agreed which would need further detailed work by officials, such as: who would determine the level of depreciation and interest charges; whether interest rates would be fixed or variable; who would pay interest charges and into which account they would go.

3. Until these practical issues were resolved, the Chief Secretary said he would be cautious about going beyond a system of notional charges for capital entered in management accounts, to a system of real cash charges. He recognised that cash charges would provide a sharper management incentive but he would first want to establish and resolve the practical problems through a notional-charge system. This would be no easy task. The Secretary of State was happy with this approach provided it was strengthened by a declared intention of subsequently moving to a cash-charging system. The Chief Secretary agreed. Neither he nor the Secretary of State would, however, want to sign up in advance to any particular time period between the establishment of a notional charging system and moving on to cash charging.

4. In further discussion other practical difficulties were identified, such as compiling and valuing asset registers, and how to deal with large differences in asset values between areas (in part due to differing land values). It was agree that any system of capital charges would apply equally to all hospitals including self governing hospitals. The Chief Secretary noted a potential presentational problem associated with a cash-charging system: that the public would see money being paid to health authorities, presumably to provided health care, merely being paid back to some higher authority in order to cover capital charges. There could also be problems about charging for hospitals originally established from charitable donations.

5. Concluding this part of the meeting, the Chief Secretary and Secretary of State agreed that the joint paper they would put to the Review Group on Tuesday (8 November) would: seek endorsement of the capital charging principle; note that officials were working on the practical difficulties of the system and would report back in due course; and indicate that it was intended to move towards a system of real (cash) charges as soon as practicable after a workable notional-charge management accounting system had been established.

Private Finance

6. The Chief Secretary said he assumed it was agreed that the aim in all public expenditure was to achieve best value for money, that private finance was not a way of circumventing public expenditure control, and that simple leasing arrangements with the private sector did not represent good value for money. The Secretary of State replied that he had never quite seen the sense of the best value for money requirement when it meant that worthwhile cost-saving investments were not undertaken because insufficient public finance was available. He felt the aim should be to increase the amount of such capital investment available to the NHS. He therefore attached particular importance to the second of the three relaxations proposed by DH in their paper - the sort of scheme proposed for Bromley DHA. Discussion then turned to the three types of private financing to which the Secretary of State wished health authorities to have freer access.

Private developments of non-NHS facilities

7 These included such developments as shopping malls and pay-bed wards, on NHS sites. The Chief Secretary said he had no objection to this proposal as it literally stood in the Note by DH and Treasury officials, but wondered whether all understood the same thing by it. If the private developer built, funded and bore the risks of the development, then there was no problem. Mr Anson emphasised that the important point was that the NHS be separated from risk. It did not have the expertise to engage in speculation

which could easily turn out to be very costly. Mr France said that health authorities should be able to lease land out to private developers, in order to retain a risk-free interest in the subsequent development of the land, rather than simply having to sell the land. The Secretary of State said that there would however be no profit to the NHS if it did not bear some of the risks of a development. He recalled the example of the Hyde Park Hospital, where the health authority had had to sell its 50% share and so was missing out on the profits to be had from the subsequent redevelopment of this prime West End site. It was a recurrence of such cases which he wished to avoid. The Chief Secretary did not believe it was right for the NHS to indulge in what was properly private sector, commercial risk-taking, business.

Building against security of future land sales

8. On the Bromley scheme the Secretary of State said that the proposal to finance a new hospital, built by a private developer in return for the proceeds of future land sales, was a useful way of releasing revenue savings without diverting capital funds away from projects in other parts of the country. The Chief Secretary said that the proposal involved speculative judgements about land values which might not represent the best stewardship of public funds. Mr Anson said that if the scheme produced substantial revenue savings it should be given higher priority in resource allocation. The Chief Secretary said that the best way of providing funds for such schemes was to establish a capital loans fund which could be topped up with receipts from asset sales

Long-term contracting out

9. The Chief Secretary said that the aim should be for officials to draw up ground rules which would define the circumstances in which the private finance rules need not apply to contracting out. These might include de minimis exceptions for capital investment by private contractors, and criteria for the proportion of cost represented by capital and the length of contracts. In principle, very long term contracts would be seen as a form of capital leasing in which the public sector would cover the contractor's financing costs.

10. In the light of the points raised on the three types of scheme outlined in the note by officials the Chief Secretary and Secretary of State agreed that it would be very difficult to arrive at a generic description of what sort of scheme would be acceptable. It would, therefore, be best to present colleagues with specific, clear, illustrations of the sort of schemes envisaged. The starting point would be for Department of Health officials to draw up a list of illustrative examples of schemes which had arisen in the past, and which might arise in the future, which could then be used as the basis of discussions with Treasury officials to draft ground rules acceptable to both departments. The Chief Secretary proposed, therefore, that the joint paper to the Review Group on Tuesday (8 November) should say that a list of examples was being prepared by officials so that it would be possible to establish the practical impact of the rules on private finance and that the Secretary of State and he would report back to the Group on the results of this work with the objective of making a general statement of policy in the White Paper. The Secretary of State agreed to this way of taking matters forward.

Other Matters

11. The Secretary of State said that he had proposed further constraints on public "£ for £" matching of community fund-raising schemes in the light of earlier objections, and believed these were now acceptable to the Treasury. The Chief Secretary said he thought there would be presentational problems with the proposal because affluent areas would benefit at the expense of poorer areas, and because no incentive to fund-raising was necessary as hospitals were already highly successful at it. He was also concerned that such schemes would divert resources to projects such as scanners which were popular fund raisers but did not necessarily represent the top priority for the NHS.

12. The Chief Secretary and Secretary of State were agreed that control of capital investment by self-governing hospitals would, subject to de minimis exceptions, have to remain with RHAs, but that they still needed to persuade colleagues of this.

Cmys Evans

H M Treasury
10 November 1988

MISS C EVANS
Private Secretary

Circulation: those present
Chancellor of the Exchequer

pxe.mo/docs/4.11.4

FROM: M J SPACKMAN
DATE: 4 November 1988

MISS M P WALLACE 12/2

Ch/ This gets more and more bizarre. I am not at all sure that the fact that this article contains (i) 2 yr old data on attitudes to tax (with 2 Budgets since), and (ii) the very juxtaposition we complain about, at all strengthens case for publishing. MPW

SOCIAL TRENDS

You asked about past precedent in commissioned articles.

2. As I thought, some have been original, others adaptations of work published elsewhere. Last year's Social Trends had an article by Sir Richard Doll on "Epidemics of the 20th Century" which was a popularised version of an academic paper published at about the same time.

3. The publication on attitudes reported this week in the press was mainly reporting the author's most recent (1987) annual survey. The article commissioned from them for Social Trends is somewhat broader. In particular it includes (at the CSO's request) the results on attitudes to taxation which were collected in 1986. Thus while the material published this week does not set attitudes to spending against attitudes to tax, the Social Trends article does do this.

new kind

M J SPACKMAN

0017A

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~~ ~~XXXXXXXXX~~ Health

COVERING SECRET

Paul Gray Esq
10 Downing Street

4 November 1988

Dear Paul

Further to my letter yesterday enclosing papers for the next meeting of the Review Group, I now enclose a joint paper by my Secretary of State and the Chief Secretary which records the outcome of their discussion yesterday morning on capital.

We have also identified an error in Table 2 of Annex I to HC49 (Funding Issues). I enclose a replacement page which I would be grateful if you could insert in your copy.

I am copying this to the Private Secretaries to the Chancellor of the Exchequer, to the Secretaries of State for Scotland, Wales and Northern Ireland, to the Chief Secretary; and to the Minister of State and Sir Roy Griffiths in this Department; and also to Professor Griffiths and Mr Whitehead at the No. 10 Policy Unit, and to Mr Wilson in the Cabinet Office.

Yours ever
Andy

ANDY McKEON
Private Secretary

✓ 4/11

NHS REVIEW

MANAGEMENT OF CAPITAL

Note by the Secretary of State for Health and the Chief Secretary to the Treasury

Introduction

1. This note records that we have reached agreement on the introduction of capital charges in the NHS; and on a programme of work on the scope for access to private capital. We invite colleagues to note this progress and the next steps which we have put in hand. We believe that the issues do not now need to be discussed within the Group meetings, but we will keep colleagues in touch with further work.

Charging for the use of capital assets

2. We consider that capital should not in future be regarded as a free good by the NHS. We believe that a system of charges can and should be introduced so that the users of capital assets are required to meet the cost of those assets, as reflected (subject to normal depreciation) in their current valuation. The introduction of such a system will enable:

- effective management information on the use and value for money of assets

- more cost-effective allocation of future investment

- clear signals on the need for replacement of assets

- a proper basis for charging between hospitals and between the public and private sectors.

3. The introduction of charges is intended to provide clear incentives for authorities and self governing hospitals to rationalise capital holdings, and to invest most effectively. These market disciplines need to apply equally to all public sector hospitals, whether run by health authorities, or self governing.

4. The capital assets used by the NHS are, and will remain, primarily public ones financed by public sector funds. As was recognised at the last meeting of the Group, no impression should be given that elements of the NHS may be alienated from this essentially public ownership. Health authorities need to have freedom to manage their assets - and we envisage self governing hospitals having greater freedom - but we must retain a broad lien on the major assets they use. A minimum requirement might be that disposals of more than 5% of a self governing hospital's total capital stock would require Regional approval.

5. We see three stages in the introduction of a system of real charges. First, valuation upon an agreed basis. Secondly the introduction of a system of management accounts to enable the NHS to go through a process of familiarisation using notional accounts. Thirdly, and in the light of that experience, to move towards a fully effective system of real charges as soon as reasonably practicable.

6. Officials are working out the practical details of the system such as the definition of interest levels and depreciation schedules, the treatment of charges in the public expenditure context, and ways of achieving a smooth transition. We are confident that these are soluble, and invite colleagues to agree that we should continue to work these up, reporting back in due course. In the meantime, our White Paper should refer to the principles and objectives we have set out in this note.

Access to private sector capital

7. The issues here are more complex. We need to look at ways of enabling the NHS to work more closely with the private sector, which includes examining the scope for greater freedom of access to private capital, without losing expenditure control or being exposed to unacceptable risks with public money. A great variety of schemes may be possible, and the key issues can only sensibly be considered in relation to particular types of project. We have therefore asked our officials to prepare for us a series of key examples of schemes which have arisen in the past, and which might arise in the future, so that we can identify both the fundamental difficulties, and the scope for a more flexible approach. We shall report the results of this work to colleagues as soon as possible with the objective of making a general statement of our policy in the White Paper.

Table 1

Components of National HCHS Cost Weighted Activity Index

Inpatient plus Day Cases (Inpatient Discharges & Deaths and Day Cases)

Outpatient plus A & E (Attendances)

Day Patients (Attendances)

Health Visitng (People visited)

Home Nursing (People treated)

Ambulances (Cases carried)

Blood Transfusion (Bottles of Blood issued)

Table 2

ILLUSTRATIVE CALCULATIONS OF RELATIVE UNIT COSTS

RELATIVE UNIT COSTS
1985/6

NORTHERN	94.6
YORKSHIRE	91.1
TRENT	92.7
EAST ANGLIAN	97.5
NORTH WEST THAMES	116.8
NORTH EAST THAMES	114.4
SOUTH EAST THAMES	105.8
SOUTH WEST THAMES	116.3
WESSEX	94.7
OXFORD	94.4
SOUTH WESTERN	97.9
WEST MIDLANDS	100.4
MERSEY	98.5
NORTH WESTERN	89.5
TOTAL	100.00

Notes:

1. Relative unit costs: actual expenditure divided by estimated expenditure using national cost weights.

2. Variations will reflect, in part, the effects of regional variations in input prices - London Weighting etc.

B:D5.29/6

Copy No: 2

HC 54

NHS Review

THE PUBLIC AND PRIVATE SECTORS

Note by the Secretary of State for Health

1. This note

* assesses the impact of the review on the distinction between public and private health care; and

* makes specific proposals for carrying forward the competitive tendering of pathology and radiology services.

2. In summary, the key elements are:

i. blurring the distinction between public and private sectors.

ii. enabling the private sector to trade and compete freely and on a fair basis.

iii. extension of competitive tendering, to the clinical as well as non clinical field.

Blurring the distinction

3. One of the key objectives of the review has been to blur the distinction between the private and public sectors in health care. Taken together, many of the reforms we are planning will achieve this in the most effective way possible: by helping the private sector to trade and compete freely with the public sector.

4. In presenting our conclusions, especially to those who are looking to the review for a boost to private health care provision, I suggest we emphasise three points in particular:

(i) we are building in strong incentives for health authorities and, especially where they have their own budgets, GPs to look to private as well as public sector providers for the best available deals, especially in elective acute services.

(ii) we are breaking the monolith of public provision by enabling self-governing hospitals to operate much more like private sector hospitals, but within the public sector.

(iii) we are "levelling the playing field" so that public and private sector hospitals can compete on equal terms.

5. My discussions with the Chief Secretary on charging for capital are particularly relevant to (iii). More generally, we must ensure that the new funding arrangements set out in HC49 are developed in a way which does not build in significant advantages or disadvantages to NHS providers - in terms of training costs, for example.

6. There are two other changes which would help further to blur the distinction:

(i) easing the constraints on the access of public sector providers to private capital. This too I am discussing separately with the Chief Secretary.

(ii) making progress towards the competitive tendering of pathology and radiology. The remainder of this note makes specific proposals to this end.

Competitive tendering

7. We have made good progress in recent years in the competitive tendering of non-clinical support services. My paper on reconstituting health authorities (HC52) suggests that we accelerate the contracting out of other non-clinical functions at Regional level. For clinical services generally, and elective surgery in particular, the new funding arrangements we propose will themselves generate more competition.

8. As we have acknowledged, the main outstanding area to address is the potential for competitive tendering of clinical support services, particularly pathology and radiology. We must not overlook the importance of excessive demand from clinicians for diagnostic tests, whether or not these tests have been contracted out: we must continue to tackle this through the resource management initiative, and medical audit will also be relevant. But that need not prevent us from addressing the need for competitive tendering. My proposal here, which I outlined in an earlier paper, is that we proceed by fostering local initiatives.

9. There is clear scope for competitive tendering of pathology and radiology, for example to reap the full benefits of economies of scale and to make the most effective use of expensive capital equipment. The routine processing of samples in chemical pathology is one example. There is considerable scope for the

private sector to respond. But there are also legitimate professional concerns: that we must secure proper quality control; and that clinicians do not lose their ready access to the expert advice of pathologists and radiologists.

10. In the light of these concerns the profession have been assured, for example in a letter from John Moore to the Royal College of Pathologists last November, that we have no plans for a "central initiative" in this field. But initiatives by individual health authorities are not ruled out, as long as the views of the profession are taken into account.

11. It should not be difficult to foster local initiatives of this kind, and to learn from early experience how best to meet the profession's proper concerns. This is the course I recommend. If colleagues agree I shall draw up and implement an action plan along these lines. The White Paper will need to be drafted in terms which leave the way open but which are also consistent with the assurances the profession have been given.

November 1988

B:D5.30/5(DC4)

Copy No. 2

HC 55

NHS Review

PROFESSIONAL AND EMPLOYMENT PRACTICES

Note by the Secretary of State for Health

1. This note responds to the Group's wish for a paper on "restrictive practices", which I have interpreted broadly to cover professional and employment practices generally in the NHS. It concentrates on doctors, nurses and the "professions supplementary to medicine" (physiotherapists, radiographers, chiropodists and so on).

2. In my judgement the most important requirement in this field is to tackle the rigidities caused by professional boundaries. The paper deals mainly with this issue, but also with employment practices. I have not addressed directly activities such as advertising and "price fixing", which are subject to wider legislation on fair trading which we should be ready to invoke as necessary; nor the scope for local flexibility on pay, which DH and the Treasury are to discuss further. The specific possibility of employing consultants on short-term contracts to reduce waiting lists is addressed in my paper on "Funding Issues" (HC 49).

3. In brief, I propose

(i) a major - but rapid and well-focused - inquiry into the best use of professional resources in the NHS.

(ii) reform of the national conditions of service of NHS staff, in the interests of greater flexibility.

(iii) further action on the efficient use of nursing staff.

I PROFESSIONAL BOUNDARIES

4. A note summarising the statutory framework for the main professions covered by this paper is at Appendix A. The health care professions are by definition self-regulating, setting their own standards for entry and training and thereby defining the scope of their work. As a result rigid professional boundaries have tended to grow up, both between the different professions and between professional and non-professional staff.

5. The problems are probably most serious where medical, nursing and social services are available in people's homes, aggravating the risk of the same patient being seen by

different professionals for similar purposes. In hospitals too the existence of distinct professional roles can inhibit the deployment of less skilled staff and the use of one profession rather than another (such as the use of nurses or midwives to carry out tasks traditionally associated with doctors).

6. Any action in this area will need to take account of the following:

i. The NHS is a very large employer of (particularly female) school leavers with a reasonable level of academic qualification (5 GCSEs or more). This group is declining quickly in numbers and will continue to do so until the middle 1990s. There will be little recovery before the end of the century.

ii. It will be necessary to eliminate any unnecessary restrictions on entry to professional training, and to maximise recruitment from older age groups. It will also be essential to develop more flexible training patterns which allow non-professional staff to progress into professional training, and more flexible working practices.

iii. The "skill mix" between professional and non-professional staff needs further research to establish the optimum mix of staff in different circumstances.

iv. In community settings in particular the respective roles of different professional groups need review. This may mean identifying more positively those staff who have a primary diagnostic, caring or therapeutic role and those who, in effect, act more as consultants to patients' families and to other health care staff.

v. We need to explore to the full the scope for shared education and training.

Action in hand

7. Some small progress - no more - has been made on inter-professional issues. But a good deal of useful, collaborative work is under way with the professions to tackle the problem of boundaries between professional and non-professional staff.

8. Some examples are set out in Appendix B. A great deal of progress is being made with the nursing profession in the context of Project 2000, and also, for example, with occupational therapists and clinical phychologists. Others, such as physiotherapists and radiographers, are being more cautious, although constructive discussions are in hand. The spread of clinical budgets will put increasing pressure on the professions themselves to find more flexible ways of using staff; and some changes will be forced by demographic constraints on recruitment, even if the results are sometimes

less than ideal. (A higher ratio of non-professional to professional staff is not necessarily either more cost-effective or in the interests of the patient; but nor are traditional role boundaries.

An inquiry

9. It will be important to maintain the momentum of these developments. Where we can make progress through collaboration between management and the professions we should do so. But much of our work so far has been opportunistic, and hence piecemeal. And progress is uneven.

10. The climate is right for a major, objective examination of professional boundaries. Many of the health professions are becoming more receptive to change as they recognise the likely impact of labour market developments in the 1990s. The Government has set the tone in other fields, most recently on the legal profession (although the parallel here is not exact): there could be no suggestion that the health professions were being unfairly singled out in our drive for greater flexibility.

11. We must proceed carefully nonetheless. For example, any legislative attempt either to curtail current restrictions on rights to practise or to redraw the boundaries around and between professions would be exceptionally contentious and fraught with definitional difficulties. Whether we need to legislate or not the ground must be carefully prepared.

12. If colleagues agree I propose to set up a small inquiry team consisting of, say, 3 or 4 lay people of suitable standing. Any attempt to make the team respresentative of the professions themselves would be impossibly cumbersome, but the inquiry could and should take evidence from all the relevant professional bodies, as well as from NHS management and other interested parties. It would be desirable to secure commitment to the inquiry's proposals from at least some of the professions involved.

13. It would be important to ensure that the inquiry was not seen as a crude attempt to "de-skill" health care but as an objective scrutiny of problems and solutions. Its task would be to examine, from first principles, the mix of professionally qualified and other staff required to deliver a given level of service safely and economically. It would be asked to take into account the labour market circumstances and other factors summarised in paragraph 5. Most importantly, its terms of reference should focus on how to make the best use of professional resources in the interests of patient care.

14. The inquiry should be free to make both general recommendations and recommendations which are specific to individual professions. It would need to examine

- supply, training and education.

- personnel, employment and working practices.

- the substitution of technology or capital for labour.

- changes in the culture of the service and in professional attitudes.

- the consequences of the inquiry's proposals for patterns of service delivery.

- the management, financial and information implications.

15. We would need to guard against two, potentially serious, risks: first, that the sheer range of issues and professional interests would lead the inquiry to lack a clear focus; and, secondly, that the useful work already in hand would be stalled whilst the inquiry took place. To avoid these dangers I would propose asking the team to

i. take account of the wide range of projects already under way - as exemplified in Appendix B.

ii. let me have early proposals - within, say, two or three months - as to the issues on which they wished to focus their attention. I could then agree with them a more specific remit and timetable for the main part of their work. There might be advantage in seeking an early report on some issues and allowing more time for others; subject to that, the team might be asked to complete its work by, say, the end of 1989.

iii. concentrate not on producing a comprehensive and detailed report but on identifying areas where insufficient progress is being made and recommending solutions.

16. If colleagues are content with this proposal I shall work up the detailed arrangements - and try to identify a Chairman - so that we can move forward quickly after the publication of the White Paper.

II EMPLOYMENT PRACTICES

Terms and conditions of service

17. I suggest that the White Paper should also signal an intention to give managers greater flexibility to determine the conditions of service of NHS staff, which are currently determined mainly by national negotiation in the Whitley Councils. My proposals for self-governing hospitals envisage that these hospitals will be wholly removed from Whitley constraints. Leaving aside the issue of pay flexibility, that

still leaves room for the present detailed and prescriptive agreements on conditions of service to be replaced by arrangements which give health authorities generally scope for greater flexibility.

18. Following a recommendation of the Griffiths Inquiry, the Department last year commissioned a radical review of conditions of service by a seconded NHS personnel specialist. His report is due by the end of the year and will provide the basis for a programme of reform. I propose that the White Paper should state our intention to carry through these reforms. To do so it will be necessary to amend the relevant Regulations, which at present severely restrict our scope for progress other than by negotiations through established machinery.

Efficient use of nursing staff

19. At our last meeting the Group also raised the issue of working patterns in nursing.

20. The NHS Management Board has devoted considerable effort recently to improving health authorities' capacity to plan the demand for nursing staff. Most authorities now use one of a number of recommended methodologies.

21. Staff must also be deployed and used to best advantage. A whole range of measures is needed here, from reducing wastage and absenteeism to restructuring the workforce to produce taut, effective management structures and the best possible grade mix. Some of the relevant work in hand is among that referred to in Appendix B. As soon as the initial pay assimilation process is completed I shall be taking steps to ensure that authorities use the restructuring opportunities created by the new clinical grading structure.

22. An area particularly needing attention is matching staffing levels more closely to workloads. This includes the elimination of shift overlaps which are not justified by peaks in activity levels. Authorities are beginning to use computerised work scheduling systems, and the resource management initiative will give these a considerable boost. Progress is not, however, dependent on information systems, and while some authorities have made good progress others still lag behind.

23. I am considering how to give greater focus and impetus to the considerable range of work which is going on in this whole field. I should be happy to bring forward proposals for inclusion in the White Paper if colleagues agree that that would be appropriate.

November 1988

B:DC2.7/6

APPENDIX A

THE STATUTORY FRAMEWORK

Professional self-regulation

1. The statutory framework for doctors, nurses and the professions supplementary to medicine is founded on the principle of self-regulation. For some at least of these professions the activities of the statutory and/or professional bodies may encompass, among other things:

(a) maintaining a register of qualified members - only those on the register may practise the profession.

(b) protecting the profession's title.

(c) establishing codes of professional conduct and removing members from the register in the event of breaches of the code or unfitness to practise.

(d) controlling entry standards for, the content and length of - and sometimes the numbers in - training,

(e) through a combination of (a),(c) and (d), determining the role of the profession, including the role of non-professional support staff.

(f) determining staffing and other criteria for suitable clinical placements during training.

(g) specifying mandatory refresher training.

Doctors

The General Medical Council

2. The General Medical Council is an independent statutory body whose constitution and functions are regulated by the Medical Act 1983. The general duty of the Council is to protect the public and uphold the reputation of the profession. Specifically its duties cover registration; standards of education and experience; standards of professional conduct and medical ethics; and professional discipline.

3. The Council consists of 97 members, of whom 50 are directly elected by registered practitioners, 34 appointed by universities with medical schools and by the Royal Colleges, and 13 (including 11 lay members) nominated by the Privy Council. It elects a President from among its members.

SECRET

The Royal Colleges

4. There are seven English Royal Colleges (Surgeons, Physicians, Psychiatrists, Radiologists, Pathologists, Obstetricians and Gynaecologists, and General Practitioners), each established by Royal Charter. Together with similar bodies covering other specialties (such as the Faculties of Anaesthetists and Community Medicine), they have the general aim of promoting standards of excellence in their respective specialties, for example by providing courses, promoting research and publishing reports. In practice they control the standards and content of specialist training, by conferring post-graduate qualifications (diplomas, memberships and fellowships) and through a system of regular inspection of all junior medical posts. In these ways they have considerable power to shape specialist practice. There is machinery for co-ordinating College views, but it is weak.

Nursing

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting

5. The United Kingdom Central Council is an independent, statutory body set up by the Nurses, Midwives and Health Visitors Act 1979. The Council's functions cover registration; standards of training and professional conduct; and professional discipline. Each of the four National Boards (see below) nominates seven members, and 17 are appointed by the Secretary of State. The Council elects its own Chairman.

The National Boards

6. Four National Boards - for England, Scotland, Wales and Northern Ireland - have been set up under section 6 of the 1979 Act. The job of each Board is to ensure that pre-qualification training courses are provided and examinations held, and that the courses meet the requirements of the Central Council as to their content and standard. The Boards also carry out preliminary investigations of cases of alleged misconduct. The majority of the members of the Boards are directly elected by members of the professions, the remainder being appointed by the Secretary of State. A majority of appointed members are nurses, midwives or health visitors appointed to ensure that all branches of the profession are adequately represented. The Boards elect their own Chairmen.

Professions Supplementary to Medicine

7. Machinery for the state registration of a range of health professions was set up under the Professions Supplementary to Medicine Act 1960. The seven professions currently within scope of the Act are chiropodists, dietitians, medical laboratory scientific officers, occupational therapists, orthoptists,

physiotherapists and radiographers. State registration under the Act is a pre-requisite for employment in the NHS.

8. There is a separate Board for each profession, whose membership is drawn mainly from that profession, and which is responsible for maintaining the register and for the regulation of professional education and conduct. The Boards approve courses, curricula and institutions as suitable to lead to state registration in their respective disciplines. In the majority of the professions the qualification so approved is the diploma of the professional body concerned.

9. The Boards are supervised and co-ordinated by a Council for Professions Supplementary to Medicine. The Council may comment on, but not veto, the Board's recommendations, which are submitted to the Privy Council for approval. The Health Ministers appoint either directly or indirectly (by advice to the Privy Council) seven of the Council's 21 members and its Chairman. A further seven members are appointed by, and represent, the individual Registration Boards. Most of the remaining members are appointed by medical colleges.

APPENDIX B

PROFESSIONAL BOUNDARIES

1. A substantial programme of action is either planned or in hand concerning the boundaries of professional practice in health care, both between professions and between professionals and their non-professional support staff. Among this work is the following:-

a. Project 2000. The Government's acceptance in principle of the Project 2000 reforms of nurse education and training depends on developing the role of non-professionally qualified support workers to nurses and the possibility of progression from support work into professional training. The UK Central Council has work in hand to identify vocational qualifications, as well as academic qualifications which might satisfy the entry criteria to nurse training; and is also looking at alternative entry procedures for potential mature students.

b. Nursing. Following up a current, small-scale study at the University of Warwick on skill mix within the acute ward team, concentrating on the role of ward clerks, the University has been commissioned to undertake a major two year study of cost-effectiveness and skill mix within nursing.

c. Nursing and technicians in high technology care. A short study of possible overlap between the roles of nurses and technicians in high technology care has been completed. This identified overlap in many areas of work. We plan to follow this up shortly with a larger study which will encompass the deployment and training implications of these findings.

d. Occupational therapy. A report on skill mix and manpower requirements for occupational therapy in the NHS and local authorities is expected by autumn 1989. This work will form part of a longer term project which will continue with a review of competencies and training requirements.

e. Physiotherapy. A study of workload measurement and supply is in hand. This work is expected to lead on to an examination of skill mix.

f. Clinical psychology. We are planning a study to identify common or core skills; to determine the levels of staff and skill mix required; and to examine both the possibility of introducing supporting staff and the feasibility of delegating tasks to, or sharing them with, other groups.

g. Pathology. A recent report on pathology service staffing has suggested that there is scope for greater use of non-graduate laboratory assistants.

h. Speech therapy. We are funding a study of skill mix in speech therapy, and in particular the role of speech therapy helpers.

i. Shared training. Examples of current initiatives include significant progress towards shared training between nurses and social workers in the field of mental handicap, and a joint working party of the Royal College of Nursing, the College of Occupational Therapists and the Chartered Society of Physiotherapy on the scope for joint working, including shared training, between the three professions.

2. Action is also in hand on nurse prescribing. Outside the hospital service the ability to prescribe and/or supply drugs and medicines is limited to preparations ordered by a medical or dental practitioner. The Cumberlege Report on Community Nursing recognised that in practice community nursing staff were frequently operating in circumstances that required them to supply a limited range of preparations to patients with whom they were in direct contact. The Report recommended that nurses should be able to prescribe and/or supply a limited list of preparations, and also, in carefully defined circumstances, to control and vary drug dosage.

3. The Government has made clear its general support for this recommendation. The Department has established a small working group, including all the professional interests involved, to examine the professional and ethical issues. These issues range from the nature of prescribing and the appropriate categories of nurse to engage in it, through the types of items which might be covered and the financial and legal consequences. There are related questions of security, training and personal liability. The Group expects to complete its work by June 1989.

4. The Group will confine itself essentially to the Cumberlege recommendation, which was limited in scope. The consultation exercise which followed Cumberlege gave the other professions the opportunity to voice their concerns, but it was recognised that to a large extent the recommendation would regularise existing practice and opposition from other professions was limited. Any attempt to go further would be fiercely resisted. Primary legislation may nonetheless be needed to achieve the necessary changes.

4.11.4

SECRET

FROM: R B SAUNDERS

DATE: 4 November 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr MacAuslan
Mr Parsonage
Mr Griffiths
Mr Sussex
Mr Call

NHS REVIEW

I attach, for your meeting on Monday:

a. brief notes on the four papers by Mr Clarke which are due to be discussed at the Prime Minister's meeting on Tuesday.

b. Some defensive notes on capital, just in case Mr Clarke, despite agreement that the joint paper should not be discussed, should raise the points about which we know he is most concerned. See also Mr Parsonage's minute of today.

in sep orange folder

c. A draft "20 questions" minute, which you might put to the Prime Minister on Monday.

2. I will let you have next week some comments on the other 3 papers which have been circulated but are not due to be discussed: a better service to patients, the public and private sectors, and professional and employment practices. I will prepare a draft letter covering any points which it seems worth making. This might be an opportunity to ask for a paper on consultants. Alternatively (and perhaps better) you could do so at Tuesday's meeting if an opportunity presents itself.

SECRET

3. You will wish to be aware of some exchanges between Mr Phillips and Mr Heppell at DoH about costs. Mr Clarke is being briefed to raise the question in the following terms.

> "A number of the papers seek to quantify the likely costs of proposals. This is intended as an aid to decision taking, not as bids for more resources. Any question about additional resources will be taken up, as necessary, in future surveys."

Mr Phillips told Mr Heppell that we would not regard this as adequate reassurance, and that Treasury Ministers would be briefed to respond in the terms of paragraph 15 of the draft minute to the Prime Minister. (DoH officials do not know that you are likely to be putting in written comments before the meeting.)

R B SAUNDERS

SECRET

MEDICAL AUDIT (HC50)

Main points from paper

1. Introduce medical audit in all hospitals, building on present initiatives, the precise form to be for local agreement.

2. Management to be able to call on regional health authority for independent professional audit.

3. Self-audit by GPs, based on indicators produced by FPCs, with small audit teams attached to each FPC.

4. Strong emphasis on moving with consent of profession.

5. Costs £25m in consultants' time and £10m for FPC audit teams. No estimates of training costs or costs of regional professional audit.

Main points to make

1. Generally acceptable, but will need to keep under review extent to which profession is prepared to make voluntary progress.

2. Important that procedures should not be set up in a way which inhibits scope of new VFM audit by Audit Commission. They must be free to carry out studies similar to those recently published in respect of the police (eg finger printing).

4.11.2

SECRET

FUNDING ISSUES (HC49)

Main points from paper

1. Regional RAWP abolished from 1990-91. Regions significantly under target "bought out". Larger increases in annual allocations for those regions showing the most rapid population growth. Periodic review of resulting "baseline".

2. Long term aim of weighted capitation basis for funding districts. Transition to be managed by region "carefully over a period of time".

3. Regions to have responsibility for earmarking funds for GP practice budgets.

4. Existing arrangements for funding supra-regional services to continue, and central funding of training costs. More direct funding of cross-boundary flows.

5. Performance funding scheme run by regions, using top-sliced £50m, which would be "a bid for additional funds".

6. 120 additional consultant posts over 2 years, cost around £15m per year.

Main points to make

1. Regional and district allocations - see Chancellor's minute to Prime Minister.

2. Agreement with MOD over service hospitals (Annex B) highlights difficulties in contractual approach. That is about health authorities placing patients in service hospitals. Not how NHS works - GPs refer patients direct to consultants, without intervention of health authorities. So not a good precedent.

3. See need to fund training of doctors centrally, but should not training of nurses and other staff be an overhead for hospitals?

4. Do not accept that money for performance funding should be additional. Can be top-sliced out of HCHS resources.

SECRET

RECONSTITUTING HEALTH AUTHORITIES (HC52)

Main points from paper

1. Regional and district health authority membership reduced, with higher proportion of executive members, and no local authority nominations.

2. RHAs reduced in size by delegating or contracting out common service functions; no proposals for taking responsibilities away from regions.

3. Retain NHS Management Board in broadly its present form. Abolish supervisory board. Delegate day-to-day management to executive committee, chaired by chief executive.

4. Management board assumes responsibility for FPS.

Main points to make

1. Role of regions - see Chancellor's minute to Prime Minister.

2. Proposals for slimming down RHAs modest in comparison with extra functions. Net increase in size and responsibility likely. What will this cost?

3. Reorganisation of management board appears to revert to initial structure of supervisory board chaired by Minister, with operational board chaired by Chief Executive (Victor Paige). What reason to suppose it will work any better this time?

SECRET

MANAGING THE FPS (HC51)

Main points from paper

1. Strengthen ability of FPCs to deal with excessive prescribing by making more medical expertise available to them, and by giving them powers to impose financial penalties on persistent offenders.

2. Similar steps to be taken in respect of referral decisions, but further work to be done first on developing appropriate information bases and drawing up criteria for when referral is necessary and when not. (NB practices who opt to hold budgets will not be exempt from this discipline, since the budgets will cover elective surgery only; for other types of referral, eg emergency and medical, they will be controlled in the same way as other practices.)

3. Practice budgets calculated on the capitation basis proposed in the earlier paper (HC47). Only those practices opting to hold referral budgets would have the further option of holding a drug budget.

4. Defer a final decision on controlling GP numbers until it is possible to assess the reaction of the profession as a whole. Subject to that, Mr Clarke agrees in principle to legislation to take the necessary powers. Reduce GPs retirement age to 65 from the 70 it will become on the Health and Medicines Bill getting Royal Assent.

5. Do not merge FPCs with districts. Instead, strengthen their management and introduce new chief executives (cost £3m a year).

6. Change FPC composition to reduce professional input.

7. Make FPCs accountable to regions.

4.11.3

SECRET

Main points to make

1. GP budgets - see Chancellor's letter to Prime Minister.

2. Strengthened FPCs will be yet another layer of bureaucracy. Still favour pursuing merger and cash limits.

3. Can financial penalties be made to stick? Will there be provision for appeals and/or litigation?

4. Are the medical teams helping FPCs monitor prescribing practice (paragraph 9(i)) the same as the teams which FPCs will have to do medical audit? (The final sentence of paragraph 2 suggests that the two are separate.)

5. Is it sensible to reduce GP retirement age so soon after controversy of introducing age 70 retirement in the Health and Medicines Bill?

6. Proposals on controlling GP numbers very feeble. Argument in paragraph 18 that this would be inconsistent with approach to freeing trade restrictions is quite ridiculous. GPs are not small businessmen operating in a competitive market - they are contractors wholly remunerated by the taxpayer. Trying to exercise some control over that expenditure has nothing to do with policy on small businesses.

7. If decision goes against merger with districts, content with proposals for FPCs to report to region (a first step towards merger), for appointment of chief executives, and new composition.

SECRET

MANAGEMENT OF CAPITAL (HC56) - defensive brief

Give health authorities the power to go into joint ventures with, eg property development companies?

- Property development is a high risk business appropriate to the private sector, not the public sector.

- This is precisely the sort of thing we have been trying to stop local authorities doing (see separate note from Mr Parsonage).

- In any case, this is not an issue of private finance. If health authorities were able to invest in commercial ventures themselves, the money to do so would have to come from their capital allocations.

Bromley scheme offers sensible way of freeing up surplus land?

- The sensible way to do this is through a capital loan fund within the programme, as proposed by DoH in this year's public expenditure survey. Have already said that we have no objection to this.

- Getting the property company to put up the money is bound to cost more. Accounting Officer will have the greatest difficulty in explaining to PAC why public capital programme was not used. Problems will be increased if property prices subsequently move against the health authority.

- This is really an argument for a higher capital programme than that which Mr Clarke agreed during the Survey.

But selling property is always risky?

- If property sold at the time it becomes free, there is a risk, but at least one can take the best advice available as to the appropriate price. If, however, the property is sold <u>forward</u> (ie setting a price now for a future sale - as with the Bromley proposal) an extra dimension of risk is added - speculation on the course of future land prices. As already argued, it is not necessary to expose the Accounting Officer further in this way.

35/3/JJ/5002/37

CONFIDENTIAL

FROM: M A PARSONAGE
DATE: 4 November 1988

1. MR PHILLIPS

2. CHIEF SECRETARY

The immediate value is in the examples, and the argument, for e.g. that Mr Clarke could be running the N.H.S. into something like British Rail was.

HP.
4/11

cc Chancellor
Sir P Middleton
Mr Anson
Sir T Burns
Miss Peirson
Mr Turnbull
Mr MacAuslan
Mr Richardson
Mr Saunders
Mr Griffiths
Mr Sussex
Mr Call

NHS REVIEW: JOINT VENTURES

Following your meeting yesterday with the Secretary of State for Health, I attach a short note on Mr Clarke's suggestion that health authorities should be empowered to engage in joint commercial ventures with the private sector.

2. It may be useful background if Mr Clarke seeks to raise this again at the Prime Minister's meeting on Tuesday, in discussion of the joint paper on capital which has just been circulated in draft form by Mr Saunders.

MP.

M A PARSONAGE

7
204

35/3/JJ/5002/39

NHS REVIEW: JOINT VENTURES

At the Chief Secretary's meeting on 3 November with the Secretary of State for Health, Mr Clarke said that he saw attractions in health authorities being empowered to undertake joint commercial ventures with private sector companies. These might include activities altogether separate from health service provision, for example property development schemes on land surplus to NHS operational requirements.

General Line

- Proposal runs counter to the Government's general policy of rolling back the frontiers of the state and seeking as far as possible to locate commercial or market-based activities in the private sector; speculative ventures are not the business of government.

- Privatisation is the fullest expression of this policy; applies not just to whole industries but also to the peripheral activities of bodies which remain in public ownership; in other words, public bodies should concentrate on their main line of business and not engage in fringe activities better done by the private sector.

- Policy applies with particular force to the NHS, where the new breed of general managers are beginning to get to grips with running the health service efficiently and will be even more fully stretched in implementing changes following the present review; NHS Management Board have already had to issue warnings to health authorities not to get carried away in devising new income generation schemes, for fear of diverting management effort from the main business of providing efficient health care.

Examples

- British Rail illustrate the case of a public body disengaging from peripheral activities; have sold off Sealink, BR Hotels

and British Transport Advertising, and are in the process of selling off British Rail Engineering Ltd and Travellers' Fare. (But note: BR continue to be involved in joint property development schemes of the type favoured by Mr Clarke for the NHS.)

- Many examples in the field of industrial policy of government departments taking commercial judgements that have gone wrong, at heavy cost to the public purse; well-known abortive attempts to "pick winners" include De Lorean, Lear Fan Jets, Nexos Computers.

- The Crown Agents crash in the 1970s illustrates the dangers of entry into the property market by public sector bodies with insufficient relevant commercial experience and expertise. Crown Agents had invested in and lent heavily to the property and secondary banking sectors, but in 1973/4 a number of these companies went into liquidation or receivership. Asset values of the Crown Agents had to be written down and financial backing obtained for operations involving some £600 million; the Government was obliged to make an exceptional Vote of £85 million to cover losses.

- Finally, there are many examples from local government of failed commercial ventures; these include: the Harrogate Conference Centre, a council-owned white elephant which has hugely overrun on capital costs and is unlikely even to cover its running costs; a large docks development project in Bristol which entailed heavy losses for the council; a loss-making ice cream factory once owned by Torbay Council; and the decision by Guildford Council to invest all its spare cash in the stock market just 10 days before the crash of October last year.

cst.pas/docs/9.4.11

SECRET

FROM: MARK CALL
DATE: 4 NOVEMBER 1988

CHANCELLOR

cc Chief Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr MacAuslan
Mr Richardson
Mr Saunders
Mr Griffiths
Mr Sussex

NHS REVIEW: BETTER SERVICES TO PATIENTS

This paper still looks pretty woolly and platitudinous. I have two chief concerns.

2. Firstly, the rather opaque offering "better information about clinical outcomes" is not fully developed. Secondly, Mr Clark continues to push health indicators - have we tried to reopen a discussion of the possible pitfalls?

3. On the first, a frequent complaint by patients (admittedly on statistically insignificant personal experience) is that nobody tells them what is going on. Health indicators are an aggregated, collective approach, and would be of no comfort to the individual. They carry the risk that they simply provide ammunition for special pleading. A requirement that they be told what is wrong with them and what treatment they are about to receive would do more to relieve anxiety among patients. The paper (paragraph 11i) talks about providing information on how to prepare oneself for going into hospital and how to get there. All very useful, but hardly as significant as a greater flow of clinical information is developing personalisation of the service and a feeling of responsibility towards patients. It is the occasional example of arrogant anonymity which wrankles so much.

4. But before embarking on a paper setting down how to improve patients' perception of service, it would be sensible to know what

those patients think of the current service and what changes they would value. If the DH don't have such opinion research maybe they should commission some? I'm pretty sure health indicators would come far down the wish list.

5. Optional Extras available at a charge (paragraph 8 iii) are welcome but a bit buried in the paper. One service that might be added to the list is a general check-up. This could complement the health awareness measures outlined in paragraph 25. If the NHS is to charge for optical and dental check-ups, why not the rest?

Don't GPs already charge?

6. Finally the review announcement will have to be very convincing on waiting lists. Paragraph 10 is a long way away.

M. J Greeves

pp. **MARK CALL**

st.ln/min/2.4.11

CONFIDENTIAL

FROM: MISS M E PEIRSON
DATE: 4 NOVEMBER 1988

CHANCELLOR OF THE EXCHEQUER

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Mr Phillips
Mr Beastall
Mr Potter
Mr Saunders
Mr Call

AUDIT OF THE HEALTH SERVICE

Mr Ridley has now written to you (letter of 31 October), following your talk with him, expressing willingness to consider inclusion of the necessary legislation in his own Bill.

2. There is no need for you to respond at this stage. DOE are now preparing a paper discussing the options:-

i) legislation in two phases (a general enabling clause in the DOE Bill, followed by major legislation in a DH health review Bill);

ii) legislation in one phase (major legislation only), and if so:-

a) in the DOE Bill or

b) in the DH Bill.

3. Treasury and DH officials will be consulted in the drafting of the paper, and when it is agreed it will be put to Ministers including yourself. That will be within two or three weeks: there is some urgency because the DOE Bill is due to be published fairly soon (probably January, but possibly before Christmas).

4. One of the points we shall bear in mind is the likely relative timing between the publication of the DOE Bill and a statement on the outcome of the health review.

MEP

MISS M E PEIRSON

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~~ ~~XXXXXXXXXX~~ Health

COVERING SECRET

Already actioned.

Paul Gray Esq
10 Downing Street

4 November 1988

Dear Paul

Further to my letter yesterday enclosing papers for the next meeting of the Review Group, I now enclose a joint paper by my Secretary of State and the Chief Secretary which records the outcome of their discussion yesterday morning on capital.

We have also identified an error in Table 2 of Annex I to HC49 (Funding Issues). I enclose a replacement page which I would be grateful if you could insert in your copy.

I am copying this to the Private Secretaries to the Chancellor of the Exchequer, to the Secretaries of State for Scotland, Wales and Northern Ireland, to the Chief Secretary; and to the Minister of State and Sir Roy Griffiths in this Department; and also to Professor Griffiths and Mr Whitehead at the No. 10 Policy Unit, and to Mr Wilson in the Cabinet Office.

Yours ever
Andy

ANDY McKEON
Private Secretary

NHS REVIEW

MANAGEMENT OF CAPITAL

Note by the Secretary of State for Health and the Chief Secretary to the Treasury

Introduction

1. This note records that we have reached agreement on the introduction of capital charges in the NHS; and on a programme of work on the scope for access to private capital. We invite colleagues to note this progress and the next steps which we have put in hand. We believe that the issues do not now need to be discussed within the Group meetings, but we will keep colleagues in touch with further work.

Charging for the use of capital assets

2. We consider that capital should not in future be regarded as a free good by the NHS. We believe that a system of charges can and should be introduced so that the users of capital assets are required to meet the cost of those assets, as reflected (subject to normal depreciation) in their current valuation. The introduction of such a system will enable:

- effective management information on the use and value for money of assets
- more cost-effective allocation of future investment
- clear signals on the need for replacement of assets
- a proper basis for charging between hospitals and between the public and private sectors.

3. The introduction of charges is intended to provide clear incentives for authorities and self governing hospitals to rationalise capital holdings, and to invest most effectively. These market disciplines need to apply equally to all public sector hospitals, whether run by health authorities, or self governing.

4. The capital assets used by the NHS are, and will remain, primarily public ones financed by public sector funds. As was recognised at the last meeting of the Group, no impression should be given that elements of the NHS may be alienated from this essentially public ownership. Health authorities need to have freedom to manage their assets - and we envisage self governing hospitals having greater freedom - but we must retain a broad lien on the major assets they use. A minimum requirement might be that disposals of more than 5% of a self governing hospital's total capital stock would require Regional approval.

5. We see three stages in the introduction of a system of real charges. First, valuation upon an agreed basis. Secondly the introduction of a system of management accounts to enable the NHS to go through a process of familiarisation using notional accounts. Thirdly, and in the light of that experience, to move towards a fully effective system of real charges as soon as reasonably practicable.

6. Officials are working out the practical details of the system such as the definition of interest levels and depreciation schedules, the treatment of charges in the public expenditure context, and ways of achieving a smooth transition. We are confident that these are soluble, and invite colleagues to agree that we should continue to work these up, reporting back in due course. In the meantime, our White Paper should refer to the principles and objectives we have set out in this note.

Access to private sector capital

7. The issues here are more complex. We need to look at ways of enabling the NHS to work more closely with the private sector, which includes examining the scope for greater freedom of access to private capital, without losing expenditure control or being exposed to unacceptable risks with public money. A great variety of schemes may be possible, and the key issues can only sensibly be considered in relation to particular types of project. We have therefore asked our officials to prepare for us a series of key examples of schemes which have arisen in the past, and which might arise in the future, so that we can identify both the fundamental difficulties, and the scope for a more flexible approach. We shall report the results of this work to colleagues as soon as possible with the objective of making a general statement of our policy in the White Paper.

Table 1

Components of National HCHS Cost Weighted Activity Index

Inpatient plus Day Cases (Inpatient Discharges & Deaths and Day Cases)

Outpatient plus A & E (Attendances)

Day Patients (Attendances)

Health Visitng (People visited)

Home Nursing (People treated)

Ambulances (Cases carried)

Blood Transfusion (Bottles of Blood issued)

Table 2

ILLUSTRATIVE CALCULATIONS OF RELATIVE UNIT COSTS

RELATIVE UNIT COSTS
1985/6

NORTHERN	94.6
YORKSHIRE	91.1
TRENT	92.7
EAST ANGLIAN	97.5
NORTH WEST THAMES	116.8
NORTH EAST THAMES	114.4
SOUTH EAST THAMES	105.8
SOUTH WEST THAMES	116.3
WESSEX	94.7
OXFORD	94.4
SOUTH WESTERN	97.9
WEST MIDLANDS	100.4
MERSEY	98.5
NORTH WESTERN	89.5
TOTAL	100.00

Notes:

1. Relative unit costs: actual expenditure divided by estimated expenditure using national cost weights.

2. Variations will reflect, in part, the effects of regional variations in input prices - London Weighting etc.

B:D5.29/6

chex.md/mw/104 **CONFIDENTIAL**

FROM: MISS M P WALLACE
DATE: 4 November 1988

MISS M E PEIRSON

cc PS/Chief Secretary
PS/Paymaster General
Sir P Middleton
Mr Anson
Mr Phillips
Mr Beastall
Mr Potter
Mr Saunders
Mr Call

AUDIT OF THE HEALTH SERVICE

The Chancellor has seen and was grateful for your minute of 4 November.

MOIRA WALLACE

7.11.4

covering SECRET

mp

FROM: R B SAUNDERS

DATE: 7 November 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr MacAuslan
Mr Parsonage
Mr Griffiths
Mr Sussex
Mr Call

never sent

NHS REVIEW

I attach, as discussed this morning, a revised draft of the minute to the Prime Minister.

Ra Reeves

pp R B SAUNDERS

7.11.3

SECRET

DRAFT MINUTE FROM THE CHANCELLOR TO THE PRIME MINISTER

NHS REVIEW

I have now read the papers circulated by the Secretary of State for tomorrow's meeting. I am concerned that some of the proposals they contain are not ready to form the basis for a White Paper.

2. First a general point about costs. The Chief Secretary and I cannot be expected to endorse proposals which may cost more money without being given a clear idea of how much is involved. We must have the references in the papers to additional costs fully quantified and the whole package properly costed. We should not be faced in subsequent surveys with bids which are then described as unavoidable flowing from uncosted White Paper commitments.

Funding

3. I see some difficulties with the Secretary of State's proposals in this paper. The long term aim of weighted capitation fees for districts, to which they would move over a period of years, is strongly reminiscent of the present system of targets and allocations, only at district rather than regional level. The paper acknowledges in any case that allocations to regions would have to adjust progressively in response to changing population and other factors. Moreover, it seems to me that the "buying out" in the first year of those regions who are below target can only be at the expense of the rest. This will be very controversial, particularly since some of those other regions will have been progressively squeezed over the last 10 years.

4. We have two broad choices. We could adopt the Secretary of State's proposals, which would involve a substantial shift towards RAWP targets in the first year, followed by a system not dissimilar to RAWP. The alternative would be to accept that we can neither freeze nor abolish RAWP without offending very many health authorities up and down the country, and therefore to allow it to continue to run its course, since the biggest adjustments are now behind us. I would favour this second alternative, but would wish to see the system modified and improved, so that full account was taken of prospective as well as actual population changes, and a more immediate and direct compensation for cross-boundary flows.

5. On a more detailed point, the paper talks mainly about the allocation of current expenditure. We also need to consider how capital allocations should be made, and how current allocations should be adjusted to take account of any cash charges in respect of capital assets.

Managing the FPS

6. I think we should be taking more positive action to gain control over FPS expenditure. My clear preference is still for merging FPCs and DHAs, and subjecting them to joint cash limits. To this end, taking control of GP numbers is essential.

7. If we leave FPCs separate from districts, and instead beef up their management, there is a danger of creating a new bureaucratic powerbase within the NHS. We have seen too often how this process results in increased bureaucratic in-fighting rather than improved efficiency.

8. The paper refers at several points to the proposed GP practice budgets. I do wonder whether this idea has been sufficiently worked up. I see considerable problems in setting budgets, since a simple capitation basis will not do for practices with a high proportion of patients who do not use the NHS. I am not sure how the system of allocating budgets can take account of this.

9. Without such adjustments, the practices who will opt for these budgets will tend to be those with large numbers of patients with private insurance, or who would otherwise have lower referral costs than the average (eg because their patients smoke and drink less than average). If they can refer patients for private treatment, what is to stop this turning into a way of substituting public money for private? If people know they can get referred privately at public expense, why should they bother to make provision for themselves?

10. I would like to propose a more limited scheme. GPs would be given smaller budgets which they could use selectively, at a public or private hospital, for their patients who were already on waiting lists and perhaps had been for a specified minimum period. The decision who should get favoured treatment would rest with the GP, who is best placed to assess priorities among his patients. And a tight budgetary constraint would ensure that only the most deserving would benefit.

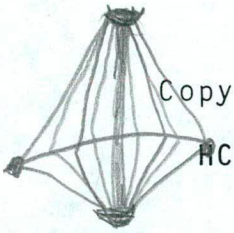
SECRET

Reconstituting the health authorities

11. The funding system now proposed will be more complex than now, so as to allow money more efficiently to follow the patient. The "contractual" basis of funding will involve sophisticated administration. Responsibility for many important aspects - managing the system which replaces RAWP, running the capital charging system, oversight of GP budgets and cost control of the FPS, and managing the transition of hospitals to self-governing status - will fall squarely on regions. We must consider whether this focus on the regional tier is right, and in particular whether they have the expertise, competence and resources to carry these tasks through.

12. I am copying this minute to the Secretaries of State for Health, Scotland, Wales and Northern Ireland, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr Wilson and Mr Whitehead.

SECRET



Copy No: 2

HC 50

NHS Review

MEDICAL AUDIT

Note by the Secretary of State for Health

1. This paper sets out my proposals for securing the accountability of doctors for the quality and cost-effectiveness of medical work.

2. In brief, I propose that we work with the medical profession, nationally and locally, to establish

* a system of medical audit in every District and self-governing hospital, based on self-audit and peer review and with a facility for management to initiate an independent professional audit; and

* a parallel system for general practice.

I HOSPITALS

Context

3. A major objective of the review is to ensure that consultants take more responsibility for the management and delivery of hospital services, and are more accountable for the quality and cost-effectiveness of what they do. There are two main aspects of this:

i. on primarily management issues, such as whether doctors are putting in the hours they are contracted to work, accountability will be secured through the management of consultants' contracts, supported by financial and VFM audit as appropriate. We have agreed on the steps we must take to make both the management of contracts and VFM audit more effective.

have we? What are they?

ii. on primarily professional issues, such as whether a doctor is using the most appropriate procedures for diagnosis and treatment, we need to secure accountability through medical audit. Medical audit will need to cover both the clinical treatment of individual patients and services to the population (cancer screening programmes and child development surveillance, for example).

B:DC4.10/35

SECRET

4. This paper is concerned mainly with (ii) - although we must also ensure that nothing falls into the cracks between (i) and (ii). The main focus is on the quality of medical care, which stands up well in comparison with other countries but remains, in places, uneven.

Medical audit in practice

5. Medical audit is a systematic, critical analysis of the quality of medical care, ~~including~~ the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome for the patient. It necessarily requires both a specialised knowledge of current medical practice and access to medical records (which are the medical audit equivalent of accounts). I suggest that we should aim to have a system of medical audit in place, within the next two years, in every District and self-governing hospital.

6. It would be a mistake to prescribe precisely what each system should look like: medical audit is, by definition, primarily a professional matter, and it cannot be implemented by Government without the active participation of the profession. We also need to recognise that

i. medical audit is a relatively recent development in this country. Opinions about its use and value vary, and knowledge of its aims, scope and methods is thinly spread. Yet we need all hospital doctors to be intellectually convinced of its validity.

ii. medicine is an inexact science. Every diagnostic technique and treatment has an inherent element of risk. Medical audit must not encourage doctors to be reluctant to take on difficult but essential clinical work.

iii. we lack comprehensive, robust and professionally acceptable measures of the outcome of the work of individual doctors or of services.

7. In my view, therefore, we must consult the profession nationally about exactly how medical audit would work, and how prescriptive we (or they) should be, so that we can carry them with us. But we must do so on the basis of the kind of system we have in mind. I envisage a two-part approach: medical audit as a regular part of local medical practice; and a system of independent medical audit which can be initiated by management.

8. Subject to the outcome of consultation, I see <u>regular, local audit</u> working along the following lines:

i. every consultant would be expected to participate in a locally agreed form of medical audit, covering both self-audit and peer review. Accountability for the quality of work would be built into the standard job description for all consultants. Medical audit would become a fundamental element of continuing medical education.

ii. District management would be responsible, and accountable, for ensuring that this system was in place; that the work of each consultant's team was subjected to peer review at whatever regular, frequent intervals were agreed locally; and that there was a rolling programme under which the treatment of particular conditions was reviewed by the relevant doctors collectively at regular intervals.

iii. the system itself would be medically led. One approach might be for local practice and procedures to be overseen by a hospital or District medical audit advisory committee, chaired by a senior clinician. Peer review findings would normally be confidential to the consultants involved, unless they agreed otherwise, not least to avoid the risk of exposure to legal action. But it would be all the more important for the lessons learned to be published more widely, as the profession is already beginning to do.

iv. there would probably be a similar advisory committee or equivalent at each Region: partly to oversee the medical audit of less common specialties where a Regional approach seemed sensible; and partly, when necessary, to help doctors at District or hospital level to find consultants from outside the locality to help with peer review.

9. The ability of management to initiate an independent professional audit will be particularly important in the grey area between "management" and "professional" issues (paragraph 3(i) and (ii) above). Typical examples might be an unusually low proportion of day surgery or an unusually high rate of diagnostic tests: both might consume more resources than management believed to be necessary, yet either might be justified by the consultant concerned on clinical grounds. An independent audit could also be important where there was cause to question the quality of a service (for example evidence of unexpected outcomes such as a high death rate), or where the quality of a service was being examined in relation to its cost.

10. The fuller integration of consultants into hospital management should help considerably in such circumstances, but it will remain essential for management to be free to call on some form of peer review. This might often be done through any local advisory committee (8(iii) above), and there might

also be advantage in a formal mechanism for approaching the Region - preferably with the agreement of the local advisory committee chairman. A District general manager should, I think, be free to invoke such a procedure either in respect of a District service or in respect of a self-governing hospital with which the District has a contract.

11. In both routine medical audit and independent professional audit the best results will be achieved where the system works on the basis of consent, both as between doctors and as between clinicians and management. Nor should we underestimate the impact on a doctor of praise, advice or criticism from his peers. But there remains a risk that some consultants would refuse to participate in whatever form of medical audit was agreed locally, or decline to act on the findings of an independent professional audit. I propose we deal with this as follows:

(i) The General Medical Council (GMC) is likely to recommend soon that the medical records of all patients treated within the NHS should in principle be available for peer review, and that audit of medical work should be an obligatory element in continuing medical education. This will be more acceptable, and at least as effective, as any management attempt to enforce participation, and I suggest that we encourage the GMC to proceed accordingly.

(ii) Where a consultant refuses to act on the findings of an independent professional audit, management should invoke the normal disciplinary procedures, on grounds of professional incompetence.

(!) (iii) The quality of medical work should be taken into account in the criteria for distinction awards.

12. An effective system of local medical audit needs strong leadership. This in turn requires time and - experience suggests - some secretarial support (for example to collate and present relevant data). More generally, all hospital doctors will need to devote a significant proportion of their time to taking part. Even assuming every consultant devotes just one-twentieth of his week to medical audit the cost in consultants' time would be around £25 million.

Other Action required

13. If we are to put in place arrangements of the kind described in paragraphs 6-12 of this paper, and are to do so within the two years I suggest, we need to build on the current growth of interest and experimentation within the profession itself. For example:

i. The Confidential Enquiry into Perioperative Deaths (CEPOD), a major study of all deaths within 30 days of surgical operation in 3 Regions, showed that in a small proportion of deaths there were preventable factors. This study is now to be extended nationally, with DH funding, and will be run by the Association of Surgeons, the Association of Anaesthetists, and the Royal College of Surgeons.

ii. The Royal College of Surgeons is now insisting that medical audit is a prerequisite for recognition of a unit for training purposes.

iii. A Royal College of Physicians Working Party will shortly publish a report commending the need for audit and requiring it as a prerequisite for the approval of training posts. They will also publish guidelines on how to undertake audit.

iv. Medical audit is already widely practised in many branches of pathology, where the quality and accuracy of the work is more readily measurable than that of other disciplines. The Royal College of Pathologists have developed protocols for checking standards.

14. Action by Government must be carefully judged to go with the grain of these developments. Our aim must be for Government and management to be supporting, using and reinforcing procedures developed by doctors themselves. There is nonetheless much we can do to generate still greater momentum by working with the profession nationally. In particular:

i. I have asked the statutory Standing Medical Advisory Committee, which represents the full range of authoritative medical opinion, to consider and report on how the quality of medical care can best be improved by means of medical audit, and on the development of indicators of clinical outcome.

ii. we should press all medical colleges to make participation in medical audit a condition of a unit being allowed to train junior doctors, by an agreed date.

iii. we should invite the profession to take part in a national initiative to support and monitor the development of medical audit locally. This might build on existing inspections of training posts, carried out nationally by the Royal Colleges. It might also be possible for each College to establish guidelines for the diagnosis and treatment of common conditions.

iv. we should encourage the further development by the profession of national audit schemes such as CEPOD.

15. I believe we should also insist that a hospital has an acceptable system of medical audit before we can agree to self-governing status. I am considering how best to reduce to a minimum the criteria for self-governing status, but I suggest that adequate medical audit remains one of them. This should prove a useful, additional incentive. Districts buying the hospital's services will no doubt wish to ensure, through their contracts, that an effective system of medical audit remains in place subsequently.

The private sector

16. In principle, medical audit should apply to private as well as public sector hospitals. At present quality control is generally weaker in the private sector: for example, an untrained person can offer surgery, such as cosmetic surgery; and a laboratory can offer to undertake tests, or to provide a service such as breast cancer screening, without any quality control. Medical records tend to be relatively scanty.

17. There is no legal framework within which the Government could impose standards or require the adoption of medical audit. I suggest that the best approach would be to

i. encourage the profession nationally to extend medical audit into private practice. One example of this approach is a current Royal College of Pathologists' proposal to establish an accreditation scheme for private sector laboratories.

ii. encourage the GMC to make peer access to medical records obligatory in the private sector too.

iii. ensure that Districts which buy services from the private sector insist on adequate medical audit being in place before they do so, just as I am suggesting where they buy services within the public sector.

18. These measures, taken together, should prove an effective stimulus to the development of medical audit in private sector hospitals, and should also help further to blur the distinction between the public and private sectors.

II GENERAL PRACTICE

The problem in general practice

19. The circumstances of primary care differ from those in the hospital service in several ways which bear on the nature of medical audit. For example:

i. care is delivered in more places - 10,000 surgeries, plus patients' homes.

ii. periods of treatment are less well defined, so that record and audit systems must handle continuing care, perhaps over many years.

iii. medical records are usually less detailed.

iv. monitoring the work of independent contractors is different in principle from - and potentially more difficult than - monitoring the work of salaried doctors in hospitals.

20. Nonetheless, as in the hospital service, there is a range of problems varying from the almost entirely professional to the mainly organisational. For example:

i. Are we diagnosing breast and bowel cancer early enough? Are referrals to hospital always appropriate, and are all those who need referral referred? Are drugs used effectively and efficiently?

ii. Does the coverage of clinics, and do clinic times, suit patients? Should doctors in partnerships have separate or merged lists of patients. Are relationships between doctors, community nurses and health visitors satisfactory? Is night and weekend cover arranged satisfactorily?

As with hospitals, we need to take primarily management action to deal with (ii), and also ensure that the profession itself takes action on (i) in a way which enables FPCs to invoke peer review procedures whenever necessary.

Action required

21. Again there are valuable professional initiatives on which we can build. The Royal College of General Practitioners (RCGP), in its "Quality Initiative", has shown the way. The Joint Committee on Postgraduate Training in General Practice audits practices in which young GPs are trained. There is also an increasing amount of self-audit, the launching of the new national prescribing information system (described in HC 51) being a recent example. We must press the RCGP to continue to develop and encourage medical audit, and the inspection of training practices and development of criteria of care by the profession will provide useful foundations.

22. Unlike the hospital service, the FPS has little by way of an organisational framework for a universal system of medical audit to fit into. Again the precise arrangements would need to be subject to consultation, but I envisage something along the following lines:

i. the GMC should be encouraged to require peer review access to GP as well as hospital consultants' medical records.

ii. medical audit locally would be based primarily on self-audit by GPs and GP practices. Local practice and procedures would be medically led, supported and encouraged by a medical audit advisory committee established by each FPC.

iii. each FPC would establish a system for identifying possible signs of poor quality care. Many different indicators could be relevant: inadequate records or equipment; inappropriate referrals; emergency admissions resulting from poor health surveillance or failure to refer sooner; avoidable deaths; and so on. Local clinical protocols could be developed on a selective basis (setting out the action required during antenatal care, for example), and clinical records assessed against these protocols. The local advisory committee would help to arrange an external audit of a GP or GP practice where necessary.

iv. each FPC, in consultation with its GPs, would set up a small unit of doctors and other staff to support and monitor the audit procedures of contracting practices. The unit would be accountable to the FPC manager and work under the guidance of the local steering committee. The staff costs and travelling expenses each FPC's unit might average as much as £100,000 a year, or approaching £10 million for England as a whole.

23. In short, as with hospitals, I would suggest a system which is based firmly on the principles of self-audit and peer review but in which action can also be initiated by management.

November 1988

SECRET

Copy No. 2

HC 52

NHS Review

RECONSTITUTING HEALTH AUTHORITIES

Note by the Secretary of State for Health

Introduction

1. We are agreed that we should review the constitution of health authorities in the light of our review proposals, with the aim of making them excecutive bodies. This paper sets out my proposals for achieving this. It also considers the implications of our review proposals for the NHS Management Board.

2. In summary, the key proposals are:

(i) District health authorities (DHAs) would devolve more functions to hospitals but retain responsibility for directly managed services and for monitoring and planning local services. As buyers, they would be accountable to Regional Health Authorities (RHAs) and Ministers for services provided for their residents.

(ii) To minimise disruption, boundary changes would be kept to a minimum. But where DHAs become too small to be viable, for example when hospitals become self governing, mergers may be necessary.

(iii) DHAs should be reduced from their present 16-19 to 5 non executive and 5 executive members plus a non executive chairman.

(iv) Appointment procedures would remain broadly as they are. But local authorities would no longer be able to appoint members.

(v) DHAs would continue to meet in public, with private sessions where necessary.

(vi) No change would be made to Community Health Councils (CHCs).

(vii) Slimmed down regional health authorities would have a continuing role in ensuring that Ministerial policy is carried out and in overseeing the implementation of the review proposals.

(viii) Membership of RHAs should be similar to that of DHAs.

B:D5.26/6

SECRET

(ix) RHAs would be streamlined by delegating or contracting-out existing non head office functions e.g. hospital design and computer and legal services.

(x) The NHS Management Board (NHSMB) under Ministerial chairmanship would continue to be part of the Department of Health (DH), not divorced from it.

(xi) The Board would focus on strategic and policy issues. The present Health Services Supervisory Board would go.

(xii) Day to day operational issues would be handled by an executive committee, chaired by the Chief Executive.

District health authorities

(a) Existing responsibilities

3. Annex A lists current DHA responsibilities. Briefly, these are to assess the health needs of the local population and monitor the effectiveness of the services provided; to manage health services in the district, including the provision and development of community health services; to integrate, with primary care and social services, the planning of general hospital services and services for the priority groups - the elderly, mentally ill and mentally handicapped; and to provide clinical facilities for medical education.

(b) Future role

4. One of the themes of the White Paper will be the need to build on the introduction of general management into the hospital service by pushing down further decision-making to the unit level. I shall need to scrutinise their functions to make sure this is done to the fullest possible extent. The proposals in HC46 for introducing self-governing hospitals will accelerate the process in those DHAs where the main acute hospital becomes self-governing. DHAs will however retain responsibility for the management of the remaining services, including hospitals for the priority care groups and their key responsibility for monitoring and planning the provision of services in their locality. Crucially, as the buyers of services for their resident population, they will also continue to be accountable to RHAs and Ministers for the quality and cost-effectiveness of the services provided for their residents.

(c) Size of districts

5. While these changes will signal a major shift in responsibilities in all DHAs from the health authority to the hospital unit, it is in the smaller, single DGH districts where the impact will be greatest. It may therefore be desirable to merge some of the smaller districts in order to create a viable health authority. District mergers are disruptive and can cause considerable controversy locally. I would therefore want to keep

the number of boundary changes to the minimum necessary. In putting forward proposals for self governing hospitals, RHAs should be asked to consider the options for sensible mergers as part of their submissions.

(d) Membership of DHAs

6. Annex B sets out the present constitution and membership of health authorities and their statutory basis. It is clear from this that health authorities are not presently constituted as management bodies. As a result, they do not always supervise their managers adequately. Neither does the size and membership of DHAs lend itself to crisp decision-making. In recent years, there have been many examples of health authorities becoming bogged down in local politics. I therefore propose that DHAs should be reduced from their present 16-19 members to 5 (non executive) members and 5 executive members plus a non-executive chairman. The non-executives would be chosen in particular for their managerial and financial skills and there would no longer be any local authority members as of right. DHAs that covered a teaching hospital should include a representative of the medical school. The executive members would include the general manager and up to 4 other officers. This would enable the district medical, nursing and finance officers to be included.

7. The basis for the appointment of DHA members is set out in the 1977 NHS Act and we shall need primary legislation to amend this.

(e) Members' appointment procedure

8. As I have indicated, a central role of the newly-constituted DHA will be to act as the buyer of services on behalf of its resident population. It is therefore operating in effect on behalf of the local community. The removal of local authorities' (LAs) statutory right to appoint members directly will be highly contentious and will need careful presentation, not least to some of our own supporters. RHAs should retain the right of appointment of DHA members in order to avoid complaints about excessive centralised patronage. In future RHAs would not be bound by the LAs' recommendation but where there are good candidates, they would be appointed on their merits. DHA Chairmen would continue to be appointed by the Secretary of State.

(f) Community Health Councils

9. Because of the sensitivity of the DHA membership issue, I am not proposing any changes in the LA membership of Community Health Councils (CHCs). At present, local authorities appoint half of the CHC membership. The remaining third are appointed by the voluntary organisations and a sixth by RHAs. While this

inevitably politicises many CHCs, DHAs are experienced at dealing with them. I therefore see no need to alter the membership of CHCs or make any other changes to their role. In the White Paper we can stress their continuing importance as the local consumer watchdog.

(g) DHA meetings in public

10. As we recognised at our last meeting, there is no need to make any change in the existing requirement under the Public Bodies (Access to Meetings) Act 1960) for health authorities to hold their meetings in public. Authorities already have some discretion under this Act to exclude the public e.g. because of the confidential nature of the business to be transacted.

Regional health authorities

(a) Role and functions

11. Annex C lists current RHA responsibilities. I believe that a slimmed down regional tier should continue to be the main vehicle for ensuring that Ministerial policy is being carried out on the ground. RHAs will also have a crucial role in managing the changes brought about by the White Paper. In my view the size and nature of the management task are such that these changes could not be managed by regional arms of the Department. RHAs contain the necessary local knowledge and act as an important buffer between Ministers and the operational level. The changes I propose below in the membership of RHAs will strengthen them for their task of ensuring that our proposals are carried out in the most efficient and effective way.

(b) Membership of RHAs

12. Membership at regional level should match that at the district level. That is, RHAs should comprise 5 non executive members and 5 executive members plus a non executive Chairman. It would be desirable for medicine, the relevant university and FPC interests to be represented if the latter are made accountable to RHAs. As at present, members and Chairman would be appointed by the Secretary of State.

(c) Reducing the size of RHAs

13. Following the introduction of general management into the NHS, RHAs are already signed up to devolving as many functions as possible to districts and their units. But I have no doubt that there is further scope for reductions in RHAs' staffing and costs. It is important however to distinguish the "head office" functions invested in RHAs - principally the development and monitoring of services and the allocation of resources - from RHAs' current responsibilities for providing certain technical and support services such as computers and supplies.

14. The scope for savings in RHAs' "head office" functions will be modest, if they are going to manage districts effectively and spearhead the introduction of many of the reforms which will emerge from the Review. But I am convinced that scrutiny of the remaining RHA functions will produce many blocks of work which can be streamlined, delegated to districts, or contracted out altogether. Indeed many Regions have already begun the process, so the scope for action varies from Region to Region. The work which can be streamlined or disposed of includes management services, design of hospitals, storage and distribution of supplies, computer services, and legal services. The effect of these proposals on the size of RHAs will vary from region to region but I would expect to see a significant reduction. My aim is that, after taking account of the additional work Regions take on in implementing our proposals, there should be a net reduction in their staffing and costs.

The role of the NHS Management Board

15. There are many people and bodies within the NHS who demand that the NHS Management Board should be divorced from my Department, under independent chairmanship. Although the distancing of NHS management from Ministers clearly has some attractions, the disadvantages are even greater. I do not think so large and politically sensitive a public service, which is going to continue to be overwhelmingly vote financed, can in practice be separated from the political process. A separate Board would resemble nothing so much as the Board of a nationalised industry. Parliament would not tolerate Ministers trying to hide behind the Board to avoid responsibility for key issues. An independent Board would quickly become an extra tier in the management chain between Ministers and the real health services and, almost certainly, a new lobby for more public money. I believe therefore that we should use the opportunity of the White Paper to refute the case for separating the NHS Management Board from Ministers and the Department of Health.

16. We would however streamline management arrangements within the Department by giving the Board a clear role in major NHS strategic issues.

17. I propose four main changes:

first, responsibility for the family practitioner services will be brought under the Board. The better integration of primary care with hospital services is an important objective.

second, the Board, - as now under Ministerial chairmanship - would deal with strategic and policy issues, as well as the more critical operational matters. The Board would be reduced in size and reconstituted to contain a higher proportion of non-executive members appointed from the commercial and industrial worlds.

third, as in most companies, much of the day to day work would be handled by an executive committee of the Board chaired by the Chief Executive.

fourth, the Health Services Supervisory Board would no longer have a role to play and would go.

ANNEX A

THE RESPONSIBILITIES OF DISTRICT HEALTH AUTHORITIES

The functions of DHAs are as follows:

1. Promoting health, preventing illness and planning services

   - review the status of health of the population and assess needs;
   - develop strategic and operational plans;
   - implement plans;
   - liaise with local authorities; FPCs and voluntary sector;
   - produce guidelines for local service developments;
   - evaluate outcome.

2. Performance and review

   - setting objectives and targets for units;
   - monitoring and reviewing performance against targets.

3. Provision of Patient Services

   - hospital and other accommodation;
   - medical, dental and nursing services;
   - facilities for the care of expectant and nursing mothers and young children;
   - facilities for the prevention of illness, including health education and promotion;
   - arrangements for surveillance, prevention and treatment of communicable diseases;
   - arrangements for the proper care of persons suffering from or recovering from illness or disability;
   - other services required for the diagnosis and treatment of illness including domiciliary nursing and other forms of care provided in the community, including collaboration with local authority;
   - medical and dental inspection and treatment of school children;
   - family planning advice, treatment and supplies;

- facilities for private patients.
- services to local authorities to enable them to carry out their social services and education functions;
- facilities for clinical teaching and research;
- health centre accommodation;
- assistance in the conduct of relevant research.

4. Finance

- provide management accountancy function;
- analyse financial data including identification of potention over/under spends;
- ensure DHA financial strategy is achieved.

5. Personnel

- reconcile units' collective demand with national etc policies and estimate impact of local authority, private or voluntary sector requirements; determine manpower requirements for District functions; reconcile collective demand with resource assumptions;
- identify sources of supply for staff groups where district can be self sufficient (e.g technical and nursing staff);
- establish policies and targets for recruitment, retention, return, deployment; monitor performance; establish manpower targets (where relevant, eg. (Administrative and Clerical);
- monitor effective skill mix;
- promote image of NHS as employer locally; maintain contact with local education system, careers service, Department of Employment.

6. Building and Estates

- management of delegated capital budgets;
- procurement of minor health building schemes;
- monitoring of unit compliance with fire, health and safety standards; etc
- control of smaller disposals and Joint planning with local authorities and FPCs on estate matters;

- monitor cost effectiveness of unit based maintenance staff.

7. Support Services

- ambulances;
- transport;
- sterile supply;
- laundry.

ANNEX B

CONSTITUTION AND MEMBERSHIP OF HEALTH AUTHORITIES

Regional and District Health Authorities

1. It is the duty of the Secretary of State by order under Section 8 of the NHS Act 1977 to establish Regional and District Health Authorities for such regions and districts as he may specify. Under Schedule 5 to the Act, the Secretary of State may specify how many members shall constitute a RHA or a DHA. The chairman and members of a RHA shall be appointed by the Secretary of State, as shall the chairman of a DHA. The Secretary of State shall consult on the appointment of members of a RHA except in some prescribed circumstances. A specified number of members of a DHA shall be appointed by the relevant local authority and the remainder by the relevant RHA, either after consultation with or on the nomination of various other bodies, including any university whose medical school is associated with the district. There are limited exceptions to the RHA's duty to consult.

2. RHAs are constituted and their regions specified under subordinate legislation (SI 1981/1836 and SI 1975/1100). The constitution of DHAs and the districts for which they are to act are specified in SI 1981/1838 and SI 1981/1837. Under these provisions, 14 RHAs and 190 DHAs have been constituted. These each consist of a chairman and between 16 and 19 members. The composition of DHAs is set out in the appendix.

3. SI 1983/315 provides for the appointment and tenure of office of chairman and members of RHAs and DHAs and for the procedures of those authorities. Terms of office shall not exceed four years. The procedural requirements include rules as to meetings and proceedings of authorities, disability on account of pecuniary interest and the appointment of committees and sub-committees.

Special Health Authorities

4. The Secretary of State has discretion to establish Special Health Authorities by order under the NHS Act 1977 to carry out such functions as he shall direct. The Secretary of State specifies by order the number of members who shall constitute each SHA and appoints the chairman and members. There are regulations governing the procedures of SHAs and the appointment and tenure and office of their chairman and members.

APPENDIX

COMPOSITION OF DISTRICT HEALTH AUTHORITIES

1. The membership of DHAs is governed by Schedule 5 to the NHS Act 1977, the NHS (Constitution of Districts) Order (SI 1981/1838), and by Departmental guidance (Health Circular (81)6). The position is as follows:

Chairman

Appointed by the Secretary of State who is not required to consult before doing so.

Membership

There are 16-19 members per DHA. On average 12 are appointed by the RHA and 4-6 by relevant local authorities. The membership is comprised as follows:

Appointed by RHA

(i) one hospital consultant (ii) one general medical practitioner (iii) one nurse, midwife or health visitor.	The Act only requires RHAs to consult appropriate medical and nursing bodies before making appointments. These specific appointments are required under HC(81)6.
(iv) a nominee/s of the appropriate university medical school (1-3 members)	The Act requires the RHA to appoint a university nominee - Teaching Districts and those with a dental school have additional members under SI 1981/1838
(v) On average 8 generalists including members drawn from the wider TU movement	The number of generalists is prescribed in the constituting SI 1981/1838 but under the Act the RHA has to consult "any federation of workers organisations who appear to be concerned". There is no TU place as of right.

Appointed by Local Authorities

(vi) 4-6 LA members	The Act gives LAs direct right of appointment. The RHA has no leverage here whatsoever. The

Constitution Order (SI 1981/1838) specifies the numbers of members which relevant LAs can appoint to each District. Maximum 4 year term, but LAs decide expiry date.

ANNEX C

THE RESPONSIBILITIES OF REGIONAL HEALTH AUTHORITIES

The functions of RHAs are as follows:

1. Planning, Performance and Review

   - establish regional strategic and operational plans;
   - management of capital programme;
   - management of performance and accountability review process;
   - facilitation of joint planning.

2. Finance

   - allocation of resources to districts;
   - monitoring of spending against operational objectives;
   - monitor cost improvement and other VFM activities;
   - manage funds for regional specialties and capital programme.

3. Personnel

   - guidance to districts on personnel and industrial relations;
   - hold medical consultants', registrars' and senior registrars' contacts.

4. Building and Estates

   - provision of design services;
   - provision of specialist technical services;
   - advise on disposals;
   - provision of technical advice/skills on estate matters.

5. Managed services

   - manage

     blood transfusion service

     ambulance service

- provide services to districts

  central stores

  computing services

  management services

  legal services

SECRET

DRAFT

FUNDING THE HOSPITAL SERVICE

Note by the Chief Secretary to the Treasury and the Secretary of State for Health

This paper considers the mechanisms by which:

a. the Department of Health allocates funds to regional health authorities

b. regions allocate funds to district health authorities, and

c. districts fund hospitals, including both self-governing hospitals and those managed by the districts.

Introduction

2. As a Group we are agreed that RAWP, the present system for allocating funds to regions, should be transformed into a simpler system along the lines of the model set out in paper HC35. Under the new system, regions would be funded by the Department on the basis of "weighted capitation" (total population adjusted for age structure and morbidity). There would be no published "targets". Regions would fund districts broadly on the same basis, and hospital funding would be based much more than now on performance and success in attracting additional patients. Cross-boundary

flows (of patients across health authority borders) would be handled by way of cash payments from the district in which the patient resided to that where he or she was treated.

3. We are also agreed that health authorities should continue to be responsible for securing those "core" services which have to be available locally: casualty, urgent medical treatment, paediatric services, maternity and ante-natal care, some types of long stay care, and so on. Hospitals must be funded in order to make these available on demand, as now. They would also compete for contracts to supply other types of service, mainly elective surgery, to districts, who would be acting on behalf of their local populations.

4. This new system will introduce new incentives to improve efficiency. Health authorities will secure health care from the hospitals they consider best able to provide it, while hospitals will be able to compete for business from both their own district and other health authorities. Under the present system, by contrast, money is allocated largely according to where the hospitals are, irrespective of their efficiency. The RAWP process has been seeking over several years to equalise the spread of hospitals between regions, with considerable upheaval and protest in consequence.

5. When fully operational, the new system will make redundant the present role of regions in allocating funds to districts and the adjustments to regional and district funding on account of cross-boundary flows. But both will have to be retained during the

transitional period. So it is important to keep in mind the distinction between regions and districts in moving to the new system. The problems are quite different at the two levels. We look first at the regions.

The regional transition

6. Until we end the role of regions in allocating funds, the aim should be to fund regions year-by-year, transforming RAWP into a simpler system. Allocations would be based on regional populations, weighted according to age structure and demographic mix, with some adjustment for, eg, London weighting pay costs. There already exist generally accepted methods for doing this, based on the average cost to the NHS of people in different age groups. The overall health of the region's population would also figure, although the precise method would have to be considered further. There is a range of possible indicators that could be used here, and further study is needed of which would be the best and most acceptable measure. The Department of Health will bring forward proposals in due course.

7. It will be essential to remove the present arrangements where cross-boundary flows are reflected only in complicated, obscure and belated modifications to population weightings. Instead there would be explicit cash adjustments based on the most recent data for numbers and up-to-date costings of different types of treatment. (Such costings are expected to start becoming available in 1990.) Moreover, these adjustments would, unlike the present system, be made to allocations, ie the money paid to the regions,

and not to the artificial targets. In this way, cross-boundary adjustments would become much fairer and much more transparent. Ultimately, as the transition at district level proceeds, the need for regional cross-boundary adjustments would fall away.

8. Getting to the new distribution of funds will be a problem. The existing pattern of allocations is unlikely to match it very well. Just how great will be the mismatch can best be judged from the existing RAWP targets, which are the best indication we have of the shift in funds that would be implied by an immediate switch to a weighted capitation system. This is discussed further in Annex A, which shows that while most regions are now fairly close to target, quite sizeable transitions are still implied for three - NE Thames, NW Thames and East Anglia.

9. There are three broad options for managing the transition:

a. move to a weighted capitation system as soon as possible, with if need be some transitional "buying out" of those regions now below RAWP targets

b. an immediate move to weighted capitation for the 11 regions within 3% of RAWP targets, phasing in the system for the other three

c. bring all regions to a weighted capitation distribution, perhaps over a period of, say, three years, with those above target losing resources to those now below target.

10. The "levelling up" implied by the first of these options would be very expensive indeed: full levelling-up, without imposing cuts or freezes elsewhere, would cost well over £3/4bn a year, while anything less would mean that significant disparities would remain. Nor do we think it would be acceptable to treat a minority of regions differently from the rest, as the second option would imply: this will create confusion, and would if anything prolong rather than remove the problems created by RAWP targets.

11. So in our view the best course would be a phased adjustment. This could be achieved over 3 years from 1989, although some residual transitional protection might be needed for NE Thames. Those regions who lost money would not however be obliged to respond with unplanned hospital closures: their hospitals will, under the new system of "contractual" funding, be able to compete to attract patients from outside the region.

12. To sum up, therefore, we recommend moving to the new weighted capitation system, with no published "targets" different from the cash allocations. This would be over a period of 3 years with cash adjustments for cross-boundary flows. After the transitional period, allocations would be set year-by-year based on the new, simplified formula.

The transition for districts

13. At present districts are funded by regions, but on varying bases. Some use formulae akin to RAWP, but most fund their districts according to where hospitals happen to be located. Under

the new system, we would propose, as with regions, to move to weighted capitation allocations, with direct payment between districts for cross-boundary flows.

14. But there are significant complications to the district-level transition:

- the change will have to run alongside the move to contractual funding for hospital services. It will take time to develop a system for districts to enter into contracts with hospitals which make sense in terms of financial management without unacceptably limiting the ability of GPs to refer their patients to where they can be treated quickest or most cost-effectively;

- variations in provision between districts are much larger than between regions, and it would be placing an unrealistic weight on cross-boundary adjustments to expect them to compensate for all differences between population and provision;

- any shift in funds away from inner city areas with historically high hospital use to suburban and rural areas would have to take account of differences in primary care standards, and be managed carefully over time; and

- the capital charging system proposed in HC56 (not yet discussed by the Group) will have differing impact on districts, according to the state of the capital stock they inherit, and will have to be phased in carefully.

15. For these reasons, the transition to weighted capitation at district level is likely to take longer than that at regional level.

16. A start cannot be made without improved information at district level about population, movement of patients and costs of different types of treatment. Once that is available, and it should come naturally from the improved information systems we are proposing more generally, cross-boundary flows could be dealt with by a rather similar process to that for regions.

- Explicit cash adjustments would be made to allocations in anticipation of cross-boundary flows based on the previous year's experience. Until we have legislation allowing inter-district charging, allocations to districts would be net of such adjustments.

- Districts would then physically pay the adjustments to each other, once the necessary legislation was in place, the amounts being determined in the first instance by a formula set at regional level.

- Finally, regions would stand back entirely from the process of cross-boundary payment between districts. The payments would simply follow as a result of contracts agreed between districts. Regional formulae would no longer be needed.

17. To sum up, the transition at district level will take longer than at regional level. Substantial progress should be possible within about 5 years, but the information is not yet available on which to base a firm timetable. The Department of Health will come forward with proposals within a year. The general principles - the objective of weighted capitation funding and transparent cross-boundary charging - are however the same as for regions. Once "contractual" funding is in place, cross boundary adjustments to allocations and - ultimately - the regional role in funding can be phased out. The internal market will predominate.

Performance funding of hospitals

18. The final stage in the resource allocation process is the passage of money from districts to hospitals. Once the new system is fully operational, there will be automatic performance incentives, since districts will be seeking the most cost-effective deals from hospitals. But during the transitional period, a system of top-sliced performance funding, along the lines set out in HC27, is necessary. This will help to deal with the common complaint that hospitals which increase their efficiency cannot make commensurate improvements in the numbers of patients they treat without some additional funding to cover the variable cost element of treating those extra patients. The scheme would also include incentives for some hospitals to concentrate on waiting list cases and to draw in patients from elsewhere so as to have the maximum impact on waiting lists. The amount of money to be set aside for the scheme within the agreed total provision for health expenditure should be the subject of annual discussion between us in the public expenditure survey.

Self-governing hospitals

19. There is no reason why the process of transition to the new funding arrangements should delay the programme of self-government in hospitals. It is of the essence of self-governing hospitals that they will be funded by contracts with districts. We need to ensure that districts are ready to negotiate these contracts, possibly before they are set to move into "contract funding" more generally. To that extent, the introduction of self-governing hospitals will help to accelerate the pace of change at district level. These hospitals will need contracts to supply both "core" and "contract" services on behalf of local districts. Further work by the Department of Health is in hand on the form that these contracts will take, and on the costings that will underpin them.

20. One effect of hospitals switching to self-governing status may be to denude some districts of most of their functions. They will need to amalgamate with other neighbouring districts. If districts had already merged with the - in terms of area, larger - FPCs, which the Group has agreed should be included as a consultative option in the White Paper, this subsequent disruption might be avoidable.

GP practice budgets

21. While there is agreement that the principle of GP practice budgets has attractions, the Treasury have reservations about the practicability of a full-blown scheme. This is to be addressed

separately. Assuming for the moment, however, that these problems are resolved, GP practice budgets would be an alternative mechanism for funding part of the acute hospital sector. The money for them would therefore need to come out of the hospital and community health services budget, not the FPS.

22. Whether the allocation should be made by districts or by regions depends on whether a decision is taken to merge districts and FPCs. If we go ahead with merger, it would be logical and sensible to give the merged bodies responsibilities for setting budgets for those practices who opt to hold them. If however districts and FPCs remain separate, there would be problems of accountability if districts are allocating money to GPs who are then not responsible to FPCs for their stewardship of it. It would be better in these circumstances to give the responsibility to regions, to whom both districts and FPCs would be reporting.

Capital

23. The capital programme is at present allocated to regions. We see no need to change this principle, although the formula on which it is based will in future need to be the same as that for current expenditure.

24. Self-governing hospitals would have to bid against regional budgets if they wished to undertake new capital investment, as would districts. In both cases, they would do so in the knowledge that appropriate capital charges would have to be paid from their income. They would be required to produce investment appraisals

which would demonstrate the soundness of the proposed investment against the normal criteria applied to NHS capital projects. We considered whether self-governing hospitals should be relieved of this discipline, but concluded that they should not. Their capital investment should pass the same value for money tests as anywhere else in the public sector.

Timetable and summary

25. The proposals in this paper may be summarised in the form of the following schematic timetable.

April 1989 - Transitional allocations, based on existing RAWP formula, but with more transparent cross-boundary adjustments.

- Begin work on improved information about population etc at district level.

April 1990 - First year of transition to new weighted capitation formula as basis for allocations to regions.

- Experimental schemes for contractual funding of hospitals

- New top-sliced performance funding scheme.

April 1991 - Introduction of explicit cash payments for cross-boundary flows between districts; no adjustments to regional allocations.

April 1992 - Extend contract funding to all districts

- Cross-boundary adjustments negotiated between districts.

- Transition to weighted capitation at regional level complete

April 1994 - Introduction of contract funding completed; cross-boundary adjustments at district level and performance funding phased out.

April 1995 - Substantial progress towards weighted capitation at district level.

ANNEX A

REGIONAL ALLOCATIONS AS COMPARED WITH WEIGHTED CAPITATION

The best proxy for weighted capitation that is available at present is RAWP targets. These give distributions between regions, according to population, adjusted for age mix, morbidity and cross-boundary flows. The follcwing table shows the actual allocations in 1989-90 (with estimates in brackets of what the figures would be without adjustment for cross-boundary flows), and the distances of the allocations from target in 1988-89 and 1979-80. Most regions are within two or three percentage points of target now, except for East Anglia (4% below) and NW and NE Thames (4½% and 7% respectively above target). While the changes in individual regions vary quite considerably over the period - compare, for example the progress of NE and SE Thames respectively towards target - largely as a result of the targets themselves shifting with population changes, the general picture is of very considerable movement towards target, and hence a more equal spread of provision across the country.

	Allocation 1988-89 (and estimated allocation without cross-boundary flow adjustment) £m	Percentage distance of allocation from target 1988-89	Percentage distance of allocation from target 1979-80
Northern	735 (731)	- 1.56%	- 7.47%
Yorkshire	830 (834)	- 1.39%	- 3.68%
Trent	1010 (1034)	- 2.70%	- 7.25%
East Anglia	438 (426)	- 3.99%	- 5.10%
NW Thames	808 (837)	+ 4.46%	+12.98%
NE Thames	1007 (987)	+ 7.29%	+11.46%
SE Thames	898 (905)	+ 1.69%	+10.03%
SW Thames	746 (754)	+ 0.97%	+ 5.90%
Wessex	615 (625)	- 1.79%	- 3.70%
Oxford	482 (494)	- 2.58%	+ 0.58%
South Western	732 (721)	- 1.39%	- 4.01%
West Midlands	1186 (1174)	- 1.32%	- 5.81%
Mersey	586 (583)	+ 1.48%	- 1.00%
North Western	1005 (972)	- 1.35%	- 8.76%
Average distance from target	-	2.43%	6.27%

From: Robin Cook MP

HOUSE OF COMMONS
LONDON SW1A 0AA

Rt Hon John Moore MP
Secretary of State for Social Security
Richmond House
79 Whitehall
LONDON SW1A 2NS

7 November 1988

Dear John

I was greatly taken with the Chancellor's announcement this afternoon of a new scheme to provide additional help to pensioners. I am writing to clarify quite what the Government has in mind and I should be grateful if you could answer the following points.

Why was this scheme omitted from the uprating statement in the House ten days ago?

How many pensioners will benefit from it?

What is the estimated cost of the scheme?

Will it be funded by extra resources or from within the existing planning figures for your Department's budget?

I look forward to receiving your response.

Yours sincerely

Robin Cook MP

dg8.11.3

MF P/folder.

FROM: D P GRIFFITHS
DATE: 7 November 1988

MR GIEVE

cc PS/Chancellor
PS/Chief Secretary
PS/Paymaster General
Mr Anson
Mr Phillips
Miss Peirson
Mr Saunders

NHS SERVICE CUTS

This is to let you have advance warning of potentially controversial service cuts likely to take place at the Royal West Sussex Hospital in Chichester District Health Authority.

2. At the end of August the Hospital was over-spent by £150,000 and if this trend were to continue the District's total overspend could be £300,000 by the end of the financial year. This would be the second year running in which the Hospital was over-spent despite having been given additional resources this year. The DHA considers the only way to avoid an overspend is to cut services.

3. The proposals being put to the DHA entail the closure of 2 female surgical wards with the loss of 42 beds. other bed use would need to be adjusted accordingly to maintain adequate emergency capacity and a balance between the sexes. Effectively this means eliminating elective surgery for the rest of the year with a rise in waiting lists of up to 1,000 cases. The proposals are due to be discussed at the DHA's public meeting on 8 November.

Line To Take

4. These are temporary measures to bring the authority's spending back into line. The DHA will receive substantial growth monies next year (£650,000) and is undertaking a major review of its priorities aimed at securing a sounder basis for managing its acute services.

D P Griffiths

D P GRIFFITHS

chex.mw/docs/health SECRET

FROM: MOIRA WALLACE
DATE: 7 NOVEMBER 1988

CHANCELLOR

cc PS/Chief Secretary

HEALTH - AIDE MEMOIRE

We agreed that, as it was now too late to send a minute round, I would concoct an aide memoire based on Dick's revised draft, and the points made at the briefing meeting.

Funding

- on **RAWP**, present system unpopular enough, but transition proposals worse. Some regions still some distance to go to reach targets. Closedown in one year would mean sudden big gains for below-target authorities who have gained steadily over the years, but nothing for others who have been steadily squeezed. Recipe for disaster.

- better to let present system finish its job (3 or 4 years?). Then have regular **annual reviews**, based on **more up-to-date** information, to deal with minor population changes promptly.

- contest bid for **top-sliced money** to be additional

Reconstituting Health Authorities

- **regions acquiring more functions than losing** eg managing RAWP or successor, running capital charging , oversight of GP budgets, cost control of FPS, managing transition to self-governing hospitals. Are they the right people for the job? And if so, are we really slimming down regions?

Managing the FPS

- DoH paper brings out unsatisfactoriness of status quo. Lack of effective management, and inadequate information about activity, costs, outcomes, efficiency. So agree need to beef up FPCs.

- but present proposals don't go far enough. Last thing want to do is create new beefed-up tier of health administration but still leave it spending someone else's money, and with no incentives to take tough decisions itself. Still believe cash-limiting FPS the only way to set up effective management structure, and create incentives for more economical prescribing,referrals etc.

- also still favour merging FPCs and DHAs. For every other tier accept need for better integration of primary care and hospital services (eg HC52, para 17 proposes FPS to be brought under NHS management Board). Why not at district level? Paper expresses concern about "interests of hospitals dominating those of primary care" (HC51 para 26). But in recent years the squeeze has been the other way. Isn't it time to rectify that?

- also concerned about detail of proposed GP practice budgets. If we set budgets on capitation basis, doctors who opt will be mainly those with large numbers of privately insured patients (and therefore below average referral costs). But if we allow optant GPs to refer to private hospitals, risk of patients who would otherwise have got private treatment at BUPA's expense getting it paid for from public money. Alternative of detailed controls over circumstances in which optant GPs can refer to private sector bureaucratic and hard to defend politically.

- suggest more limited scheme with better vfm. GPs given smaller budgets for selective use at public or private hospital for patients already on waiting list for some specified time.

Loose ends

Issue reminder that all proposals must be costed.

Ask for paper on consultants. Still await the Griffiths plan.

Raise handling of health indicators?

MOIRA WALLACE

CONFIDENTIAL

08 NOV 1988

PRIVY COUNCIL OFFICE
WHITEHALL. LONDON SW1A 2AT

7 November 1988

Mrs. M. E. Brown
PPS, CST Sir P. Middleton
Mr. March, Mr. Allen
Mr. Moore Mr. Tarkowski
Mr. Revolta Mr. S. Wood
Mr. Tyrie Mr. Call.

cc: Mr. Phillips Mr. Saunders
Miss. Peirson

Dear Roger,

The Lord President held a meeting at 10.45 today with your Secretary of State, the Lord Privy Seal and both Chief Whips to discuss some outstanding handling issues on the Water Bill, the Football Spectators Bill and the Housing and Local Government Bill. The Financial Secretary, Treasury was present during the discussion of the Water Bill. Also present at the meeting were First Parliamentary Counsel and Anthony Langdon and Shaun Mundy (Cabinet Office).

Water Bill

Your Secretary of State said that, as he had indicated in his letter of 26 October to the Lord President, he now believed that it was necessary for the Water Bill to receive Royal Assent by the end of June. He intended that a number of issues which could have an important bearing on flotation should be dealt with in secondary legislation rather than on the face of the Bill. There was a risk that confidence in the flotation would be undermined if there were any uncertainty about the content of the secondary legislation as would be the case, for example, if negative resolution instruments remained subject to annulment. The Financial Secretary, Treasury endorsed your Secretary of State's remarks.

In discussion, it was noted that the alternative of incorporating into the Bill those matters which it was currently intended to deal with by way of secondary legislation was very unlikely to be practicable. It was clear that such provisions could not be got ready in time for the introduction of the Bill, which meant that they would need to be introduced by way of amendment. This would expose a voluminous series of mainly technical provisions to detailed debate and would considerably complicate the passage of the Bill.

The Lord President said that, while the Business Managers clearly could not guarantee that enactment could be secured on the timetable proposed by your Secretary of State, they believed that, provided the Bill was introduced right at the start of next Session and was made subject to an early and demanding guillotine motion, it should be possible to deliver Royal Assent by either the end of June or the very beginning of July. This would leave sufficient time for those Orders which might have an important bearing on flotation to be approved before the Summer Recess.

Football Spectators Bill

The Lord President said that it had recently emerged that, in terms of the overall handling of next Session's legislative programme, there might well be a strong case for introducing the Football Spectators Bill in the House of Lords rather than, as presently planned, in the House of Commons. An arrangement under which your Department's Bills did not all begin in the Commons might also be helpful to Ministers handling the Bills.

Your Secretary of State indicated that he would be content in principle for the Football Spectators Bill to be introduced in the Lords.

Contd 2/ . . .

The Lord President said that he was most grateful to your Secretary of State for his willingness to assist on this matter. The next step would be for the Chief Whip, Commons to explore the possibilities with the Opposition so that a judgment could be made about whether it would indeed be in the best interest of the overall handling of next Session's programme for the Football Spectators Bill to be introduced in the Lords. If the decision were made to introduce the Bill into the Lords, the Lord Privy Seal would be looking to receive it before Christmas or, at the very latest, by mid-January.

Housing and Local Government Bill

The Lord President said that he had seen a copy of your Secretary of State's letter to the Chancellor of the Exchequer about the possibility of incorporating into the Housing and Local Government Bill provisions to extend the role of the Audit Commission to cover the Health Service. He was concerned that the expansion of the Bill to deal with Health Service matters would greatly complicate its passage. Your Secretary of State added that this would also raise controversial issues relating to the role of the National Audit Office in auditing the Health Service. It was agreed that there should be a meeting between the Lord President, your Secretary of State and other interested Ministers; and I confirm that we will put in hand the arrangements for this.

Your Secretary of State said that, as he had indicated in his letter of 26 October to the Lord President, he felt on balance that it would be better to deal in the Housing and Local Government Bill with those provisions on the local government ombudsman which were earmarked for a handout Bill. However, while it would certainly be useful to implement the proposals on this topic, this was not a matter to which he attached high priority. It was noted that it would be apparent well before the introduction of your Bill whether or not a Private Member had taken up a handout Bill on this subject and it was agreed that, in the event that the Bill were not taken up, further consideration should be given to whether the provisions could be included in the Housing and Local Government Bill.

I am copying this letter to Private Secretaries to Ministers present at the meeting, First Parliamentary Counsel, Anthony Langdon and Shaun Mundy.

Yours,

Alison

ALISON SMITH
Private Secretary

Roger Bright Esq
Private Secretary to the Secretary of
State for the Environment
Department of the Environment
2 Marsham Street
LONDON
SW1P 3EB

OK as [illegible] by PM.

Ch

Peter enquired abt this & I showed him draft. He suggested omitting "off-the-record" from beginning of 4th para, so as not to raise that hare.

See also Amber Tyne! ~~[illegible]~~ redraft below. [illegible]

[illegible]

chex.ps/aa/87

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

8 November 1988

Gordon Brown MP
House of Commons
LONDON
SW1

Thank you for your letters of 7th and 8th November.

As I told the House, very clearly, on 7th November, what the Government is working on is a plan to provide extra help for poorer pensioners.

I note that your letters are merely a smokescreen intended to obscure this welcome news.

As for my ~~off the record~~ remarks to a group of journalists on Friday, I regret that no transcript exists. But today's Daily Telegraph published an account supplied by the most senior of the journalists present. So far as I can recall, it is broadly accurate. As you will see, nothing in it remotely justifies either the scare stories published in the Sunday press, or the allegations you and your colleagues have seen fit to make on the basis of those stories.

To repeat, what we have in mind is extra help for poorer pensioners, over and above the basic State pension, which itself will continue to be uprated in line with prices.

I hope you will accept this and cease repeating what you know to be untrue.

NIGEL LAWSON

cst.rj/docs/9.11.1

Andrew Tyrie draft.

DRAFT REPLY TO GORDON BROWN MP

On 7th November I told the House that the Government was working on a plan to provide extra help for pensioners most in need. I made it clear that, apart from this extra help, the Government has no plans to alter existing help to pensioners.

Neither you in your letter to me nor Mr Kinnock in the House have had the guts [good grace?] to welcome this news.

No transcript exists of my off the record remarks to a group of journalists on Friday. Last night's Evening Standard carried an account supplied by the most senior of the journalists present which appears to be broadly accurate. That transcript does not justify the scare stories published in the Sunday press, as you well know.

Ch:

SOCIAL TRENDS

This just won't go away. Spachman now tells me authors say they cannot square our proposed rewording with their statistical consciences. (excluding the "don't knows" the problem, apparently) They want the rewording I've marked in pencil on my minute behind.

What next? [A propos, I will let PEM's office know of this further hitch since Mr Spachman has not committed it to paper]

MPW.

chex.ps/mw/26 **RESTRICTED**

FROM: MISS M P WALLACE
DATE: 8 November 1988

MR SPACKMAN

cc Sir P Middleton (with pps)
Mr Anson

SOCIAL TRENDS

The Chancellor was grateful for your minute of 2 November, and for the further information you provided in your note of 4 November ... (copy attached for Mr Anson).

2. On the first, the Chancellor was not content with the authors' proposed redraft of the sentence above deleted Table A8. The figures show that the majority of those who expressed a view is over 70 per cent. This is an overwhelming majority. If, however, the authors won't accept "overwhelming" then the Chancellor thinks we ought to quote the actual figures, as follows:

Of those who expressed a view,

"On the other hand almost nobody felt that they were currently undertaxed. People divided [broadly] into 24 per cent who feel that tax levels are acceptable and 70 per cent who feel that they are too high or much too high."

the majority (61 per cent)

3. On your note of 4 November, the Chancellor was surprised to discover that the material on attitudes to taxation, which it is proposed to publish this coming January, was collected as long ago as 1986. He thinks it essential that the article in Social Trends should make this explicit.

MOIRA WALLACE

chex.ps/aa/87

cc. CST
FST
PMG
EST
Sir P. Middleton
Sir T. Burns
Mr Anson
Mr Phillips
Miss Pearson
Mr McIntyre
Mr Saunders
Mr Grieve
Mr Pickford
Mrs Chaplin
Mr Tyrie
Mr Call
Mr N. Forman MP

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

8 November 1988

Gordon Brown MP
House of Commons
LONDON
SW1

Thank you for your letters of 7th and 8th November.

As I told the House, very clearly, on 7th November, what the Government is working on is a plan to provide extra help for poorer pensioners.

I note that your letters are merely a smokescreen intended to obscure this welcome news.

As for my remarks to a group of journalists on Friday, I regret that no transcript exists. But today's Daily Telegraph published an account supplied by the most senior of the journalists present. So far as I can recall, it is broadly accurate. As you will see, nothing in it remotely justifies either the scare stories published in the Sunday press, or the allegations you and your colleagues have seen fit to make on the basis of those stories.

To repeat, what we have in mind is extra help for poorer pensioners, over and above the basic State pension, which itself will continue to be uprated in line with prices.

I hope you will accept this and cease repeating what you know to be untrue.

Yours sincerely,

NIGEL LAWSON

FROM: J P MCINTYRE
DATE: 8 November 1988

CHANCELLOR

cc Chief Secretary
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Gieve
Mr Saunders
Mr Ramsden
Mr Tyrie
Mr Call

PENSIONS ETC: LETTER FROM GORDON BROWN MP

I attach a draft reply to Mr Brown's letter of 7 November.

2. The reference to NHS charges is a little difficult to handle, since the NHS Review contains some charging proposals (for optional extras in hospitals). The square-bracketed sentence in the draft meets the point head-on. The Prime Minister has in the past fallen back on the formula that the Government is pledged for the duration of this Parliament not to introduce hospital hotel charges. But this would invite the riposte: what about other charges? And it is uncomfortably close to the area of charging for optional extras. ST2's preferred option would be to omit all reference to other NHS charges.

3. The draft assumes that you will not want to say any more about the pensioner proposals at this stage.

4. Mr Brown also asks whether Attendance Allowance and Mobility Allowance will be uprated in line with inflation and if they will be means-tested. The first point can be handled by referring to Mr Moore's uprating statement, which included a full uprating of these benefits (Attendance Allowance is among the pledged benefits but Mob A is not). The second is more difficult. One way of answering this would be to refer it to Mr Moore. Another would be to say that all the disability benefits are being reviewed in the light of OPCS. Both are open to the accusation of dodging. It may be preferable therefore to say there are no plans to means test them (which of course is true).

5. We have <u>not</u> shown this draft to DH or DSS. Perhaps your office could send the approved draft to Mr Moore's and Mr Clarke's

private secretaries for confirmation that they are content.

6. Mr Cook has written separately to Mr Moore on pensions aspects. We have told DSS officials that they must let us see a draft of the reply so you can have an opportunity to comment.

JPM

J P MCINTYRE

DRAFT LETTER TO:

Gordon Brown MP
House of Commons
LONDON SW1A OAA

Thank you for your letter of 7 November.

As I made clear in my statement to the House on 7 November, we are considering how best to provide additional help for poorer pensioners. We will bring forward these proposals when they are ready.

You also mention Attendance Allowance and Mobility Allowance. The Secretary of State has already announced that these benefits will be fully uprated next April. There are no plans to means test them.

As far as prescription charges are concerned there are no plans to change the existing exemption for pensioners. [You will not of course expect me to rule out any future changes in the system of NHS charges.]

NIGEL LAWSON

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~~ Security

CONFIDENTIAL

Dominic Morris Esq
Private Secretary
10 Downing Street
LONDON
SW1A

CHIEF SECRETARY
REC. - 8 NOV 1988
ACTION Mr McIntyre
COPIES TO Cx, Sir P Middleton, Mr Anson, Mr Phillips, Miss Peirson, Mr Turnbull, Mr Bush, Mr Ramsden, McCall

November 1988

Dear Dominic

OPCS SURVEYS OF DISABILITY: SECOND REPORT

I wrote to you on 17 October about the timing of publication of the reports on the OPCS surveys of disability and the content of the key second report on the financial circumstances of disabled adults in private households. I am now writing to let you know the arrangements for publishing the second report.

We intend that the report will be published after Questions on Tuesday 15 November. Publication will be low key and will be announced in response to an inspired PQ. Both OPCS and DSS will issue press notices.

Presentation of the report requires careful but positive handling. The main finding is that disabled people do generally have low incomes but do not have substantial extra costs arising from their disabilities. We can expect commentators on the report to focus on the position of disabled people in the income distribution, particularly those below pension age. There will be pressure to provide additional resources and to expand existing help with extra costs arising from disability to people who are less severely disabled. There may also be demand for increased publicity for the extra costs benefits, Attendance Allowance and Mobility Allowance, in response to the OPCS finding that a significant proportion of very disabled people receive neither benefit (22% of the most severely disabled and 41% of the next most severely disabled group).

E.R.

Positive responses to these points include the growth in expenditure on disability benefits - £7 billion in current expenditure, a real terms increase of more than 90% since 1979 - and the improved support given to many disabled people in the social security reforms introduced in April 1988, after the survey was carried out. We can also draw attention to the OPCS findings that Attendance Allowance and Mobility Allowance are well targeted on the most common and most expensive indicators of disability costs; that actual extra costs are in general much lower than the current level of these benefits; and that take-up of both Allowances has risen by almost 40% since the OPCS data was collected.

I am copying this letter to the private secretaries of members of H Committee and to Trevor Woolley.

Yours,
Stuart

STUART LORD
Principal Private Secretary

HOUSE OF COMMONS
LONDON SW1A 0AA

Rt Hon Nigel Lawson
The Chancellor of the Exchequer
11 Downing Street
London

November 8th

Dear Chancellor

I am writing to ask you to confirm the statements that have been attributed directly to you as a result of your briefing of journalists on Friday last.

I would welcome a distinct answer to each of the points set out below which are supported by notes made by journalists at your briefing of them.

Will you confirm that you adopted, among other things, the following positions;

1. That you stated that "clearly there is a case " for restructuring child benefit and that you would have sought to means test child benefit but for a comma in your manifesto , preventing you doing so in this Parliament .

2. That you said specifically there is a"minority"of pensioners who have"difficulty in making ends meet".

3. That targeting is"the way we are likely to go " but that your backbenchers will have to be educated to accept means testing generallly.

4. That,for you,the way ahead is means testing of all benefits, other than benefits covered by pledges inconsistent with means testing.

I would also ask you to confirm that a taperecording was made of the briefing and that a tape exists.

Yours faithfully

Gordon Brown

Gordon Brown
Treasury spokesman

chex.rm/ad/9

PWP

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

8 November 1988

Stuart Lord Esq
Principal Private Secretary
Secretary of State for Social Security
Richmond House
79 Whitehall
LONDON
SW1

Dear Mr Lord

LETTER FROM MR DUCKWORTH

... I enclose a further letter with attachments that Johnathan Taylor (PS) has received from Mr Duckworth regarding his complaint against the DHSS for alleged irregularities concerning his National Insurance affairs.

Once again we would be grateful if you could ensure that a full reply is sent to Mr Duckworth.

Yours Sincerely
A A Dight

A A DIGHT

DUCKWORTH & CO.
Chartered Accountants

Charles G. Duckworth, C.A.
A. Shardow, ACCA

2 CREECHURCH LANE
LONDON EC3A 5AY

Telephone: 01-283 3921
Telex: 934022 V. KASS G
Fax: 01-621 1492

ASSOCIATED OFFICE IN
PIRAEUS, GREECE.

Jonathan Taylor Esq
Private Secretary to the
Rt.Hon. Nigel Lawson,M
11 Downing Street
London SW1

31 October 1988

Dear Mr Taylor,

Complaints lodged by Mr C G Duckworth
against the DHSS for alleged irregularities

I refer you to my letter to you dated 23 September in which I advised you of severe problems that I was having from the DHSS who had deducted 50 weekly contributions of Class 2 and then used that as a nexcuse to try and avoid making them reckonable for 1986/87.

I am pleased to say that I believe it was through your intervention that the DHSS have now sent me a letter of apology a copy of which is attached.

However, I do not have trust or confidence in them and I am suspicious of the fact that if they can make mistakes like the one I wrote to you about, they can make mistakes on other years also. i have therefore written back to them and enclose a copy of my letter.I have asked them to confirm that all the other years in which i have paid Class 2 contributions are fully up to date and reckonable for pension purposes. If they write back and say they are not then I shall be writing to you again because the DHSS will be guilty of taking my weekly contributions under false pretences. Hopefully, they will write back stating all is in order in which case I am prepared to let the matter drop.

Yours sincerely,

Charles G. Duckworth.

Charles G Duckworth.

DUCKWORTH & CO.
Chartered Accountants

Charles G. Duckworth, C.A.
A. Shardow, A.C.C.A.

2 CREECHURCH LANE
LONDON EC3A 5AY

Telephone: 01-283 3921
Telex: 934022 V. KASS G
Fax: 01-621 1492

ASSOCIATED OFFICE IN
PIRAEUS, GREECE.

DHSS
Arndale House
Arndale Walk
Wandsworth
London SW18 4BU

COPY

31 October 1988

Your ref: P A Edwards Ass't Manager

Dear Sir

Complaints lodged against you by
Mr Charles G Duckworth, CA, FRSA
and advised in writing to the Private
Secretary of the Chancellor of the Exchequer

We are in receipt of your letter dated 12 October but which in fact only arrived at Mr Duckworth's residence on 18 October1988.

With respect, your previous letters dated 3 June 1988 and 30 August 1988 were verbose in the extreme and unintelligible even to Mr Duckworth, who is a Member of the Institute of Scottish Chartered Accountants. We have examined the correspondence carefully and we are of the opinion that unless Mr Duckworth had written to you you would have been quite happy to have taken his 50 weekly contributions for 1986/87 and eventually NOT to have let that year be reckonable. If you wished Mr Duckworth to pay the two weeks outstanding for that year (and your computer letter of 3 June 1988 mentioned only ONE) then why on earht couldn't someone at your anonymous department take the honest initiative of writing a simple letter to Mr Duckworth saying all he had to do was to pay the additional two contributions because the DHSS had made a mistake.

We are concerned that irregularities like these can arise. We appreciate that your letter of 12 October confirms in writing that as Mr Duckworth has paid all the contributions required of him for 1986/87 that that year is FULLY RECKONABLE for pension purposes. However, as Mr Duckworth has little confidence in the manner in which you have dealt with this matter, would you be so kind as to confirm that all the earlier years referred to in Mr Payne's letter dated 16 October 1986 will count for pensionable purposes i.e. fiscal years 1982/83 through to 1986/87? Also, please confirm that the fiscal year 1987/88 is fully reckonable for pensionable purposes as Mr Duckworth is NOT prepared for you to come back at him in a few months time alleging that any weekly contributions are underpaid.

This letter is being sent by Recorded Delivery.

Yours faithfully,

Charles G. Duckworth.

Charles G Duckworth-Duckworth & Co.

MF29(A4)

Department of Health and Social Security
Arndale House Arndale Walk Wandsworth SW18 4BU

Telephone 870-1451
EXT 250

Mr C G Duckworth
71 Exeter House
Putney Heath
LONDON
SW15 5TQ

COPY

Your reference

Our reference

Date
12 October 1988

18 OCT 1988

Dear Sir

Your letter of 23 September 1988 has been passed to me for attention.

The law relating to Retirement Pension requires that where a contributor is self-employed, a minimum of 52 contributions (53 in appropriate years) must be recorded in any year in order that it may be reckonable. Where a contributor has some contributions recorded in any year but insufficient to qualify for a reckonable year, the contributor is advised accordingly and invited to remit the necessary sum in order to make the relevant year reckonable for benefit purposes. Hence the computer produced letter of 3 June 1988.

I refer to the Department's letter of 30 August 1988 which explained how the discrepancy of these two weeks arose. This was an error, and I repeat the apology on behalf of the Department contained in the letter. I have to refute the suggestion contained in your letter that any officer acted with fraudulent or mischievous interest. It would be inconsistent for any officer to act in this way, and having examined all the documents I am satisfied that the error was a genuine mistake.

I can confirm that the 1986/87 year will now be reckonable for pension purposes. I note that you have written to the Private Secretary to your Member of Parliament and I shall be pleased to answer any questions which may arise.

Yours faithfully

P A Edwards
Assistant Manager
(Compliance)

MP

Rt Hon Nigel Lawson
The Chancellor of the Exchequer
11 Downing Street
London

November 8th

Dear Chancellor

I am writing to ask you to confirm the statements that have been attributed directly to you as a result of your briefing of journalists on Friday last.

I would welcome a distinct answer to each of the points set out below which are supported by notes made by journalists at your briefing of them.

Will you confirm that you adopted, among other things, the following positions;

1. That you stated that "clearly there is a case " for restructuring child benefit and that you would have sought to means test child benefit but for a comma in your manifesto , preventing you doing so in this Parliament .

2. That you said specifically there is a"minority"of pensioners who have"difficulty in making ends meet".

3. That targeting is"the way we are likely to go " but that your backbenchers will have to be educated to accept means testing generallly.

4. That,for you,the way ahead is means testing of all benefits, other than benefits covered by pledges inconsistent with means testing.

I would also ask you to confirm that a taperecording was made of the briefing and that a tape exists.

Yours faithfully

Gordon Brown
Treasury spokesman

dg9.11.1

FROM: D P GRIFFITHS
DATE: 9 November 1988

MR GIEVE

cc PS/Chancellor
PS/Chief Secretary
PS/Paymaster General
Mr Anson
Mr Phillips
Miss Peirson
Mr Saunders

NHS SERVICE CUTS: ROYAL WEST SUSSEX HOSPITAL

Further to my minute of 7 November I have now been informed by Department of Health that a last minute deal was arranged with Chichester Health Authority to prevent the planned ward closures at the Royal West Sussex. South West Thames RHA have stepped in to bail out Chichester this year on condition that there is a thorough review of priorities and action taken to prevent Chichester getting into the same mess next year.

D P GRIFFITHS

CHANCELLOR OF THE EXCHEQUER

Ch/ just to confirm the figs Alex gave you on the phone:

Total pensioners 9 3/4 m

on IS + HB 1 3/4 m

on HB only 1 1/2 m
(ie on the tape)

CONFIDENTIAL

FROM: J P MCINTYRE
DATE: 9 November 1988

CHIEF SECRETARY

cc PS/Chancellor
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Gieve
Mr Ramsden
Mr Speedy
Mr Call

DISABILITY: OPCS SURVEYS

DSS propose to publish the second OPCS report, on the financial circumstances of the disabled, on Tuesday 15 November. They had previously planned to publish tomorrow but have now switched to next week, which may help to distance publication a little from the pensioners issue. (DSS Ministers are aware that Parliament will probably be prorogued next Tuesday, which could lead to criticism of a decision to publish that day. But they apparently feel that further delay in publishing a report which the press have suggested is ready might provoke even more criticism). Mr Moore's private secretary has written to No 10 (8 November) to warn of the publication and of the likely reaction to it.

2. DSS officials have sent us separately the final version of Volume 2, including a Summary - attached at Annex A. I have marked up the interesting bits. At Annex B is a draft DSS press release which would also serve as the text for a Written Answer on publication day. (We had not been consulted about them - nor had we previously seen the summary of the report.)

3. There can be little doubt that the Opposition and the disability lobbies will use this, perhaps the most important of the OPCS reports, to attack the government's record and press for higher benefits. Given that two thirds of the OPCS 6 million are pensioners, a link may well be made with that issue as well.

4. The very brief summary in the third paragraph of the DSS letter is a little misleading. It says the main finding is that disabled people generally have low incomes but do not have substantial extra costs arising from their disabilities. In fact, the report shows that disabled pensioners' incomes are, on average, similar to those of pensioners generally; this is quite an important qualification. Disabled non-pensioners have incomes which, on average, are 72 per cent of non-pensioners generally. As for extra costs, the average extra costs which the most severely disabled say they incur are £11.70 a week (1985 prices). Many of the disabled would no doubt regard £11.70 as a pretty substantial call on their incomes.

5. However, the levels of the extra costs benefits do look reasonable, even generous, in relation to these extra costs. The lower rate of Attendance Allowance is £22.00 (higher rate £32.95), and Mobility Allowance is £23.05. As the DSS letter says, there may be more concern expressed about the indication that many of the more severely disabled do not take up AA or Mob A, notwithstanding the recent large increase in claimants.

Draft press release/written answer

6. This gets over some of the key points:

   i. 90 per cent real terms increase in expenditure on disability benefits since 1979;

   ii. Extra money in April 1988 reforms for poorest disabled (and for those with children in the extra 50p from next April);

   iii. Steep rise in take-up of extra costs benefits (Mob A and AA);

   iv. Growth of private provision through occupational sick pay schemes.

7. But not all of these points are made as effectively as they might be. And other points are not mentioned eg no reference is made to the role of LA services in helping the disabled - OPCS did

not include the value of services to the disabled in assessing their living standards. It is true that LA provision is patchy (a later OPCS report will cover services and no doubt expose this) but to leave the impression that the living standards of the disabled are determined entirely by cash resources, without mentioning services, is misleading. A further point is that the estimates of average incomes are after housing costs, so they exclude the contribution of housing benefit to the incomes of over ½ disabled households.

Summary of Volume 2

8. This has one or two unfortunate own goals. On the second page:

> "Disabled pensioners had similar incomes on average to those of pensioners in general since all pensioners are largely dependent on state benefits..." (my underlining).

As you know, we have been able to make a good deal of the fact that, not only have pensioners' average real incomes been rising significantly since 1979, but pensioners have become less dependent on the state pension and benefits. Benefits as a proportion of pensioners' average incomes have declined from 61 per cent in 1979 to 58 per cent in 1986. (The reason the fall is not steeper is that average SERPS entitlements have been rising.)

9. The other point, which could be more damaging to the presentation of the report, is the final sentence:

> "Overall, disabled adults are likely to experience some financial problems and to have lower standards of living than the population as a whole as a result of having lower average incomes" (my underlining).

In fact, the survey reports that 70 per cent of disabled adults are satisfied with their living standards and 8 per cent of disabled households thought they were getting into financial difficulties.

Conclusions/Handling

10. The summary has now been printed as part of the bound volume, and I understand there is now no chance of amending it short of getting a re-print which would mean a delay of some weeks.

11. However, the draft press release/written answer can be changed, and a private secretary letter to Mr Scott's office may be the most effective means of communicating the amendments we want. Alternatively, we could write at official level. (I have already warned DSS officials of some of these points, while stressing that you had not yet had an opportunity to comment).

12. If you agree, a draft is attached.

13. Other members of H will not have seen the draft press release etc. They have only the private office letter of 8 November. So you may not want these detailed comments copied round.

JM

J P MCINTYRE

Summary

ANNEX A

The OPCS surveys of disability in Great Britain were commissioned by the DHSS in 1984. They aim to provide up-to-date information about the number of disabled people in Great Britain with different levels of severity and their circumstances for the purposes of planning benefits and services. Four separate surveys were carried out between 1985 and 1988, covering adults in private households, children in private households, adults in communal establishments and children in communal establishments.

The results of the surveys are being published in a series of reports of which this is the second. The first report[1] described the main concepts and methods common to all the surveys and presented the prevalence estimates from the two surveys of disabled adults. This report examines the financial circumstances of disabled adults living in private households. Later reports present the prevalence estimates for children and describe other aspects of the circumstances of disabled people in Great Britain.

In examining the financial circumstances of disabled adults living in private households, three specific aims were identified:

(i) to examine the extent to which disability affects people's income;

(ii) to establish whether extra expenditure is incurred as a result of disability and to estimate the magnitude of that expenditure;

(iii) to evaluate the overall impact of disability on the standard of living and financial circumstances of disabled adults and their families.

The survey of disabled adults in private households was carried out in 1985 and so all the financial information relates to that point in time. Since then there have been a number of changes affecting the social security benefits paid in respect of disability and these are summarised in the annex to Chapter 1.

Chapter 1 describes the approach used to examine the financial consequences of disability and gives details of the main measures used in the analyses: income, extra expenditure resulting from disability and measures of the family's financial situation and standard of living. The basic unit for data collection and analysis is the family unit, that is a single adult or married couple together with any dependent children.

Chapter 2 describes characteristics of disabled adults relevant to the examination of their financial circumstances. As the first report, on the prevalence of disability, emphasised, a high proportion of disabled adults are elderly: 69% were aged 60 or over compared with 26% of adults in the general population. Although two thirds of those aged under 60 were married, many of the older disabled adults were widowed: 56% of women and 20% of men aged 60 or over. Also, because so many were aged 50 or over, few disabled adults had dependent children, only 10% altogether, although a third of non-pensioner married couples had one or more independent children living in the household.

The majority of disabled adults or their spouses were householders (89%). Non-householders were predominantly young unmarried people living with their parents or pensioners living with their adult sons or daughters. Although the majority (60%) of unmarried non-pensioners were living with other adults, 70% of single pensioners were living alone. Not surprisingly, the most severely disabled adults were least likely to be living alone.

Disabled adults under pension age were less likely to be in paid work than adults in the general population, even allowing for differences in age, sex and marital status. Only 31% of non-pensioner disabled adults were working, and this proportion fell with increasing severity of disability from 48% of those in severity category 1 to 2% of those in severity category 10. Unmarried disabled adults were less likely than the married to be working, as were those aged 50 or over as opposed to under 50.

Chapter 3 describes income from earnings, benefits and other sources. Looking first at the earnings of disabled adults, it was apparent that both men and women full-time employees earned less than full-time employees in the general population, and that the differences were not accounted for by differences in hours worked. Among disabled full-time employees there was a decrease in earnings with increasing severity. For the majority of married disabled adults under pension age at least one member of the family was earning since, even if the disabled adult was not working, many had a non-disabled spouse who was. This resulted in such families being less reliant on state benefits than other types of family.

Although most disabled adults and their families received at least one state benefit, two of these, child benefit and state retirement pension, are not in any way related to disability or its possible consequences. Almost all pensioners were receiving a state retirement pension and in

addition 23% received supplementary pension. Thirty-five per cent of non-pensioner families received one of the disability-related income maintenance benefits, most commonly invalidity benefit, and 23% of the non-pensioners were receiving supplementary benefit. Over half of all householders were in receipt of housing benefit.

The disability costs benefits—attendance allowance and mobility allowance—were paid to 8% and 7% of all disabled adults respectively and their receipt was related to severity of disability, strongly so in the case of attendance allowance: 74% of disabled adults in severity category 10 were receiving attendance allowance and 67% of disabled adults under pension age in the same severity category were receiving mobility allowance.

Besides earnings and benefits half of all disabled adults had another source of income, the most common sources being pensions or redundancy payments from a former employer and income from savings and investments, both of which were more likely to be received by older respondents.

The average net income from all sources (except housing benefit) was £82.20 for all disabled adults and their families and varied between different types of family from £53.80 for unmarried pensioners to £130.00 for married non-pensioners with children. The proportion of income coming from earnings was much higher on average for married non-pensioners than for other families for whom the contribution of state benefits was proportionately much higher. For non-pensioners in severity categories 1 and 2 earnings formed 56% of their income and benefits 30% on average, whereas for those in severity categories 9 and 10 the position was almost reversed: 35% and 55% respectively. Altogether three quarters of disabled adults relied on state benefits (including retirement pension) for their main source of income.

In order to compare the incomes of different types of families, we have used equivalence scales, using a married couple as the basis for comparison, to allow for differences in their size and composition. Unmarried childless non-pensioners had the highest equivalent incomes (£ = 115.20) while families with children had the lowest (£ = 70.30 for single parents and £ = 79.30 for married parents). Childless non-pensioners with no earnings had very similar equivalent incomes to pensioners and in general it was apparent that earnings had the largest effect on total income; the number of earners in the family unit explained more variation in income than any other single factor. Among families with no earners, income rose with increasing severity of disability because of increases in the proportions receiving attendance allowance and/or mobility allowance in addition to other benefits.

Comparisons with the equivalent incomes of familes in the general population showed that disabled non-pensioner families had significantly lower incomes than non-pensioners in general: 72% of the latter on average. Much of the difference was due to disabled adults being less likely to have earned income. However, families of disabled adults with one or more earners still had lower average incomes than families in the general population with the same number of earners. Disabled pensioners had similar incomes on average to those of pensioners in general since all pensioners are largely dependent on state benefits and have on average lower incomes than non-pensioners.

Chapter 4 describes how estimates of extra expenditure resulting from disability were obtained and some of the problems encountered. Lump sum expenditure on items of equipment, special furniture etc. was collected only if it occurred in the past year. Only 16% of disabled adults had made such a purchase in the past year, spending £78 on average, so averaged over all disabled adults this represents about £12.50 per year. However, there was considerable variation in the amounts spent by different individuals.

Altogether 60% of disabled adults said they had incurred regular expenditure in the past year on items required solely because of their disability. Chemist items required because of disability, costs associated with visits to hospital, prescriptions and home services such as home helps or private domestic help were the items more frequently mentioned. The proportion of disabled adults incurring such extra expenditure increased with severity of disability, as did the average amount spent per week. The average expenditure on this type of item was £2.20 for those who had such expenditure or £1.30 for all disabled adults.

The third type of additional expenditure examined was regular expenditure on items required by most people but on which disabled people may need to spend more. This covers a large variety of items among which additional expenditure on fuel, clothing and bedding, travel, food, laundry, telephone calls and maintenance of the home were most often mentioned. Seventy-one per cent of disabled adults said they had incurred this type of additional expenditure because of their disability in the past year and had spent £6.70 on average, which amounts to £4.80 on average for all disabled adults. Again, the proportion of disabled adults with expenditure of this kind and the average amount spent rose with increasing severity.

Considering both types of regular extra expenditure together, whether for items required solely because of disability or additional on normal items, disabled adults were spending an extra £6.10 per week. This varied between £3.20 for those in severity category 1 to £11.70 for those in severity category 10, but there was considerable variation around the average amounts for different individuals in each severity category. One reason for this was variations in the type of disabilities among people in a particular severity category. Another was differences in income and hence the amount of money available to be spent in connection with disability; average additional expenditure on disability rose with income and also rose

more steeply with severity of diability for those in the higher income bands. For example, for those in severity categories 1 and 2 average additional disability-related ex[redacted]e was £3.00 per week for those with disposable incomes of under £40 per week compared with £5.40 for those with disposable incomes of £120 per week or more. Comparable additional expenditure for people in the same income bands in severity categories 9 and 10 was £8.20 and £23.40 per week. Altogether 24% of disabled adults thought they needed to spend more because of their disability but could not afford to do so.

Although for reasons explained in the chapter it was not possible to make precise estimates of the additional expenditure associated with each of the different types of disability, the analysis enabled disabilities to be ranked in order of the amount of additional expenditure with which they were associated, taking into account the overlap between different types of disability. From highest to lowest they were: eating, drinking and digestion (a very small group), locomotion, disfigurement (which includes amputations), personal care, behaviour, continence, reaching and stretching, dexterity, consciousness, seeing, hearing, intellectual functioning and communication.

Chapter 5 examines the impact of disabilities on the resources of disabled adults by calculating the income remaining after disability-related expenditure had been subtracted and using equivalence scales to adjust the remaining income for differences in family composition. The resulting amount is referred to as *equivalent resources*. On average net equivalent resources were 92% of net equivalent income, that is 8% of income was spent on disability-related expenses. Although the absolute amount of expenditure on disability was lower for those on lower incomes, as a proportion of their income lower income families spent more in connection with disability. In addition, the proportion of income spent on disability rose, and thus the resources remaining fell, with increasing severity: those in severity category 10 were spending an average of 15% of their income on disability-related expenses compared with 4% for those in severity category 1.

Chapter 3 shows that disabled adults had, on average, lower equivalent incomes than families in the general population, so when the extra costs of disability are taken into account, disabled adults have lower equivalent resources available to spend on other things. The average equivalent resources of disabled non-pensioners were £=91.70 per week compared with an average equivalent income of £=136.50 for non-pensioners in the general population. Forty-one per cent of disabled non-pensioners had equivalent resources of less than half this amount compared with 23% of non-pensioners in general. The differences between pensioners, however, were not so marked: the average equivalent resources of disabled pensioners were £=83.70 per week compared with £=93.70 for all pensioners.

Chapter 6 examines the financial situation of disabled adults by describing both subjective and objective measures of the extent to which they experienced financial problems and their standard of living. Most of the analysis in this chapter was confined to disabled householders, since the situation of non-householders is likely to be substantially affected by that of the householders with whom they live and about whom we had little information.

Altogether 8% of disabled householders thought they were getting into financial difficulties, but pensioners were very much less likely to say this than non-pensioners. Of the small group of single parents, 36% said they were getting into difficulties as were 23% of single childless householders but only 3% of pensioners. Objective measures, based on experience of a number of problems of debt and arrears, confirmed the subjective views. Both subjective views and objective measures were related strongly to equivalent income and rather more strongly to equivalent resources. Families with children and also unmarried childless non-pensioners were most likely to experience financial problems, whereas few pensioners had debts or arrears.

The majority of disabled householders (70%) said they were satisfied with their standard of living, but those who said they were not were most likely to be families with children or unmarried childless householders, regardless of the size of their income. Subjective views of standard of living were more closely associated with equivalent resources than equivalent income.

Four measures of standard of living are examined: the average number of consumer durables from a list of nine which the family did not possess and the average number lacking from a list of eight basic items and, for both consumer durables and basic items, the average number said to be lacking because the family could not afford them.

All four measures related to people's subjective views of their standard of living in the expected direction, but the number of consumer durables lacking for whatever reason show a less close relationship than the other three measures, and indeed a higher proportion of consumer durables than basic items were lacking from choice. Although all four measures correlated with equivalent income and equivalent resources, the relationships were stronger for the latter, that is when spending on disability had been taken into account. Moreover, the relationships were stronger for not being able to afford items rather than just not having them, as might be expected. In general, for a given level of disposable resources, the unmarried non-pensioners were lacking both the most consumer durables and the most basic items because they could not afford them, while the pensioners were lacking least for this reason.

A question at the very end of the interview asked disabled adults what they would do with a windfall of £200. Most people said they would spend at least some of it rather [redacted]ving it all and were most likely to say they would [redacted] for home improvements or repairs. Spending on or saving towards clothes, holidays, presents and paying off bills or debts were the other most frequently mentioned items.

The survey shows two broad effects of disability on the financial circumstances of disabled adults. As a consequence of being less likely than the population as a whole to have earned income, disabled adults have on average lower incomes than the rest of the population: disabled adults are both less likely to work and, if they are able to work, likely to earn less than adults in general. State benefits paid to compensate for the extra costs of disability go some way to compensate for lower incomes, and the likelihood of their receipt increased with severity of disability. The majority of disabled adults incur extra expenditure as a consequence of being disabled, the amount of which is related to the nature and severity of their disability, and also to the income they have available to spend in connection with their disability. Overall, disabled adults are likely to experience some financial problems and to have lower standards of living than the population as a whole as a result of having lower average incomes.

Reference

[1] OPCS surveys of disability in Great Britain. Report 1: The prevalance of disability among adults.

ANNEX B

DRAFT PRESS RELEASE

SECOND OPCS REPORT ON DISABILITY

Nicholas Scott, Minister for Social Security and the Disabled, today announced in reply to [John Hannam, MP] the publication of the second report on disability by the Office of Population Censuses and Surveys.

Mr Scott said -

"The Office of Population Censuses and Surveys has today published the second report on the findings of the surveys of disability in Great Britain carried out between 1985 and 1988. The report covers the financial circumstances of disabled adults living in private households. It is the second of six reports on the survey's findings which will be published by OPCS over the next eight months.

The report contains a wealth of detailed information about the effect of disability on people's income and expenditure, and thus the overall impact of disability on the financial circumstances of disabled adults and their families. The report indicates that disabled people are less likely than the population as a whole to have earned income: as a result they have lower incomes than the rest of the population. The extra costs incurred as a consequence of being disabled are found to vary according to the nature and severity of the disability and also according to the individual's income. Average extra costs ranged from £3.20 per week for the least disabled to £11.70 for the most severely disabled.

Substantial resources are devoted to providing help to disabled people through social security benefits. Since 1979 there has been a significant rise in the numbers receiving benefits for long-term sick and disabled people. Current expenditure on benefits is about £7 billion which represents an increase of over 90 per cent in real terms under this Government. The implementation of the social security reforms in April 1988 has meant that there have been major changes affecting the circumstances of disabled people in greatest financial need since the OPCS surveys were carried out. An extra £60 million has been made available through the income support disability premium awarded to 270,000 people. A further £8 million is being spent on the severe disability premium paid to 7,000 disabled people. And we have made £5 million available in 1988/89 for awards made by the Independent Living Fund. Disabled people with children in the poorest families will also benefit from the extra 50p a week which will be added to the child allowances in income support, family credit and housing benefit in April next year.

The report shows Attendance Allowance and Mobility Allowance are well targeted on the heaviest sources of extra costs. The OPCS data indicates that actual extra costs are generally far lower than the current level of these benefits. Take-up of Mobility Allowance has increased by over 400% since 1979 and the numbers receiving Attendance Allowance have risen by more than 150% over the same period. And since 1985, when the data for the OPCS report was collected, take-up of these benefits has increased by almost 40%. Attendance Allowance is now awarded to 670,000 people and there are 490,000 recipients of Mobility Allowance.

A report on occupational sick pay schemes published by the Department of Social Security on 8 November adds to the information collected by OPCS. The report by IFF Research Ltd reveals a significant growth in the number of employees covered by occupational sick pay schemes. 91% of employees are now covered by a scheme and 58% have some form of long-term sick pay cover.

The OPCS findings will also be supplemented by information comparing expenditure by disabled people and their families with expenditure by other families. This information will be obtained from the Family Expenditure Survey carried out between July 1986 and June 1987 and we expect to publish the results in the Autumn of 1989. Together with the data from the OPCS surveys this information will help us to evaluate whether the £7 billion now spent on benefits for disabled people is directed to those in greatest need.

Over the next year the reports on the OPCS surveys' findings and the related FES project will bring together the most comprehensive and detailed information ever collected about the circumstances of disabled people in this country. We will welcome comments on the reports as they are published."

NOTES TO EDITORS

1. The OPCS surveys of disability were commissioned by the former Department of Health and Social Security and carried out by OPCS between 1985 and 1988. Four separate surveys covered adults in private households, children in private households, adults in communal establishments and children in communal establishments.

2. The first report, "The prevalence of disability among adults", was published on 28 September 1988. In addition to the second report, published today, a further four reports presenting the surveys' findings will be published by OPCS during the next 8 months. The reports will cover:

- prevalence estimates for children;

- the financial circumstances of the families of disabled children living in private households;

- other aspects of the circumstances of adults and children with disabilities, such as use of services, transport, employment.

3. The second report on OPCS surveys of disability in Great Britain, "The financial circumstances of disabled adults living in private households", by Jean Martin and Amanda White is available from HMSO price £11.50.

CONFIDENTIAL

DRAFT LETTER TO:

Nicholas Bromley Esq
Private Secretary to the Minister of State for Social Security and the Disabled
Department of Social Security
Richmond House
79 Whitehall
LONDON SW1

DISABILITY: OPCS SURVEYS

Thank you for sending me a copy of your letter of 8 November to Dominic Morris at No 10. The Chief Secretary has also seen the draft press notice and written answer which your officials have kindly sent to ours, together with the final version of the second OPCS report. Officials have already been in touch about this material.

He believes it would be helpful if the statement made clear that the report's assessment of living standards takes no account of the provision of services by Local Authorities. A related point is that the figures given for average incomes of the disabled are after housing costs and do not therefore reflect the contribution of housing benefit to the incomes of many disabled householders. Taken on their own, without these qualifications, figures given for average incomes in the report may give a false impression of the living standards of disabled people.

As well as mentioning the 90 per cent real terms increase in expenditure on disability benefits, the Chief Secretary thinks it would be a good idea to refer to the substantial

increases in provision which have been agreed in this year's Survey. He thinks that, in the circumstances of this report, it would be reasonable to depart from the general practice of delaying publication of detailed figures for particular benefits until the White Paper.

The Chief Secretary was interested by the reference to your Department's new report on the coverage of occupational sick pay schemes. He wonders whether the importance of this point might be emphasised a little more by concluding the relevant paragraph with a sentence on the following lines:

> "This shows that there is increasing private sector provision against the risks of long term sickness and disability among employees, as well as growing public expenditure on disability benefits."

The Chief Secretary was also interested by the reference to the expected publication next Autumn of research based on the Family Expenditure Surveys comparing expenditure by disabled people and their families with expenditure by other families. The Chief Secretary assumes that this further report, coming some time after the final OPCS volume early next summer, would not prevent the government announcing its conclusions from the disability review next Summer or Autumn, with the possibility of legislating in the 1989-90 Session (if Ministers were agreed that this was a desirable timetable). The Chief Secretary suggests that, if there is any doubt on

this point, it would be better to omit the relevant paragraph from the press statement and written answer.

On the figures for take-up in the draft statement, the Chief Secretary would see some merit in including a table of figures for all the main benefits, not just Attendance Allowance and Mobility Allowance. The increases might also be more effectively described by giving the actual numbers in receipt of each benefit in 1979 and the expected take-up this year.

The Chief Secretary thought that one interesting point which might be brought out in the statement or the briefing for publication day was that nearly one third of disabled people are in employment, with the figure rising to about half for those in category one (the least disabled).

Finally, the Chief Secretary was disturbed by some of the statements made in the summary of volume 2. In particular, he does not understand why it is said on page 2 that "all pensioners are largely dependent on state benefits" when the fact is that there has been a decline in the proportion of pensioners' average incomes accounted for by benefits to less than 60 per cent. Second, the final sentence of the summary says that "overall, disabled adults are likely to experience some financial problems and to have lower standards of living than the population as a whole..." The report makes clear elsewhere that the majority of those classified as disabled in the survey (ie pensioners) have incomes broadly in line

with pensioners in the population as a whole and that 70 per cent of the disabled reported that they were satisfied with their living standards.

The Chief Secretary understands that it is now too late to amend the summary to deal with these points, but he hopes that as much as possible will be done in the press release and briefing of the press, the lobbies, and interested back-benchers to counter the impressions given in the summary on these questions.

[I am sending a copy of this letter to the private secretaries of other members of ~~H~~ H Committee and to Trevor Woolley.]

CARYS EVANS

st.ln/min/1.9.11

FROM: MISS M E PEIRSON
DATE: 9 NOVEMBER 1988

CHIEF SECRETARY

cc PPS
PS/Financial Secretary
Sir P Middleton
Mr Anson
Mr Monck
Mr Phillips
Mr Beastall
Mr Moore
Mr M E Brown
Mr Potter
Mr Revolta
Mr Saunders
Mr S N Wood
Mr Tyrie
Mr Call

NHS AUDIT: PS/LORD PRESIDENT'S LETTER OF 7 NOVEMBER

The letter of 7 November from the Private Secretary to the Lord President, addressed to DOE, raises the question of provision in the Housing and Local Government Bill to extend the role of the Audit Commission to cover the health service. The Lord President proposes a meeting with Mr Ridley and "other interested Ministers".

2. As you know, we are anxious to press ahead with the legislation needed to allow the Audit Commission to take over the audit of the health service, and you might like to attend the proposed meeting. I have asked the Financial Secretary's office to ensure that Treasury Ministers get an invitation. We do not necessarily want to insist that legislation should be taken in the Housing and Local Government Bill: as I said in my submission of 4 November to the Chancellor, there are various options (I expect to get a draft of the promised DOE note on the options very soon, and will brief you accordingly). But we don't want the possibility of early legislation to go by default, and the Lord President and Mr Ridley seem worried about getting it through.

3. In particular, the letter says that Mr Ridley suggested that inclusion in his Bill of the suggested provision "would also raise controversial issues relating to the role of the NAO in auditing the health service". That is apparently simply based on his previous experience of the problems caused by PAC chairmen in past debates in the House. I have heard that the C and AG (having been informed by Mr Anson of the proposed change in the health service audit) mentioned to the Permanent Secretary of DOE that he was concerned about possible duplication of value for money work between the NAO and the Audit Commission, and would want to discuss the matter further with the Treasury and others; but it is apparently unlikely that Mr Ridley based his remarks on that.

Water Bill, Football Bill, Local Government Ombudsman

4. There is nothing else in the letter on which Treasury officials would advise commenting: all the other suggestions are satisfactory.

MEP

MISS M E PEIRSON

NB return to Mottram.

chex.dg/docs/9.11.4

RESTRICTED

FROM: A G TYRIE
DATE: 9 November 1988

CHANCELLOR

9/11

Cc: CST
PMG
Mr Culpin
Mr MacIntyre
Mrs Chaplin
Mr Call

MEMBERS' BRIEF ON PENSIONS

I attach a draft for this which incorporates suggestions from Judith Chaplin and Paul MacIntyre and was based on an earlier version by Ian Stewart.

I have beefed up the Labour-bashing section quite a bit, but not too much, I think!

2. Paul MacIntyre pointed out that it could benefit from a paragraph on "the Pensioners' Revolution", possibly something along the lines:

> "This Government has led the way in extending choice in pensions by giving people the right to opt out of occupational schemes and by creating personal pensions. In the years to come this will contribute to a further reduction in the dependence of many pensioners on the State for support."

3. Turning to presentation of the pensioners' issue more generally, DSS are about to publish Volume 2 of the OPCS Report on Disability which deals with the financial circumstances of the disabled. As you know six million are supposed to be disabled, of whom four million are pensioners - hence the obvious read-across. The DSS have decided not to release this document until next Tuesday, not, I suspect,

blue folder behind

because of the current pensions fracas but because the DSS have first order PQs on Monday!

4. John Moore has not yet seen this brief but will read it at 8 am tomorrow morning.

5. I would be grateful if copy recipients could check the relevant passages.

AGT.

A G TYRIE

PENSIONERS. AN EXCELLENT RECORD. MORE HELP FOR THE NEEDY

More Help for Britain's Needy Pensioners. On the 7th November, the Chancellor of the Exchequer, Mr Nigel Lawson, announced that the Government was planning to direct extra resources to the minority of needy pensioners. As Mr Lawson said: "I have been discussing with my Rt Hon Friend the Secretary of State for Social Security a scheme to give special help to poorer pensioners" (Hansard, 7 November 1988, Col. 21). This will be in addition to the recently published spending plans for the Department for Social Security. As the Chancellor has explained "what we have in mind is extra help for poorer pensioners, over and above the basic State pension, which itself will continue to be uprated in line with prices" (letter to Mr Gordon Brown MP, 9 November 1988).

The Objective. The details of these proposals, which have been under discussion between Mr John Moore, Secretary of State for Social Security, and the Chancellor since the summer, have yet to be finalised. It is crucial that the additional money goes where it is most needed.

Labour's Poor Record. Socialists purport to be on the side of the needy. But their conspicuous lack of welcome for the announcement of new money for the elderly has been striking. Neither Mr Kinnock, who had two opportunities in the House, nor Mr Brown, in two letters to the Chancellor of the Exchequer, have felt able to welcome the scheme. This suggests that Labour's adoption of the pensioners' issue owes more to politics than a genuine care for their concerns. It also betrays an extraordinary lack of

confidence in their own record. This is hardly surprising. The last Labour government broke its promises to pensioners:

- The commitment to uprate pensions in line with prices or earnings, whichever was the greater, was broken in 1976 and 1978 - and would not have been honoured in 1979.

- Labour swindled pensioners of £1 billion at today's prices by switching from the historic to the forecast method of uprating, and then grossly underestimating inflation.

- The Christmas bonus was withheld in 1975 and 1976.

- Inflation destroyed the savings of provident pensioners and forced many into dependency on the State.

Socialist economics failed pensioners just as it failed the nation. It could not deliver the prosperity required to help the needy. Pensioners' average total net incomes hardly grew at all - by a measly 3% in real terms over the entire period of the last Labour Government. Since 1979, they have been growing nearly 3% a year in real terms.

The Conservative Pledge. Unlike Labour the Conservatives have kept their promises. The Conservative commitment is unambiguous: "We will continue to maintain the value of the State retirement pension" (The Conservative Manifesto, The Next Moves Forward, May 1987). Next year:

- single pensioners will ~~receive~~ £43.60 a week - 1979's figure was £19.50.

- a married couple will ~~receive~~ £69.80 - 1979's figure was £31.20.

Result of Economic Success. Only a prosperous nation can afford to make £50 billion worth of social security payments every year. As the Prime Minister has said: "Never has more been spent on social security payments and the Health Service, because the wealth created by enterprise under this Government has enabled us to do that" (Hansard, 1 November 1988, Col. 820). Economic competence and compassion are indivisible. A revitalised economy has enabled the Government to increase its benefit spending on the elderly by 27 per cent in real terms since 1979 - only half of this is due to the increased number of pensioners. Fully 50% of the current social security budget now goes on spending on the elderly. This is some 9.6% of GDP, the third highest level of spending in the EC. [This is a 1983 figure. Can DSS please provide an up-to-date and accurate figure?]

Existing Extra Benefits for Pensioners. The basic pension ~~is supplemented by~~ there is a whole range of other benefits:

- Income Support goes to ~~1¼~~ 1 3/4 million pensioners. For example, a single pensioner living on the basic state pension of £41.15 could be eligible for Income Support of £2.90 per ~~w~~eek.

- Housing Benefit assists no fewer than 3½ million pensioners. For example, a pensioner couple with gross income of up to £95 per week could be eligible for help with their rates.

- Severe Weather Payments have been extended to every pensioner on Income Support.

- Pensioners are able to take advantage of concessionary bus and rail travel.

Overall, between 1979 and 1986 pensioners' average income from benefits rose by 19% in real terms, [check] much more than under the last Labour Government.

D.SS say Ok.

Rising Living Standards. A responsible Government not only maintains the value of the pension, it ensures that pensioners' other incomes are protected - particularly against the ravages of inflation. It creates the conditions in which pensioners can earn a reasonable return on their savings. Between 1979-86, pensioners' average incomes from savings increased by over 7% [check] a year in real terms. Under the last Labour Government, with inflation rocketing up to a twentieth century peak of 27%, pensioners' savings fell by 3.4% a year.

Today, over 80% [check] of pensioners now have a regular income other than the basic pension. As Mr Moore, the Secretary of State for Social Security, said at the Conservative Party Conference: "Since 1979, pensioners' total incomes have grown twice as fast as

those for everyone else and more than four times faster than under the last Labour Government" (Brighton, 12 October 1988).

Ownership. Pensioners have shared in the country's growing prosperity. Even among low income pensioner couples, [check, this is on average?] 99% own a television, 81% own a washing machine and 96% own a refrigerator. 20% of shareholders - almost 2 million people - are aged over 65. Pensioners have participated in the rising tide of home ownership. [More pensioners than ever before own their own homes, perhaps?]

Budget Boosts for Pensioners. The Chancellor's last Budget has already made the average tax paying pensioner couple £4-£10 a week better off. Since 1979 the age allowance has risen by 16% in real terms. Almost 1 million elderly couples will be better off following the introduction of independent taxation of husband and wife.

The 1987 budget introduced a new personal tax allowance for people over 80 years of age. For them, the age allowance has been raised to double the rate of inflation. This helps about 40,000 elderly single people and married couples and has taken 25,000 of them out of tax altogether. [check]

chex.dg/9.11.1

FROM: A G TYRIE

DATE: 9 November 1988

MR MACINTYRE

Cc: PS/Chancellor

PS/CST

Mr Anson

Miss Peirson

Mr Gieve

Mrs Chaplin

Mr Call

ROBIN COOK'S LETTER TO JOHN MOORE

I think this can be answered crisply and factually, something along the following lines:

> "On the 7 November the Chancellor told the House that he and I were working on a plan to provide additional help to pensioners most in need. This will be over and above the existing level of benefits. As soon as the details of the scheme can be worked out we shall, of course, announce them."

I don't see the need to say any more.

AGT.

A G TYRIE

FROM: J P MCINTYRE
DATE: 9 November 1988

PS/CHANCELLOR

Ch/ Tyrie version also behind. But I think Doss's own will do. OK? MPW

OK -

cc PS/Chief Secretary
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Gieve
Mr Tyrie
Mr Call

PENSIONERS: LETTER TO MR MOORE FROM ROBIN COOK MP

Mr Moore's office sent you a draft of the reply to Mr Cook's letter of 7 November, which Mr Moore has approved.

2. I see no difficulties in the draft. It does not attempt to say anything further about the scheme or when it might be introduced. But it emphasises the main point, also to be made in your reply to Mr Brown's letter of the same date, that additional resources will be available.

3. If the Chancellor is content, you will want to convey this to Mr Moore's office and also let them know what the Chancellor proposes to say in his letter to Mr Brown.

done

JPM

J P MCINTYRE

DRAFT

CH/EXCHEQUER	
REC.	-9 NOV 1988
ACTION	Mr McIntyre *
COPIES TO	CST, Sir P Middleton, Mr Anson, Mr Phillips, Miss Peirson, Mr Turner, Mr Grieve, Mrs Chaplin, Mr Tyrie, Mr Call

* Does DRAFT reply to R Cook. For any urgent comments pl.

GM8540p

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

Robin Cook Esq MP

November 1988

Thank you for your letter of 7 November.

The details of our proposals for poorer pensioners are being considered. I will be making an announcement in due course. We have already made it quite clear that additional ~~measures~~ resources will be available.

JOHN MOORE

PERSONAL AND CONFIDENTIAL

FROM: J P MCINTYRE
DATE: 9 November 1988

CHIEF SECRETARY

cc Mr Phillips
Mr Ramsden

POORER PENSIONERS

I found out from Mr Chislett today how DSS thinking on the new scheme was developing. He told me the following on a personal basis, so please protect.

2. The scheme DSS have in mind (and Mr Moore is apparently 'excited' about it) is still being worked out in detail. But the essential point is that a 'Pensioner Plus' (or whatever we choose to call it) would be paid to all pensioners over, say, 75 with a SERPS or occupational pension entitlement below a certain threshold. The range for this threshold which DSS are considering is £2, which they consider the absolute minimum, to £5, which they think may be too expensive. There would be no means test as such. The pensioners with SERPS or occupational pension entitlement below the threshold could be identified fairly readily from the contribution records in Newcastle. Administration would therefore be relatively simple and inexpensive. And the beneficiaries themselves would not need to fill out an extra claim form; they would get the money with their basic pension.

3. The payments would be disregarded for the purposes of calculating IS and HB entitlements, so that there would be no offsetting cuts in means-tested benefits.

4. Primary legislation would be needed (this would be a new benefit). Mr Moore would like to be able to announce the outline of the scheme when his new Bill is introduced before Christmas*, with the detailed clauses to be inserted at Committee Stage. Assuming Royal Assent in July, order books could begin to be adjusted in the Autumn of next year with the extra payments reaching pensioners from April 1990.

*I now see that Mr Moore intends to introduce his Bill on 23 November. Announcing the new scheme on that day looks a very ambitious timetable.

5. Further urgent work is being done on the number of pensioners who would gain on various sets of assumptions about the age threshold and the size of the 'Pensioner Plus' payment. Mr Chislett mentioned that around £300 million might be involved; Mr Moore had apparently said that a sum of this order would now be needed to make the necessary 'splash'. (I said that £300 million sounded way above what we had thought likely and reasonable, and that we would need to see detailed costings on a variety of assumptions.)

6. Apart from the cost, I can see two potential problems with a scheme on these lines:

i. Although the scheme would be 'targeted' on those with little or no SERPS or occupational pension entitlement, it would not be means tested and would therefore allow some pensioners (though I do not know how many) with considerable savings in other forms to gain from the scheme. It would look as though the government were, to this extent, backing away from means-testing. The scheme would also sit uncomfortably with the means-testing (particularly of pensioners) for purposes of housing benefit and income support, where of course all forms of "free capital" over £6,000 (IS) or £8,000 (HB) are taken into account. I should have thought that, at the minimum, DSS would need to convince us that the great majority of beneficiaries would be on IS or just above. We would also want to see whether the self employed, many of whom will have built up considerable pensions under their own special arrangements can be excluded.

ii. Timing. Although the announcement would be relatively soon, implementation would not follow until April 1990. The need for legislation and administrative preparation might not be sufficiently good answers to the question: why not sooner? There is also the point that a <u>later</u> announcement might have given us the option of bringing together the poorer pensioner proposals with those for equality of state pension age. There might have been some presentational advantage in that.

On the other hand, Mr Moore's initial reaction seems to be that 1990 is ok, given the need for legislation, and it does of course suit us from the public expenditure point of view. As for the pension age, Mr Moore is committed to bringing forward proposals before the end of the year, but we do not know how soon Ministers collectively will have agreed anything which could be made public.

7. As you know, the Chancellor has been concerned that whatever the exact mechanism, it should 'fade away'. I think the DSS scheme would fade away, in that, increasingly, pensioners will be retiring with either a significant SERPS or occupational pension. So fewer and fewer people when they reach the age of 75, or whichever age threshold is chosen, would stand to gain from the scheme. I do not think it would be necessary, therefore, to use the Chancellor's idea of a qualification based on date of birth in order to make the scheme fade away.

8. I asked Mr Chislett if DSS were considering an option based on IS, since this would be most obviously targeted at the poorest. He said not. He doubted whether adding something to the pensioner premia in IS would now be an adequate response, and it would be attacked on the grounds that some pensioners were reluctant to take up means-tested benefits.

9. This is very much a progress report. But subject to the cost and finding ways of excluding the self employed and some others with large savings outside SERPS and OPs, I think the scheme is attractive. I will let you have details of the costings and number of gainers as soon as I can extract them from DSS.

JM

J P MCINTYRE

chex.ps/aa/88 **UNCLASSIFIED**

FROM: A C S ALLAN
DATE: 9 November 1988

PS/CHIEF SECRETARY (*)

cc **PS/Financial Secretary (*)**
PS/Paymaster General (*)
PS/Economic Secretary (*)
Mrs Chaplin
Mr Tyrie
Mr Call

Mr N Forman MP
Mr A Howarth MP

(* + one for PPS).

LETTERS FROM GORDON BROWM MP

... I attach a draft reply to Gordon Brown's two letters, which the Chancellor would like to discuss at Prayers this morning. I also ... attach copies of some relevant background articles etc.

ACSA

A C S ALLAN

chex.ps/aa/87

For signature

DRAFT REPLY TO: GORDON BROWN MP
House of Commons

Thank you for your letters of 7th and 8th November.

As I told the House, very clearly, on 7th November, what the Government is working on is a plan to provide extra help for poorer pensioners.

I note that your letters are merely a smokescreen intended to obscure this welcome news.

As for my off-the-record remarks to a group of journalists on Friday, I regret that no transcript exists. But ~~last night's Evening Standard~~ today's Daily Telegraph published an account supplied by the most senior of the journalists present. So far as I can recall, it is broadly accurate. As you will see, nothing in it remotely justifies either the scare stories published in the Sunday press, or the allegations you and your colleagues have seen fit to make on the basis of those stories.

To repeat, what we have in mind is extra help for poorer pensioners, over and above the basic State pension, which itself will continue to be uprated in line with prices.

I hope you will accept this and cease repeating what you now know to be untrue.

NIGEL LAWSON

CATCHCHANN MSG

Telegraph Story. PV

By Our Political Staff

THE FIRST detailed account of Mr Nigel Lawson's controversial briefing to lobby journalists on the future of pensions and other benefits for the elde was made public yesterday.

Mr John Warden, a senior lobby correspondent who writes for the Sunday Pc Dundee, took up the challenge issued by Mr Lawson in the Commons on Monday ''look in his notebook'' for the correct version of the off-the-record briefing.

Mr Lawson described as a ''farrago of invention'' Sunday newspaper report that the Government was considering means testing some benefits for pensioners, including the £10 Christmas bonus and their exemption from prescription charges.

The Treasury, however, has declined to produce a transcript of the briefi given at the Chancellor's official residence No 11 Downing Street on Friday saying that there had been a ''fault in the tape machinery''.

Mr Warden yesterday produced his account of the exchanges on pensioners f the shorthand notes he took at the meeting, filling in the odd gap from memory. This is how the exchanges went.

Q. What about pensioners, Chancellor? They are not exempt from the new heal charges for eyes and teeth, and that is the first time. Does this set a pattern?

A. The problem with pensioners is that there is a minority who do have difficulty in making ends meet.

Q. A minority?

A. Yes, a tiny minority. Pensioners as a whole are doing very much better t before. More of them have occupational pensions or SERPS on top of their ba state pension, and their savings are not being eaten away by inflation as t were under Labour. As a result, the incomes of pensioners have been rising faster on average than incomes of people with wages.

Q. What are the implications for benefits?

A. We have to see in the evolution of the social security system whether we can do better there, so that we can help the minority of pensioners who do genuinely have difficulty in making ends meet.

Q. Doesn't that mean you will have to educate your backbenchers in view of what happened this week? (The Tory backbench revolt on the new health charges, which reduced the Government's majority to eight).

A. The rebellion comprised people who had very different motivations.

Q. How will you do targeting?

A. There is no study group or anything of that sort. But in my opinion this the way we are likely to go. Of course, the state pension is regularly uprated. It is a pledged benefit. Child benefit was not pledged. You can f all these benefits and whether they are pledged or not in Parliamentary answers.''

When the journalists checked later on the unpledged benefits, as suggeste by the Chancellor, they included the Christmas bonus. They regarded the Chancellor's answers as confirming that the increasing numbers of better o pensioners would be reflected in longer term of targeting state benefits.

Mr Lawson, however, told the Commons that he had been hinting at a new scheme to give special help to poorer pensioners ''over and above'' the existing level of benefits.

And the Treasury last night refused to confirm Mr Warden's account. A spokesman said:'' The briefing was off the record and there is no transcri But the accounts that have been given of what the Chancelor said do not support the stories of threatened cuts for pensioners.''

end

(END)

chex.ps/aa/88 **UNCLASSIFIED**

FROM: A C S ALLAN
DATE: 9 November 1988

PS/CHIEF SECRETARY (*)

cc PS/Financial Secretary (*)
PS/Paymaster General (*)
PS/Economic Secretary (*)
Mrs Chaplin
Mr Tyrie
Mr Call

Mr N Forman MP
Mr A Howarth MP

(* + one for PPS).

LETTERS FROM GORDON BROWM MP

... I attach a draft reply to Gordon Brown's two letters, which the Chancellor would like to discuss at Prayers this morning. I also ... attach copies of some relevant background articles etc.

ACSA

A C S ALLAN

chex.ps/aa/87

DRAFT REPLY TO: GORDON BROWN MP

Thank you for your letters of 7th and 8th November.

As I told the House, very clearly, on 7th November, what the Government is working on is a plan to provide extra help for poorer pensioners.

I note that your letters are merely a smokescreen intended to obscure this welcome news.

As for my off-the-record remarks to a group of journalists on Friday, I regret that no transcript exists. But last night's Evening Standard published an account supplied by the most senior of the journalists present. So far as I can recall, it is broadly accurate. As you will see, nothing in it remotely justifies either the scare stories published in the Sunday press, or the allegations you and your colleagues have seen fit to make on the basis of those stories.

To repeat, what we have in mind is extra help for poorer pensioners, over and above the basic State pension, which itself will continue to be uprated in line with prices.

cst.ps/5ce10.11

PERSONAL AND CONFIDENTIAL

FROM: MISS C EVANS
DATE: 10 November 1988

MR McINTYRE

cc: Chancellor
Mr H Phillips
Mr Ramsden

POORER PENSIONERS

The Chief Secretary was grateful for your minute of yesterday which he discussed with you and Mr Phillips this morning. You emphasised that Mr Chislett had told you about the DSS scheme on a personal basis and that our knowledge of it should not be revealed.

2 The Chief Secretary agrees that the DSS scheme is a worthwhile, administratively simple and well targeted new option which should be worked up. However he thinks £300 million would be too expensive, although he recognises that the previous Nick Scott scheme of £70 million would not be enough. Among possible disadvantages with the scheme are that

PM would have a fit

- it would have a continuous cost since new over 75s would join each year, though the cost would decline as increasing numbers of over 75s would have SERPS or occupational pension entitlement above the threshold;

- people over 75 with sufficient pension means to take them just above the threshold would be aggrieved and the scheme could thus be seen as a disincentive to thrift. But it was recognised that this problem would arise with all schemes having a means tested element.

Further detailed work would be needed to establish whether any deserving cases, such as single women with no pension record at all, would fall through the net.

3 The Chief Secretary is anxious to ensure that DSS do not come forward with only one scheme. He would like two further options to be evaluated as well:

- a scheme providing a top up pension to all those born before, say, 1 January 1914

- a straightforward increase in income support

4 The first would be a universal scheme with the eligibility date set to bring in people who would have been unable to build up a SERPS entitlement above, say, £3. The advantage of this scheme would be universality, simplicity, and no penalty for thrift. In effect it would buy for those people a modest SERPS entitlement when they had been unable to accure.

5 You explained that it would not be possible to set a date after which pensioners could be assumed to have a particular SERPS entitlement, since entitlement depended on time worked and earnings. If it were decided to choose the date after which the average SERPS entitlement was above the chosen figure, there would always be some people excluded from the scheme who were poorer than those benefiting from it. The Chief Secretary agreed that the extent of this problem would need to be investigated, as would the number of clearly undeserving cases who would benefit.

6 If a scheme along these lines were chosen it would be possible to start with a high initial cost since this would fall away rapidly and ultimately disappear.

7 It was noted that since this scheme would not be related to income it could be difficult to reconcile with a stated objective of working up a scheme targeted effectively on the most needy. On the other hand, if it could be shown that in fact those born before the chosen date were overwhelmingly the most deserving, then the date of birth criterion could itself represent an effective and easy to understand form of targeting, without a means test.

8 Finally the Chief Secretary asked that we consider the two new options alongside a straightforward increase in income support which would be well targeted and enable a higher payment for the same cost. You mentioned that Mr Moore's view was that this straightforward option would not suffice in the light of expectations of a new scheme based on detailed work. The Chief Secretary nevertheless felt that we should keep this option open.

9 You agreed to ask DSS to cost these two options for consideration with their new proposal as soon as possible.

Cathy Evans

MISS C EVANS
Private Secretary

chex.md/mw/107 **UNCLASSIFIED**

FROM: MISS M P WALLACE
DATE: 10 November 1988

MR MCINTYRE

cc PS/Chief Secretary
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Gieve
Mr Tyrie
Mr Call

PENSIONERS: LETTER TO MR MOORE FROM ROBIN COOK MP

The Chancellor was grateful for your minute of 9 November, covering the DSS's proposed reply to Robin Cook. The Chancellor and Chief Secretary were both content with this, and I have passed this message on to Mr Moore's office.

MOIRA WALLACE

cst.ps/2ce10.11

CONFIDENTIAL

other PPs
cc:
PS/Chancellor
Mr Anson
Mr H Phillips
Miss Peirson
Mr Turnbull
Mr McIntyre
Mr Gieve
Mr Ramsden
Mr Speedy
Mr Call

Treasury Chambers, Parliament Street, SW1P 3AG

Nicholas Bromley Esq
Private Secretary to the Minister of State for Social Security and the Disabled
Department of Social Security
Richmond House
79 Whitehall
London
SW1

10 November 1988

Dear Nicholas

DISABILITY: OPCS SURVEYS

Thank you for sending me a copy of your letter of 8 November to Dominic Morris at No. 10. The Chief Secretary has also seen the draft press notice and written answer which your officials have kindly sent to ours, together with the final version of the second OPCS report. Officials have already been in touch about this material.

He believes it is extremely important that the statement makes clear that the report's assessment of living standards takes no account whatsoever of the provision of services by Local Authorities. This is clearly an omission. A related point is that the figures given for average incomes of the disabled are after housing costs and do not therefore reflect the contribution of housing benefit to the incomes of many disabled householders. Taken on their own, without these qualifications, figures given for average incomes in the report may give a false impression of the living standards of disabled people.

As well as mentioning the 90 per cent real terms increase in expenditure on disability benefits, the Chief Secretary thinks it would be a good idea to refer to the substantial increases in provision which have been agreed in this year's Survey. He thinks that, in the circumstances of this report, it would be reasonable to depart from the general practice of delaying publication of detailed figures for particular benefits until the White Paper.

The Chief Secretary was interested by the reference to your Department's new report on the coverage of occupational sick pay schemes. He wonders whether the importance of this point might be emphasised a little more by concluding the relevant paragraph with a sentence on the following lines:

> "This shows that there is increasing private sector provision against the risks of long term sickness and disability among employees, as well as growing public expenditure on disability benefits."

The Chief Secretary was also interested by the reference to the expected publication next Autumn of research based on the Family Expenditure Surveys comparing expenditure by disabled people and their families with expenditure by other families. The Chief Secretary assumes that this further report, coming some time after the final OPCS volume early next summer, would not prevent the government announcing its conclusions from the disability review next Summer or Autumn, with the possibility of legislating in the 1989-90 Session (if Ministers were agreed that this was a desirable timetable). The Chief Secretary suggests that, if there is any doubt on this point, it would be better to omit the relevant paragraph from the press statement and written answer.

On the figures for take-up in the draft statement, the Chief Secretary would see some merit in including a table of figures for all the main benefits, not just Attendance Allowance and Mobility Allowance. The increases might also be more effectively described by giving the actual numbers in receipts of each benefit in 1979 and the expected take-up this year.

The Chief Secretary thought that one interesting point which might be brought out in the statement or the briefing for publication day was that nearly one third of disabled people are in employment, with the figure rising to about half for those in category one (the least disabled).

Finally, the Chief Secretary was disturbed by some of the statements made in the summary of volume 2. In particular, he does not understand why it is said on page 2 that "all pensioners are largely dependent on state benefits" when the fact is that there has been a decline in the proportion of pensioners' average incomes accounted for by benefits to less than 60 per cent. Second, the final sentence of the summary says that "overall, disabled adults are likely to experience some financial problem and to have lower standards of living than the population as a whole ..." The report makes clear elsewhere that the majority of those classified as disabled in the survey (ie pensioner) have incomes broadly in line with pensioners in the population as a whole and that 70 per cent of the disabled reported that they were satisfied with their living standards.

The Chief Secretary understands that it is now too late to amend the summary to deal with these points, but he hopes that as much as possible will be done in the press release and briefing of the press, the lobbies, and interested backbenchers to counter the impressions given in the summary on these questions.

CONFIDENTIAL

I am copying this letter to Dominic Morris and to the Private Secretaries of other members of H Committee and to Trevor Woolley.

Yours ever

Cathy

MISS C EVANS
Private Secretary

novst1.12

BF 16/11 BF 23/11

Line to take has been agreed with DSS. JM 10/11.

FROM: J C J RAMSDEN
DATE: 10 November 1988

1. MR MCINTYRE
2. CHIEF SECRETARY

cc Chancellor
Financial Secretary
Paymaster General
Economic Secretary
Mr Anson
Mr Phillips Mr Turnbull
Miss Peirson Mr Grieve
Mr Speedy
Mr Towers
Mr Ford
Mrs Chaplin
Mr Tyrie
Mr Call

Who is the Chair of NACAB?

MEANS-TESTED BENEFITS; NACAB REPORT

The press has picked up a report by the National Association of Citizens Advice Bureaux (NACAB) which is critical of the April reforms (see the attached extract from the Independent for 9 November). You may like to have a brief note on this.

2. The NACAB report claims that :

- 82% of Supplementary Benefit claimants are worse-off as a result of the switch-over to Income Support;

- over 50% of working families are worse-off overall because losses on Housing Benefit (HB) have wiped out any gains from Family Credit;

- most losers among working families are over £5 a week worse-off; and

- HB claimants were worst-hit of all, with 90% of claimants losing and almost half of these losing over £5.

3. These claims are of course in total conflict with Government estimates in the 'Technical Annex' which DSS still consider the most reliable indicator of the effect of the April reforms. Overall the Government claims that 61% of claimants gained in cash terms, 21% got the same, and 12% lost.

4. The flaw in the NACAB statistics is that they claim to represent the experience of all claimants but are only based on the experience of those who have complained to a Citizens Advice Bureaus. In other words the Sample used by NACAB is fundamentally biased. Had NACAB presented their survey simply as an indication of how some of the losers from the reforms had fared, their report would have carried more weight. A NACAB spokesman is quoted by the Independent as conceding that the sample used in the report might not be representative.

Line to Take

- NACAB report based on an unrepresentative sample, confined to those who consulted CA Bureaux over problems.

- Latest official estimates indicate that over 60 per cent of claimants gained from April reforms.

J C J RAMSDEN

Extract from The Independent 9.11.88!

Reference .....

Poorest claimants 'worse off under benefit changes'

MANY OF the poorest claimants, particularly poorer pensioners, have been left worse off by social security changes last April, the National Association of Citizens Advice Bureaux said yesterday, **Nicholas Timmins writes.**

And some claimants who took a job now found themselves worse off, it added.

In the biggest survey so far of the impact of the changes, the association said a study of 30,000 people who consulted its bureaux in May showed four-fifths of the poorest claimants to be worse off after the changes.

Stricter means tests were discouraging people from applying for help, particularly from the Social Fund. And key aspects of the new system were undermining work incentives, the association said.

The Government's aims are to improve targeting on the most needy, and to encourage people to escape the "dependency culture" by getting into work. Ted Craven, the association's acting director, said many of the changes were missing the target and work incentives were being hit.

Nicholas Scott, Minister for Social Security, said the study was undertaken as the changes came in, and were "old news on a very small sample". Mr Craven said many of the difficulties "are not teething troubles that will go away, but things built into the structure of the system".

The association conceded that its bureaux tend to see people with problems, so that the proportion it saw who were losing might not be representative. But the structural problems would affect all claimants, it said.

Although two out of three on the new income support had more cash, nearly half of these only gained because they had "transitional protection" which stopped their benefit being cut in cash terms but meant many would see no increase in benefit next April. As a result, 82 per cent were worse off in real terms, either immediately or from next April.

The cut from 30 to 24 hours a week in the amount of work people on income support could do had left husbands who were unemployed, but whose wives had small part-time jobs, having to persuade the wife to give up work so that they could claim income support.

Families with children who moved on to Family Credit when they got a job found themselves worse off because their mortgage interest was no longer paid. And single parents could claim less for child care and work expenses while working part-time on benefit, so that either their income was cut or they had to give up work.

Grants for tools or clothing to equip people for work were no longer available; and people could no longer claim for the first fortnight they worked, having to take a loan if they could get one, or an employer's advance, so that "people start work with a debt," Carol Smith, of the NACAB's West Yorkshire Money Advice Support Unit said.

Cuts in housing benefit and inadequate compensation for the loss of free school meals also left a majority of those who consulted bureaux worse off on the new Family Credit.

CONFIDENTIAL

FROM: J P MCINTYRE
DATE: 10 November 1988

CHANCELLOR

cc Chief Secretary
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Gieve
Mr Saunders
Mr Ramsden
Mrs Chaplin
Mr Tyrie
Mr Call

PENSIONS ETC: LETTER FROM GORDON BROWN MP

Mr Brown's letter of yesterday. You may not want to answer Mr Brown's questions, line by line. You cannot, in any case, say any more about the new scheme at this stage. But you may want to consider whether you can answer enough of his questions about other benefits (child benefit etc) to have some prospect of bringing the correspondence to a close. Unless some of his specific questions are answered, Mr Brown may appear justified in continuing to press you.

2. On the health side, Mr Brown repeats his questions about whether there are plans to means test free prescriptions for pensioners or to introduce new health service charges (questions 5 and 6). A new development here you should be aware of is that Mr Clarke is reported in today's press (copy attached) as having told the Social Services Committee yesterday that there is no prospect of the government introducing charges for general medical services such as visits to the doctor and screenings for cervical and breast cancers.

3. The attached draft reply confirms that there are no plans to change the existing exemption for pensioners from prescription charges, but does not rule out future changes in the system of NHS charges. The latter is consistent with Mr Clarke's reported remarks in that he apparently referred only to charges for general medical services.

4. Turning to benefits, Mr Brown's letter raises the following points:

Question 1: Child Benefit

Mr Brown wants you to reveal what you said in your briefing about restructuring child benefit. If you want to address this particular point, one response would be to repeat what you said on Panoramma, confirming the manifesto commitment but leaving open the position beyond this Parliament.

Question 2: The "minority of pensioners"

Mr Brown is interested in what you said in your briefing rather than the substance. As you know, the facts are that around 1¾ million pensioners get income support and about 3½ million get housing benefit. This is out of a total pensioner population of some 9¾ million. However, I doubt whether reciting these figures to Mr Brown will convince him that there is indeed only a "minority of pensioners" in difficulty. Nor would we want to concede the point that the level of means-tested benefits for pensioners by definition left all those in receipt of them in difficulty. If you wanted to address this question at all in your reply, a more effective response might be simply to repeat that, on average, pensioners have been doing well, but that the government is drawing up plans to provide further help for poorer pensioners on top of existing benefits. You will not want to be drawn on how large or how small you think the minority is which has difficulty making ends meet. On balance, however, I think this question is best ignored. You could say that you have nothing to add about what was said in your briefing.

total (including IS)

Question 3: Targetting

Again, Mr Brown is interested in what you said in your briefing about targetting. This could be handled in the same way as Question 2.

Question 4: Further means testing

As for Questions 2 and 3.

Question 5: Attendance Allowance, Mobility Allowance, Christmas Bonus

There may be some advantage in confirming that there are no plans to means test any of these.

Questions 7-8: The New Scheme

You will not want to be drawn.

Question 9: Housing Benefit Cuts etc

Mr Brown suggests that pensioners have been hit by withdrawal of housing benefit, the minimum 20 per cent rates requirement, and the introduction of loans rather than grants under the Social Fund. On housing benefit, the answer is that many pensioners did lose as a result of the April 1988 reforms but of course many of the biggest losers are now eligible for compensation under the transitional scheme. On 20 per cent rates, those on Income Support get assistance towards their payment, and the effect on those just above Income Support has been softened by the decision earlier this year to cut the income taper from 20 per cent to 15 per cent when the community charge is introduced. On the Social Fund, pensioners are a priority group for the purposes of allocating community care grants within the Fund, as well as being eligible for loans. But all this is pretty detailed DSS territory, and I assume you will not want to get into it.

Question 10: The tape

Mr Brown seeks confirmation that a recording of your briefing was made. You may want to confirm that there is no transcript.

5. I attach a draft reply, to which ST2 have contributed.

JM

J P MCINTYRE

Ch
Would it be worth laying out as answers to his ten points? Or broad-brush approach as Loc?

DRAFT LETTER TO:

Gordon Brown MP
House of Commons
LONDON SW1A OAA

Thank you for your letter of 9 November.

As far as our plans for giving extra help to poorer pensioners are concerned, I have already said that we will announce our proposals in due course when they are ready. And as I told you in my letter of 8 November, nothing in my remarks to a group of journalists last Friday remotely justified the stories which appeared in the Sunday Press or the allegations you have since made on the basis of those stories. There is no transcript of the briefing. I do not think there is anything I can usefully add on any of these points.

On the question of child benefit, we have made it clear that there are no plans to change the structure of the benefit and that we will continue to fulfil our manifesto commitment. There are no plans to means test attendance allowance and mobility allowance, or the Christmas Bonus.

As far as prescription charges are concerned, there are no plans to change the existing exemption for pensioners. You will not of course expect me to give a commitment that there will be no future changes in the system of NHS charges.

You can't say this.

NIGEL LAWSON

Thursday, November 10, 1988

THE INDEPENDENT

Extra cash given to NHS 'should avoid bed closures'

By Colin Brown

THE ADDITIONAL £2.2bn for the NHS should avoid any bed closures due to lack of funds next year, Kenneth Clarke, the Secretary of State for Health, assured the Commons Select Committee on Social Services.

Mr Clarke said he could not control the actions of all the district health authorities, but he assured the committee that the additional money should be enough to avoid bed closures.

But Mr Clarke warned that hospital managers would have to resist the demands for more money by nurses over the restructuring of their pay. He said this would be the first test for the managers.

The Department of Health also will be providing a special one-off payment to wipe out the debts of some authorities who have gone into deficit. However, close monitoring will be carried out by the Department to ensure the authorities do not get back into "bad practices", Mr Clarke added.

Individual health authorities will be told shortly how much extra they will receive from the additional money for the NHS next year.

Mr Clarke was unable to give details yesterday, but he assured the cross-party committee that no sums were being held back for the completion of the Government's fundamental review of the NHS.

He confirmed the additional money would include doubling the budget for Aids prevention and care.

Mr Clarke was closely cross-examined on whether he had demanded additional sums from the Treasury to cover inflation in the NHS at a higher level than the retail price index. But Mr Clarke made it clear he did not believe in special inflation figure for the NHS. He also cast doubt on the validity of assumptions that the NHS automatically needed an additional 2 per cent each year to ensure real terms growth.

He said he had taken the Chancellor's assumption on inflation as the yardstick and the likely cost of pay increases for his bids for extra funding from the Treasury. However, he disclosed that John Major, the Chief Secretary to the Treasury, with whom he had negotiated the extra money, had been "predisposed as were his colleagues to giving higher priority to health" in his annual review of public expenditure.

Mr Clarke refused to be drawn by Frank Field, the Labour chairman of the committee, on which

Clarke: 'Nothing held back'

group of ministers had decided to give higher priority to health spending from other departments. He said that it had been done with the agreement of the full Cabinet.

The Secretary of State was also challenged by Nicholas Winterton (Con Macclesfield) and Jerry Hayes (Con Harlow), two Conservative MPs who voted against the Government on the introduction of charges for eye tests and dental check-ups. Mr Clarke defended the decision, arguing that the check-ups and tests could not be compared to screening for fatal diseases. When it was pointed out that some fatal diseases were identified by dental check-ups, Mr Clarke insisted that the check-ups were not primarily for screening. He caused laughter when he said dental decay did not cause fatalities.

But Mr Clarke was pressed into an unequivocal assurance that there would be no new charges on medical care. He said: "I have no intention of extending charges into medical areas."

Since 1951, it had been accepted that dental and optical areas of care were legitimate areas for charges, but, he added, "to go into general medical services to consider introducing new forms of charge, for example, visiting the doctor" would be wrong.

David Mellor, the Secretary of State for Health, told the committee that he was still considering a range of proposals for improving the delivery of care in the community for the mentally handicapped. These included the report by Sir Roy Griffiths, deputy chairman of the NHS management board, who recommended giving the lead to local authorities, which Margaret Thatcher is believed to have rejected. Another option being considered would give the lead to a primary care authority.

Clarke gives pledge on free visits to doctor

FINANCIAL TIMES

SOCIAL SERVICES COMMITTEE

By Richard Donkin

MR Kenneth Clarke, the Health Secretary, assured a Commons select committee yesterday that there was no prospect of the Government introducing charges for general medical services such as visits to the doctor and screenings for cervical and breast cancers.

At the same time he did not envisage bed closures for financial reasons among well-run health authorities in England and Wales within the next year.

He said he could not speak for 190 health authorities and qualified his remarks by saying that one of the first tests of authorities would be whether they succumbed to pressure from nurses contemplating industrial action over regrading.

He made it clear, however, that government would be monitoring the income and expenditure accounting of health authorities in future to prevent what he described as short-term accounting prob-

rary ward closures, delayed openings and delayed provision of beds to overcome their spending shortfalls.

Mr Clarke had been challenged by Mr Nicholas Winterton, the Tory MP for Macclesfield, to define the difference between the imposition of charges for eye and dental tests and the provision of free breast screening and checks for cervical cancer.

Medical screening, said Mr Clarke, was designed to detect disease where eye tests had originally been for the fitting of spectacles and dental tests had been designed to find chips and cavities in teeth. The possibility of glaucoma or oral cancer was an indirect result of the tests, he said.

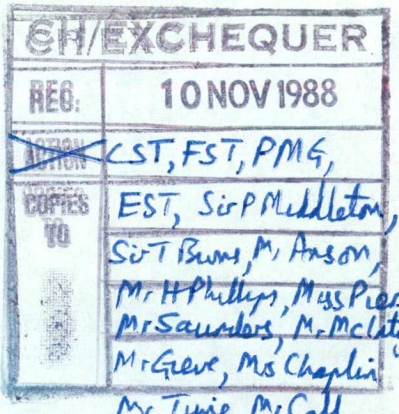
Pressed by Mr Winterton for an assurance on free medical tests, Mr Clarke said: "I have no intention of extending charges into the medical area."

He said there was no prospect of the Government making additional charges for gen-

back Alex
LS

HOUSE OF COMMONS
LONDON SW1A 0AA

✓ 10/11



Rt Hon Nigel Lawson
The Chancellor
11 Downing Street
London

Dear Chancellor

Thank you for your letter . Far from my questions being a smokescreen it is your failure to answer specific and legitimate questions of public policy that constitutes the real smokescreen.

I would be grateful if you would now answer the very direct and specific questions I have put to you , now ten unanswered questions which you have clearly sought to ignore

1. I asked you to confirm whether you had said that "clearly there is a case " for restructuring child benefit and that you would have sought to means test child benefit but for a comma in your manifesto , preventing you doing so in this Parliament

2. I asked you to confirm whether you said that there is a"minority"of pensioners who have"difficulty in making ends meet". I would ask you to confirm specifically that this was said

3.I asked you whether you said that targeting is"the way we are likely to go " but accepted that your backbenchers will have to be educated to accept means testing generallly.

4.I asked you also whether your view was that the way ahead is means testing of all benefits, other than benefits covered by pledges inconsistent with means testing.

5. In my letter of November 8th I asked you to clarify your views by giving specific committments that there is or will be no plan to means test attendance and mobility allowance; the Christmas bonus or free prescriptions for pensioners.

6.I asked you to deny any plan to introduce new health service charges

7. I asked for details of the cost, the time scale and the number who are to benefit from the new and unspecific announcement that you made on Monday

8. I asked you whether any pensioners would benefit from your announcement this winter or next

9. I asked whether one reason why poorer pensioners need more help is the Government's decisions on withdrawl of housing benefit and the imposition of the 20% rates requirement and the introduction of loans instead of grants under the new Social Fund

10. I asked you to confirm that a tape recording was made of the briefing and a tape exists. This remains unresolved in your answer

I also deprecate your last sentence in which you accuse me of "repeating what I know to be untrue".I do not do that, never have done and invite you to withdraw.

On Monday you asked journalists present at your briefing to "open their notebooks". Now that they have done so and raised the questions that I now put to you I hope you will agree that you have an obligation to the House and to the country to be equally open and candid in your answers.

Yours sincerely

Gordon Brown

Gordon Brown
Treasury spokesman

Brief from Sedgwick BF

cc PEN [redacted]
TB [redacted]

in partic abt priorities for review.

PSM 2 latime

Giles?

C/ Mrs Jennifer Radice has rung to see if you will agree to see for half an hour the Group undertaking the Scrutiny of Government Economic Statistics, towards the end of next week or the beginning of the week 19 Sept.

As you know Stephen Pickford heads the group & the others are Mrs Radice, Robin Lynch Graham White & John Cunningham.

Content to see them?

If so I will try & find a suitable time.

Julie
5/9.

6057.

Sedgwick.
Jun Hubbard.
John O'Shea.

TB
PEM.