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PART 4

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PART G

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PART G

CHANCELLOR'S PAPERS ON HEALTH AND SOCIAL SECURITY SERVICES

Begins: 28/11/88

Ends: 7/12/88 (CONTINUED)

DD: 25 years

15/9/95

PO -CH /NL/0223
PART G

chex.ps/mw/14 **CONFIDENTIAL**

BF 29/11

FROM: MISS M P WALLACE
DATE: 28 November 1988

MR McINTYRE

cc PS/Chief Secretary
Mr Anson
Mr Phillips
Mr Turnbull
Mr Gieve
Mr Ramsden
Mrs Chaplin
Mr Tyrie
Mr Call

CHILD BENEFIT/FAMILY CREDIT/INCOME SUPPORT

The Chancellor was grateful for your note of 25 November.

2. He comments that it is essential that we have a good line worked up on this. And what we say needs to be reconciled with the Chancellor's comment on Panorama that:

> "Under the way the system works, with any increase in child benefit they lose income support or family credit, pound for pound, so that poor families couldn't possibly benefit from an increase in child benefit. What they will benefit from is the very substantial increase that we have announced over and above the normal uprating of family credit .

3. It is clear from what you say in your minute that we cannot claim that child benefit increases are offset against family credit in the same straightforward way as they are against income support. However, could we use the arithmetic in your paragraph 3, to make the related point that the family credit child credits are derived from the corresponding income support child premia minus child benefit plus school meals? Is this a formalised link, eg in the legislation? If not, are we prepared to expose it publicly, and thus run the risk of formalising it for the future? And are there any nasties in the calculation -

eg how is the school meals compensation calculated, and how is it uprated?

4. If this approach cannot be used, what is the next best? Do we want to draw attention to the 45p we have added on to the FC child credits to compensate for the freeze on child benefit? Again, is there any awkwardness about exposing this publicly if, for example, it is thought to commit us for any future occasion?

5. The Chancellor notes that all this will need to be sorted out before an oral Lords PQ put down by the Countess of Mar, for answer on 15 December. However, as it is also possible that this could be raised in tomorrow afternoon's Debate, the Chancellor would be grateful for your view on the line to take before then.

MOIRA WALLACE

CONFIDENTIAL

CH/ The answer to your question is that the calculation at X on earlier minute was

FROM: J P MCINTYRE
DATE: 29 November 1988

CHANCELLOR (a) not a formal rule, and ∴ not in legislation, and (b) wd reveal nasties on the school meals front (Y over). So we are left with the line below. Overall, not a very productive exchange.

cc Chief Secretary
Mr Anson
Mr Phillips
Mr Turnbull
Mr Peirson
Mr Gieve
Mr Ramsden
Mrs Chaplin
Mr Tyrie
Mr Call

CHILD BENEFIT/FAMILY CREDIT/INCOME SUPPORT MPW.

I see two possible lines of attack if this subject is raised this afternoon: low take-up and the fact that child benefit increases are not offset by cuts in family credit, as they are in income support. On both fronts, I see every advantage in keeping our response brief and simple, leaving DSS to defend in detail. I suggest the following lines to take.

Low take-up of family credit

In terms of expenditure, take-up so far is about 60 per cent. That is, we are spending 60 per cent of the amount we would spend if all those entitled to family credit were to claim it.

Child benefit increases NOT offset by cuts in family credit: so family credit families WOULD gain from child benefit uprating

Important point is that it makes no difference to those on family credit whether or not child benefit is uprated. They get the same increase either way. Next April they will get an extra 45p a week through family credit instead of through child benefit. On top of that, they will get the additional 50p a week announced by my RHF in his uprating statement.

BACKGROUND

On take-up, the 60 per cent figure (if you use it) will be new to the House. DSS Ministers have not so far used it. It is much

higher than the 30-40 per cent figure mentioned in the press and by Opposition spokesmen. The reason for the difference is that the 30-40 per cent figures are for caseload ie the number of claimants as a proportion of the total entitled to claim. The 60 per cent figure is for expenditure. It is higher because many of those who do not claim have relatively small entitlements. DSS emphasise that it is an extremely rough estimate but they are content for it to be used if the issue is raised.

On the interaction with child benefit, I think it would be dangerous and unnecessary to go into the mechanical differences between family credit and income support. The key point is that, whether or not child benefit is uprated, it makes no difference to families on either benefit.

The answer to your first specific question (Miss Wallace's minute of yesterday) is that there is no legislative requirement to construct the child credits in family credit in the way described in my 25 November minute. And this method was used only to construct the original rates when family credit was introduced last April. Upratings (including the one for next April already announced) will be simply by the ROSSI (RPI minus housing) index. There will be no separate uprating of the original school meals component. (Thus, to the extent that the cost of school meals rises faster than ROSSI, family credit families will lose out. For this reason, it would be better not to draw attention to the origins of the April 1988 child credit rates.)

On the second specific question in Miss Wallace's minute, I see no difficulty at all in highlighting the 45p increase in next April's family credit rates. That is how compensation for the child benefit freeze is achieved. Although it is discretionary, I suspect that in practice we would not want to oppose DSS taking the same action in future, if child benefit were again frozen. (It is the 50p addition we may not want to see repeated.)

JM

J P MCINTYRE

NICs - OPTIONS FOR CHANGE

1. Smoothing

pro - removes cliff edges

cons - presentationally complex
- involves higher standard NIC rate

(query: open up debate on this issue in the future?)

2. Abolition of UEL substantial increase to UEL

pros - removes/reduces anomalous drop in marginal tax rates between UEL and higher tax rate
- makes NIC structure more progressive
- removes major obstacle to merging tax and NICs

cons - creates substantial "tax" increases to all earners above current UEL unless offset by significant cut in tax rates
- break with contributory principle; employees pay more for no extra benefit

3. Reducing all rates

con - reduction in 9 per cent main rate unsustainable for NI fund

4. Raising LEL to single person's tax threshold or above

con - big problem for contracted-out and their employers.
- raising LEL increases NICs that contracted-out have to pay

KEY ELEMENTS OF PREFERRED (AFFORDABLE) PROPOSALS

1. LEL/UEL linked to earnings

pros - allows SERPS contribution to be protected and personal pensions
- NICs is a tax on earnings. Logical to increase limits in liability for NICs in line with earnings growth rather than prices growth
- earnings increasing by more than prices so earnings link means fewer paying NICs over time
- linking UEL with prices has meant it becomes less and less a measure of higher earnings

con - linking LEL to earnings removes benefit title from some low earners

2. Reduce lower rates % down and bands increased

pro - "tax" cuts aimed at low paid

con - increasing height of cliff edge to higher rate

3. Money

(a) Surplus

For 1989-90 Fund surplus of £1/2 bn. predicted by Actuary, based on conservative assumption on growth of earnings (7.5%). Surplus in 1989-90 could be as high as £1bn if earnings grew at 9.5%.

(b) Balance

Balance end 1989-90 predicted to be £10.5bn by Actuary. Minimum target balance 1989-90 one sixth of benefit expenditure about £4.5bn.

(c) Resources must be left in fund for cost of extra contracting out arising from the DISABILITY Review.

4. Legislation: Secondary legislation only needed to change reduced rates and increase earnings brackets.

Primary legislation need to increase LEL and UEL in line with earnings - currently limits linked to basic pension.

OPTION

a Lower and Upper Earnings limits linked to Earnings

b. 1 per cent reduction in the reduced rates for low earners and their employers.

c. Expansion of reduced rate earnings brackets, for employees and their employers.

d. Employers pay 10.45 per cent in respect of people earning above £165 a week, as proposed from April 1989.

Proposed Rates	Proposed Brackets	Current Rates	Brackets 1988-89 (NOW)	Brackets 1989-90 (PROPOSED)
4%	£44 (LEL)-£100	5%	£41(LEL)-£70	£43-£75
6%	£100 -£130	7%	£70-£105	£75-£115
9%	£130 -£330(UEL)	9%	£105-£305(UEL)	£115-£325 (UEL)

Employers pay 9% in respect of people earning between £130 a week and £165 and 10.45 per cent in respect of people earning at or above £165 a week.

2. EFFECT ON THE NATIONAL INSURANCE FUND IN 1989-90+ £MILLION

	Option 1(a)
Gross Class 1 contribution effect	-815
Offset (Higher UEL)	+30
Contracted Out Rebate effect:	-++
Net Class 1 Contribution effect:	-785
Class 2/3 effect: +++	- 45
Total receipts	-830
Total full year cost (accruals)	-955

\+ Receipts in 1989-90 into the NI Fund. (Part year changes would mean lower estimates). Receipts effect approximately 87 per cent of full year effect). All figures rounded to nearest £5 million. All comparisons with announced 1989-90 proposals.

++ Negligible

+++ The combined effect of a slightly higher LEL and a lower NIC rate for the lowest earnings bracket, would reduce Class 2 and Class 3 rates. (8 per cent of £44 equals £3.50 a week giving a reduction in the Class 2 rate of about £0.75 a week).

3. NUMBER OF CONTRIBUTORS AFFECTED (MILLION)

	Option 1(a)
Affected by cut + in rates to:-	
4%	1.9
6%	0.9
Total removed from NIC++	-
Liability by higher LEL	
Affected by increased +++ earnings brackets	
4% bracket	1.3
6% bracket	1.0
Total	5.1

All comparisons with the 1989-90 announced re-rating proposals.

\+ This group remain in the same earnings band but they benefit from lower reduced NIC rate.

++ This group removed from NIC liability through the higher LEL. Less than 0.1 million

+++ This group switch brackets. Those paying 6% would have formerly paid NIC at 7%.

Losers

Estimated numbers of losers

i Above the current UEL

Approximately 2.8 million earners above the UEL would pay more under all of the options. Most would pay an extra £0.45 pw.

2.2 million of these are likely to be married men, 1.4 million with families.

Total offset (GAD estimate): £30 million.

ii contracted -out losers below the UEL

Contracted-out employees earning above £130 pw would pay slightly more under the option because the rise in the LEL reduces the tranche of earnings to which the contracted-out rebate applies. In this case, where the LEL only rises by £1 a week, the loss is negligible; 2p for the insured person and 4p for his employer.

Earning £130 to £325 : 6 to 6.5 million

4. TYPES OF PEOPLE AFFECTED

The characteristics of the gainers is as follows:

Total gainers (millions)	5.1
Married men	0.5
Married women	2.2
Single people	2.4
Part-time workers	1.6
Full-time workers	3.5

Further analysis of Gainers and Losers Option 1(a)

Option 1a. Range of gains by earnings level

Earnings band	Numbers affected	Range of gain[1] (per week)
£43 to £44	less than 0.1m	£2.15 to £2.20 pw
£44 to £75	1.9m	£0.44 to £0.75 pw
£75 to £100	1.3m	£2.25 to £3 pw
£100 to £115	0.9m	£1 to £1.15 pw
£115 to £130	1.0m	£3.45 to £3.90 pw

(1) Changes shown for contracted-in employees, Gains for contracted-out employees lower in some cases.

Charts 1 and 2 give a graphical representation of gainers and losers for contracted-in (Chart 1) and contracted-out (Chart 2) respectively.

CHART 1

NATIONAL INSURANCE CONTRIBUTIONS

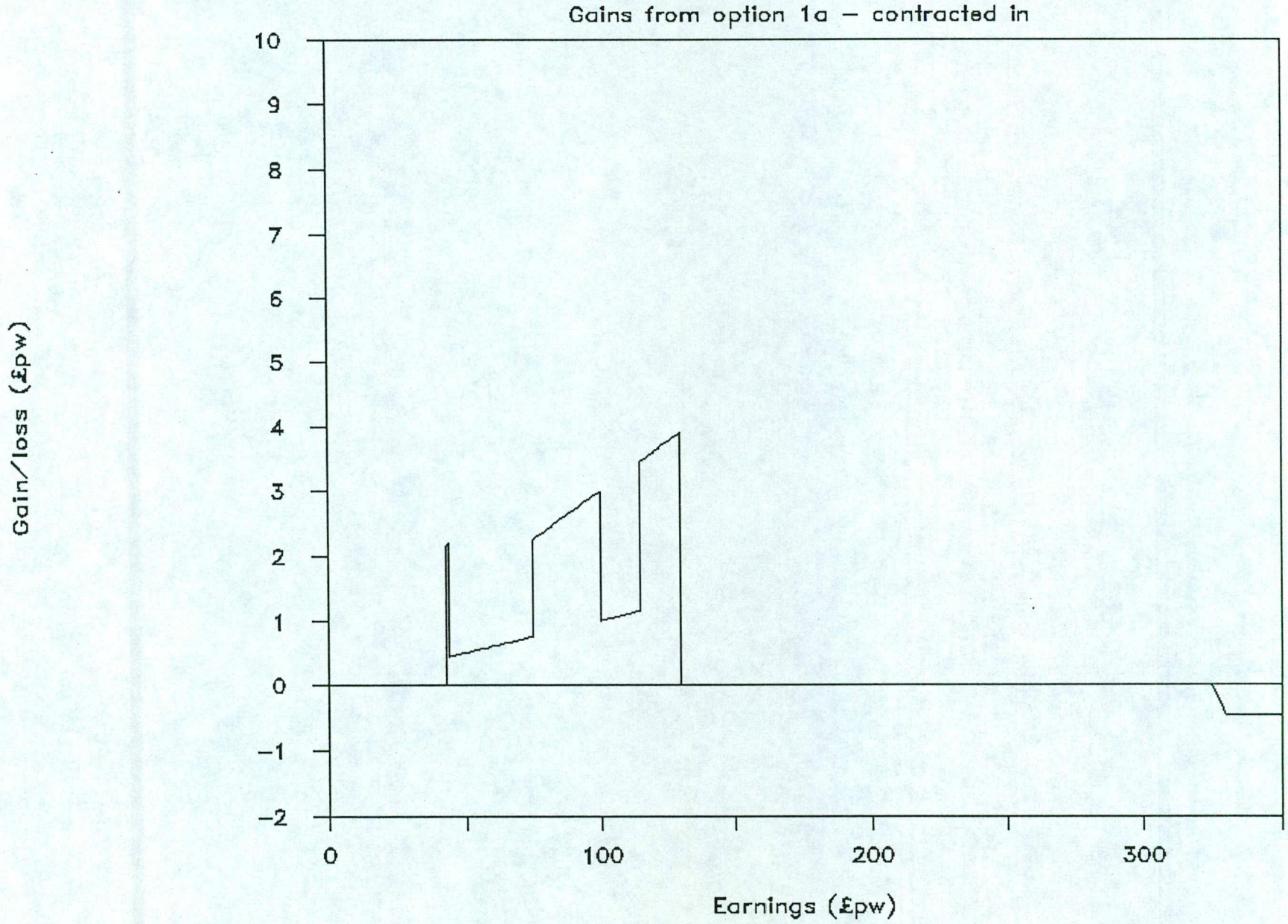
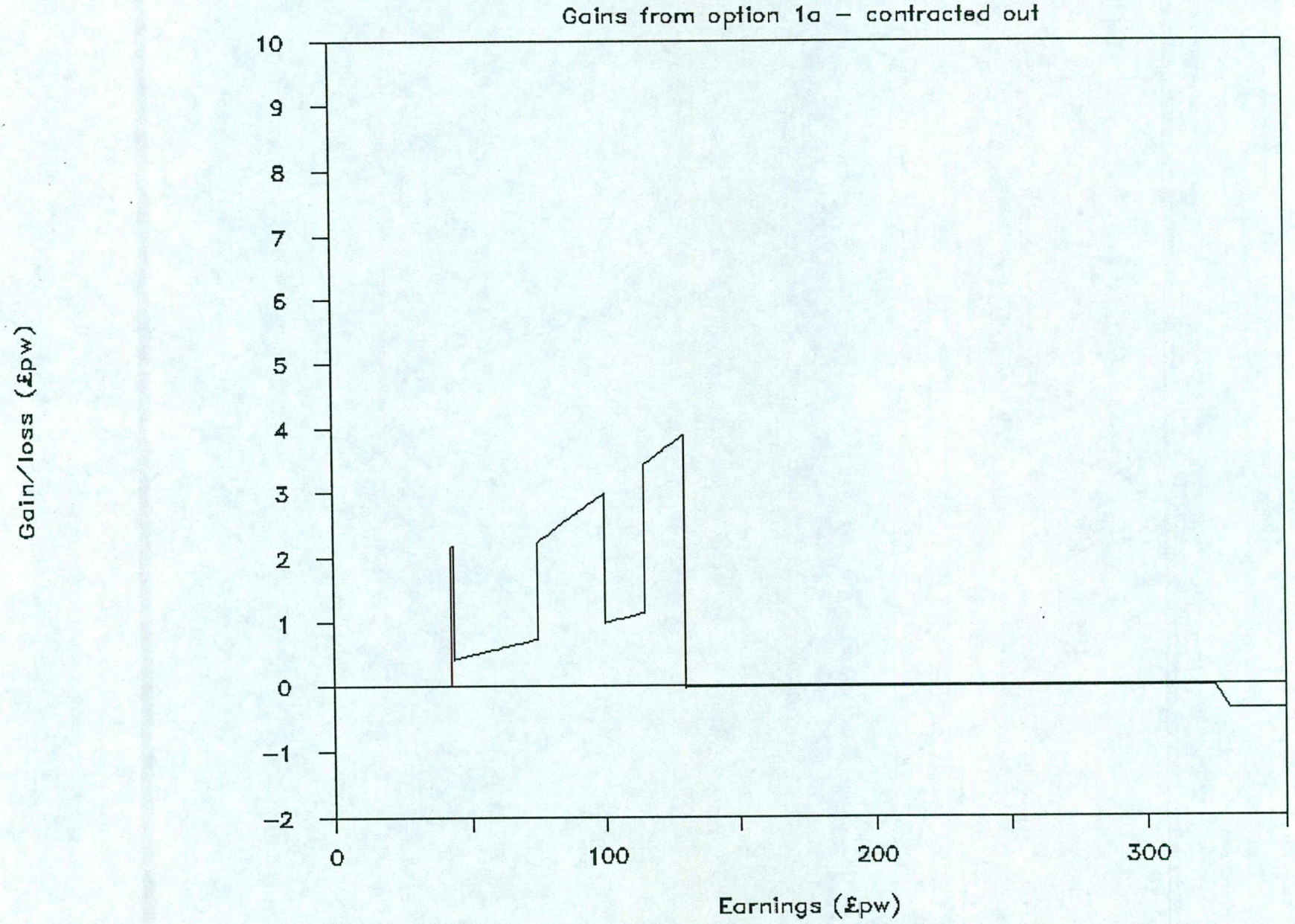


CHART 2

NATIONAL INSURANCE CONTRIBUTIONS



5. BENEFIT IMPLICATIONS

Family Credit

Numbers floated off benefit: 2500

Reduction of expenditure: £10 million

(Assuming current take up of Family Credit.)

Housing Benefit

The numbers affected are likely to be too small to give reliable estimates; Housing Benefit effects negligible.

Short-term contributory benefits

Increased LEL would have negligible effect on benefit claims during the PES period.

6. EFFECT ON INCENTIVES

The effects of the option can be summarised as follows:

a. Unemployment Trap

Replacement ratios reduced: fall of 0.9 percentage points to 84.6 per cent (Married couple + 2 children), and 2.3 percentage points to 44.8 per cent (single householder) at £125 a week.

b. Poverty Trap

Combined deduction rate reduced at around £125 a week:

Fall of 1 percentage point to 79 per cent (Married couple + 2 children) of 3 percentage points to 31 per cent (single householder) at £125 a week.

Married couple earning £125 a week £1.13 better off, single householder earning £125 a week £3.76 better off. Comparison in terms of net income after housing costs.

Net income gains of low income families negligible because of benfit tapers: effect particularly true whilst Housing Benefit is in payment - until around £75 a week for a single householder and £90 a week for a married couple with children.

cc Mr McIntyre personal

FROM: J GIEVE
DATE: 29 November 1988

CHANCELLOR

cc Mr Tyrie

EXTRA SUPPLEMENTARIES ON PENSIONS

In case the subject is raised during the Debate or at the TCSC, I attach a consolidated Q & A note on the lobby briefing itself which supplements the material on the new scheme for help for pensioners.

J. Gieve

J GIEVE

Ch

I think the 3 sidelined questions are the most likely.

Chancellor's briefing revealed hidden agenda for means-testing

No hidden agenda. No plans to extend means-testing to other benefits. Note there is same number of means tests now as under Labour.

Agree that only "tiny minority" of pensioners have difficulty making ends meet?

Group of pensioners concerned are certainly a minority. For example, 18 per cent claim income support.

True that senior officials at DSS were called over the weekend of 5-6 November (after the lobby) to work up proposal?

No. This is simply false.

Why did Government leave it until Monday 7 November to deny the Sunday stories?

They didn't. Both HMT and DSS made clear to press on Sunday that there were no plans to introduce new means tests for pensioners. When hubbub continued on Monday, Chancellor and SoS made position crystal clear.

Were ITN given separate briefing by Treasury on Saturday 5 November which corroborated Sunday stories?

No. Understand ITN got wind of stories being prepared from sources outside Government who had spoken to lobby journalists. They checked with HMT that a briefing had occurred and benefits had been discussed but did not raise issue of additional means test.

What about the tape recorder?

The position is perfectly simple: the machine did not record so there never has been a tape or transcript. However the journalists took shorthand notes and their accounts of what the Chancellor said have been published and are broadly accurate. It is clear that his comments do not support the stories that millions of pensioners faced loss in benefits.

2 million gainers: tiny minority?

A minority. Over half have incomes above income support and gain through housing benefit. 7 million single pensioners and pensioner couples receive State retirement pension.

"Need to educate backbenches"?

My backbenches frequently try to educate me so I hope they will not be offended if I very occasionally try to reciprocate. (Alternatively, that was not my phrase but I certainly think that any Government has continually to persuade its own backbenches of the merits of the policies it wishes to adopt.)

"Only a comma in the Manifesto that prevents means-testing of Child Benefit"?

I made very plain at the briefing that our Manifesto ruled out restructuring of CB and that there was no question of our going back on that.

Is CB freeze indefinite?

We will continue to look at the level of CB each year in the normal way.

Why not make things clear to the lobby and say that there was extra money?

I was not seeking to announce a new scheme at that stage, I was merely identifying a group of pensioners who had not shared in the general rise in prosperity and to whom I wish to give more help when and if it were possible.

Those were not my words. But I have to say that I am a great believer in education.

How come all ten journalists agreed on a different interpretation and why do they hold to their accounts now? Do you hold to your view that the stories were "the most inaccurate..... irresponsible of any I have seen in..... ten years of Government.....farrago of invention"?

Since the journalists themselves admit that they discussed the briefing after they left Downing Street, I do not find the similarity of their stories amazing. As for the content, I would merely make two points: first by their own accounts the headlines suggesting that millions of pensioners faced cuts in benefits went far beyond what I said at the briefing and second that they were wholly false.

I simply ask the hon gentleman to read the journalists own accounts of what I said, and see if they justify such stories as "millions of pensioners could lose their right to such universal benefits as free prescription charges and the annual £10 Christmas bonus" or "a whole range of welfare benefits, including the £7.25 weekly child allowance, pensioners' Christmas bonus, automatic extra help for the over 80s & statutory sick pay are being considered for the axe".

SUNDAY PRESS STORIES ON MEANS-TESTING ETC

Observer (p1) (Robert Harris)

"Millions of pensioners could lose their rights to such universal benefits as free prescription charges and the annual £10 Christmas bonus in a future restructuring of the social security system."

Sunday Telegraph (p1) (Donald MacIntyre)

"The automatic right of pensioners to claim universal benefits is under threat in a long-term shake-up of the social security system designed to target benfits at the least well-off."

Sunday Times (p1) (David Hughes)

"Plans to cut welfare benefits for the better off among Britain's 10m state retirement pensioners are being considered at Cabinet level."

"The review also opens up the longer term prospect of a switch to means-tested benefits for pensioners and a move away from universal up-rating of payments in line with inflation."

Sunday Express (p1) (Michael Toner)

"A whole range of welfare benefits, including the £7.25 weekly child allowance, pensioners' Christmas bonus, automatic extra help for the over 80s and statutory sick pay are being considered for the axe."

"In the new climate of only giving cash help when it is needed, items like the annual Christmas bonus seem to be heading for the scrap-heap."

Mail on Sunday (p1) (Adrian Lithgow)

"A revolutionary shake-up in the way State benefits are payed is being planned by the Government. There will be a 'means test' on a wide range of payments to target the poorest members of society. And better-off mothers and pensioners will end up with less State cash. Top of Chancellor Nigel Lawson's hit list is child benefit ... [it] will be scrapped in the Chancellor's long-term plans, It will be replaced by a sliding scale of payments based on income. Also in Mr Lawson's sights is a range of top-up benefits received by pensioners, such as payments made to the over-80s and the annual Christmas bonus, both paid irrespective of income."

"Even more potentially explosive is the Government's determination to rethink its commitment to keep benfits for all up in line with inflation, rather than focussing extra cash on the needy. Currently old age pensions, widows' pensions, war pensions, unemployment benefit and sickness benefit are all protected by index-linking."

Sunday Mirror (p1) (Alastair Campbell)

"Though the State pension is safe, the move could affect old people's right to free prescriptions, the £10 Christmas bonus and other allowances. In future, benefits may not be raised across the board, but withheld from better-off pensioners."

Mail on Sunday (leader)

"The Government's determination to 'means test' every single benefit available from the State to the ordinary citizen will be met with predictable cries of outrage."

CONSOLIDATED TRANSCRIPT

Child Benefit

Question: [Child Benefit]

Answer: We are commited for this Parliament by what was put in the manifesto. If there were to be a major restructuring - and clearly there is a case for that - it would not be compatible with the manifesto commitment. So we cannot do it. What we can decide is what the level should be, whether it should be uprated or not.

I think we are bound at some stage to look at this [ie restructuring]. [But] we take our manifesto commitments very seriously. The view we have taken, and it may be an excessively austere view, is that any restructuring would be contrary to the Manifesto.

We would not be able to go back on the Manifesto commitment because of the comma. [Chancellor quoted from manifesto and explained about comma]

Question: Who was responsible for putting the comma in?

Answer: I don't know. Not me.

Question: What about leaving child benefit to erode in real terms, in the same way as mortgage tax relief?

Answer: That is one option, yes. It took a long time to get across the point with child benefit. It's not the case that you help everyone by increasing child benefit across the board. An increase in child benefit exclusively benefits the non-poor. It is perverse targetting.

Pensioners etc.

Question: What about pensioners Chancellor? They are not exempt from the new health charges for eyes and teeth, and that is the first time. Does this set a pattern?

Answer: The problem with pensioners is that there is a minority who do have difficulty in making ends meet.

Question: A minority?

Answer: Yes, a tiny minority. Pensioners as a whole are doing very much better than before, because more and more of them have occupational pensions, more and more have SERPs on top of their basic State pension, and their savings are not being eaten away by inflation as they were under Labour. As a result, the incomes of pensioners have been rising faster on average than incomes of people with wages.

Question: What are the implications for benefits?

Answer: We have to see in the evolution of the social security system whether we can do better targetting there, so that we can help the minority of pensioners who do genuinely have difficulty in making ends meet.

Question: Doesn't that mean you will have to educate your backbenchers in view of what happened this week?

Answer: The rebellion comprised people who had very different motivations.

Question: How will you do targeting?

Answer: There is no study group or anything of that sort. But in my opinion this is 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 find all these benefits and whether they are pledged or not in Parliamentary answers.

Notes

In general, this takes the fullest version of each remark attributed to the Chancellor. There clearly still some of the Chancellor's remarks missing, especially on child benefit. The only point which might be disputed in this consolidation is the answer to the question about educating backbenchers, where the Independent, Observer, Sunday Times and Sunday Mirror (ie all except Warden) have the Chancellor agreeing to the proposition, though without attributing any quotes.

CONSOLIDATED TRANSCRIPT

(For sources see note at end)

Child Benefit

[Warden and S Mirror do not cover child benefit at all]

Question: [Child Benefit]

Answer: [Observer]

"We are commited for this Parliament by what was put in the manifesto."

[Indep + S Times + Observer]

"If there were to be [a] major restructuring, and clearly there is a case for that," [Indep has 'any' major restructuring; all three have slight variants on 'clearly there is a case']

[S Times + Observer]

"it would not be [compatible] with the manifesto commitment. So we cannot do it." [Observer has 'that would not be consistent with our manifesto']

[S Times only]

"What we can decide is what the level should be, whether it should be uprated or not."

[Indep + Observer + S Times]

"I think we are bound [at some stage] to look at this."

[Indep omits 'at some stage']

[S Times only]

"We take our manifesto commitments very seriously. The view we have taken is that any restructuring would be contrary to the manifesto."

[Indep + Observer + S Times]

"The view we have taken, and it may [be] an excessively austere view, is that [any restructuring] would be

contrary to the Manifesto [commitment]." [Observer has '...may well have been an excessively austere view...'; S Times has 'it' in place of 'any restructuring'; and only S Times has 'commitment' at the end of the sentence.]

[Indep + Observer]

"We would not be able to go back on the Manifesto [commitment] because of the comma." [Indep omits 'commitment']

[S Times: Chancellor drew attention to crucial comma]

[Indep + S Times + Observer]

Question: Who was responsible for putting the comma in?

Answer: "I don't know. Not me."

[S Times only]

Question: What about leaving child benefit to erode in real terms, in the same way as mortgage tax relief?

Answer: "That is one option, yes. It took a long time to get across the point with child benefit. An increase in child benefit exclusively benefits the non-poor. It is perverse targetting."

[Indep has, not related to a specific question].

"It's not the case that you help everyone by increasing child benefit across the board."

[Observer has]

"If you increase child benefit, you only help the non-poor." [followed by an account of the Chancellor's explanation]

Pensioners etc.

[Warden + S Times + Observer + Indep + S Mirror]

Question: What about pensioners Chancellor? They are not exempt from the new health charges for eyes and teeth, and that is the first time. Does this set a pattern?

[S Mirror: Lawson spoke of pensioners' increased prosperity]

[Others]

Answer: "The problem with pensioners is that there is a minority who do have difficulty in making ends meet."

[S Times]

"It is a tiny minority."

[Warden, Observer + Indep]

Question: A minority?

Answer: "Yes, a tiny minority."

[Warden, Observer, S Times + Indep]

"Pensioners as a whole are doing very much better than [ever] before" ['ever' is only in Observer]

[Warden] "Most of them have occupational pensions or SERPS"

[Indep, Observer + S Times] "because more and more [of them] have occupational pensions, more and more have SERPs" [Observer omits 'of them']

[Warden, Observer, S Times + Indep]

"on top of [their] basic State pension," [S Times and Observer have 'that' in place of 'their']

[Warden + Indep]

"and their savings are not being eaten away by inflation as they were under Labour. "

[S Times]

"and more and more have savings bringing in a real

return."

[Warden]

"As a result, the incomes of pensioners have been rising faster on average than incomes of people with wages."

[S Times]

"The incomes of pensioners have been rising faster on average than the incomes of the waged."

[Observer]

"Unlike when inflation was high, the income of pensioners has been rising faster on average than the increase of the waged"

Question: What are the implications for benefits?

[All, including S Mirror]

Answer: "We have [got] to see in the evolution of the social security system whether we can do better [targetting] there,

[NB everyone has 'targetting' except Warden in DT]

[only Observer has 'got']

so that we can help [the] minority of pensioners who do genuinely have difficulty in making ends meet."

[Observer and S Mirror have 'that' in place of 'the'; Observer has '...who have genuine difficulty...']

[All except Warden in ES and PG]

Question: Doesn't that mean you will have to educate your backbenchers in view of what happened this week?

[Observer has '...more of your backbenchers']

Answer: [Indep: Chancellor replied in the affirmative]

[S Times: The Chancellor agreed they would need educating and went on to point out that back-benchers rebelled for a variety of different motives]

[S Mirror: He [Chancellor] agreed]

[Observer: Mr Lawson agreed but went on]

[Warden + Observer]

"The rebellion comprised people who had very different motivations."

[S Times do first bit of next question in reported speech; S Mirror only do first sentence of answer]

Question: How will you do [targeting]? [ES + PG have 'this']

Answer: [Observer]

"There are no study groups at the moment"

[Others]

"There is no study group or anything of that sort. [PG has '...anything like that'; S Mirror has '...this sort']

[All except S Mirror]

"But in my opinion this is 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." [PG has '...was not a pledged benefit.']

[All including S Times]

"You can find all these benefits and whether they are pledged [or not] in Parliamentary answers." [S Times omits 'or not']

Notes

Based on the following accounts:

Warden: Evening Standard 8 November;
Daily Telegraph 9 November;
UK Press Gazette 14 November.

Sunday Times: David Hughes 13 November.

Independent: 9 November (no by-line).

Sunday Mirror: Alastair Campbell 13 November.

Observer: Robert Harris 13 November.

All differences in remarks directly attributed to the Chancellor have been brought out. Differences in the accounts of the

questions asked have not been, except where they appeared significant.

0176A

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

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

CONFIDENTIAL

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

CHIEF SECRETARY
REC. 29 NOV 1988
ACTION MrSaunders
COPIES TO CX, PMG, Mr Anson, Sir P Middleton, Mr Mowbray, Miss Peirson, Mrs Brown, Mr Turnbull, Mr Call

29 November 1988

Dear Chief Secretary

GPFC: PRIVATISATION AND THE NHS REVIEW

As you know we plan to privatise the General Practice Finance Corporation during the current financial year. The Health and Medicines Act is now on the Statute Book and we are on course to issue the Information Memorandum for the sale next week.

During the process of verification of the Memorandum I have had to consider the implications for privatisation of the Review of the NHS. The point here is that any plans which we may have to alter the arrangements for financing family practitioner services in a way material to the business and prospects of the successor company to the GPFC, when it is sold, should be disclosed to prospective purchasers.

Section 10 of the Memorandum contains in the third paragraph a reference to the Review in the terms in which the Prime Minister announced it in January of this year. A copy is enclosed. It seems to me to be sufficient at this time. Nothing which we have so far agreed in the Review could be said to affect adversely either the need for or the ability of family doctors to acquire and pay for practice premises, the financing of which is the present business of the Corporation. Indeed the idea of practice budgets could be seen as enhancing the attractiveness of GPs as clients to a prospective purchaser.

I believe that the same applies to matters currently under consideration, and I cannot imagine that anything likely to be raised in our discussions in the time remaining to us before publication of the White Paper is likely to diminish the need for doctors to acquire and improve practice premises or their ability to pay for them.

E.R.

In view of this, and of the fact that a January publication date means that short-listed purchasers will have an opportunity to read the White Paper for themselves before a deal is concluded, it is my intention to issue the Information Memorandum during the week beginning 5 December. We have, as you know, a PES obligation to find £80 million from this source by 31 March and are hoping for receipts of some £150 million. There is a great deal of interest from the Press and from prospective purchasers and it is important that uncertainties over the Review should not mar what promises to be a very successful privatisation.

A copy of this letter goes to the Prime Minister.

Yours sincerely

A.J. McKean

P.P. KENNETH CLARKE

(Approved by the Secretary of State and signed in his absence).

9. Future prospects

The high quality of GPFC's assets and customer base, and the long experience of its executive management represent a firm foundation on which to build a business with good prospects for growth. The proposed sale will remove the statutory constraints impeding the business. The future prospects of the Company should be considered in the light of the opportunities arising from these changes.

Opportunities for growth are also provided by the continuing increase in the number of family doctors in Great Britain, and the expected increase in demand for finance for surgery premises.

The removal of the constraints which now apply to the GPFC will allow the Company to expand the core businesses, to begin lending in Northern Ireland (where the GPFC is prohibited from lending) and to offer services to doctors operating outside the NHS and to others such as dentists, opticians and pharmacists.

Whilst maintaining the core business, and the GPFC's contacts with family doctors, the Company will also be in a position to lend money for a wider variety of purposes, such as to finance working capital and for purchases of equipment.

Finally, the Company's business need not be restricted to lending or leasing and could expand into the provision of other financial services to the medical profession.

10. Relationship with H.M. Government

Following the sale of the Secretary of State's shares in the Company, H.M. Government will cease to have any direct interest, financial or otherwise in the running of the Company. In particular, the terms of sale will include the repayment of the GPFC's indebtedness to NILO, and the withdrawal of the HM Treasury guarantee which will not be extended to the Company. There will, however, be an obligation on the purchaser to deliver the audited statutory accounts of the Company for each year to the Secretary of State so that they may be laid before Parliament.

In terms of the Company's future dealings with other bodies or organisations connected with HM Government, such as the DH or the FPCs, the intention of HM Government is that the Company should not receive any advantage which is not available to other organisations involved with lending to family doctors.

The Government are undertaking an internal and wide ranging review of the National Health Service, with special emphasis on the hospital service. The conclusions of this review will be announced in due course.

Where, to satisfy local needs for the availability of family doctors, it is necessary for the Secretary of State to provide a special financial incentive for the funding of a particular project, the Health and Medicines Act contains a section allowing the Secretary of State, with the consent of HM Treasury, to make provisions for guaranteeing loans made to family doctors. Such arrangements would apply equally to loans made by the Company and other lenders.

CONFIDENTIAL

CHIEF SECRETARY

FROM: B H POTTER

Date: 30 November 1988

cc: Mr Anson
Mr Phillips
Mr Beastall
Mr Edwards
Miss Peirson

NHS AUDIT: AUDIT COMMISSION WIDER POWER

I understand from Miss Peirson that you are interested in the 'option 3' approach (the general enabling power to undertake audit/value for money work anywhere in the public sector at the request of the relevant Secretary of State). You asked why LG1 were concerned about this proposal.

Assessment

2. I appreciate that there are tactical and presentational advantages to option 3: it would enable an earlier start for Audit Commission work on the National Health Service without embroiling the Government in discussion of plans for the NHS audit before the Government is ready. But there are reasons of both principle and practice against giving such wide powers to the Audit Commission.

3. In support of extending the role of the Audit Commission, DOE have argued that it would allow better use of the considerable expertise in value for money work which the Commission has built up. This could have advantages in the future if say a comparison between the work of housing associations and local authorities in providing low cost housing for rent were to be undertaken. The Audit Commission also offers a ready source of expertise that would be available for both regularity and value for money work, when functions or organisations are transferred from local authorities to the private sector.

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6. The scale and diversity of such transfers from local authorities to the private sector seems likely to increase as, for example, schools opt out of local authority (LA) control; former LA housing moves more into housing associations or outright private sector ownership; and, perhaps, some local authority community care institutions also transfer to the private sector. As noted, DOE believe the experience of the Audit Commission argues for their maintaining the audit/value for money role in future. But in practice, the Commission has drawn heavily upon private sector resources already in undertaking both regularity audit and value for money consultancy work. So there are the skills, experience and resources available within private accountancy and other firms to take on such work. This could include value for money comparisons with the LA sector (some management consultants do this kind of work already).

7. Secondly, I believe that the understanding reached with the C&AG over the proposals on the NHS is on the basis that the Audit Commission is taking over the statutory external audit of the NHS (health authorities and FPCs) from the Department of Health, and will therefore be providing a service for the Secretary of State for Health rather than Parliament. The C&AG might be less happy with a wider extension of the Commission's powers, not least since the Commission could be moving into areas where the external audit function is the responsibility of the NAO, eg British Museum (albeit contracted out to the private sector). Discussions with DOE and the Audit Commission indicate there are a range of such bodies which the Audit Commission has in its sights.

8. Third it has seemed to us that, provided with an opportunity to extend the role of the Audit Commission into areas like housing associations, urban development corporations etc, the present Controller of the Audit Commission would be only too willing to take on the additional work. But the Audit Commission ought to be extremely busy over the next few years auditing the NHS in addition to its local authority work. LG1 and ST have been concerned that extending the role of the Audit Commission too widely too quickly might divert its attentions from local authorities and the NHS.

Conclusion

9. On balance therefore, LG1 would prefer not to see option 3 pursued but rather the narrower power set out in option 2. If it were decided that option 3 is tactically the best method for getting the Audit Commission to work on NHS quickly, we must ensure that the general enabling power is suitably circumscribed. This might be done in one of two ways:

(a) restricting the Audit Commission to value for money work rather than regularity audit; (although we have some concerns that this might be an inefficient use of resources);

(b) any proposal for the Audit Commission to undertake audit or value for money work for any body outside the NHS or local authorities, should be subject to Treasury approval.

The drawback with (b) above is that once the power is created there would certainly be pressure for it to be used. At best an understanding might be reached with the Audit Commission that they should not extend their role beyond the local authorities and the NHS until such time as the NHS work had built up to a satisfactory level.

Barry H. Potter

BARRY H POTTER

Draft (30.11.88)

OUTLINE OF WHITE PAPER

Chapter I: Foreword

A draft foreword is attached.

Chapter II: Delivering a better service

This sets out the Government's overall approach, emphasising the focus on services to patients. A draft is attached.

Chapter III: Self-governing hospitals

This puts one of the Government's key proposals up front, underlining the commitment to early changes. It describes in some detail how such a system might work and sets out the Government's objectives of pushing down decision-making to the local level, harnessing talent and restoring pride in local hospitals.

Chapter IV: GP practice budgets

These are presented as a second main plank of the Government's strategy of introducing more competition by giving more responsibility to the buyers of hospital services and increasing patient choice.

Chapter V: Funding hospital services

This chapter describes how the bulk of hospital services will be funded in future, with emphasis on a simpler allocation system and money following the patient.

Chapter VI: The role of doctors

The main theme here will be the Government's wish to see all doctors playing a fuller role in management and assuming greater responsibility for their use of resources. It encompasses the Government's proposals for hospital consultants and GPs, including the management of consultant contracts, distinction awards and the management of contracts with GPs. This chapter will also cover medical audit.

Chapter VII: Managing resources

Improving incentives and introducing more competition is of limited value if service providers have little control over, or information about, their use of resources. In addition to introducing self-governing hospitals, the Government therefore proposes to build on the introduction of general management into the HCHS by pushing down further decision-making to the local level. This will include giving managers more flexibility in the use of capital and in setting the pay, conditions and working arrangements of staff. The chapter also includes the proposals for improving the flow of information to managers and professionals and can summarise recent developments affecting the nursing profession.

Chapter VIII: A mixed economy of care

The theme of this chapter will be the benefits to the NHS of collaboration with the private sector; the greater choice to patients from the existence of a private sector; and, continuing the value for money theme, the benefits of extending competitive tendering and income generation.

Chapter IX: A better organisation

All these changes imply different roles for regional and district health authorities. This chapter sets out the Government's proposals for organisational change, including:

- changes in the role and functions of RHAs and DHAs;
- consequent changes to the constitution, size and composition of RHAs and DHAs;
- improvements in the management of FPCs leading to:
- the amalgamation of FPCs and DHAs;
- changes in the role and composition of the NHS Management Board.

[Chapter X: Health services in Wales, Scotland and Northern Ireland]

[Chapter XI: A programme of change

A possible summary of the changes proposed and their timetable.]

Draft (5.12.88)

I FOREWORD

1.1 This White Paper explains how the Government plans to build a modern, strong National Health Service, fit for the 1990s. It complements the Government's earlier White Paper on primary health care ("Promoting Better Health", Cm 249) by concentrating mainly on hospital services. It takes further the principles of better management already established during the Government's period of office, particularly following the implementation of Sir Roy Griffiths's report on management.

1.2 Underlying everything we propose is a simple aim: a service that puts patients first. The Government's approach is not to tell those working in the NHS how to do their job. It is to make the service itself more businesslike - more sensitive to its customers and both keener and better able to meet their needs.

1.3 The principles on which the NHS was founded 40 years ago are not - and never have been - in question. The Government believes that health care should be available to everyone, regardless of their income, and should be financed mainly by general taxation. Our task is to take the best of the NHS and raise the rest to that high standard. The NHS will continue to thrive only if those working within it at local level feel a strong incentive to respond to their customers, and are enabled to do so.

1.4 Later in 1989 the Government will bring forward legislation to give effect to those of the proposals in this White Paper for which legislation is needed. Other proposals do not depend on legislation and their implementation will begin as quickly as possible. Change on the scale proposed will require huge effort and commitment from management and staff. It will not always be easy. Nor will it happen overnight, for the new, modern NHS must have strong foundations. But that is the more reason to act now, and act vigorously.

Draft (5.12.88)

II DELIVERING A BETTER SERVICE

Introduction

2.1 The NHS has an enviable record of success. Since it was established in 1948 it has played a major part in improving the nation's health. Immunisation and vaccination have virtually wiped out previously common diseases such as diphtheria and poliomyelitis. Medical advances have meant that people not only live longer but can enjoy a better quality of life. Transplant surgery, for example, is now commonplace: the UK has more patients with a successful kidney transplant than any other European country.

2.2. Activity in the NHS has increased dramatically. The service is treating 1¼ million more in-patients, 4½ million more out-patients and over half a million more day cases than it was ten years ago. This has been made possible both by improvements in productivity and by a substantial increase in the resources provided by Government. The NHS now employs 13,000 more doctors and dentists and 65,000 more nurses than it did in 1978.

2.3 But these and other successes must not breed complacency. The Government announced early in 1988 that it was undertaking an internal review of the NHS. This announcement in turn stimulated a wide-ranging debate. Many proposals for reform have been aired, often by people who are working within the NHS and are proud of its achievements, but who also believe that change is needed to fit the service for the 1990s and beyond.

Better services for patients

2.4 Only the medical profession itself can assess the quality and effectiveness of medicine and surgery. Government and management are responsible nonetheless for ensuring that NHS patients are offered good quality, cost-effective medical treatment. Chapter [VI] sets out the Government's proposals for ensuring that the quality of NHS treatment is sytematically monitored and, as necessary, improved by doctors themselves.

2.5 These proposals are of central importance. But the Government's main concern in this White Paper is to improve the efficiency and sensitivity with which services are delivered.

2.6 The needs and wishes of the NHS's customers - the patient - are changing and will continue to change. People are less and less willing simply to accept the service on offer, however grateful they may be to those who deliver it; and are more and more concerned - rightly so - to demand a service which meets their personal needs and convenience.

2.7 Many people are still having to wait too long for treatment, and still have little if any choice over the time and place at which treatment is given. The Government has already done much to tackle this problem. Over the past two years, for example, an additional £55 million has been spent on reducing waiting lists and waiting times, allowing over 200,000 more patients to be treated. A half of all waiting list patients are now admitted from the list in five weeks or less. But the problem remains.

2.8 More generally the service provided by a hospital for its patients is still too often impersonal, inflexible and even stressful. This is both unacceptable in itself and inimical to effective treatment and care. The practical improvements that may be often needed include:

* appointments systems which give people individual appointment times which they can rely on. Waits of two or three hours in out-patient clinics are still far too common.

* quiet and pleasant waiting and other public areas, with proper facilities for parents with children, for counselling worried patients or relatives, and so on.

* clear information leaflets about the facilities available and what patients need to know when they come into hospital.

* once someone is in the hospital, clear and sensitive explanations of what is happening: on practical matters, such as where to go and who to see; and on clinical matters, such as the nature of an illness and its proposed treatment.

* clearer, easier and more sensitive procedures for making suggestions and, if necessary, complaints.

* rapid notification of the results of diagnostic tests.

* a wider range of optional extras and amenities for patients who are prepared to pay for them - a choice of meals, single rooms, personal telephones, TVs and so on.

A businesslike service

2.9 More can and will be done to build on existing initiatives, national and local. But the Government has concluded that a new approach is also needed, for two reasons. First, experience suggests that direct, central government direction and control of the kind which has characterised the past 40 years is not the most

effective way of improving services for patients. Secondly, the needs and wishes of patients will not only change over time but also be open to new solutions. It is essential that those whose job it is to meet those needs and wishes have the authority, flexibility and incentive to innovate and adapt.

2.10 In short, the NHS must become more businesslike. The best businesses are geared, first and last, to satisfying their customers. They also know that their customers will be satisfied only if the unseen parts of the organisation are working well - if resources are used efficiently; if talent if found and given its head; if everyone working for the organisation has the right incentives.

2.11 These characteristics can and should apply to the NHS. The Government's approach to achieving this is twofold. The first strand is to free the system, in a more radical way than has yet been achieved, or even tried. The second strand is to enable management to do its job.

Freeing the system

2.12 The NHS is full of people - doctors, nurses, managers and others - who are committed to improving services for patients; who know how to do so; but who are constrained by the way in which the service is presently organised and budgeted for. The Government is determined to tap this reservoir of skill, experience and initiative.

2.13 The most fundamental reforms proposed in this White Paper are directed to this end. In particular:

* hospitals will be given much more responsibility for running their own affairs. Major acute hospitals will be able to apply for self-governing status within the NHS. Self-governing hospitals will be free, for example, to

determine the rates of pay of their own staff [and, within limits, to raise capital in the private market]. They will to sell their services to other parts of the NHS, to the private sector and to patients. They will thrive to the extent that they are successful in making the quality of their services attractive to their customers.

* there will be much more scope for money to follow the patient, especially for so-called "elective" surgery for which there is in principle some choice over the location and timing of treatment. At present a hospital or service which becomes more efficient and could treat more patients may be prevented from doing so by its budgetary limits. A hospital or service which is failing to deliver is still paid its share of NHS resources, calculated by means of a complicated formula. Any exercise of choice by patients and their GPs is thereby made ineffective. Hospitals are not funded in any way which depends on the amount of work they do. The Government is proposing new funding arrangements which will tackle these perverse incentives without jeopardising expenditure control.

* large GP practices will be able to opt to have their own budgets for buying a range of hospital services directly. This will enable GPs and their patients to back their own choices with money, and will build in new incentives for hospitals to satisfy GPs and for GPs to satisfy their patients. The Government sees general practice as one of the great strengths of the NHS, and the GP as the key adviser to the patient who wants to have a choice of service for himself and his family.

2.14 These and related reforms are set out fully in chapters [III-V]. They represent a radical shift of power and responsibility to people whose job it is, at local level, to advise patients, to provide services to them, or to fund services for them. These same reforms will also inject new incentives, including an element of competition, both to provide the services which patients and their GPs are looking for and to do so efficiently.

Empowering management

2.15 In recent years the Government has given a high priority to strengthening the management of the NHS, most importantly through the introduction of general management following a report by Sir Roy Griffiths in 1983. The reforms outlined in paragraph [2.13] will build on this progress and take it further. It will become all the more important that objectives for improving services, and responsibilities for achieving those objectives, are clear; and that money is not spent ineffectively or inefficiently when it could be used to buy more or better services in other ways. Achieving objectives through the efficient use of resources is the job of management. Local managers in particular must be not only freer but also better equipped to do that job.

2.16 Chapters [VI-IX] propose a range of important changes to this end. They will build on the introduction of general management, and on the proposals for the better management of the family practitioner services (FPS) set out in "Promoting Better Health" (Cm 249). Among the most important aims behind these changes are:

* ensuring that hospital consultants - whose decisions effectively commit substantial sums of money - are involved in the management of hospitals; are directly

responsible and accountable for their own use of resources; and are given stronger incentives to use those resources more effectively.

* ensuring that GPs also take greater responsibility for their use of resources, including their use of hospital services.

* providing the audit support which management needs, by extending the audit of medical care by doctors themselves and through a stronger and more independent source of financial and value-for-money audit.

* improving the information available to local managers, enabling them in turn to make their budgeting and monitoring more accurate, sensitive and timely.

* contracting out functions which do not have to be undertaken by health authority staff and which could be provided more cost effectively by the private sector.

* turning both District and Regional Health Authorities into tighter, more effective management bodies.

* restructuring the national management of the service to provide for a corporate management team which is freer to manage the service within policy objectives and financial targets set for it by Government.

CONFIDENTIAL

CHIEF SECRETARY

FROM: B H POTTER

Date: 30 November 1988

cc: Mr Anson
Mr Phillips
Mr Beastall
Mr Edwards
Miss Peirson

NHS AUDIT: AUDIT COMMISSION WIDER POWER

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Barry H. Potter

BARRY H POTTER

cst.ps/9ce30.11

CONFIDENTIAL

FROM: MISS C EVANS
DATE: 30 November 1988

MISS PEIRSON

cc: Chancellor
Sir Peter Middleton
Mr Anson
Mr H Phillips
Mr Saunders
Mr Potter
Mr McIntyre
Mr D Rayner

COMMUNITY CARE/NHS AUDIT

The Chief Secretary spoke on the telephone yesterday to Mr Clarke about the Griffiths Report. He said that he was not in favour of handing responsibility for community care to local authorities. He was opposed to this on both financial and political grounds. He saw no need for early decisions and thought that we should take time to think through the whole subject far more carefully.

2. Mr Clarke said that he agreed on the undesirability of giving responsibility to local authorities. He was more worried than the Chief Secretary about timing believing that it would be difficult not to say something about this when the White Paper on the NHS was published. In his view the Griffiths Report was comparatively lightweight, used a lot of jargon and lumped together a number of groups with very different problems i.e. the elderly, mentally ill and mentally handicapped people. He was anxious for the Treasury and the Department of Health to get together to find alternatives to the solution those proposed by Griffiths and to try to find fresh ideas on the issues.

3. Mr Clarke said that he agreed with the official view that no change was not an option. Apart from the predictable enthusiasm of the Directors of Social Services for the local authority option, and a number of other people were putting forward quite sensible arguments for it. It would be necessary therefore to produce a very coherent alternative. Mr Moore's concern to remove from his budget the problem of the escalating social security cost of private residential care led him to support the local authority solution. No doubt the Department of the Environment would support it too.

4. The Chief Secretary said that he would have another look at the Griffiths Report and the report of the inter-departmental group before a meeting with Mr Clarke. But he could not promise an early meeting.

5. Mr Clarke also suggested that it would be useful to have a meeting with the Chief Secretary, Mr Ridley and the Lord President to discuss the options for legislation on the powers to enable the Audit Commission to audit health authorities. The Chief Secretary agreed.

Cary Evans

MISS C EVANS
Private Secretary

passed on.

DMP

Ch/

Mr Moore plans to do a further piece for the Sunday Express, behind. I have marked a few scribbles.

Anything to pass on?

MPW

Mrs Evans C2
Mr Brereton SD2
Mr Brown SD1
Mr Williams B2A
Mr Leigh FPS2A3
Miss Burnett FPS2A5

from : H Lumsden ID
date : 30 November 1988

SoSS
As I mentioned, there are still comments to come from officials on points of detail but you will want to consider the overall thrust.

Sunday Express

On 13 November the Secretary of State contributed an article on pensions to the Sunday Express.

There was a large mailbag and the paper asked him to respond to a selection. Because everybody who could advise on a reply wasabsorbed with last week's pensions announcment no reply was possible. On 27 November the letters were printed with a note saying "We have asked Mr Moore to respond and we are askeing him again." I believe he would be well advised to do so and that he is so minded.

I have drafted a composite response. I suspect that the paper who like to print an individual reply to each letter. I do not recommend that.

I would be pleased if recipients would cast a careful eye over my draft. It is deliberately "quieter" than the original. I attach a copy of the that article and the published letters.

Hamish Lumsden
RH 401 ext 5238

Draft article/letter from Secretary of State to Sunday Express

My article about pensions a couple of weeks ago has brought a rich haul of letters. They show that Sunday Express readers have strong views and being sensible, prudent people they want to the reassure themselves about the future.

So I will try to deal with their arguments and questions.

Last week I announced more money for poorer pensioners over the age of 75 and disabled ones over the age of 60. £2.50 a week extra for single people snd £3.50 a week for couples, on top of the normal annual increase shows that we have done what most people want. Just as I promised the last time I wrote in the Sunday Express, this is extra money. We are not means testing better off pensioners. We are not taking money away from them.

We have also promised to protect pensions against price increases. That will reassure Mr Sims. Graduated pension and state earnings-related pensions will be increased ~~at least~~ in line with inflation just like basic pensions.

Some correspondents, Mr Brown and Mr Bennett for example, queried that pensioners were getting better off. But the facts cannot be disputed. Pensioners as a group have incomes which have been going up faster than other people's.

my comment

The extra income comes from company pension schemes, from the state earnings related scheme and from interest on savings. You may say that's nothing to do with government. But it certainly is. This government and, to be fair, the last Labour government, has said that every employer must have a pension scheme or must pay more national insurance so that their employees can get a state earnings related pension. The longer people pay into these schemes the more they get out. That is one of the reasons for pensioners getting better off.

ensures

This government has done more than that. We have created the right conditions for British business which is stronger than ever. And raging inflation is passing further and further into history. So company pensions are nowadays built on successful investments and the pensions thay pay hold their value. They aren't eaten away by years of rising prices. Nor are pensioners' nest egg savings.

a thing of the past

Not all pensioners have joined this rising prosperity. Which is precisely why I announced an additional £200 million a year for pensioners who retired some time ago or who may not have benefited from pay-related pensions.

Mrs Goodsell and Mrs Langham are concerned about prescription and other health charges. As soon as they get to pension age everyone is entitled to free NHS prescriptions. Everyone on Income Support, not just pensioners, gets free dentistry, free eye tests and free glasses, lenses as well as frames. People on low incomes above Income Support level can get help with some or all of these costs. Mrs Langham mentioned "teeth repairs". If she means dentures she can be reassured. The NHS will repair anyone's dentures without charge.

She also mentioned rates and heating bills. Poorer pensioners get substantial help with rates; I recently announced better ways of providing cash help during cold weather and, allowing for inflation, electricity and gas charges are now actually lower than ~~they were when this Government came into office~~ five years ago.

Lastly Mr Barton raised the issue of a capital limit for rates rebate. Help with rates and rents is based on people's income, capital and actual costs. I do not believe that anyone, anywhere can seriously argue that help should be given no matter how much money people have in the bank. Of course there are different views about limits. I listen to them. That is why in May this year I raised the capital limit for help with rates and rent to £8000.

I believe that it is the job of Government to provide a basic pension and to help people to make their own arrangements to top that up. We have promised to protect the basic pensions against inflation and we are making it easier for people to make their own additional arrangements.

I believe that society, through the Government, should help people in need. We are doing just that. We are directing more and more resources towards poorer people, whether they are pensioners, or families with young children or disabled.

control of inflation.

And I believe that the best guarantee for pensioners now and into the future is a successful ~~industry~~ and ~~a strong, stable pound~~. We have brought you them. Without them the outlook could be bleak.

economy

Some points that John Moore is urged to answer

I AM a lifelong Conservative and an OAP. I agree with the idea of giving the poorest pensioners more money at the expense of the richer. But please Ministers, do not make the income limit too low, as appears to have been done with the Poll Tax.

To say that an OAP with no other income but the interest on £6,000 savings doesn't need a rate rebate is disgusting. The limit should be based on income not capital.

Also, does this mean that a person with a state pension plus a private pension but no savings would get the rebate, while one with a state pension only plus £6,000 would not?

Don't rob the poor to pay the poorest, Maggie.

Mr R Barton, FCCA, Wrenthorpe, Wakefield.

* * *

MR MOORE says that there is to be no means test of the basic retirement pension. Clarification is needed of the term "basic pension."

In addition to the fixed amount, I receive a small Government pension relative to the now defunct Graduated Pension Scheme and also in respect of the current Earnings Related Pension Scheme.

I should be pleased to learn, if you are able to confirm whether these two schemes are within Mr Moore's definition of basic pension or whether they are to be the subject of a Government revision.

Kenneth Sims, FBIM, FCIT, FFA, Shirley, Croydon.

* * *

HOW can pensioners have become "better off than ever?" For their incomes to have gone up faster than people in work, they would have required increases of more than 21% ABOVE INFLATION as at June last year.

Mr F R Brown, Newton Flotman, Norfolk

* * *

JOHN MOORE did little in his article to dispel the fears of many pensioners. No mention of the threat to age allowance, where a pensioner is in receipt of a modest company pension paid for over 45-50 years out of salary.

Mr Kingzett: Fears

S J Kingzett, Hall Green, Birmingham.

* * *

I READ with interest that "pensioners' incomes are rising faster on average than incomes of the waged."

Having recently read that wage increases are on average exceeding eight per cent this year alone, I feel something must be wrong with my arithmetic since pensioners received just one per cent increase in '86, 2 per cent in '87 and 4 per cent in '88 which produces a total increase of 7 per cent in three years. Still less than wage earners in one year!

A J Bennett, Luton, Beds.

* * *

WHEN I reached 80 in March I got the rich sum of 12½ pence extra. Not enough to buy a bottle of milk.

Mrs K M Border, Weston-Super-Mare.

* * *

COME ON pensioners, you have worked all your lives. If you do not want to write in and protest at least withdraw your votes for such people.

Mr Frank Scott, Sutton Coldfield.

* * *

MR MOORE'S article was pathetic. He seems to have forgotten Mr Lawson's Budget in April, whereby millions of pensioners lost out on allowances.

Moore: Under fire

Len Berry, Limperley, Cheshire.

* * *

I AM 62 years. My weekly pension is £43 per week—not nearly enough to live on. My husband died last year and because he was disabled for a good many years our savings went down very rapidly.

There is nothing at all left after buying the food and saving in order to pay the bills. I—and many others like me—are very worried about the future.

Mrs O Garfield, Spinney Hill, Northampton.

* * *

WE ARE not better off. General rates, water rates, gas and electricity bills are higher, and the state benefit increase does not cover the additional amounts payable for such outgoings. Where does £10 go?

We still pay for teeth repairs (without the added check-up fee), plus glasses: £60-£80. The amount paid for heating is definitely nowhere near enough for the "poorer" pensioners.

Mrs Pamela E Langham, Earley, Reading.

* * *

I WISHED people would not keep saying "pensioners are better off now than ever." I for one, am not. I have the state pension and a little help from income support. I have no other monies at all.

I have five prescriptions per month, one of which I have to pay for. I can never afford to go anywhere. There is no quality to my life.

Mrs Ann Goodsell, Milland, Hants.

* * *

JOHN MOORE'S article turned out to be a damp squib.

The first half was taken up with criticism of Labour's past performances, followed by a column telling the pensioners how well off they are, and containing the ludicrous statement that pensioners' incomes have risen faster than people at work, without a shred of evidence to support it.

He finishes with vague statements about extra money in the future. Not a very convincing justification for your headline.

J F F Gregory, Cromer, Norfolk.

SUNDAY EXPRESS

Just give us a fair deal

Worried and angry pensioners protest in their hundreds after hearing news of Lawson's planned welfare shake-up

by MICHAEL TONER

1

FROM the moment they saw the front page of the Sunday Express three weeks ago, with the headline proclaiming Government plans for "a massive welfare shake-up," readers of this newspaper have hardly been able to contain their anger.

That story, which arose out of the now notorious lobby briefing given to Sunday newspaper journalists by Chancellor Nigel Lawson could hardly have made a greater impact.

Readers from all over the country wrote to us in their hundreds. The overwhelming majority protested bitterly that the Government was not treating the pensioners fairly. We publish a selection of those letters below.

There were consequences in Whitehall too. Throughout Sunday November 6, the day the story broke, there was an uncanny silence both from the Treasury and the Social Security Department. Many felt that the Minister in charge, Mr John Moore, had been caught on the hop by the unguarded comments of the Chancellor.

As the days passed, Ministers recovered their poise. It was said that the Chancellor had been misunderstood at that famous briefing, and that he had only intended to hint that more help would be available for the old.

Mr Moore chipped in with an article in this newspaper, claiming: "What I mean—and what Mr Lawson means—is more money."

None of those answers satisfied many Sunday Express readers. Letters of complaint continued to come in.

We passed on a list of the most frequent comments to Mr Moore's office, requesting that the Minister should reply to them point by point.

But by this stage the uproar from the Labour Party, and from the disgruntled Tory back benches, was beginning to pose a real worry for the Government. Something had to be done to take the steam out of what was a major problem, if not quite a crisis.

That something became clear last week, when Mr Moore made a surprise announcement in the Commons of a £200 million package to help 2.5 million of Britain's poorest pensioners. There is no doubt that the announcement was made much earlier than the Government intended. Nor is there much doubt that the sum involved was very much higher than it would have been, had there been no controversy.

Mr Len Berry: Pensioners lost out in Budget

One senior Tory backbencher growled afterwards: "That may have been the most expensive lobby briefing in history"—a reference to that meeting between Sunday journalists, myself included, and Mr Lawson which started the whole row.

Yet though the issue has now been largely defused, with Tory backbenchers delighted at this unexpected display of generosity, there are still signs that the Government is unhappy with the course events have taken.

Meanwhile all those points made by Sunday Express readers are still on Mr Moore's desk. We shall be pressing him for more answers this week . . .

Moves
Need More

NIGEL LAWSON KEEPS HIS EYE ON THE TARGET

Plan for massive welfare shake-up

MINISTERS at the Cabinet's most senior level are preparing the way for the ultimate

by MICHAEL TONER

How the Sunday Express reported the news

PENSIONS
The truth at last

WATCHING the Opposition struggling to turn the Government's plans to provide more money for poorer pensioners into a disaster plot to dismantle the

by the Rt Hon JOHN MOORE MP
Secretary of State for Social Security

'What I mean, and

We, what these pa... to get a share o... the nation's growing prosperity. It is what Nigel Lawson said last week and it has been shamelessly distorted by Labour. Don't listen to them.

We are not going to... means test the basic pension... we are not

John Moore spells out his views

13 NOV 1988

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SUNDAY EXPRESS

PENSIONS
The truth at last

WATCHING the Opposition struggling to turn the Government's plans to provide more money for poorer pensioners into a sinister plot to dismantle the Welfare State may be a great spectator sport for those who are not involved.

But once again it shows that the Labour Party is more than ready to create fear and uncertainty in the minds of this country's elderly population in pursuit of a political vendetta.

They pretend that our policies are a threat to pensions. What rubbish!

INTEREST

This isn't the first time. But look at what the Labour Government actually *did* for Britain's pensioners:—

- They let soaring inflation savage pensioners' savings, leaving them worse off.
- In two years out of five they didn't even pay the Christmas bonus.
- They gave no extra help in cold weather.

Let's look at that a bit more closely. Take inflation. Remember Mr Rising Price? Month in, month out in the 1970s, prices went up and up.

Look what that did to savings: Pensioners lost more from inflation than they got in interest. So they got poorer and poorer.

Once, retirement was something to be feared—just like inflation. No longer. Nowadays, most people get at least the basic retirement pension.

Most pensioners have far more than that.

Over half of new pensioners get a pension from their job. Nearly a half get an extra pension, based on their actual earnings, from the Government.

PLEDGE

Once, pensioners were the poor—now, far fewer figure among the poorest. That's what the Tories' successful policies and strong economy have meant for pensioners.

What has *this* Government done for the pensioners?

- As a whole, they are better off than ever.
- Their total incomes have gone up faster than people in work.
- Roaring inflation has gone.
- The Christmas Bonus is now law.
- Poorer pensioners get extra cash help during very cold weather.

Since 1979, pensioners' incomes have grown twice as fast as income in general. There are more pensioners, too. A million more are on pension than when we came into office in 1979.

Even though we have honoured our pledge—and will continue to do so—to protect the basic pension against price rises, some pensioners haven't kept up with the rest.

We want to do more. We want these pensioners to get a share of the nation's growing prosperity. It is what Nigel Lawson said last week and it has been shamelessly distorted by Labour. Don't listen to them.

We are not going to means test the basic pension. We are not going to abolish the Christmas Bonus. It is mischief to say we are. Labour has set out, quite unfeelingly, to frighten people. Don't let them get away with it.

We intend to put extra money the way of our poorer pensioners.

PEOPLE

It is no secret that I think money is best spent where it is most needed. If you listen to Labour, you will learn that *they* think taxpayers' money should be spread thinly to everyone, even the wealthiest. What use would that be to poorer pensioners?

My job is to find the best way of getting the money to the right people.

What I mean—and what Nigel Lawson means—is extra money. Money on top of what is available now.

Don't listen to the scaremongers. There's no threat to your pension from us. There's only one threat to pensioners: It comes from Labour.

They failed last time. They will fail again.

by the Rt Hon
JOHN MOORE MP
Secretary of State for Social Security

'What I mean, and Nigel Lawson means, is extra money'

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udit

CONFIDENTIAL

FROM: J. ANSON
1st December, 1988.

CHIEF SECRETARY

c.c. Chancellor
Sir P. Middleton
Sir T. Burns
Mr. Phillips
Miss Peirson
Mr. Beastall
Mr. Potter
Mr. Saunders
Mr. Call

NHS AUDIT

As you know, we met the C&AG recently and persuaded him to drop his objection to the Audit Commission taking over the NHS statutory audit.

2. I agreed with Mr. France that the best way to report this outcome would be for you to write round to the Ministers concerned. Miss Peirson has provided the draft at flag A for this purpose. I am sorry that there has been a little delay while it has been cleared with the Department of Health; we thought it was prudent to do this so as to avoid triggering off more correspondence at Ministerial level on this point.

3. I will at the same time confirm the outcome of the meeting in writing to Mr. Bourn.

4. As I have explained separately, this concordat risks being overturned if the proposal on NHS audit is linked with a more general extension of the Audit Commission role. I think however that it is still best for you to report to colleagues now on where we have got so far; and this will be relevant background to the meeting which the Lord President is arranging for next week. It would be helpful, therefore, if you could write, on the lines suggested at flag A, before the weekend if possible.

J. ANSON

st.ln/min/2.25.11

CONFIDENTIAL

FROM: MISS M E PEIRSON
DATE: 30 NOVEMBER 1988

MR ANSON note above

cc Mr Phillips
Mr Beastall
Mr Potter
Mr Saunders

NHS AUDIT

1. Following your meeting with the C&AG, I attach a draft letter from you to Mr Bourn, and a draft letter from the Chief Secretary to his colleagues, both of which I have cleared with the other departments. (Clearance took rather a long time: I am sorry for the delay.) In particular, Mr France, DH, has seen the drafts and made amendments (see below).

2. Before writing to Mr Bourn, though, you might like to clear your letter with him too. I attach a draft covering letter. It might be as well to do that (if at all) before putting to the Chief Secretary the draft letter from him.

I do not think it is necessary to wait for this.

3. I should draw your attention to one point in the draft letter from you, paragraph 4, first sentence. I had drafted "about the publication of Audit Commission reports", but Mr France suggested the amendment shown. I think it is not quite apt, but acceptable.

MEP

MISS M E PEIRSON

st.ln/dra/2.21.11

CONFIDENTIAL

DRAFT LETTER FROM CHIEF SECRETARY TO SECRETARY OF STATE FOR HEALTH.

LORD PRESIDENT,

COPIES TO THE PRIME MINISTER, AND THE SECRETARIES OF STATE FOR THE ENVIRONMENT, FOR WALES AND FOR SCOTLAND

NHS AUDIT: THE ROLE OF THE NAO

1. We agreed that we should approach the NAO to explain our decision to hand over the statutory external audit of the NHS to the Audit Commission.

2. My officials accordingly wrote to the NAO, and subsequently had a meeting with the Comptroller and Auditor General, together with representatives of your department and the DOE and Welsh Office.

3. The C&AG's first reaction had been to suggest that the NAO should themselves take over this second tier of NHS audit. However, when it was pointed out to him that for this purpose the Audit Commission would be reporting to the Secretary of State (ie yourself or Peter Walker), the C&AG readily understood that he could not take on that role. He is of course an officer of Parliament; and the proposition that he should take over the second tier audit was rejected when the Bill which led to the National Audit Act of 1983 was first under discussion.

4. I understand that, as a result of the discussion among officials, Mr Bourn said he could explain our decision to the PAC on the basis that the Secretary of State (you or Peter) was

improving the systems available to him for ensuring that the funds provided by Parliament for the health service were being properly spent. The Audit Commission must in that role report to him.

5. Mr Bourn added, I understand, that he would explain to the PAC that the expectation would be that the Audit Commission's reports would be published under the authority of the Secretary of State, though he would make it clear that that need not mean control of publication by the Department in all cases. That is of course important, because we want the Audit Commission reports to influence health authorities and public opinion, and the reputation which the Audit Commission have built up for independence will be a significant contribution to that sort of influence.

6. I understand that Mr Bourn raised some legitimate points about the boundary between the work of the NAO and the work which the Audit Commission will be doing. We shall have to think about those: the working group of officials will be considering the matter and making recommendations. But the important point we shall be able to emphasise to the PAC is that the NAO's role is unaffected, and that the Audit Commission will be an instrument of the Secretary of State, though with a much more independent character than the present statutory audit.

7. I am copying this letter to the Prime Minister, Peter Walker, Nicholas Ridley and Malcolm Rifkind.

John Wakeham

NHS

CONFIDENTIAL

MP

FROM: J. ANSON
1st December, 1988.

CHIEF SECRETARY

Ch/ a mass of paper on this topic. Officials are digging in their heels (anxious to avoid another round with the C+AG) and Mr Ridley is sitting on the fence. Do you see force in any of their arguments? MPW. Yes.

c.c. Chancellor
Sir P. Middleton
Sir A. Wilson
Mr. Phillips
Mr. Beastall
Mr. Edwards
Miss Peirson
Mr. Potter

NHS AUDIT AND THE AUDIT COMMISSION

I should like to amplify one aspect of the note which Mr. Potter sent to you on 30th November. It concerns the likely Parliamentary reaction to option 3 (a general power to extend Audit Commission into other fields).

2. You will have seen the C&AG's initial reaction to the decision to introduce the Audit Commission into the NHS (attached to Miss Peirson's minute of 16th November). We persuaded Mr. Bourn that, in the particular context of the NHS, the use of the Audit Commission as an instrument of the Secretary of State could co-exist with the NAO's external audit of the NHS as a whole. But that kind of argument could not be used to justify an extension of the Audit Commission simply as an external auditor of other public bodies. The NAO could be expected to resist such extensions, and to advise the PAC to do so.

3. The possible limitations described in paragraph 9 of Mr. Potter's minute would not solve this problem. The first (restricting the Audit Commission to value for money work) would not make sense, since the whole basis of the Audit Commission technique is to use the regularity audit visits as a means of gathering information for - and subsequently making effective - the value for money work. Moreover, it is particularly in the value for money field that the NAO see the Audit Commission as a threat to their position.

4. The second (making any extension subject to Treasury approval) would not cut any ice in Parliamentary terms. It would still be a decision of the Executive. To deal with that concern it would have to be subject to Parliamentary approval, eg by Affirmative Resolution.

5. Even if that safeguard were added, however, it is likely that the PAC and like-minded Members would either oppose the general power or, perhaps more probable, use the opportunity to raise the issues which were set aside when debate on the National Audit Act was brought to a premature end by the 1983 General Election. This is a kind of issue on which back-bench support cannot be taken for granted. Mr. Ridley has already commented (in the manuscript note on his letter of 28th November) that it could open up the whole debate about the audit of the nationalised industries.

6. I share the desire to make progress with getting the Audit Commission into the NHS. But for the reasons above I see considerable downside risk in doing this through the general power envisaged in option 3. It was put forward as a simpler and more subtle way of making early progress on the NHS audit. It could turn out to be the reverse. By linking the NHS audit proposal with a potentially much wider power, it would probably make it more controversial rather than less. It would certainly reopen the understanding we have reached with the C&AG so far.

7. My recommendation, therefore, is that the NHS audit proposal should be included in full in health legislation at the earliest opportunity, and that any necessary paving legislation in the DoE Bill, should be limited to the NHS only.

J. ANSON

week.28.11/m.14

CONFIDENTIAL

MP

FROM: H PHILLIPS
DATE: 1 December 1988

CHIEF SECRETARY

cc Chancellor
Financial Secretary
Paymaster General
Sir P Middleton
Mr Anson
Mr Monck
Miss Peirson
Mr Turnbull
Mrs Brown
Mr Saunders
Mr Richardson
Mr Lyne
Mr Griffiths
Mr Rayner
Mr Call

GPFC: PRIVATISATION AND THE NHS REVIEW

Two points on Mr Saunders's submission of today.

2. First, I think there is a case for delaying the privatisation of the GPFC. Although the review is unlikely to amend the GPs' cost and rent scheme we cannot be certain that proposals will arise in discussion in the next few meetings which might affect it.

3. Second, the statement proposed to describe the ambit of the review was that used when the Prime Minister announced the review almost a year ago. Although the review is still focused primarily on the hospital service the changes it is likely to propose which affect the FPS and the GPs are fairly radical. It would be safer, I believe, for this prospectus to delete the words "with special emphasis on hospitals".

4. Because of the planned timing of the White Paper I would not press on you the arguments for delay, but I would recommend the revised form of words I have suggested.

5. I attach a revised draft letter.

pp Maria Reader

HAYDEN PHILLIPS

st2.ar/docs/1.12.88

CONFIDENTIAL

DRAFT LETTER FROM THE CHIEF SECRETARY TO THE SECRETARY OF STATE FOR HEALTH

GPFC: PRIVATISATION AND THE NHS REVIEW

Thank you for your letter of 29 November.

I agree that, for the reasons you give, we should not delay the sale on account of the Review. But as a number of our likely recommendations will have a major impact on GPs and the FPS. I would prefer to delete the words "with special emphasis on the hospital service". Given the planned timing for the White Paper I doubt whether this need create any greater uncertainty in the minds of potential purchasers than the paragraph I propose. But I do, in any event, suggest that your Department and its advisers should stand ready to assure them that they would not be expected to commit themselves finally to the purchase before they had had an opportunity to see the outcome of the review. As you say, this will present no problems given the timetable we have now agreed for the review.

I am copying this letter to the Prime Minister.

st2.ar/docs/1.12.88

CONFIDENTIAL

FROM: R B SAUNDERS

DATE: 1 December 1988

CHIEF SECRETARY

cc Chancellor
Financial Secretary
Paymaster General
Sir P Middleton
Mr Anson
Mr Monck
Mr Phillips
Miss Peirson
Mr Turnbull
Mrs Brown
Mr Richardson
Mr Lyne
Mr Griffiths
Mr Rayner
Mr Call

GPFC: PRIVATISATION AND THE NHS REVIEW

Mr Clarke's letter of 29 November proposes that we should not delay the privatisation of the General Practice Finance Corporation, which is scheduled to be completed by 31 March 1989, on account of the NHS review. This submission recommends that you agree. I attach a draft letter accordingly.

2. The question arises because of the familiar point that relevant information must be disclosed to prospective purchasers. The existence of the NHS review is clearly material to the sale of GPFC, since the remuneration system of GPs effectively guarantees the creditworthiness of its clients. While the review is mainly about hospital services, it is public knowledge that it could potentially have implications for the FPS. In particular, the GMSC (the GPs' branch of the BMA) have been put on notice that the present negotiations following the primary care White Paper last Autumn are without prejudice to further proposals which may emerge from the review. This was a condition of allowing the negotiations to proceed at all. So we need to mention the review in the information memorandum, as in the extract attached to Mr Clarke's letter.

3. But there is nothing further we need to disclose. As Mr Clarke says in his letter, there have been no decisions so far which impinge on the GPs' remuneration system. And, while the Prime Minister has indicated that the Review should consider whether a greater proportion of GP remuneration should be

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capitation fees, the clear implication is that this would be at the expense of the basic practice allowance. There has been no suggestion of amending the cost rent scheme, under which GPs are reimbursed a substantial proportion of their accommodation costs.

4. The main problem is the uncertainty which a reference in these terms may create in the minds of potential purchasers. But, as Mr Clarke points out, the timetable agreed by the NHS Review Group, culminating in publication in mid to late January, means that purchasers will in practice have any fears allayed before they have to complete. We cannot yet go public on the likely publication date of the White Paper. The best way out might therefore be to be assure potential purchasers who ask about the review, prompted by the paragraph in the memorandum, that they would not be expected to complete before publication of the White Paper.

5. This would minimise the risk of uncertainty about the review damaging sale proceeds. It would introduce a new timing risk, in that if the NHS review were delayed beyond January, the proceeds might slip into the next financial year, with a supplementary estimate and a claim on the Reserve in 1988-89, but a corresponding increase in the Reserve for 1989-90. Indeed GEP would prefer this, and we shall be exploring with DOH the possibility of slipping the proceeds into next year in any event. But delaying the sale itself (as opposed to the timing of the proceeds) would carry risks. It would add to uncertainty (there is an expectation that the information memorandum will be published soon) and might risk further management departures following the "redundancy" of the general manager a couple of months ago. This could severely reduce sale proceeds, since much of the goodwill element would be lost.

6. I suggest therefore that you make this point in your reply to Mr Clarke. PE and GEP agree.

R B SAUNDERS

CONFIDENTIAL

DRAFT LETTER FROM THE CHIEF SECRETARY TO THE SECRETARY OF STATE FOR HEALTH

GPFC: PRIVATISATION AND THE NHS REVIEW

Thank you for your letter of 29 November.

I agree that, for the reasons you give, the proposed paragraph about the NHS review in the information memorandum is appropriate, and that we do not need to delay the sale on account of the Review. But we do need to minimise any uncertainty which the paragraph may create in the minds of potential purchasers. I suggest therefore that your Department and its advisers should stand ready to assure them that they would not be expected to commit themselves finally to the purchase before they had had an opportunity to see the outcome of the review. As you say, this would present no problems given the timetable we have now agreed for the review.

I am copying this letter to the Prime Minister.

chex.ps/mw/18 **CONFIDENTIAL**

FROM: MISS M P WALLACE
DATE: 1 December 1988

PS/CHIEF SECRETARY

cc Mr Anson
Mr Phillips
Mr Turnbull
Miss Peirson
Mr Gieve
Mr McIntyre
Mr Ramsden
Mrs Chaplin
Mr Tyrie
Mr Call

CHILD BENEFIT/FAMILY CREDIT/INCOME SUPPORT

The Chancellor was grateful for Mr McIntyre's minute of 29 November.

2. He notes Mr McIntyre's view that although the extra 45p we have given family credit recipients to compensate them for the child benefit freeze is discretionary, in practice we would not want to oppose similar action in future if CB were again frozen. He wonders whether we should seriously consider formalising this practice, as a defence against future CB increases.

MOIRA WALLACE

0190A/4

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

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

CONFIDENTIAL

other pps pl

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

CHIEF SECRETARY
REC 02 DEC 1988
ACTION Miss Peirson.
COPIES TO Chief P Middleton
Mr Anson, Mr Phillips
Mr Saunders, Mr McIntyre
McCall

1 December 1988

Dear Stuart

GRIFFITHS REPORT ON COMMUNITY CARE

I enclose a copy of the note of Tuesday's meeting between my and your Secretary of State and the Secretary of State for the Environment. Officials will want to develop the option outlined at the meeting as suggested at paragraph 9 of the note.

I am sending a copy of this letter to Roger Bright (Environment) and Carys Evans (Treasury).

Yours
Andy

A J McKEON
Principal Private
Secretary

0190A

CONFIDENTIAL

NOTE OF A MEETING TO DISCUSS THE GRIFFITHS REPORT ON COMMUNITY CARE 29 NOVEMBER 1988

PRESENT:

Secretary of State for the Environment
Secretary of State for Health
Secretary of State for Social Security

Ministers began by setting out their views on the Griffiths' proposals and the possible policy options.

2. The Secretary of State for Health said that he was not persuaded that the Griffiths' proposals would provide the necessary financial and political solution. If possible a different solution to Griffiths should be sought although he recognised that no-one had yet proposed a coherent sensible alternative. In his view, progress needed to be made quickly in formulating a collectively agreed proposal. He noted that the Chief Secretary agreed with his views except on the question of the need for speed. He was not convinced that a single all embracing solution was appropriate for the different client groups (elderly, mentally ill etc), particularly as mentally ill people required medical treatment rather than simply care.

3. The Secretary of State for the Environment agreed that the issue needed to be tackled quickly. Although the issue was the best way of providing care, the problems could not be approached entirely independently of the Government's relations with local government. In any case, provision of care was essentially a local matter. The subject was ideal for local government. There would be different needs in different localities, local authorities already provided a significant amount of care for the client groups and had responsibilities for housing which would be crucially involved. He was in favour of an arrangement whereby the local government role was to "enable" and organise services. Assessors of individual needs however should be independent. He recognised that no better alternative to Griffiths had so far been proposed. He considered that any proposals should be carefully worked out first and then presented to local government as non negotiable. He believed local authorities would welcome the new responsibilities and would accept the Government's terms.

4. The Secretary of State for Social Security agreed that the issue needed to be tackled rapidly. There were underlying problems such as the rapidly expanding social security budget for board and lodging payments which needed to be addressed. The financial pressure and its origins meant that he might need to consider seeking a PES transfer from the Department of Health unless a wider solution was found. This might be along Griffiths lines but

he was broadly neutral towards these. If the official Inter Departmental Working Group's proposals with any necessary constraints were not judged right then there was a case for passing responsibility for the financial aspects of the problem to the Secretary of State for Health as his Department already had policy responsibility for the client groups concerned and for the registration and inspection of homes.

5. The meeting then considered how the main components of any system should be tackled; the assessment of individuals; the buying and providing of services and the control of expenditure.

6. Assessment. The meeting considered that different assessment arrangements would be necessary for different client groups. General Practitioners might be part of any assessment team but Ministers would probably oppose any suggestion that they should be the main "gatekeeper". There was a strong case for ensuring that any assessors also had responsibility for meeting the financial consequences of their assessment. The Secretary of State for the Environment noted however that if District councils had responsibility for assessment they would be likely to increase provision substantially and that assessment would best be done at county level. An inspectorate (possibly the Social Services Inspectorate) would be needed to monitor the quality of assessment as well as of provision. There was a danger of a large bureaucracy being created to make assessments and cost comparisons of different ways of providing care which would need to be avoided.

7. Buying and Providing of Services. It was agreed that the buying and provision of services must be separated. Local authorities would buy services but would either need to be legally prevented from providing services or required to put their existing services to competitive tender. The latter process would need to be enforced by the District Auditors. There were doubts that local authorities would adjust to this role quickly but the Secretary of State for the Environment considered that local government culture had changed significantly.

8. Control of Expenditure The Secretary of State for Health was in favour of funding local authorities for community care services through a specific grant but was not convinced that this would apply an adequate control to total expenditure. He feared that local authorities would increase provision over and above what could be afforded from any specific grant thus greatly increasing the community charge which they would claim was in response to new responsibilities imposed by central government. The Secretary of State for the Environment agreed that specific grants would not provide expenditure control. Control would have to rest on restraining the level of the community charge and a national standard of provision and efficiency. He believed his officials could devise a method of needs assessment taking account of variations between authorities but there might be particular difficulties where different levels of authority were involved. This problem could be eased if say assessment and purchase of services was confirmed to one level of authority. On balance he

prefered any government funding to be included in the block grant rather than as a specific grant. Specific grants gave local authorities the opportunity directly to question the level of funding whereas in block grants the sum involved was not clear cut and any errors were lost. Funding would need to follow any new responsibilities if the community charge was not to be impossibly loaded. Existing social security payments would make up a large element of the central funds available.

9. The Secretary of State for Health concluded the meeting by noting that all were agreed on the need to tackle the subject quickly. A new option had been evolved. Its key features were for local authorities (possibly at county level) to be responsible for assessment of needs and purchasing of services. They would either be legally prohibited from providing services or asked to put existing services to competitive tender. Their total expenditure on community care would need to be restrained. An inspectorate would be required to monitor the quality of assessment and provision. He himself would also prefer separate arrangements for mentally ill people. Officials should be asked to develop an option along these lines. In the meantime he would meet the Chief Secretary to discuss further possible alternatives.

pso.jt/Sargent/13.2.12

CONFIDENTIAL

From: S D H SARGENT

Date: 2 December 1988

PS/CHIEF SECRETARY

cc PS/Chancellor
Mr Anson
Sir A Wilson
Mr Phillips
Mr Beastall
Mr A Edwards
Miss Peirson
Mr Potter

NHS AUDIT AND THE AUDIT COMMISSION

Sir Peter Middleton has seen Mr Anson's minute to the Chief Secretary of 1 December. He strongly supports his recommendation that the NHS audit proposal should be included in full in health legislation and that any paving legislation that is needed in the DOE Bill should be limited to the NHS only.

S D H SARGENT
Private Secretary

cst.ps/12ce2.12

CONFIDENTIAL

pyp

FROM: **MISS C EVANS**
DATE: **2 December 1988**

MISS PEIRSON

cc: Chancellor
Sir Peter Middleton
Sir T Burns
Mr Anson
Mr H Phillips
Miss Peirson
Mr Beastall
Mr Potter
Mr Saunders
Mr Call

NHS AUDIT

As you know, the Chief Secretary had a word with Mr Anson today about the potential difficulties with the PAC and the NAO if we sought to include in the Local Government Bill a general power enabling the extension of the Audit Commission's role to unspecified areas. The Chief Secretary agreed that in the light of these difficulties, and since the publication of the bill is now due to come after the publication of the NHS review White Paper, the preferred option was to legislate in the Local Government Bill for a specific power to enable the Audit Commission to audit health authorities.

2 As discussed he would like to write to the Lord President ahead of next Tuesday's meeting setting out his preferred option and the reasons for it. This would make clear that what was needed was cover for the first twelve months' work by the Audit Commission, set out the length of legislation envisaged, whether it would be paving or substantive, and explain what would be lost if we delayed until the health bill the following session. The letter should also consider Mr Wakeham's likely objection to adding this measure to the Local Government Bill by saying that this Bill is likely to be guillotined in any case.

3 For the meeting on Tuesday he would welcome a handling brief setting out

a) the planned timetable for the Local Government Bill, and the parallel timetable for the preparatory work on NHS audit assuming this could start after 2nd reading.

b) an aide memoire of the 3 options: specific power in the Local Government Bill, general power in the Local Government Bill, wait for NHS legislation, the advantages of the first and disadvantages of the two latter options;

c) a one page background note of the NAO/PAC background to the anticipated difficulties with a general power. It would be helpful if Mr Beastall would provide this.

4 As agreed, it would be helpful to have the draft letter to Mr Wakeham as early as possible on Monday, with the brief later in the day.

Cathy Evans

MISS C EVANS
Private Secretary

cst.pas/mc/1.2.12

FROM: MARK CALL
DATE: 2 DECEMBER 1988

CHANCELLOR

cc Chief Secretary
Financial Secretary
Paymaster General
Economic Secretary
Mrs Chaplin
Mr Tyrie

EXPOSING THE FALLACY OF SUPPLY SIDE SOCIALISM

Tautology would be a better word*, but probably too long for political knockabout. It seems to me that the key to exposing this nonsense lies in the establishing that there can be no such thing as an interventionist supply-side policy.

2. If investment were to be constrained by the Government to go into certain areas (eg R&D, training etc) this would not be the free working of the supply side. The latter implies removing the constraints on voluntary action. Labour's travesty of supply side action is a latter day attempt to 'back winners'

3. Secondly, as Mr Neuberger argues, Labour do not distinguish between public and private spending. His comment that they were 'too pessimistic in assessing the net cost of our plans' shows that they would expect to get the same economic growth out of public expenditure as private. The performance of the nationalised industries under their stewardship gives the lie to that.

4. Is it worth working up a demolition job for the eventuality that Bryan Gould reiterates the notion in a speech?

MARK CALL

Tuesday, November 29, 1988

The Guardian

Labour follow Lawson lead

Patrick Wintour

AS Labour prepares to renew its attack today on the Chancellor over the trade deficit, interesting developments are occurring within Labour's own economic policy thinking.

Gradually, the leadership is moving away from its traditional emphasis on demand reflation towards what it describes as supply side socialism. Most intriguingly, Labour leaders are privately admitting they owe Nigel Lawson a debt of gratitude for allowing them to make this shift in emphasis.

In a private memo to the Shadow Cabinet prepared by Mr Bryan Gould, the trade and industry spokesman, backed by a more detailed paper by his economic assistant Henry Neuburger, it is admitted that Labour must thank Mr Lawson for nullifying one of the most potent and long-standing criticisms of Labour's reflationary strategy.

In his memo, which was discussed at the recent two-day Shadow Cabinet meeting in Rottingdean, Mr Gould admits: "Before the last election, we were vulnerable to the charge that by proposing to raise public spending as a means of reducing unemployment, we were ready to take risks with inflation and the balance of payments."

He now claims that the Tories have already reflated "to a much greater degree and to much more damaging effect than anything we might have done, by encouraging spending in the private sector rather than making investment an essential economic strength".

Labour at the last election proposed in its job creation programme a net annual increase in public spending of £6 billion for two years with no changes in fiscal policy or monetary targets. The Conservatives since 1986, Mr Gould claims, have presided over a fiscal expansion of at least that much — about £12 billion gross — and in addition have permitted a £30 billion increase in private sector credit, far in excess of the £10 billion proposed by Labour.

This analysis produces two conclusions for Labour. In economic terms, the reflation has achieved the desired objective of reducing unemployment as Labour predicted. More importantly, economic growth has had a far more beneficial impact on Exchequer revenues and public spending than Labour assumed prior to the election.

Mr Nueburger concludes: "The turn-round in public finances suggests that we were far too pessimistic in assessing the net costs of our plans. If the experience of the past two years is anything to go by, a gross expenditure of £10 billion per annum would have led to net costs considerably less than the £6 billion we quoted at the time of the election.".

However, Mr Gould believes Mr Lawson's reflation has had a far more important political significance for Labour. He contends the reflation has produced "a major shift in the economic situation which offers us great advantages, but which we have yet to exploit fully. We can say that our policies do not now imply a major shift in the fiscal balance or in monetary targets.

"The Tories' expansion of demand means we no longer have to argue that our policies for defeating unemployment and strengthening the industrial base depend on reflating the economy. The Tories have done this for us, but in the most damaging way, by stoking asset inflation and sucking in imports."

The Conservatives, by implementing Labour's call for more demand, had given Labour "a whole new terrain on which to criticise the Government. The key word is balance — between demand and supply, between the over heating South-east and the less prosperous regions, between those who have benefited from top rate tax cuts and those whose Christmas benefit might be means tested".

Labour would switch the spending from private sector credit to investment. But Mr Gould acknowledges that such a policy would not only tackle the real economic problems, but would also draw support from independent commentators and industrial leaders.

Increasingly Labour's leaders are referring to the emphasis on investment as "supply side socialism." This offers an interventionist approach towards research and development, training and technology, where Britain is by most international indicators faring poorly.

For Mr Gould, the underlying message of the mounting trade deficit is that the Conservative approach — deregulation and loosening of labour monopolies — has failed to deal with inefficiencies on the supply side.

2/2

st1.33 **CONFIDENTIAL**

FROM: J P MCINTYRE
DATE: 2 December 1988

CHANCELLOR

cc Chief Secretary
Financial Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Dame Ann Mueller
Mr Byatt
Mr Scholar
Mr Phillips
Mr Culpin
Miss Peirson
Mr Mowl
Mr Gieve
Mr Gilhooly
Mr Riley
Mr Ramsden
Mr Speedy o.r.
Mrs Chaplin
Mr Tyrie
Mr Call

NATIONAL INSURANCE FUND: GOVERNMENT ACTUARY'S REPORT

The GAD report on the national insurance benefits and contributions uprating Orders will be laid before Parliament on 7 December. The Orders themselves will be published on the same day, and they will be debated in the Commons on 20 December and in the Lords on 22 December.

2. A copy of the version sent to the printers is attached, for information. There is no need to read it in detail, and there is no action. You may just like to be aware of the main points. These are:

a. The NIF surplus for 1988-89 is now put at £2.7 billion, compared with the GAD's last published forecast (in February) of £1.8 billion. The biggest single factor in the increase is higher earnings: a 6½ per cent increase was assumed in the February report, against 8¾ per cent in the new report. This adds nearly £700 million to the surplus.

b. The NIF surplus for 1989-90 is projected at £0.6 billion. The main reason for the sharp fall from this year's estimate is, of course, abolition of the Treasury Supplement which will cut NIF income by about £1.75 billion next year.

c. The balance in the Fund at the end of this year is put at 39 per cent of outgo, falling to 38 per cent at the end of 1989-90. (This compares with the GAD's recommended minimum of 17½ per cent and a high in recent years of 39 per cent in 1977-78.)

d. The value of contracted out rebates in 1989-90 is put at £5.9 billion (compared with gross Class I contributions of £34.9 billion). One of the assumptions underlying this figure is GAD's estimate of the effect of the new incentives to contract out, including the opportunity to take out personal pensions. They assume this to be about £260 million in additional rebates this year, and £690 million in 1989-90. This explains the reference in paragraph 17 to the reduction in net contributions of £430 million on these grounds, comparing next year with this. GAD stress these estimates are little more than guesses at this stage, pending receipt of data about take-up of personal pensions.

3. The large surplus in the current year (up from £1 billion in 1987-88) may well be used by the Opposition to call for increases in benefits and/or cuts in contributions. If so, DSS will point to the sharp fall in the projected surplus next year and say that, in any event, decisions on benefits and contribution rates cannot be made on the basis of one year's NIF surplus. They will also point to the uncertainty about the effect on the NIF of the recent pensions reforms.

4. The GAD's projections for the surplus are rather lower than those in the last Treasury internal forecast, especially for next year. The Treasury forecast showed a NIF surplus in 1988-89 of £3.2 billion (versus GAD's £2.7 billion) and in 1989-90 of £2.2 billion (versus £0.6 billion). Part of the difference is

accounted for by different economic assumptions, for the level of unemployment and for earnings growth. The winter internal forecast will of course be reviewing the NIF position again.

JM

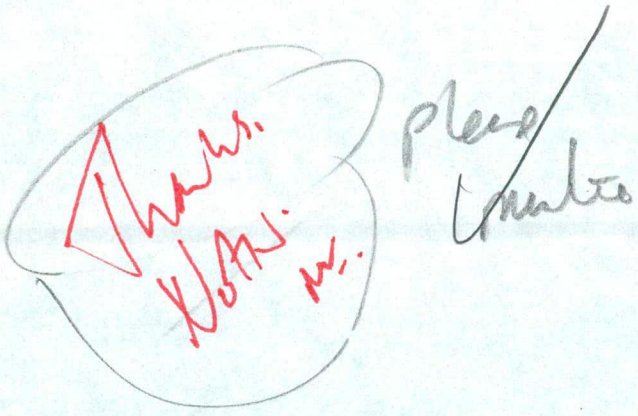
J P MCINTYRE

CONFIDENTIAL

FROM: J P MCINTYRE
DATE: 2 DECEMBER 1988

CHANCELLOR

cc Chief Secretary
Financial Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mr Scholar
Miss Peirson
Mr Culpin
Mr Gilhooly
Mr Riley
Mr Ramsden
Mr Speedy o.r.
Mrs Chaplin
Mr Tyrie
Mr Call



NATIONAL INSURANCE CONTRIBUTIONS AND THE NIF SURPLUS

A DSS official told me today (in confidence, please protect) that Mr Moore was likely to approach you in the next week or two with proposals to reduce the NIF surplus. He may seek a private word with you initially (which my source thought more likely) or else write with his proposals. He wants to influence your thinking ahead of Chevening.

2. You will remember that Mr Moore's letter to you of 22 October, about the Autumn NICs review, said that he believed it "essential that we now begin to take a careful look at the longer term options that are available to us for reducing [the NIF] balance, and I have asked my officials to begin preliminary work immediately". Mr Moore no doubt expects to come under pressure on the surplus during passage of the Social Security Bill and following publication of the new GAD report next week showing a much larger surplus this year than was predicted in the last report in February (see my separate submission of earlier today).

3. Although your letter of 25 October to Mr Moore asked if his officials could keep the Treasury in touch with their work on options for the NIF surplus, we have not been consulted so far. I gather Mr Moore wants to decide himself on the proposals he wants to put to you before the Treasury is brought in.

4. I suspect Mr Moore will make two proposals. First, he will seek your agreement that the maximum annual increase in the NHS allocation should be raised from the current 0.1 per cent. You said in your 25 October letter that this was one option you would not want to rule out and that, if it were agreed to be desirable, the necessary provisions might be included at a later stage in the new Social Security Bill. As you know, this would be an accounting change which would have no overall effect on government finances and would not therefore cut across your Budget strategy. But we will of course have to review all the arguments when we see exactly what Mr Moore proposes.

5. The second proposal would have a substantive impact on government finances, in that Mr Moore is expected to want some NIC reductions at the lower end. I have the impression that he is unlikely to press for very radical reform (for example, a withdrawable allowance) but rather to suggest a cut in the 5 per cent and 7 per cent rates and possibly an increase in the Lower Earnings Limit. An alternative approach Mr Moore is considering would involve extending the reduced rate bands further up the income distribution (which, of course, you considered about a year ago). In terms of reduced income to the NIF, I suspect Mr Moore is looking at proposals costing in the low hundreds of millions.

6. We can supply further briefing when Mr Moore brings forward his proposals.

JM

J P MCINTYRE

First report July '87

ANNEX 2

BACKGROUND

THE PRESENT SYSTEMS

1. At present there are two systems of public support for residential care: local authority finance and the supplementary benefit scheme.

LOCAL AUTHORITY FINANCE

2. Local authorities have a general duty under Section 21 of the National Assistance Act 1948 (Section 12 of the Social Work (Scotland) Act 1948) to "make arrangements for providing residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them". Such accommodation is known as Part III, from Part III of the National Assistance Act 1948. (Part IV in Scotland, from Part IV of the Social Work (Scotland) Act 1968.) Local authorities are also required to provide residential care provision under Schedule 8 of the National Health Service Act 1977. Authorities may provide residential care either in their own Residential Care Homes or by sponsoring a person in a private or voluntary Home.

3. People provided with residential care by a local authority are required to pay for that care; the amount of the charge depends on their financial circumstances. For those provided with residential care under the National Assistance Act, and for most of those provided with residential care under Schedule 8, there is a minimum charge, currently £31.60 per week. Residents of local authority homes or those sponsored by authorities in independent homes are entitled to an allowance for personal expenses of £7.90 per week. The personal expenses allowance and the minimum charge are deliberately set at rates which, when added together equal the rate of the basic retirement pension. This avoids the need for claims for supplementary benefit from the majority of those provided with residential care by a local authority. Those who do not qualify for the basic retirement pension and whose other resources are insufficient to cover the local authority's charge and personal expenses

allowance can claim supplementary benefit. For those over retirement age and for all in local authority homes, the amount of supplementary benefit payable is limited to the level of the minimum charge plus personal expenses. For those under retirement age in private and voluntary homes supplementary benefit may be paid up to the appropriate maximum limit for the home.

"Topping up" Supplementary Benefit"

4. In England and Wales "topping up" is the name given to the arrangements that allow a local authority to meet part, rather than the whole, charge to a supplementary benefit recipient below pensionable age in Residential Care Home where the charge exceeds the benefit payable. What happens is this. The local authority makes an arrangement under powers consolidated at schedule 8 of the NHS Act 1977 with a voluntary or privately run Home for the person's care. For people with mental disorders these arrangements are approved by LAC (19)74 and for certain other people by paragraph 5 of LAC(28)74. The authority pays the Home's charges for that person in full (it is not empowered to pay only part of the charge) and then recovers the supplementary benefit board and lodging payment from the resident. The result is that the authority is left bearing the difference betweent the Home's charges and the amount of supplementary benefit that the resident received. This measure does not extend to arrangements made for accommodation under Part III of the National Assistance Act 1948 where the legislative provisions do not allow more than the minimum amount of supplementary benefit to be paid to residents.

5. In Scotland, there are also no powers expressly providing for "topping up" but authorities are able to give such assistance under their powers at section 12(2) of the Social Work (Scotland) Act 1968.

SUPPLEMENTARY BENEFIT

6. The other source of support for residential care is through the supplementary benefit scheme. Residents of private or voluntary homes can get supplementary benefit to help with the home's charges provided they satisfy the normal conditions of entitlement to benefit. The amount of benefit payable is based on the Home's fees, subject to national limits and an allowance for personal expenses, currently £9.25.

7. Before 1980 discretionary help was available from the supplementary benefit scheme for certain people living in Residential Care and Nursing

Homes. From 1980 formal effect was given to a similar approach under the new regulated supplementary benefit scheme. Regulations enabled people in these establishments who could not meet the fees to receive towards the cost up to an amount comparable to that allowed for ordinary board and lodging generally in the locality. However there was the facility to pay above the level of the local limit where it was unreasonable to expect a person to move.

8. From 1983, separate limits were set in each locality for Nursing Homes, Residential Care Homes and ordinary board and lodging accommodation. Limits were set at levels corresponding to the highest reasonable charges rather than average charges. A further amount could be paid in recognition of special care needs.

9. There was widespread criticism of the 1983 system, and substantially more variation in local limits than could be explained by cost differences. After a consultation period during which the then local limits were frozen for 5 months, in 1985 the Department introduced a revised structure of supplementary benefit board and lodging allowances, which recognised the higher costs of care in certain specialist Homes. New regulations took effect from 29 April 1985 setting national limits for Residential Care Homes differing according to the category of care ("registeration category") provided.

The Categories

10. The maximum supplementary benefit payable depends on the category of care provided by the Home, normally its registered category. The categories are as follows:-

Residential Care Homes - Care on account of -

	Limits from April 1987
Mental Handicap	£150
Physical disability incurred below pension age	£190
Any other condition including old age	£130

Special limits

11. In July 1986 two new features were introduced:-

* a special limit for the very dependent or blind elderly now £14!

* a London premium which allows the limits for all Homes in Greater London to be extended by up to £17.50

Financial Assessment

12. The financial assessment used by local authorities to determine how much a client can afford to pay is different to that used in the assessment of supplementary benefit. For example:

Capital

LA * capital under £1,200 ignored

* income assumed of 25p per week for every £50 of capital above that level

* no upper limit

SB * capital over £3,000, no benefit

* no account taken of capital below this level

Personal Expenses Allowance

LA - £7.90

[LAs should supply clothing and footwear for residents to their homes]

SB - £9.25

chex.md/registry/33 CONFIDENTIAL

PWP

FROM: A A DIGHT
DATE: 5 December 1988

MR J P M MCINTYRE

NATIONAL INSURANCE FUND: GOVERNMENT ACTUARY'S REPORT

The Chancellor has seen and was grateful for your minute of 2 December.

A A DIGHT

With compliments

5 December 1988

To: Rt Hon Nigel Lawson MP

From: Bob Graham, Chief Executive

Provident House
Essex Street, London WC2R 3AX

Telephone 01-353 5212
Telex 883059 Fax 01-353 0134

Ch/ some v. good stuff here [eg p 5] Shall I circulate?

The Widening Role of the Independent Sector

I thought you might be interested in the attached speech.

With kind regards,

Bob Graham

BUPA

yes pls...

FINANCIAL TIMES CONFERENCE

29 NOVEMBER 1988

THE WIDENING ROLE OF THE INDEPENDENT SECTOR

BY BOB GRAHAM

CHIEF EXECUTIVE, BUPA

ABOUT TWO AND A HALF YEARS AGO, SOME OF US AND OTHERS - WHO HAVE SINCE LEFT THE SCENE, CAME TO THE LAST FINANCIAL TIMES CONFERENCE ON PRIVATE HEALTH CARE AND SPECULATED ON THE FUTURE OF THE INDUSTRY. WE DEALT AT LENGTH WITH THE HOT TOPICS OF THE DAY AT A TIME WHEN THE GROWTH OF INDEPENDENT HEALTH CARE WAS MODEST AND EFFECTIVE COST CONTROL HAD NOT YET BEEN ACHIEVED. PERHAPS INDEED THAT CONFERENCE WAS THE SPARK WHICH IGNITED THE INTENSE DEBATE WHICH HAS GATHERED MOMENTUM OVER THE PAST FEW YEARS AND DURING THIS YEAR IN PARTICULAR.

FEW SUBJECTS CAN HAVE INSPIRED SUCH A PLETHORA OF OPINIONS, SPECULATION AND RECOMMENDATION FROM SUCH A WIDE RANGE OF PEOPLE INCLUDING POLITICIANS, ACADEMICS, JOURNALISTS, BROADCASTERS, DOCTORS AND ECONOMIC AND SOCIAL INSTITUTIONS.

ALMOST EVERY CONCEIVABLE ROLE AND EVERY POSSIBLE FORM OF GOVERNMENT ASSISTANCE HAS BEEN ADVOCATED FOR PRIVATE MEDICINE. TO NAME JUST A FEW: THE PERENNIAL TAX RELIEF ON HEALTH INSURANCE SUBSCRIPTIONS; TAX REBATES FOR INDIVIDUALS WHO PAY FOR THEIR TREATMENT PRIVATELY; HEALTH VOUCHERS; THE RIGHT TO OPT OUT OF THE NHS FOR A REDUCED TAX CONTRIBUTION; THE PRIVATE SECTOR TO MANAGE A NATIONAL INSURANCE SCHEME OR TO RUN LARGE PARTS OF THE NHS; THE FORMING OF HEALTH MAINTENANCE ORGANISATIONS BETWEEN THE PRIVATE SECTOR AND THE NHS.

THE LATEST IDEA BEING PROPOUNDED IS THAT TAX EFFECTIVE HEALTH TRUSTS SHOULD BE ESTABLISHED FOR PRIVATE SECTOR EMPLOYERS.

BUT TWO AND A HALF YEARS LATER, AND FOLLOWING THE GOVERNMENT'S FAIRLY MUTED PRONOUNCEMENTS ON HEALTH CARE MADE AT THE CONSERVATIVE PARTY CONFERENCE LAST MONTH, WHAT IS THE REALITY? NONE OF THESE THINGS HAS TRANSPIRED. HOWEVER, HEALTH INSURANCE HAS CONTINUED TO GROW STEADILY; SOME SERVICES LIKE MEDICAL SCREENING HAVE EXPANDED RAPIDLY; AND NEW PRODUCTS AND SERVICES HAVE BEEN DEVELOPED WITHOUT ANY SPECIFIC AID FROM GOVERNMENT.

THE PRIVATE HEALTH CARE SECTOR HAS BECOME A £1 BILLION INDUSTRY, SERVING OVER 10% OF THE POPULATION AND PROVIDING ABOUT 14% OF UK HEALTH CARE. THE LATEST ESTIMATE IS THAT ABOUT 17% OF THE NATION'S ELECTIVE SURGERY IS NOW PERFORMED IN THE PRIVATE SECTOR.

OVERALL, THE INDUSTRY HAS DEVELOPED FASTER THAN THE ANNUAL GROWTH OF THE NATIONAL ECONOMY AND THIS HAS BEEN ACHIEVED WITHOUT ANY OF THE SO CALLED "INCENTIVES" PRESCRIBED FOR THE SECTOR.

THE HEALTH INSURANCE MARKET, FOR EXAMPLE, HAS EXPANDED BY ABOUT 17% IN THE PAST THREE YEARS, WHILST MEDICAL SCREENING HAS GROWN BY A QUITE DRAMATIC 50%. SHEER COMMONSENSE HAS SEEN A GREAT DIMINUTION IN THE IDEALOGICAL BARRIERS BETWEEN THE PUBLIC AND PRIVATE SECTORS AND CO-OPERATION BETWEEN THE TWO IS NOW INCREASINGLY COMMON.

IN ANY CASE, I BELIEVE THAT THE FUTURE OF THE PRIVATE SECTOR DOES NOT DEPEND ON PROPPING UP BY ARTIFICIAL ECONOMIC STIMULI OR BY THE ACCEPTANCE OF UNREALISTIC OR INAPPROPRIATE POLITICALLY INSPIRED ROLES. SUCH PLATFORMS WOULD BE AN INSECURE BASIS ON WHICH TO BUILD A BUSINESS. WE HAVE SEEN ALL TOO MANY EXAMPLES OF WHAT CAN HAPPEN TO BUSINESSES WHICH RELY ON GOVERNMENT HAND-OUTS OR PATRONAGE.

DISTORTION OF MARKET FORCES IS NOT GOOD AND IT WOULD BE UNWISE TO BASE FUTURE PLANNING ON ECONOMIC CRUTCHES GIVEN TO THE INDUSTRY BY A GOVERNMENT OF ONE POLITICAL PERSUASION WHICH COULD LITERALLY BE KICKED AWAY OVERNIGHT BY A NEW REGIME OF A DIFFERENT PERSUASION.

THERE IS ANOTHER REASON WHY I AM NOT SURPRISED THAT THE VARIOUS LEAKS AND KITE FLYING EXERCISES OF RECENT YEARS HAVE NOT BECOME REALITY - AND THAT IS BECAUSE, OF COURSE, TAX BREAKS AND SUBSIDIES ARE ALIEN TO THE BASIC PHILOSOPHY OF A CONSERVATIVE GOVERNMENT WHICH WANTS TO REDUCE THEM AND NOT ADD TO THEIR NUMBER. ITS INTENTION IS TO ELIMINATE ANOMALIES AND SIMPLIFY THE TAX SYSTEM SO THAT, AS FAR AS POSSIBLE, BUSINESSES AND INDIVIDUAL CITIZENS WILL STAND FAIRLY AND SQUARELY ON THEIR OWN ECONOMIC FEET.

IF ANYONE HAD ANY DOUBTS ABOUT THIS, KENNETH CLARKE'S SPEECH AT THE TORY PARTY CONFERENCE LAST MONTH MUST HAVE DISPELLED ANY ILLUSIONS: THERE WAS NO HINT OF AID OR PRIVILEGE FOR PRIVATE MEDICINE.

MOREOVER, I BELIEVE IT TO BE RIGHT AND PROPER THAT USERS OF PRIVATE MEDICINE SHOULD PAY THEIR FULL SHARE OF TAXES TOWARDS THE NHS THUS AVOIDING BOTH THE SUGGESTION AND THE REALITY OF A TWO TIER SYSTEM OF HEALTH CARE WITH FIRST AND SECOND CLASS SERVICES.

THERE IS LITTLE DOUBT IN MY MIND THAT THE FUTURE OF THE PRIVATE SECTOR IS FIRMLY HITCHED TO ITS ABILITY TO COMPETE EFFECTIVELY IN THE NEW CLIMATE OF POPULAR CAPITALISM WHICH HAS TAKEN ROOT IN BRITAIN AND WHICH IS SPREADING RAPIDLY NOT ONLY ACROSS THE WESTERN WORLD BUT ALSO INTO THE EASTERN BLOC. IT IS EVEN EMERGING IN THIRD WORLD COUNTRIES AS WELL.

WE ARE ALL FAMILIAR WITH THE ELEMENTS OF POPULAR CAPITALISM: PRIVATISATION, WIDER SHARE AND PROPERTY OWNERSHIP; THE ENDING OF RESTRICTIVE PRACTICES AND MONOPOLIES; THE FOSTERING OF COMPETITION; AND THE WITHDRAWAL OF GOVERNMENT TO A REGULATING ROLE.

THIS NEW WAVE OF THINKING IS TRANSFORMING ECONOMIES AND APART FROM BRITAIN, TWO CLASSIC EXAMPLES ARE JAPAN AND SINGAPORE. POPULAR CAPITALISM IS BEING EMBRACED BY SOCIALIST GOVERNMENTS IN FRANCE, AUSTRALIA, NEW ZEALAND AND SPAIN, AND BY THE COMMUNIST REGIME IN CHINA. THROUGH GLASNOST AND PERESTROIKA, ELEMENTS OF CAPITALISM ARE NOW BEING INTRODUCED IN RUSSIA AS WELL: THE NEW PRIVATE HOSPITAL IN MOSCOW IS SPECTACULAR EVIDENCE OF RAPIDLY CHANGING ATTITUDES - ATTITUDES WHICH ARE CONCERNED MORE WITH SUCCESSFUL OUTCOMES RATHER THAN THE ROUTE TAKEN, OR POLITICAL DOGMA.

ECONOMIC LIBERALISATION BRINGS WITH IT A BROADER POPULAR UNDERSTANDING OF PERSONAL ECONOMIC AND FINANCIAL AFFAIRS AND MANY MORE PEOPLE PARTICIPATE IN EQUITY MARKETS, HOME OWNERSHIP AND THE PROVISION OF THEIR OWN PENSIONS. IT ALSO ENCOURAGES INDIVIDUALS TO TAKE GREATER RESPONSIBILITY FOR THE COURSE OF THEIR OWN LIVES AND THE WELL-BEING OF THEIR OWN FAMILIES.

HEALTH CARE, AS PROBABLY ONE OF THE MOST PERSONAL AND INTIMATE ASPECTS OF HUMAN LIFE, MUST BE AN IMPORTANT ELEMENT IN THIS.

REFORM OF GENERAL TAXATION POLICY IS AN INTEGRAL PART OF THE PROCESS. WHAT HAS BEEN ACHIEVED IN THE UNITED STATES IS DRAMATIC: THERE HAS BEEN A MASSIVE SIMPLIFICATION AND MANY SPECIAL ALLOWANCES HAVE BEEN ELIMINATED. THE HIGHEST RATE OF INCOME TAX IS NOW ONLY 27% AND YET MORE REVENUE IS BEING COLLECTED THAN BEFORE.

IN THE UK THE PROCESS IS WELL UNDER WAY. WE HAVE HAD SEVERAL TAX CUTS AND CORPORATION TAX HAS COME DOWN FROM 52% TO 35%. I HAVE NO DOUBTS THAT THE SYSTEM WILL BE FURTHER STREAMLINED AND SHAPED TO KINDLE INITIATIVE AND ENTERPRISE.

ACROSS THE WORLD THERE IS ALSO THE GROWING REALISATION THAT FREE ENTERPRISE CREATES THE WEALTH AND PROSPERITY WHICH ENABLES GOVERNMENTS TO PROVIDE ADEQUATELY FOR THE DISADVANTAGED AND THE POOR.

I REMAIN CONVINCED THAT THE NHS WILL CONTINUE TO BE THE PRINCIPAL PROVIDER OF HEALTH CARE IN BRITAIN FOR THE FORESEEABLE FUTURE. I THEREFORE BELIEVE THAT IT IS ABSOLUTELY RIGHT THAT INSTEAD OF HANDING ECONOMIC BOUQUETS TO THE PRIVATE SECTOR THE GOVERNMENT SHOULD CONCENTRATE ON MAKING THE PUBLIC HEALTH SERVICE AS EFFICIENT AS POSSIBLE SO THAT IT CAN GIVE MAXIMUM VALUE FOR EVERY TAX POUND SPENT ON IT.

AS THE SECRETARY OF STATE DECLARED AT HIS PARTY'S CONFERENCE: "THE NHS IS NOT A BUSINESS, BUT IT HAS TO BE MORE BUSINESSLIKE.

"WE WILL SPREAD THE BEST QUALITIES OF THE ENTERPRISE ECONOMY THROUGHOUT IT."

THIS MEANS OF COURSE THAT THE HORIZONS OF THE PRIVATE SECTOR WILL CONTINUE TO BE BOUNDED BY THE NHS. HOWEVER, THAT STILL LEAVES ENORMOUS SCOPE BECAUSE AS WE ALL KNOW, THE DEMAND FOR HEALTH CARE IS INSATIABLE - IT SIMPLY CONTINUES TO OUTSTRIP THE GROWTH OF PROVISION. WITH PUBLIC DEMAND INCREASING AND THE INEVITABLE IMPOSITION OF PUBLIC EXPENDITURE CEILINGS, THE EXTRA RESOURCES AND SERVICES CAN ONLY COME FROM THE PRIVATE SECTOR.

I BELIEVE THERE MUST BE CONSIDERABLE SCOPE FOR INDEPENDENT HEALTH CARE IN THIS COUNTRY. THE PROPORTION OF GROSS NATIONAL PRODUCT SPENT ON PRIVATE MEDICINE IN BRITAIN IS ONLY 0.8% WHILST IN BOTH GERMANY AND FRANCE IT IS 1.8%.

THE NATURAL GROWTH OF THE PRIVATE SECTOR IN THE UK WOULD MATCH THESE FIGURES BY THE END OF THE CENTURY IF NOTHING ELSE CHANGED, BUT OF COURSE THINGS ARE CHANGING:

WE HAVE TO RECOGNISE THAT CONSUMERISM IS BECOMING THE ORDER OF THE DAY. PEOPLE ARE DEMANDING HIGHER STANDARDS AND WANT CHOICE. AND A HEALTHY ECONOMY IS ENSURING THAT THEY HAVE GREATER DISPOSABLE INCOMES TO INDULGE THEIR PREFERENCES.

THAT IS THE PRIVATE SECTOR'S OPPORTUNITY.

THAT IS ITS CHALLENGE.

IT IS UP TO US TO GAIN OUR SHARE OF RISING PROSPERITY IN THIS UNFETTERED FREE MARKET BY DEVELOPING THE PRODUCTS AND SERVICES WHICH ATTRACT THE PUBLIC AND CONVINCING IT OF THE VALUE OF PRIVATE HEALTH CARE. TO DO SO, WE MUST JOSTLE NOT ONLY WITH EACH OTHER BUT ALSO WITH EVERY OTHER TYPE OF BUSINESS WHICH IS COMPETING FOR A SHARE OF TOTAL DISPOSABLE INCOME.

BUT IT IS NOT JUST A MATTER OF COMPETING FOR A SHARE OF THE <u>INCREASE</u> - IT IS ALSO UP TO US TO EDUCATE INDIVIDUALS TO SPEND A GREATER SHARE OF <u>CURRENT</u> DISPOSABLE INCOME ON THEIR OWN AND THEIR FAMILIES' HEALTH CARE.

THE MAGNITUDE OF THE SCOPE IS CLEAR WHEN YOU CONSIDER THE HUGE SUMS SPENT ON LEISURE PURSUITS: THE £7.5 BILLION SPENT EACH YEAR ON THE THOROUGHLY UNHEALTHY HABIT OF SMOKING; THE £16.5 BILLION SPENT ON ALCOHOL (ALMOST AS MUCH AS THE BUDGET OF THE NHS ITSELF); THE £600 MILLION SPENT ON FOOTBALL POOLS; THE £4.3 BILLION SPENT ON THE DOGS AND HORSES; AND THE £1.6 BILLION SPENT ON JACKPOT MACHINES AND BINGO.

IN THE NEW POPULAR CAPITALISM, MAKING MONEY IS NOT REGARDED AS SOMETHING EVIL. SIMILARLY, THERE IS ALSO AN INCREASING ACCEPTANCE THAT MAKING REASONABLE PROFITS IN HEALTH CARE IS IN THE PUBLIC INTEREST BECAUSE IT IS THOSE PROFITS WHICH ENSURE THE AVAILABILITY OF THE SERVICES AND THE QUALITY STANDARDS WHICH PEOPLE INCREASINGLY SEEK.

THE PRIVATE SECTOR HAS, IN THE PAST, DESCRIBED ITSELF SOMEWHAT EUPHEMISTICALLY AS "COMPLEMENTARY" TO THE NHS - MEANING THAT IT SIMPLY PROVIDED ADDITIONAL RESOURCES WHICH IN COMPARISON WITH THE NHS WERE FAIRLY MODEST AND MAINLY IN THE FIELD OF ACUTE SURGERY. WHILE STILL A COMPLEMENTARY SERVICE, IT IS, HOWEVER, BECOMING MORE SOPHISTICATED AND DIVERSIFIED - SO MUCH SO THAT AS THE NHS BECOMES FREE TO MAKE PROFITS ITSELF, COMPETITION BETWEEN IT AND THE PRIVATE SECTOR IS NOW BECOMING A REALITY.

THIS IS HAPPENING NOT ONLY IN RELATION TO PAY-BEDS BUT IN MANY OTHER AREAS. ALSO, OF COURSE, WITH MORE UNFETTERED AND ENLIGHTENED MANAGEMENT, THE NHS IS NOW MUCH MORE READILY PREPARED TO BECOME A CUSTOMER OF THE PRIVATE SECTOR WHERE IT PERCEIVES GOOD VALUE AND QUALITY OF SERVICE.

AS MR CLARKE SAID AT BRIGHTON: "THE REALITY IS THAT IN FUTURE WE ARE GOING TO HAVE A MIXED HEALTH CARE ECONOMY AND OUR AIM IS TO GET THE FULL BENEFIT OF THAT FOR ALL PATIENTS."

INDEED, BUPA'S OPINION POLLS OVER THE YEARS HAVE SHOWN A GROWING PUBLIC DESIRE FOR A MIXED ECONOMY IN HEALTH CARE.

THIS COMPETITIVE TREND WILL, IN MY VIEW, SPREAD TO EVERYONE IN HEALTH CARE - INCLUDING CONSULTANTS, GP'S AND NURSES.

FOR EXAMPLE, TO QUOTE MR CLARKE AGAIN: "WE WANT THE PATIENT TO CHOOSE THE GP HE THINKS BEST FOR HIM, AND TO CHANGE HIS GP WHEN HE WANTS."

IT IS FASCINATING TO NOTE THAT THE LABOUR PARTY ALSO SEEMS TO BE BEGINNING TO REGARD THE NHS PATIENT AS SOMETHING OTHER THAN A SUPPLICANT AND TO BE EMBRACING THE MERITS OF COMPETITION IN HEALTH CARE.

FOR THE FIRST TIME THAT I CAN RECALL AT A LABOUR CONFERENCE NO RESOLUTIONS WERE DEBATED THIS YEAR WHICH CALLED FOR THE ABOLITION OF PRIVATE HEALTH CARE. INDEED, THE ISSUE OF HEALTH CARE WAS INCLUDED IN A DEBATE ON AN INTERIM REPORT PRODUCED BY A LABOUR POLICY REVIEW GROUP WITH THE INTERESTING TITLE OF "CONSUMERS AND THE COMMUNITY".

IT IS REFRESHING TO NOTE THE WORD "CONSUMER" - PERHAPS NEXT YEAR WE MIGHT EVEN GET A MENTION OF CUSTOMERS.

DURING THE DEBATE, ROBIN COOK, THE SHADOW HEALTH SECRETARY, SAID: "WE ARE GOING TO PUT BUPA OUT OF BUSINESS BY PROVIDING A BETTER SERVICE THAN BUPA CAN MATCH."

WELL MR COOK, I HAVE NEWS FOR YOU:

I ACCEPT YOUR CHALLENGE, GLADLY.

WE WELCOME COMPETITION.

WE THRIVE ON IT.

COMPETITION WILL ENSURE THAT THE PATIENT RECEIVES A GOOD DEAL AND MAXIMUM CHOICE. WHEN THE CUSTOMER IS KING, ALL CITIZENS GET BETTER VALUE FOR HEALTH CARE MONEY.

I CONGRATULATE YOU ON YOUR NEW ENLIGHTENMENT - THE PATIENT HAS NEVER HAD SUCH GOOD NEWS FROM LABOUR.

BUT WHY DO YOU WANT TO PUT US OUT OF BUSINESS? YOU WOULD SIMPLY DEPRIVE FIVE OR SIX MILLION OF THE ELECTORATE OF THE RIGHT TO CHOOSE AND INCUR THEIR ANGER, AS WELL AS LENGTHENING WAITING LISTS AND THROWING A VERY LARGE ADDITIONAL BURDEN ON THE NHS.

THE LATEST POLICY PRONOUNCEMENTS BY THE SOCIAL AND LIBERAL DEMOCRATS AND THE SOCIAL DEMOCRATS INDICATE THAT THEY ALSO SEEM INTENT ON "STAND ON YOUR OWN FEET" POLICIES FOR PRIVATE MEDICINE AND GREATER CO-OPERATION AND COMPETITION BETWEEN THE TWO SECTORS.

COMPETITION, HOWEVER, MUST BE FAIR AND THE PLAYERS MUST EXPECT TO COMPETE ON EQUAL TERMS. THE NHS, FOR EXAMPLE, SHOULD NOT BE ALLOWED TO COMPETE ON AN UNREALISTIC COSTING BASIS, OR THROUGH SUBSIDY BY THE TAXPAYER, NOR, FOR EXAMPLE, SHOULD PRIVATE PATIENTS HAVE TO PAY SO MUCH MORE FOR DRUGS THAN DO NHS PATIENTS.

RECENTLY, AS A RESULT OF A RULING BY THE EUROPEAN COURT, THE GOVERNMENT ANNOUNCED THAT PRIVATE HOSPITALS AND NURSING HOMES ARE TO PAY VAT ON NEW BUILDINGS, WHILST COMPARABLE NHS FACILITIES ARE EXEMPT. THAT IS NOT AN EQUITABLE SITUATION AND I SINCERELY HOPE THE GOVERNMENT WILL TAKE ACTION TO RECTIFY IT.

SO WHAT DOES ALL THIS AUGUR FOR THE FUTURE OF PRIVATE HEALTH CARE?

IT MEANS THAT MARKET FORCES WILL PREDOMINATE AND THAT A NATURAL BALANCE WILL DEVELOP BETWEEN THE NHS AND THE PRIVATE SECTOR IN WHICH EACH WILL LEAVE TO THE OTHER WHAT IT CAN DO BEST. THIS WOULD MEAN A TRULY COMPLEMENTARY RELATIONSHIP WITHOUT UNDUE OVERLAP OR DUPLICATION AND THE BEST POSSIBLE USE OF THE MONEY WHICH THE COMMUNITY IS PREPARED TO SPEND ON ITS HEALTH CARE NEEDS.

AS THE NHS CONTINUES TO BE MORE BUSINESSLIKE AND ARTIFICIAL BARRIERS ARE DISMANTLED, THERE WILL BE MORE DEALS BETWEEN THE TWO SECTORS. IT WILL NOT ALWAYS BE LOGICAL FOR THE NHS ITSELF TO BUILD AND OPERATE EVERY FACILITY AND SERVICE WHEN BETTER RESULTS AND LOWER COSTS CAN BE OBTAINED THROUGH SUB-CONTRACTING. SUB-CONTRACTING TOO CAN AND SHOULD BE A TWO WAY STREET. MARKET FORCES WILL ALSO DICTATE THAT IT IS WISE AT TIMES TO FORM PARTNERSHIPS AND ENGAGE IN JOINT VENTURES.

AS MR CLARKE SAID IN HIS CONFERENCE SPEECH, NHS MANAGERS SHOULD BE PREPARED TO BUY SERVICES FOR THEIR PATIENTS FROM THE PRIVATE SECTOR SO LONG AS THEY BARGAIN HARD AND PAY AS LITTLE AS POSSIBLE; AND SHOULD BE READY TO SELL SERVICES TO THE PRIVATE SECTOR AS LONG AS THEY CHARGE THE HIGHEST POSSIBLE PRICE. I HAVE NO QUARREL WITH THIS AS LONG AS IT IS REALISED THAT THE PEOPLE ON THE OTHER SIDE OF THE NEGOTIATING TABLE WILL HAVE SIMILAR OBJECTIVES.

IN THE TRADITIONAL FIELDS OF HEALTH INSURANCE AND PRIVATE HOSPITALS, I BELIEVE THAT GROWTH WILL CONTINUE TO BE STEADY.

THE PRIVATE SECTOR IS SOMETIMES CRITICISED BECAUSE OF THE COST OF HEALTH CARE. AS IN ANY MARKET SITUATION, THIS WILL REGULATE ITSELF - ALREADY WE SEE SIGNS: NEW CHEAPER INSURANCE SCHEMES ARE BEING INTRODUCED TO MEET MARKET NEEDS; DOCTORS' MONOPOLIES AND TOTAL CLINICAL FREEDOMS ARE BEING CHALLENGED AND FEES AND HOSPITAL COSTS ARE COMING UNDER PRESSURE.

AS A RESULT, THE RATE OF COST INFLATION IN HEALTH INSURANCE SUBSCRIPTIONS HAS BEEN MUCH REDUCED.

IN A FREE MARKET WITH INCREASING COMPETITION WE WILL ALSO SEE THE CONTINUING INTRODUCTION OF NEW HEALTH INSURANCE PRODUCTS TAILORED TO SPECIAL OBJECTIVES AND MARKETS. INCENTIVES FOR RISK REDUCTION ARE BEGINNING TO APPEAR. THEY INCLUDE DISCOUNTS FOR NON SMOKERS, DEDUCTIBLES, NO CLAIM BONUSES AND REDUCED BENEFIT SCHEDULES.

NEW SCHEMES ARE BEING INTRODUCED FOR THE ELDERLY, AND PAYMENT BY CREDIT CARD IS BECOMING INCREASINBLY COMMON.

PRIVATE HOSPITALS WILL CONTINUE TO GAIN ADDITIONAL REVENUE BY DEVELOPING SPECIAL SERVICES FOR LOCAL COMMUNITIES.

IT HAS BEEN SAID THAT THERE ARE TOO MANY PRIVATE HOSPITALS. THAT MAY BE PARTLY TRUE IN ONE OR TWO AREAS, BUT RATIONALISATION IS OCCURRING WHICH WILL ENSURE THAT ECONOMIES OF SCALE AND STANARDISATION PREVAIL. ON THE OTHER HAND THERE IS SCOPE FOR SMALLER SPECIALISED LOCAL HOSPITAL SERVICES THROUGHOUT THE COUNTRY. A LEADING OBSERVER SAID SOME WEEKS AGO THAT THE MARKET COULD SUPPORT 100 NEW HOSPITALS BY THE YEAR 2000.

OTHER AREAS OF GROWTH WILL BE IN DAYCARE AND COMMUNITY CARE. HOSPITALS ARE EXPENSIVE AND WILL BECOME INCREASINGLY ANACHRONISTIC IN RELATION TO THE MORE ROUTINE SURGICAL AND MEDICAL PROCEDURES. DAY CLINICS AND HOME CARE MAKE GREAT SENSE, AND WILL BE A MAJOR FEATURE OF THE HEALTH CARE SCENE OVER THE NEXT QUARTER CENTURY.

HERE AGAIN, THE PRIVATE SECTOR HAS A SUBSTANTIAL OPPORTUNITY IN PROVIDING CLINICS, TOGETHER WITH NURSING AND OTHER HELP FOR PEOPLE IN THEIR HOMES.

BUT THERE ARE AREAS WHERE I THINK GROWTH IS GOING TO CONTINUE TO BE VERY RAPID:

WHILE THE MORE TRADITIONAL SECTORS LIKE HEALTH INSURANCE AND PRIVATE HOSPITALS WILL CONTINUE TO ENJOY STEADY GROWTH, PREVENTIVE MEDICINE, THE CARE OF THE ELDERLY AND OVERSEAS VENTURES ARE PRESENTING NEW AND EXCITING OPPORTUNITIES FOR THE ALERT AND EXPERIENCED HEALTH CARE COMPANIES.

PREVENTIVE MEDICINE MUST BE A PARTICULARLY PROMISING FIELD: NEVER BEFORE HAS THE PUBLIC BEEN SO AWARE OF HEALTH MATTERS FROM DIET TO EXERCISE, AND INCREASINGLY PEOPLE ARE APPRECIATING THE VALUE OF SCREENING. NEVER BEFORE HAVE EMPLOYERS BEEN SO CONSCIOUS OF THE CLOSE RELATIONSHIP BETWEEN A HEALTHY WORK FORCE AND A HEALTHY BOTTOM LINE ON THEIR BALANCE SHEET.

THE NHS IS FULLY STRETCHED TO PROVIDE A SICKNESS SERVICE SAFETY NET FOR THOSE WHO NEED IT. PREVENTIVE MEDICINE IS THUS NOT SEEN AS A PRIMARY ROLE FOR GOVERNMENT. INCREASINGLY, BY CREATING A HEALTHY ECONOMY AND GREATER DISPOSABLE INCOMES, GOVERNMENT EXPECTS THE PUBLIC AND EMPLOYERS TO PLAY A GREATER ROLE IN MAINTAINING THEIR OWN AND THEIR EMPLOYEES' HEALTH.

THIS PROVIDES HUGE OPPORTUNITIES FOR THE PRIVATE SECTOR IN THE FIELDS OF MEDICAL SCREENING AND OCCUPATIONAL HEALTH.

ANOTHER AREA OF GREAT POTENTIAL IS THE CARE OF THE ELDERLY. IN A BUOYANT AND GROWING ECONOMY WITH MORE PERSONAL PENSION SCHEMES AND INVESTMENT SCHEMES MANY MORE PEOPLE WILL BE ABLE TO CATER FINANCIALLY FOR THEMSELVES IN OLD AGE.

THE ELDERLY ARE BECOMING A NEW ECONOMIC FORCE IN THEIR OWN RIGHT AS A GROWING PROPORTION OF OLDER PEOPLE ARE NOW COMPARATIVELY WELL OFF.

ELDERLY PEOPLE HAVE FINANCIAL MUSCLE AND A WHOLE NEW INDUSTRY IS DEVELOPING TO SERVICE THEIR NEEDS.

WITH THE NUMBER OF PEOPLE OVER 65 IN BRITAIN PROJECTED TO RISE BY A FURTHER MILLION BY THE TURN OF THE CENTURY THE SUBSTANTIAL TOTAL OF MORE THAN 10 MILLION WILL CONSTITUTE A HUGE DEVELOPING MARKET FOR THE HEALTH CARE INDUSTRY.

ALREADY, ABOUT HALF THE FACILITIES FOR THE ELDERLY ARE OWNED AND OPERATED BY THE PRIVATE SECTOR, AND THIS PROPORTION WILL INCREASE.

AS MORE COMPANIES EMERGE TO MEET THE DEMANDS FOR SCREENING AND CARE OF THE ELDERLY, THERE ARE NATURAL ANXIETIES ABOUT STANDARDS OF QUALITY, WITH CALLS FOR GREATER GOVERNMENT REGULATION, INSPECTION AND CONSTRAINTS.

WHILE REGULATION WHETHER SELF-IMPOSED OR GOVERNMENT ENFORCED IS DESIRABLE, I BELIEVE THAT AS IN OTHER FIELDS, THE BEST WAY OF ACHIEVING HIGH QUALITY IS THROUGH COMPETITION. IN HEALTH CARE PARTICULARLY THE BUSINESS WILL GO TO THOSE WHO PROVIDE THE BEST QUALITY AND VALUE FOR MONEY.

THE POWERFUL TRUTH IS THAT COMPETITION IS THE ONLY REAL GUARDIAN OF THE CUSTOMER INTEREST.

ANOTHER EXCITING FIELD OF OPPORTUNITY LIES OVERSEAS. AS POPULAR CAPITALISM SPREADS THROUGHOUT THE WORLD MANY GOVERNMENTS ARE SEEKING TO REDUCE THE HEALTH CARE TAX BURDEN ON THE STATE AND TO ENLARGE THE PRIVATE MEDICAL SECTOR. THERE IS A GREAT RESERVE OF KNOWHOW IN THE PRIVATE SECTOR IN BRITAIN IN THE FINANCING AND RUNNING OF HEALTH CARE AND IN WORKING WITH GOVERNMENT AND PUBLIC AUTHORITIES.

THUS ADVISING AND WORKING WITH OVERSEAS GOVERNMENTS AND FORMING JOINT VENTURES WITH COMPANIES ABROAD MUST BE A SIGNIFICANT BUSINESS OPPORTUNITY FOR THOSE MEMBERS OF THE BRITISH PRIVATE SECTOR WITH THE KNOW-HOW AND COURAGE TO IDENTIFY AND GRASP THE OPPORTUNITIES AS THEY PRESENT THEMSELVES. OUR AMERICAN FRIENDS HAVE BEEN DOING THIS SUCCESSFULLY FOR MANY YEARS AND THERE IS NO REASON WHY THE UNITED KINGDOM SHOULD NOT HAVE A SHARE OF THE ACTION.

I AM SURE THAT WE SHALL HEAR MANY REFERENCES AT THIS CONFERENCE TO 1992 AND I DO NOT INTEND TO DWELL ON IT AT ANY LENGTH OTHER THAN TO SAY THAT I BELIEVE THE OPPORTUNITIES AND THREATS WHICH WILL BE IDENTIFIED WITH THE PROPOSED SINGLE EUROPEAN MARKET ARE ALREADY IN EXISTENCE.

OF COURSE, THE PRIVATE HEALTH CARE SECTOR MUST PROTECT ITS HOME MARKET AGAINST INCREASING OVERSEAS COMPETITION BUT NOW IS THE TIME TO SEIZE THE OPPORTUNITIES WHICH I BELIEVE EXIST, DESPITE THE MONOLITHIC AND BUREAUCRATIC NATURE OF SOME EUROPEAN STATE HEALTH CARE SYSTEMS.

IN SHORT, MR CHAIRMAN, LADIES AND GENTLEMEN, THE ECONOMIC AND POLITICAL BAROMETER IS SET FAIR FOR PRIVATE MEDICINE - FAIRER THAN I HAVE EVER KNOWN IT IN THE PAST.

FREE MARKET FORCES WILL SET THE OPPORTUNITIES FOR OUR FUTURE. I THINK THAT THIS IS ENTIRELY RIGHT AND ENTIRELY FAIR. IT WILL ENSURE THAT THE BEST AND MOST EFFICIENT ELEMENTS OF THE HEALTH CARE INDUSTRY WILL SURVIVE AND PROSPER - AND THAT IS FIRMLY IN THE BEST INTERESTS OF THE PUBLIC.

Ends

cst.ps/9jm5.12

CONFIDENTIAL

cc:
Chancellor
Sir Peter Middleton
Sir T Burns
Mr Anson
Mr H Phillips
Miss Peirson
Mr Beastall
Mr Potter
Mr Saunders
Mr Call

Treasury Chambers, Parliament Street, SW1P 3AG

The Rt Hon John Wakeham MP
Lord President of the Council
Privy Council Office
Whitehall
London
SW1A 2AT

5 December 1988

Dear Lord President

NHS AUDIT

We are to discuss tomorrow Nicholas Ridley's letter of 28 November and the attached note by officials. The note sets out 3 options for using the Housing and Local Government Bill to give some or all of the powers to the Audit Commission which the Commission will need to carry out the statutory external audit of the NHS. I suggest that we should adopt the second option, and I hope that colleagues can agree.

The reasons which have led me to this view are as follows. I hope very much that we shall be able to introduce in the 1989-90 session the legislation we shall need to effect the various measures which we shall be proposing as result of the health review. But that will mean a delay of at least 18 months before the Audit Commission has the relevant powers under such legislation. We want the Audit Commission to start work in the health field much earlier than that if possible, because it will take a little while for the Commission to build up the necessary resources.

I understand that it may be possible for the Commission and the Department of Health (and the Welsh Office) to make some limited exchanges of staff, and for the Departments' own audit people to develop their value for money work under the Commission's guidance. But there will be limitations on what can be done, notably because the Commission is financed entirely through fees from the local authorities, and should not incur costs which cannot justifiably be recovered from such fees. So it would be of great advantage to take the opportunity of early legislation which Nick's Bill presents, to secure at least some powers for the Audit Commission to work in the NHS.

It now seems likely that the Housing and Local Government Bill will be published after the health review White Paper. So we could publish in the Bill some clauses relating to the NHS audit, and explain them by reference to what is in the White Paper. Nonetheless, I think it unlikely that we shall be ready to adopt option 1. Even if we were to delay introducing all the necessary clauses until committee stage, there might not be time for the full consideration of our position on every aspect which will be necessary if we are not to get into difficulties in Parliament.

Nor do I think we could safely adopt option 3. As I am recording in a separate letter to Kenneth Clarke, the C&AG is prepared to defend to the PAC the Government's proposal as it has been put to him, namely that the Audit Commission should take on the specific role which the Department of Health and the Welsh Office carry out at present, ie the statutory external audit of the NHS, reporting for that purpose to the Secretaries of State. The fact that the NAO's own position, in carrying out the audit of the consolidated accounts of the NHS, would be unaffected by the proposed change, was important in securing his acquiescence. But if we were to attempt to introduce a general provision to give the Audit Commission power to operate anywhere in the public sector, the C&AG would be likely to feel that that was very different from, and much wider than, the proposition that had been put to him. Under such a power, the Audit Commission would be able (if the Government so decided) to take over the audit of bodies such as the British Museum whose audit is at present the responsibility of the NAO. We should be likely to run into exactly the trouble with the PAC members which we wish to avoid, and we should not have the support of the C&AG. The debate could very well open up to embrace the question of the nationalised industries, as Nick suggested.

Option 2 seems to suffer from neither objection. As the note by officials says, it would be a simple provision, not requiring more than one clause, and would enable the Audit Commission to build up early experience in health service matters, without making any other change to the present statutory arrangements for the audit of the health service. It would be particularly important in allowing the Audit Commission to prepare the ground on the value for money side, which is exactly where we want to build up the effectiveness of the audit of the NHS. We should be able to explain that it was a paving provision to enable the Audit Commission to undertake some preliminary training, audit and value for money work for the health service under contract to the Secretaries of State for Health and for Wales. The C&AG would then help us to explain to the members of the PAC that their position, and the position of the NAO, was unaffected. We should therefore be able to avoid the sorts of problems with the PAC which Nick foresees.

I appreciate that you will not welcome any addition, however small, to the Housing and Local Government Bill. But it seems to me that that Bill is likely to have to be guillotined in any case, since it will be controversial and given the overall pressures on the legislative timetable. So one more clause, of what I hope would be a fairly non-controversial nature, should not make any significant difference.

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I hope very much that you and Nick, and Kenneth Clarke and Peter Walker, can all agree that the second option, a simple paving provision in the Housing and Local Government Bill to give the Audit Commission some powers in respect of the NHS specifically, is the best and most acceptable way of achieving what we want without undue delay, and that we should introduce it when the Bill is published.

I am copying this letter to the Chancellor, Nicholas Ridley, Kenneth Clarke, and Peter Walker.

Yours sincerely

C Evans

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

cst.ps/14jm5.12

CONFIDENTIAL

cc:
Chancellor
Sir Peter Middleton
Mr Anson
Mr H Phillips
Miss Peirson
Mr MacAuslan
Mr Griffiths
Mr Potter
Mr Fellgett
Mr Call

Treasury Chambers, Parliament Street, SW1P 3AG

MP

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

5 December 1988

Dear Secretary of State

NHS AUDIT: THE ROLE OF THE NAO

We agreed that we should approach the NAO to explain our decision to hand over the statutory external audit of the NHS to the Audit Commission.

My officials accordingly wrote to the NAO, and subsequently had a meeting with the Comptroller and Auditor General, together with representatives of your department and the DOE and Welsh Office.

The C&AG's first reaction had been to suggest that the NAO should themselves take over this second tier of NHS audit. However, when it was pointed out to him that for this purpose the Audit Commission would be reporting to the Secretary of State (ie yourself or Peter Walker), the C&AG readily understood that he could not take on that role. He is of course an officer of Parliament; and the proposition that he should take over the second tier audit was rejected when the Bill which led to the National Audit Act of 1983 was first under discussion.

I understand that, as a result of the discussion among officials, Mr Bourn said he could explain our decision to the PAC on the basis that the Secretary of State (you or Peter) was improving the systems available to him for ensuring that the funds provided by Parliament for the health service were being properly spent. The Audit Commission must in that role report to him.

Mr Bourn added, I understand, that he would explain to the PAC that the expectation would be that the Audit Commission's reports would be published under the authority of the Secretary of State, though he would make it clear that that need not mean control of publication by the Department in all cases. That is of course important, because we want the Audit Commission reports to influence health authorities and public opinion, and the reputation which the Audit Commission have built up for independence will be a significant contribution to that sort of influence.

I understand that Mr Bourn raised some legitimate points about the boundary between the work of the NAO and the work which the Audit Commission will be doing. We shall have to think about those: the working group of officials will be considering the matter and making recommendations. But the important point we shall be able to emphasise to the PAC is that the NAO's role is unaffected, and that the Audit Commission will be an instrument of the Secretary of State, though with a much more independent character than the present statutory audit.

I am copying this letter to the Prime Minister, John Wakeham, Peter Walker, Nicholas Ridley and Malcolm Rifkind.

Yours sincerely

Cairns Graham

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

st.ln/min/1.5.12

CONFIDENTIAL

FROM: MISS M E PEIRSON
DATE: 5 DECEMBER 1988

CHIEF SECRETARY

cc Chancellor
Sir Peter Middleton
Sir T Burns
Mr Anson
Mr Phillips
Mr Beastall
Mr Potter
Mr Saunders
Mr Call

NHS AUDIT

1. As requested, I attach a draft letter to the Lord President for you to send today for tomorrow's meeting. The handling brief will follow later today.

2. DH officials have briefed Mr Clarke to support option 2. They say they are getting on fast with preparations (with the Audit Commission) for developing value for money studies. They think they can do as much without legislation as the Audit Commission could with legislation, by creating their own team and getting it to carry out some national value for money studies during the coming year (all under AC guidance), in preparation for local value for money audits a year later. That team would then transfer to the Audit Commission when the health review legislation was enacted. But DH officials are nonetheless advising that option 2 would help, by avoiding any possible legal difficulties in the above process.

MISS M E PEIRSON

st.ln/dra/1.5.12

CONFIDENTIAL

DRAFT LETTER FROM THE CHIEF SECRETARY TO THE LORD PRESIDENT

COPIES TO THE SECRETARIES OF STATE FOR HEALTH, THE ENVIRONMENT AND WALES

NHS AUDIT

1. We are to discuss tomorrow Nicholas Ridley's letter of /28 November/ and the attached note by officials. The note sets out 3 options for using the Housing and Local Government Bill to give some or all of the powers to the Audit Commission which the Commission will need to carry out the statutory external audit of the NHS. I suggest that we should adopt the second option, and I hope that you and others can agree.

2. The reasons which have led me to this view are as follows. I hope very much that we shall be able to introduce in the 1989-90 session the legislation we shall need to effect the various measures which we shall be proposing as result of the health review. But even so, that will mean a delay of at least 18 months before the Audit Commission has the relevant powers under such legislation. We want the Audit Commission to start work in the health field much earlier than that if possible, because it will take a little while for the Commission to build up the necessary resources.

3. I understand that it may be possible for the Commission and the Department of Health (and the Welsh Office) to make some limited exchanges of staff, and for the Departments' own audit people to develop their value for money work under the

Commission's guidance. But there will be limitations on what can be done, notably because the Commission is financed entirely through fees from the local authorities, and should not incur costs which cannot justifiably be recovered from such fees. So it would be of great advantage to take the opportunity of early legislation which Nicholas Ridley's Bill presents, to secure at least some powers for the Audit Commission to work in the NHS.

4. It now seems likely that the Housing and Local Government Bill will be published after the health review White Paper. So we could publish in the Bill some clauses relating to the NHS audit, and explain them by reference to what is in the White Paper. Nonetheless, I think it unlikely that we shall be ready to adopt option 1. Even if we were to delay introducing all the necessary clauses until committee stage, there might not be time for the full consideration of our position on every aspect which will be necessary if we are not to get into difficulties in Parliament.

5. Nor do I think we could safely adopt option 3. [As I have recorded in my separate letter to Kenneth Clarke,] the C&AG is prepared to defend to the PAC the Government's proposal as it has been put to him, namely that the Audit Commission should take on the specific role which the Department of Health and the Welsh Office carry out at present, ie the statutory external audit of the NHS, reporting for that purpose to the Secretaries of State. The fact that the NAO's own position, in carrying out the audit of the consolidated accounts of the NHS, would be unaffected by the proposed change, was important in securing his acquiescence. But if we were to attempt to introduce a general provision to give the

Audit Commission power to operate anywhere in the public sector, the C&AG would be likely to feel that that was very different from, and much wider than, the proposition that had been put to him. Under such a power, the Audit Commission would be able (if the Government so decided) to take over the audit of bodies such as the British Museum whose audit is at present the responsibility of the NAO. We should be likely to run into exactly the trouble with the PAC members which we wish to avoid, and we should not have the support of the C&AG. The debate could very well open up to embrace the question of the nationalised industries, as Nicholas suggested.

6. Option 2 seems to suffer from neither objection. As the note by officials says, it would be a simple provision, not requiring more than one clause, and would enable the Audit Commission to build up early experience in health service matters, without making any other change to the present statutory arrangements for the audit of the health service. It would be particularly important in allowing the Audit Commission to prepare the ground on the value for money side, which is exactly where we want to build up the effectiveness of the audit of the NHS. We should be able to explain that it was a paving provision to enable the Audit Commission to undertake some preliminary training, audit and value for money work for the health service under contract to the Secretaries of State for Health and for Wales. The C&AG would then help us to explain to the members of the PAC that their position, and the position of the NAO, was unaffected. We should therefore be able to avoid the sorts of problems with the PAC which Nicholas foresees.

7. I appreciate that you will not welcome any addition, however small, to the Housing and Local Government Bill. But it seems to me that that Bill is likely to have to be guillotined in any case, since it will be controversial and given the overall pressures on the legislative timetable. So one more clause, of what I hope would be a fairly non-controversial nature, should not make any significant difference.

8. I hope very much that you and Nicholas, and Kenneth Clarke and Peter Walker, can all agree that the second option, a simple paving provision in the Housing and Local Government Bill to give the Audit Commission some powers in respect of the NHS specifically, is the best and most acceptable way of achieving what we want without undue delay, and that we should introduce it when the Bill is published.

9. I am copying my letter to the recipients of Nicholas Ridley's letter.

chex.ps/mw/21

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

5 December 1988

Dr John Studd
The Dulwich Hospital
South Wing
East Dulwich Grove
LONDON SE22 8PT

Thank you for your letter of 18 November and enclosure, which I read with interest.

If you are thinking of writing an article for one of the major daily newspapers, arguing that the private sector could and should do more to support the NHS, and that the key lies in enlarging the number of consultants posts, with a foot in each camp, I am sure it would be a most useful contribution to the NHS debate. But I would hope you would not link it, as you do in your preface, to the percentage of GDP spent on health in various countries, which in my view has little bearing on the effectiveness of medical care in different countries.

NIGEL LAWSON

mp!

FROM: Ms K ELLIMAN
DATE: 5 December 1988

PS/CHANCELLOR

cc PS/Chief Secretary
PS/Financial Secretary
PS/Economic Secretary
Mrs Chaplin
Mr Tyrie
Mr Call

EXPOSING THE FALLACY OF SUPPLY SIDE SOCIALISM

The Paymaster General has seen Mr Call's minute of 2 December.

2. He has commented, referring to paragraph 4:

"He will, or someone will".

Kim Elliman

KIM ELLIMAN
Private Secretary

st.ln/min/2.5.12

CONFIDENTIAL

FROM: MISS M E PEIRSON
DATE: 5 DECEMBER 1988

CHIEF SECRETARY

cc Chancellor
Sir Peter Middleton
Sir T Burns
Mr Anson
Mr Phillips
Mr Beastall
Mr Potter
Mr Saunders
Mr Call

NHS AUDIT: HANDLING BRIEF FOR LORD PRESIDENT'S MEETING

1. Your objective is to secure agreement to the adoption of option 2 of the note by officials attached to Mr Ridley's letter. That is, a single clause in the Housing and Local Government Bill, which would be a paving provision to enable the Audit Commission to undertake some preliminary training, audit and value for money work for the health service under contract to the Secretaries of State for Health and for Wales.

2. Attached are:-

Annex A, setting out the expected timetables which would result;

Annex B, discussing the 3 options now under consideration; and

Annex C, a note of the NAO/PAC background to the expected difficulties with a general power.

MISS M E PEIRSON

CONFIDENTIAL

Annex A

TIMETABLE

I. Housing and Local Government Bill

1. The Housing and Local Government Bill is expected to be published by about the end of January. Second reading is estimated at about mid-February, committee stage up to around June, and Royal Assent in October/November 1989.

2. Central Government can generally incur expenditure to carry out a new function, following second reading of a Bill. But it is not immediately apparent whether the Audit Commission could do so, given that (for example) we wish them to recover their NHS costs from the health authorities, not from DH or WO. We shall have to examine the point.

II. NHS Audit

3. The Audit Commission have already begun discussions with the Department of Health. Some exchanges of staff, and some training at least of DH staff, who might subsequently join the Audit Commission, could begin without waiting for legislation. The Audit Commission and DH are already discussing plans for DH to build up a small team (including hiring economists etc) to carry out national value for money studies (under Audit Commission guidance) prior to the Commission taking over.

4. Following either second reading or Royal Assent of the Local Government Bill (see above), the Audit Commission could take over full responsibility for planning the work, and could take over the DH value for money team. They could begin some local value for money studies in 1990-91. Since the Audit Commission need to build up their new structure and resources to deal with the NHS, faster progress could anyway scarcely be expected.

5. By the time the full health legislation was enacted, assuming that to be in the 1989-90 session with second reading late in 1989 and Royal Assent in summer/autumn 1990, the Audit Commission could be expected to be in a position to take over the regularity audit of the NHS in respect of 1990-91, and to be in full swing on value for money by 1991.

CONFIDENTIAL

Annex B

OPTIONS UNDER CONSIDERATION

1. The options now under consideration are:-

a) option 2 of the note by officials: a paving provision in the Housing and Local Government Bill, specific to the NHS;

b) option 3 of the note by officials: a general power in the Housing and Local Government Bill;

c) wait for health legislation.

2. Advantages of (a):

- should be acceptable to PAC,

- only one clause,

- would allow Audit Commission to build up early experience in health service, enabling it to take over fully soon after passage of health review legislation.

3. Disadvantages of (b):

- only one clause, but would be likely to cause severe trouble with the PAC,

- Audit Commission will have enough to do, just coping with NHS,

- Treasury would prefer private sector to do some of the extra audit.

4. Disadvantages of (c):

- although DH hope to make progress without legislation, there could be problems, preventing rapid build-up of value for money work.

CONFIDENTIAL

Annex C

NAO/PAC BACKGROUND TO DIFFICULTIES WITH GENERAL POWER

1. In 1980 the PAC considered the role and functions of the C&AG and concluded that he should be given much wider powers to "follow public money wherever it goes". The Committee recommended that he should become the NHS external auditor, even though the then C&AG (Sir Douglas Henley) gave evidence that he was not convinced it would be right since the Secretary of State would still need his own parallel arrangements.

2. In 1982, Mr StJohn Stevas introduced a Bill giving the C&AG access to the papers of nationalised industries, other public corporations and other publicly owned or supported bodies for the purpose of carrying out value for money examinations. The Bill also proposed that he should audit the accounts of the health authorities. The Government managed to reach various compromises with the sponsors of the Bill, and as a result the proposed power of access to the nationalised industries and public corporations was dropped, along with the proposal that the C&AG should become the external auditor of the NHS. When the latter issue was considered in Committee, Mr Higgins (and Mr Garrett) voted against the Government's amending clause.

3. The PAC are still keen to extend the powers of the NAO to examine the papers of the whole of the public sector (they returned to the issue of nationalised industries more recently, but have not published a report). Their first reaction to the suggestion that the Audit Commission should take over the statutory external audit of the NHS is likely to be the same as the C&AG's first reaction. That is, to revive the idea that the NAO should take it over instead. They will feel, as he doubtless did, that the Audit Commission will be far more of a rival to the NAO for public attention than the very low key work of the Department of Health and the Welsh Office (who anyway do not carry out much value for money work).

4. But the present C&AG was readily persuaded, like his predecessor but one, that he could not carry out the statutory external audit of the NHS, since that would mean becoming a servant of the Government, which would not be compatible with his independence as an officer of Parliament. He considers that he can persuade the PAC.

5. Such arguments relate, however, only to the special arrangements for the audit of the NHS, whereby the NAO already carry out the separate audit of the consolidated accounts of the NHS by virtue of their role in auditing the accounts of central government. There are other bodies in the public sector, such as the national museums and galleries, where at present the NAO are responsible for the audit of the body itself; and the PAC and the C&AG could be expected to react badly to any suggestion that the Audit Commission should be given powers which would enable it to carry out value for money studies of bodies which are also subject to NAO audit.

6. Therefore a general power such as option 3 of the note by officials could be expected to cause severe problems. It would not be enough for the Government to say that the Audit Commission would not be given such powers in a particular case unless a Secretary of State so decided. That would still mean that the Government was enabled to decide, rather than Parliament. And if Parliament were given the power to decide, that would risk a series of difficult debates in which all the old issues such as NAO access to nationalised industries might be raised.

Typical that there are no numbers!

Draft (6.12.88)

III SELF-GOVERNING HOSPITALS

Introduction

3.1 There are currently [ ] major acute hospitals in the UK - "major" defined as having more than 250 beds. This chapter sets out the Government's proposals for enabling as many of these hospitals as are willing and able to do so to run their own affairs.

3.2 Major acute hospitals are substantial businesses. The revenue budgets of the management units which currently run these [ ] hospitals range from £[ ] to £[ ] a year. Yet none of these hospitals can employ its own staff or enter into contracts in its own right. Nearly all of them are run by health authorities which have other responsibilities as well - psychiatric and other single-specialty hospitals, community health services, and so on. In England alone [ ] District Health Authorities (DHAs) are responsible for two or more major acute hospitals.

3.3 It is already a central plank of Government policy to push down decision making to local, operational level. Some of the larger acute hospitals now have substantial responsibilities delegated to them for running their own affairs. The Government intends to take this process a significant stage further by providing for a new, self-governing status within the NHS.

3.4 The Government believes that a number of advantages will flow from this approach. Greater independence for hospitals will encourage a stronger sense of local ownership and pride, building on the enormous fund of goodwill that exists in local communities. It will stimulate the commitment and harness the skills of those who are directly responsible for providing services. Supported by a funding system in which successful hospitals are properly rewarded, it will encourage local initiative and - particularly in urban areas - greater competition. All this in turn will ensure a better deal for the public, improving both the choice and quality of the services offered and the efficiency with which those services are delivered.

Hospital Trusts

3.5 The powers and responsibilities of each self-governing hospital will need to be formally vested in a board of management. The Government will bring forward legislation enabling the Secretary of State to establish such boards, to be known as Hospital Trusts. The Government proposes that Hospital Trusts should be constituted as follows:

* each should have ten members, five executive and five non-executive, and in addition a non-executive chairman.

* the chairman should be appointed by the Secretary of State.

* of the non-executive members at least two should be drawn from the local community, for example from hospital Leagues of Friends and similar organisations. In England these two "community" members should be appointed by the Regional Health Authority (RHA). The remaining three non-executive members in England, and all the non-executive members in Scotland, Wales and Northern

Ireland, should be appointed by the Secretary of State on the advice of the chairman. All the non-executive members should be chosen for the contribution they can make to effective management of the hospital. None should be an employee of a health authority or hospital, of a major contractor, or of a trade union with members who work in the NHS. For teaching hospitals, the non-executive members will need to include a representative of the relevant university.

* the general manager, as chief executive, should be appointed by the non-executive members.

* the remaining four executive directors should be appointed by the non-executive directors and the chief executive. They should include a medical director, the senior nurse manager and a finance director.

Freedom and responsibility

3.7 Hospital Trusts will assume all the powers and responsibilities previously exercised by the hospital's health authority or equivalent. Specifically, they will be empowered by statute to employ staff; to enter into contracts both to provide services themselves and to buy in services and supplies from others; and to generate income within the scope set by the Health and Medicines Act 1988.

3.8 In addition, the Government proposes to give self-governing hospitals a range of powers and freedoms which are not, and will not be, available to health authorities generally. The Government has considered the argument that additional freedoms of this kind will give self-governing hospitals an unfair advantage over hospitals which continue to be managed directly by health authorities. But it believes that greater freedom for self-governing hospitals is both justified and necessary, for

three reasons. First, other major acute hospitals will be encouraged to seek greater delegated responsibility and to strengthen their management so that they too are in a position to apply for self-governing status. In this way self-governing hospitals will be an important catalyst for change. Secondly, greater freedom will stimulate greater enterprise and commitment, which will in turn improve improve services for patients. Thirdly, self-governing hospitals will bridge the gap between health authority-managed and private sector hospitals, increasing the range of choice available to patients and their GPs.

3.9 The additional freedoms proposed are set out in the following paragraphs. They apply particularly to the employment of staff, to the control of capital assets, and to capital investment.

Employment of staff

3.10 The Government intends that Hospital Trusts should be free to employ whatever staff are considered necessary, irrespective of any manpower controls which may apply to health authorities. The only exception should be junior doctors' posts, which will continue to need the approval of the relevant Royal College for training purposes. The Government sees it as particularly important that Trusts should employ their own consultants. Where consultants work also for other NHS hospitals or in the private sector, a Trust will need to employ them on a part time basis consistent with their commitment to the Trust's hospital.

? upsets ideas contractual rights

3.11 The Government also intends that Hospital Trusts should be free to settle the pay and conditions of their staff, including doctors, nurses and others covered by national pay review bodies. [Expand and/or modify in the light of the Group's decisions on pay flexibility.]

Capital assets

3.12 [This section will need to be expanded and modified in the light of the Group's decisions on "Capital" (HC[ ]).] The Government intends that the assets of a self-governing hospital should be vested in the Hospital Trust, as follows:

* the Trust will be free to use the hospital's assets to provide health care, in accordance with stated purposes laid down by the Secretary of State when self-governing status is granted.

* the Trust's management of its assets will be subject to independent audit in accordance with the proposals in chapter [VII].

[* sub-paragraph on charges/"interest" payments on the Trust's initial "debt", drafted in accordance with decisions on HC[ ].]

* the Trust will be free to dispose of up to [ ]% of their current assets. Any proposal to dispose of a higher proportion will need to the approval of the RHA.

* the hospital's assets will revert to the ownership of the Secretary of State if for any reason the Trust is wound up.

Capital investment

[3.13 Paragraph[s] to be drafted following the Group's decisions on HC[ ].]

Funding and accountability

3.14 The funding arrangements proposed by the Government for self-governing hospitals are set out in full in chapter [V]. The essential feature is that a self-governing hospital will need to generate income by selling its services. The main buyers will be health authorities. Other buyers may include GP practices with their own budgets as proposed in chapter [IV]; private patients or their insurance companies, or even other self-governing hospitals. This form of funding will be both an opportunity for growth and a spur to better performance.

3.15 It will be an opportunity for growth because the money will flow to where the patients are going. If a hospital attracts more patients it will get more income. A successful hospital will then be able to invest in providing still more and better services.

3.16 The funding arrangements will be a spur to better performance for two reasons. First, they will inject an element of competition. There will not always be an alternative provider of, say, local accident and emergency services. But for some services - and in some areas for many services - the hospital will be at risk of losing business if it does not meet the needs of its customers. Secondly, the hospital's contracts will need to spell out clearly what is required of it, in terms of both price and quality.

3.17 A self-governing hospital's line of accountability will be through these contracts. The consequences of a failure to meet the terms of a contract - potential loss of future business, for example, or an adjustment to the price of the service concerned -

will be for the buyer to negotiate. The arrangements set out in chapter [V] will ensure that patients who are in need of urgent treatment are not turned away from a hospital simply because their treatment is not, or may not be, covered by a contract with that hospital.

Achieving self-government

3.18 The Government intends that establishing a Hospital Trust should be a simple, flexible process, laid down in statute. A hospital has no definable constituency equivalent to, for example, the parents of children attending a school. It will therefore be open to a variety of interests either to initiate the process or to respond to any initiative taken by the Secretary of State. These interests could include the DHA Chairman, the hospital management team, a group of staff (senior consultants, for example), or people from the local community who are active in the hospital's support.

Still a difficult point.

3.19 Similarly, the Government is not proposing a rigid definition of what a "hospital" should be for the purposes of self-government. For example, it may be sensible for two neighbouring hospitals to combine, or for a hospital to offer also to run a range of community-based services.

3.20 The Government intends that hospitals should have to meet only the minimum essential conditions to achieve self-governing status. It has two main criteria in mind. First, management must have the skills and capacity to run the business, including sufficient financial expertise and adequate information systems. Secondly, senior professional staff, especially consultants, must

be involved in the management of the hospital, and there should be a comprehensive system of medical audit along the lines proposed in chapter [VI]. The Secretary of State will also need to satisfy himself that the hospital has a viable business plan, and that self-governing status is not being sought simply as an alternative to an unpalatable, but necessary, closure.

3.21 The Government will look to RHAs to play an active part in guiding and supporting hospitals which can be expected to meet these criteria and are interested in achieving self-government. In each case the Secretary of State will need to satisfy himself at an early stage that there is a good prospect of being able to approve the creation of a new Hospital Trust. With the advice of the RHA, he will also need to identify a "shadow" chairman who can act for the hospital in preparing the ground.

3.22 The RHA will be responsible for establishing the precise range of services and facilities for which the proposed Trust will be responsible; for ensuring that the proposal to seek self-governing status is given adequate publicity locally; and for preparing and submitting a formal application to the Secretary of State. No-one will have the right to veto such an application, although the Secretary of State will need to satisfy himself that there is adequate commitment locally to the success of the Trust.

Implementation

3.23 The Government believes that self-governing hospitals have a major role to play in improving services to patients. It will therefore encourage as many major acute hospitals as possible to seek self-governing status. The Government's aim is to establish a substantial number of Hospital Trusts with effect from April 1991, in the wake of the necessary legislation. The experience gained will then inform the process of establishing more Trusts in later years.

3.24 In the period before 1991 the Government intends to take the initiative, with the help of RHAs, in identifying suitable candidates for self-government and encouraging them to seek and prepare for self-governing status. The Secretary of State will be publishing shortly a more detailed document which will form a basis for discussion with interested parties. The aim will be to ensure that the hospitals concerned make productive use of the next two years by building up their capacity to run their own affairs effectively and by securing the maximum devolution of management responsibility from their DHAs. Self-government will then be - as it should be - a natural step forward from devolved management within the present structure.

3.25 The establishment of self-governing hospitals will mean a substantial reduction in the responsibilities of the DHAs which were previously responsible for their management. The Government does not believe that this implies a wholesale reorganisation of the NHS. But, in putting forward proposals for establishing Hospital Trusts, RHAs will need to consider the viability of existing DHAs and, if appropriate, to propose a realignment of DHA boundaries. The implications for the role of DHAs are set out more fully in chapters [V] and [IX].

week.5.12/m.13

SECRET

BF → M 9/12 12/12 14/12 15/12

FROM: H PHILLIPS
DATE: 7 December 1988

CHANCELLOR

cc Chief Secretary
Paymaster General
Sir P Middleton
Sir T Burns
Mr Anson
Mr C W Kelly
Mr Culpin
Miss Peirson
Mr Saunders
Mr MacAuslan
Mr Parsonage
Mr Gieve
Mr Griffiths
Mr Sussex
Mr Call

NHS REVIEW: MEETING ON 8 DECEMBER

This note is intended as an overall guide to the papers which we believe you and the Chief Secretary should try to consider at your meeting tomorrow afternoon. As usual there are too many of them and too little time to work them into a wholly satisfactory state, and we have very few more days before they need be circulated for the crucial Review Group meeting on 16 December.

2. From the Treasury's point of view the key issues for the next meeting will be in the papers on pay and conditions (in the mainstream NHS and in self-governing hospitals) and on private finance. Both of these are meant to be agreed between the Chief Secretary and Mr Clarke. Partly as preparation for them, but also because we have a remit to make proposals on end-year flexibility for self-governing hospitals, we have worked up some new proposals for the financial regime which should govern them. We need to decide not only whether our ideas make sense but, if so, how to put them into the review. In addition Mr Clarke will be submitting for the meeting on 16 December as much of the draft White Paper as can be managed. So far at official level we have seen an opening chapter and one on self-governing hospitals.

3. As the agenda for your meeting you might like to take these issues in the following order:

(a) our draft on the financial regime for self-governing hospitals (A^1) and the DoH draft chapter on self-governing hospitals in general (A^2);

(b) pay - our latest draft which Mr Kelly is submitting separately;

(c) a paper agreed at divisional level between officials on private finance (B); and

(d) the opening sections of the draft White Paper including a chapter on Delivering a Better Service alongside a note from Mr Parsonage on waiting times (C_1 and C_2 respectively).

Self-governing Hospitals

4. The desire of the Group to give to these hospitals as much financial flexibility as possible has been driving the DoH to look for specific freedoms within the control reqime which would normally apply to a District Health Authority. The result - defining the extent of a specific flexibility and defining how it needs to be limited for control purposes - looks, and could in fact turn out to be, bureaucratic. We have therefore approached the question of the appropriate financial regime on the basis that if self-governing hospitals are wholly financed by contracts or fees which they must earn, and are therefore in the nature of trading, we could treat them for control purposes as if they were public corporations. This would give them complete end-year flexibility, and the capacity to build up reserves and to borrow.

5. I think you and the Chief Secretary need to decide two main questions of substance, and one of tactics. On the substance

(a) are you satisfied that control will adequately be achieved by a combination of cash limits on DHA's, a real

rate of return on capital to be achieved by self-governing hospitals, and an external financing-limit to control their borrowing (there is a choice to be made about the degree of restraint we envisage; hence the alternative versions of paragraph 9 in the attached paper); and

(b) what should we do about borrowing from the private sector? Officials clear preference is for them to borrow only off voted funds for reasons of transparency, accountability and control. Mr Clarke may argue this is unnecessarily restrictive and, that like a nationalised industry, self-governing hospitals should be allowed to go into the market. Our view is that as these hospitals are doing their trading almost entirely on the basis of tax-funded money, access to private capital for borrowing is unacceptable.

6. Subject to your views on the policy to adopt, we then need to decide how to feed your views into the group. There are three possibilities -

(a) put in a paper of our own;

(b) invite Mr Clarke to agree a joint paper;

(c) adapt the draft White Paper chapter to our proposals in general terms but agree the details that would underpin them with Mr Clarke.

7. My own preference would be to go for (b) above which would make sure that colleagues have the chance to see and discuss what we intend directly rather than indirectly, and which might help pave the way for realistic proposals both on pay and on private finance.

8. There are three important, but subsidiary, issues mentioned towards the end of the paper, which we need to give further thought, namely

the tax treatment of surpluses (paragraph 14);

accountability and Accounting Officer arrangements, and the role of the NAO and PAC (paragraph 18); and

what we say, if anything, about privatisation. (Paragraph 19, which is there simply as a marker to indicate how far the proposals take these hospitals ie to the edge of the boundary of privatisation. You and the Chief Secretary may judge it inadvisable to include this paragraph, but the sort of entrepreneurial activity Mr Clarke seems to want would, it could be argued, tip them over the edge.

Pay

9. The draft Mr Kelly has submitted is our initial preferred version of two previous unsatisfactory DoH drafts. Following a letter from the Chief Secretary to Mr Clarke, and a meeting I chaired with DoH officials, there is now much more common ground at official level on the approach to mainstream NHS pay. Nonetheless wherever the proposals refer to 'flexibility' they imply 'more pay'.

10. There has been a much greater difference of view over a pay regime for self-governing hospitals. What we would recommend is a process of developing additional freedoms in a way which recognises the real obstacles to Mr Clarke's 'big bang' approach eg the industrial relations and political consequences of switching individuals' employment contracts to hospitals; management's lack of experience in pay negotiation; the need to avoid bidding up mainstream NHS pay etc. If Mr Clarke's approach can be described, with a degree of irony, as imposed freedom to the maximum extent, ours is permitting self-governing hospitals progressively to develop flexibility to the extent they can manage it.

Private Finance and Capital

11. The attached draft (C) on access to private capital represents a high measure of agreement between the responsible Treasury divisions and DoH officials about permissible projects. The conclusions are summarised in paragraph 17. The difficulty will be in persuading Mr Clarke to stand on the common ground identified, especially in relation to self-governing hospitals, where paragraph 16 of the paper encapsulates his view of encouraging entrepreneurial behaviour and not constraining them by the conditions governing other public enterprises.

12. This draft is much more constructively presented than anything previously produced on this subject by the DoH but I think it will need to be turned into a paper by Ministers, which will require some careful redrafting. We also need to consider whether we float as explicitly as this draft does the idea of a separate fund for cost-saving projects which came up in the Survey and which we said DoH could introduce but without additional money; and whether the responsibilities of the Accounting Officer to the PAC could not be given greater prominence.

13. There was one problem left over from previous meetings on capital namely the proportion of a self-governing hospitals assets which it could dispose of without permission. The Prime Minister made it clear that she thought the earlier proposal of a 5% limit too low. If however our proposals on the regime for self-governing hospitals are accepted the issue falls in this form as these hospitals would be free to dispose of assets, subject only to a power for the Secretary of State to intervene if the hospital was abusing its freedoms or getting itself into difficulties.

Draft White Paper: Opening Chapters

14. The draft attached (C_1) includes an outline of the White Paper, a Foreword, and a first chapter called Delivering a Better Service. You and the Chief Secretary need not concentrate on them

now but I think that some of the key points for you to note (and which we have given DoH at official level) are that

(a) the Outline gives excessive prominence to GP Practice Budgets;

(b) the Foreword is extremely limp, and full of retrospective references which lose all the presentational tricks in the first paragraph; and

(c) Delivering a Better Service fails to persuade that a Review was necessary (paras 2.1-2.3); says that only "the medical profession can assess the quality and effectiveness of medicine and surgery" (paragraph 2.4); and is quite unconvincing when it comes to saying what practical improvements are planned in service to patients (para 2.7).

15. This is the point at which your concern with waiting times needs to be tackled explicitly, and hence Mr Parsonage's note below of 7 December (C_2) setting out some possible approaches. I agree with him that target maximum waiting times look the best bet provided the cost of any scheme is acceptable, and its management and monitoring effective.

Next Steps

16. Following your meeting, and subject to its conclusions, we need to settle the agenda and papers for the Chief Secretary's meeting at 9.30 am on Monday 12 December with Mr Clarke. We would like this to cover

self-governing hospitals (our paper)

pay (an agreed paper, based on our draft)

private finance (a Ministerial version of an agreed paper drawing on the existing draft).

We ought to aim to circulate whatever is agreed to the Review Group on Tuesday 13 December.

HP.

HAYDEN PHILLIPS

This may mean moving briefing meeting; on which a separate note in yr diary folder

MPW

0243A

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

SECRET

The Rt Hon Peter Walker MBE MP
Secretary of State for Wales
Welsh Office
Gwydyr House
Whitehall
LONDON
SW1A 2ER

CH/EXCHEQUER

REC.	-8 DEC 1988
ACTION	MR SAUNDERS
COPIES TO	CST SIR P. MIDDLETON SIR T. BURNS, MR ANSON, MR PHILLIPS, MR CALPIN MR TURNBULL, MISS PEIRSON, MR PARSONAGE MR GRIFFITHS MR CALL.

7 December 1988

Dear Peter,

NHS REVIEW: WHITE PAPER

As agreed at the Ministerial Group's meeting on 24 November, I am now working to prepare a first draft of our White Paper for discussion by the Group, in part on 16 December and as a whole on 22 December.

In preparing this draft we are finding it difficult to judge how best to deal with the circumstances and interests of Scotland, Wales and Northern Ireland. I suggest we might aim to discuss this issue when we meet on 16 December. In the meantime, I am drafting primarily in terms appropriate to England, and have asked my officials to keep in touch with yours as the drafting progresses.

You, Malcolm Rifkind and Tom King are no doubt giving some thought to what the White Paper may need to say specifically about the circumstances of your countries. If we are to keep to our timetable it will be important for the product of this work to be included in the draft to be considered on 22 December.

I am sending copies of this letter to the Prime Minister, Nigel Lawson, Malcolm Rifkind, Tom King, John Major and David Mellor, to Sir Roy Griffiths, to Professor Griffiths and Mr Whitehead in the No 10 Policy Unit, and to Mr Wilson in the Cabinet Office.

Yours ever,

KENNETH CLARKE

pse.jf/JAF10/JAF10.17M

SECRET

FROM: M A PARSONAGE
DATE: 7 DECEMBER 1988

1. MR PHILLIPS HP. 7/12.
2. CHANCELLOR

cc: Chief Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Miss Peirson
Mr Gieve
Mr MacAuslan
Mr Saunders
Mr Griffiths
Mr Sussex
Mr Call

NHS REVIEW: A BETTER SERVICE FOR PATIENTS

The review meetings of the week before last agreed that the main focus of the forthcoming White Paper should be on providing a better service for patients. Specific practical improvements should be identified, which management would then be responsible for achieving.

2. This emphasis fits in well with our view that the main shortcoming of the package is the absence of measures which would be of immediate and obvious benefit to patients. Supply-side reforms like self-governing hospitals, medical audit and the involvement of clinicians in management should in time lead to better standards of service, but the lead times are long and the improvements would be incremental. The missing ingredient is something with a rapid pay-off.

3. The obvious area for action is waiting for elective hospital treatment. This has been identified from the outset as of major importance, but little has yet been forthcoming by way of concrete proposals.

4. There is a strong case for focusing on waiting <u>times</u>, rather than waiting <u>lists</u>. According to the latest available figures, total numbers on NHS lists are currently around 720,000 (England only). In itself it is not a particularly meaningful indicator. Some mechanism is always likely to be needed for regulating the

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flow of patients into the system, and waiting lists could only be eliminated by deliberately - and expensively - running the NHS with a large element of spare capacity. Moreover, what matters to the individual patient is not whether he is on a list but how long he has to wait for treatment. More interesting than the total numbers on NHS lists are therefore the numbers who have been waiting for specified periods of time. The relevant information is as follows:

Numbers waiting more than 3 months:	474,000
Numbers waiting more than 6 months:	331,000
Numbers waiting more than 12 months:	182,000
Numbers waiting more than 24 months:	76,000

About a quarter of all patients on NHS lists have therefore been waiting more than a year for treatment, and nearly half for more than six months.

5. A possible approach would be for the NHS to set maximum waiting times for specified conditions. This could be implemented in a number of ways. The most radical variant would be for the NHS to offer guaranteed maximum waiting times (not necessarily the same for all conditions). This has presentational attractions, but also the huge drawback that it implies an open-ended public expenditure commitment. More promising is the idea of target waiting times which health authorities would be expected to achieve over a period of years. This fits in well with the theme of giving local managers clear objectives and the responsibility to secure them. There would be no statutory obligation to meet the targets, but performance against them would be a measureable indicator of management success (and could be used eg in setting performance related pay or, on a wider front, in helping to decide whether an individual hospital is ready for self-governing status).

6. Further work would be needed to develop a scheme on these lines and to assess its likely cost. For purely illustrative purposes, a possible objective might be to set target maximum waiting times of no more than 12 months for all conditions currently treated by the NHS. (In practice a more sensible

approach might be to set different targets for different conditions, depending for example on the degree of discomfort which patients endure while waiting for treatment and whether a particular condition is likely to deteriorate. There might also need to be some minor exclusions from the scheme, for example cosmetic surgery.)

7. The figures in paragraph 4 above show that there are currently 182,000 patients who have been on NHS waiting lists for more than 12 months. The average cost of treatment is estimated at about £700 per case, implying a total cost of £125-130 million.

8. This is likely to be a continuing cost if the setting of targets is to make a lasting impact. The demand for health care has a tendency to expand to fill whatever supply is made available, and as one group of patients are taken off the waiting lists, others may come forward to take their place. There are, however, natural constraints to this process (ie the number of patients needing hip replacements etc is finite), and these could be reinforced by clinical and management controls. Some slippage is nevertheless likely, and past experience suggests that while a one-for-all injection of extra resources can have a temporary beneficial effect, a sustained reduction in waiting lists will almost certainly require a permanently higher level of expenditure. The setting of management targets would be the mechanism whereby additional resources are directed towards those areas where they are likely to have the greatest effect.

9. You may like to discuss these ideas at your stocktaking meeting on Thursday.

MP

M A PARSONAGE

4.7.12 CONFIDENTIAL

FROM: C W KELLY

DATE: 7 December 1988

CHANCELLOR

cc: Chief Secretary
Paymaster General
Sir Peter Middleton
Mr Anson
Sir T Burns
Dame Anne Mueller
Mr Phillips
Mr Culpin
Miss Peirson
Mr Gieve
Mr MacAuslan
Mr Parsonage
Mr Saunders
Ms Seammen
Mr Griffiths
Mr Sussex
Mr Call

NHS REVIEW : PAY

Mr Phillips's minute of today promised a further paper on pay before your stocking taking on the NHS review tomorrow.

2. I now attach a draft. It is intended as a joint paper by the Chief Secretary and the Secretary of State for Health and is a hastily prepared alternative version of an (unacceptable) draft sent over to us by the Department of Health last night, which we discussed with the Chief Secretary this morning. It obviously requires considerable further work. But if you and the Chief Secretary are content with the general thrust we will tidy it up and use it as the basis for further urgent discussion with the Department of Health at official level, to see how much closer we can get to an agreed version.

3. Mr Clarke has strong views on the subject; and it may be necessary for him and the Chief Secretary to meet. But we are trying to get as much of a common text as we can before that happens.

4. There are really four basic questions:

i. Are you content with the proposition that the introduction of a greater degree of flexibility into the determination of NHS pay and conditions is in principle desirable, provided that (and this is of course an important proviso) effective ways are found of maintaining financial discipline? If so you do not need to focus on the precise details set out in Annex 2 to the paper now. They will be worked up and brought forward for approval in due course. But if you have doubts they ought to be expressed now.

My own view is that the general thrust of the approach favoured by the DoH is in principle as correct in the NHS as it is, for example, in our approach to Civil Service pay, though I do have some reservations about some of the details which we will be following up separately. Flexibility does have a way of being operated only in one direction. But, properly managed, it ought still to be more cost-effective than the alternative, which is likely to be greater pressure on across the board increases.

ii. Do you agree that self-governing hospitals ought to be given a considerable degree of freedom over determining their own pay and conditions, not stopping short of complete independence?

It is clearly consistent with the underlying philosophy of self-government that they should be given this freedom, and Mr Clarke is strongly in favour of it. But they will take time to acquire the necessary expertise, they will have a very difficult problem in coping with the contractual rights of their existing staff, and there must at the very least be considerable doubt about the extent to which competition will in practice prove to be a sufficient mechanism to ensure that this freedom is exercised responsibly. We could simply be creating the circumstances for a pay spiral. It requires a considerable leap of faith to think otherwise.

iii. Depending upon the answer to (ii) above, do you agree that for these and other reasons the right approach should be a relatively cautious and bottom-up one analogous in part to that adopted for Next Steps agencies in which freedom is not

imposed upon self-governing hospitals from the outset (which would be a contradiction in terms) but they are left to make their own proposals in their own time, and subject to being able to convince us that they both have the necessary expertise and are subject to the necessary competitive pressures. Mr Clarke, and perhaps others as well, would no doubt regard this as excessively bureaucratic and cautious.

iv. Do you agree that, however attractive may be the thought of undermining them, it is not realistic to expect in the immediate future to be able to exclude doctors and nurses, whether in self-governing hospitals or elsewhere, from the scope of the Review Bodies.

C W KELLY

enc

NHS REVIEW

PAY AND CONDITIONS OF NHS STAFF

This paper sets out the scope for devolving responsibility for pay and conditions to management in the main-stream of the NHS, and in self-governing hospitals.

Background

2. The present system of negotiation and control of NHS pay and conditions is highly centralised. National pay scales are negotiated centrally, or determined on Review Body recommendation. Conditions of employment are also negotiated centrally. A brief description of the arrangements are set out in Annex 1. On the whole this system has proved effective in recent years in keeping down pay rates in the NHS for non-review body staff, to the benefit of public expenditure. (Pay accounts for [75 per cent] of NHS cost). But one consequence has been the emergence in some areas of increasing recruitment and retention problems, particularly for skilled staff. [Support with figures].

3. The Government can never stand entirely aside from such an important part of public expenditure as NHS pay, particularly since it is indirectly almost the NHS' only customer: and recent experience has shown this to be an area which can politically be highly sensitive. But Ministerial involvement in the detailed determination of pay and conditions is in principle undesirable. The ideal situation would be one in which managers were given an overall financial envelope within which to operate and then left to get on with achieving set objectives within it, provided that a way can be found of doing that in ways which do not lead to escalating pay costs and continuous increases in the size of the financial envelope itself.

Flexible pay systems

4. The general thrust of government policy towards pay in the public sector, and indeed in the economy more widely, is towards introducing a greater degree of flexibility. Greater flexibility

can help to achieve better cost-effectiveness in expenditure on pay by tieing pay rates more closer to local labour market and other conditions, by making it easier to encourage and reward high performance by individuals, and generally by providing managers with greater opportunities to use pay as an instrument of management. Where greater flexibility is accompanied by greater devolution or delegation of responsibility for pay and personnel issues - which in principle is also desirable if the necessary conditions of management capability and tight financial controls can be satisfied - that can also help to lower the political profile of such issues.

5. These considerations apply in the NHS as in other areas.

Flexibility in the main-stream of the NHS

6. Some progress has been made in this direction in the NHS in recent years. But the extent to which individual health authorities have freedom to vary pay and conditions without central approval is still relatively limited. Apart from London Weighting and the London supplements for Nurses and Professions Allied to Medicine recommended by the Review Body in 1988, about neither of which they have discretion, the flexibilities available to individual authorities are confined to:

- discretionary basic rates and performance-related pay for which about 2,000 top managers are eligible and which are soon to be extended to cover a further 7,000

- regional variations for IT staff.

- bonus schemes for manual staff and

- greater flexibility for some professional, technical and scientific staff allowing the possibility of eg moving pay scales up the spine to reflect increased responsibilities or expertise.

7. Health authorities also have responsibility for grading staff within centrally agreed grading structures, which affords some flexibility of a kind which varies between different groups of staff. There is some evidence that some authorities, particularly

in London and the South East, have been misusing the grading flexibility in order to overcome recruitment and retention difficulties.

8. Officials are already looking at the feasibility of introducing further flexibilities into the pay determination arrangements for the main-stream of the NHS. In the immediate future it seems unrealistic politically to do anything other than to retain the Review Bodies for doctors and nurses. But the DHSS have been working on proposals for an important group of the non-review body staff - the administrative and clerical grades - which, while retaining central negotiation of basic rates would allow local managers to vary these rates by up to a given percentage, which could vary in different parts of the country, to meet proven market difficulties, would provide scope for productivity bargaining and would extend performance-related pay.

9. More detail on these proposals is given in Annex 2. They have not yet been discussed in detail with other departments. Unless carefully managed, local variation in pay could lead to a general escalation of pay levels rather than a more finally targeted, and hence more cost-effective, outcome than across the board increases, particularly since NHS managers have very little experience of pay bargaining and will be dealing with trade union officials who are likely to have much more. For this reason a fairly cautious approach would appear to be justified.

10. An internal review by DHSS of conditions of service is also nearing completion. Greater devolution is likely to be a key recommendation here giving managers greater freedom to devise employment packages more suited to local needs. The review has highlighted a number of central controls which could readily be abolished (eg). In addition it points to other constraints (eg) which could over time be relaxed. Local management currently has few responsibilities in any of these areas. But it ought to be possible to give them progressively greater freedom as they gain experience and develop the expertise to run a more highly devolved system.

Self-governing hospitals

11. Self-governing hospitals will be , or ought to be, those with the strongest management. They will also be expected to win their business by virtue of their greater efficiency. In order to behave entirely commercially and make full use of the potential advantages of their status, they would need ideally to be given complete freedom over the pay and conditions of their staff.

12. There are, however, a number of considerations bearing on this.

13. First, however desirable in principle, in the immediate future at least it does not seem politically feasible in practice to take doctors and nurses working in self-governing hospitals out of the remit of Review Bodies any more than it does in the case of the rest of the NHS.

14. Second, self-governing hospitals will not be starting from scratch. They will be taking on their existing staff who, even in the non-review body groups, will have existing contracts of employment which explicitly or implicitly relate to pay and conditions determined under the existing mechanisms. Attempts unilaterally to vary the method of pay determination could be held to be a breach of contract which could lead to unfair dismissal claims, and redundancy payments. It might be possible to deal with this to some extent by legislation by taking away existing public and common law rights. But that would raise a number of issues and would be likely to be extremely controversial. It is not an option which found favour with Ministers when they discussed an exactly analogous point in relation to local authority pay earlier this year. The alternative is for individual hospitals to negotiate new contracts of employment with individual members of their staff, which is likely to be time-consuming and difficult, and unlikely in the short run to be cheaper than the existing arrangement.

15. Third, it will be important to ensure that the arrangement does not simply generate higher pay costs which are passed on to the health authority as customer, and touch off a pay spiral which affects not only the hospital in question but also main-stream hospitals in competition with it for staff.

16. In principle, genuine competition for the provision of services ought to be an effective constraint on hospital management from letting pay get out of control. They would simply lose business if they did. But in some parts of the country, and in some specialities, the competition would be limited, particularly in the immediate future. It would therefore be necessary to rely upon some combination of:

i. Cash limited funding to the DHAs, which are the buyers in the market place; and

ii. The fact that hospital managers will be under performance-related contracts which will provide pay incentives to maintain and increase their volume of sales and the sack if they fail, for example because pay rises restrict the volume of service the DHA can buy.

There must be room for genuine doubts about whether either mechanisms will be a sufficient safeguard against pay leap-frogging.

17. Finally, even in self-governing hospitals management capacity will constrain the pace of change which can safely be managed. They will have little or not experience of, or capacity for, driving hard pay bargains. It will almost certainly be necessary for them to buy this in initially.

Conclusion

18. There is general acceptance of a need to introduce greater flexibility into the pay determination system of the NHS, in respect of the creation of self-governing hospitals. Proposals are in the course of being worked up which ought to help to achieve this, though there are important constraints related to the capability of NHS management to exercise discretion of this kind without creating unacceptable upward pressures on the pay bill. These proposals will be brought forward for collected discussion in due course. The DHSS review of conditions of service also seems likely to lead in due course to a number of proposals which could increase local management discretion and improve the cost-effectiveness of the NHS salary bill.

19. If they are to achieve their full potential, and because this is consistent with their underlying philosophy, there is a strong argument for giving self-governing hospitals much greater flexibility in the pay and personnel management area, not excluding complete freedom for determining their own pay and conditions, at least for the non-review body groups. But going down this road does depend upon having sufficient confidence both in the ability of the managements concerned to manage pay negotiations with trade unions and in the effectiveness of competition and other mechanisms to prevent this leading to pay leap-frogging and increases in the NHS salary bill which it would in practice be difficult not to fund.

20. In any event, it seems unlikely to be feasible politically to remove doctors and nurses from the scope of the Review Bodies, even in self-governing hospitals. Any additional flexibilities will therefore almost certainly have to be restricted initially to the non-review groups.

21. There is also a very difficult problem relating to the existing contractual position of staff in hospitals given self-governing status.

22. It would be possible to conceive of a situation in which all self-governing hospitals were given freedom over pay and related issues as soon as they acquired that status. But the considerations outlined above suggest that this kind of imposed freedom is unlikely either to be helpful to the hospitals themselves, who might well find it an additional hurdle they would have to overcome before achieving their new status, or be conducive to the avoidance of escalating pay costs. A more managed, bottom-up approach, in which self-governing hospitals determined for themselves what additional flexibilities they required, and had to satisfy the Secretary of State that the necessary conditions existed for them to exercise them, would seem preferable.

23. Colleagues are invited:

i. To note that further proposals will be coming forward in due course to increase the extent of flexibility in the main-stream of the NHS affecting both pay and other conditions of service.

ii. To endorse the conclusion that no attempt should be made in the immediate future to exclude from the scope of the Review Bodies any staff currently within their remit, whether in self-governing hospitals or more generally.

iii. To agree that self-governing hospitals should be given as much flexibility as possible over the pay and conditions of their other staff, not in principle stopping short of complete freedom to determine these for themselves.

iv. To agree that appropriate way of moving towards this is to adopt a bottom-up approach, leaving it to individual self-governing hospitals to make their own proposals, provided they can satisfy the Secretary of State about their capacity to implement them and about the reality of competitive pressures upon them.

7 December 1988

ANNEX 1

DETERMINATION OF PAY AND CONDITIONS OF SERVICE FOR REVIEW BODY GROUPS

1. There are two Review Bodies, one for doctors and dentists (DDRB) and one for nursing staff, health visitors, midwives and professions allied to medicine (NPRB). (The professions allied to medicine - PAMs - are physiotherapists, radiographers, occupational therapists, chiropodists, dietitians and orthoptists.)

2. The Review Bodies are independent bodies appointed by the Prime Minister. Their terms of reference are to advise the Prime Minister on the remuneration of the staff groups concerned. (But London weighting is at present dealt with separately - see 4 below.)

3. Conditions of service and grading questions are determined separately from pay. In the case of doctors and dentists they are negotiated between the professions and the Health Departments. For the NPRB groups there are two negotiating Councils, one for nursing staff, health visitors and midwives and one for the PAMs. Changes in the structure of allowances (as well as of grades) would normally be negotiated in the Councils and then submitted to the Review Body for pricing (although the new London pay supplements recommended this year by the Review Body for nurses and PAMs - see below - had not been so negotiated).

4. The Review Body groups are also represented on the General Whitley Council, which deals with conditions of service which are of general application to all NHS staff. It also deals (via a sub-committee, the London Weighting Consortium) with London weighting allowances for all NHS staff. The respective roles of the London Weighting Consortium on the one hand and the Review Bodies and Negotiating Councils on the other in determining special arrangements for pay in London are currently under review, against the background of the 1988 Review Body award of London supplements (payable on top of London weighting) to nurses and PAMs.

ANNEX 2

PROPOSALS FOR INTRODUCTION OF GREATER LOCAL FLEXIBILITY

The problem

1. Central bargaining with tight negotiating limits has led to increasing problems of recruitment and retention in most staff groups not covered by Review Bodies. Administrative and clerical staff are the major non-Review Body group. They include managers below general managers and board-level senior managers in regions and districts and below general managers in units. Many authorities are facing acute problems in recruiting and retaining suitable staff across the whole range from senior finance, computing and personnel to secretarial and other clinical support staff. Because of the importance of administrative and clerical staff in implementing change and securing better management of resources they have been selected as the flagship for the introduction of greater local flexibility in pay. Their occupations are particularly sensitive to labour market influences.

Senior managers

2. The current senior manager's pay arrangements are to be extended to two further levels of management including managers in units. The change is to be achieved without negotiation but individual managers will have the right to retain their existing pay and conditions of service. Key elements of the new arrangements are:-

- general managers will decide which posts they consider have responsibilities for corporate management and therefore come within the scope of the new arrangements;

- a 12-point pay range, based on a 30-point pay spine with 4% steps, will be set for each management level;

- general managers will be required to assess the relative weight of posts and propose the appropriate pay point;

- spot salaries will be authorised by the next managerial level (ie by the RHA for posts at DHA level and by the Department of Health for posts in RHAs);

- there will be local flexibility to increase basic salaries by up to the value of 2 spine points above the maximum of the range for vacant management posts which cannot otherwise be filled;

- performance-related pay based on an annual process of individual performance review can add up to 4% of salary annually and up to 20% over a minimum of 5 years.

Administrative and clerical staff

3. Proposals are being considered by Ministers which would need to be negotiated in the Whitley Council for administrative and clerical staff who are not covered by the senior managers' option outlined in paragraph 2 above. The key elements of the proposed arrangements are:-

- new tighter definitions for 10 grades on a 44-point pay spine with 4% steps (to replace over 500 pay points);

- shorter incremental scales (4 or 5 points) with elimination of age-related points from age 18;

- assimilation to the new stucture to be prescribed by reference to existing grades with personal protection where necessary;

- a facility for local management to supplement pay points where this would assist in redressing proven problems in recruitment or retention;

- flexibility to be limited initially by amount payable to individuals (up to 30% in Thames Regions and 20% elsewhere for posts up to middle management level and 10% at higher levels);

- overall use of flexibility to be controlled initially (5% of A&C paybill in Thames regions and 3% elsewhere);

- local proposals to be included in short-term plans and cleared at next management level (RHA for Districts and Department of Health for RHAs);

- use of flexibility to be monitored by separate identification of payment of supplements in annual accounts;

- system designed to permit the easy introduction of individual performance-related pay when appraisal systems fully effective.

Nursing and midwifery staff

4. Proposals have been put to the Review Body for a sum of £5m to be set aside in 1989/90 for a pilot exercise in supplementing national rates of basic pay where deemed appropriate on recruitment and retention grounds. Key elements of the proposal are:-

- aim to help to meet a small number of particularly difficult cases and to pilot the criteria and help in development;

- allocation of funds to be controlled centrally; and likely in practice to be targeted on Southern Regions (including East Anglian) but to exclude inner and outer London pay areas where universal supplements recommended by Review Body in 1988 are already payable;

- supplement to be either a percentage of basic pay or a flat-rate addition to annual salary or an additional point or points on pay spine (eg 2½%/5% of basic pay or £250/£500).

Other staff groups

5. For professional, technical and scientific staff local flexibility has been encouraged by recent settlements for certain staff groups (eg speech therapists and MLSOs) and negotiations continue for pharmacists. The concept of pay spines has been introduced and local mangers provided with flexibility in moving pay scales up the spine to reflect increased responsibilities or expertise. There is also much less prescription in the grading criteria to facilitate more flexible working arrangements. The new structures have been designed to permit easy translation to the A&C model described in paragraph 3 above.