PREM 19/3490

MT.

CONFIDENTIAL FILING.

Prime Ministers meeting with Hal Miller, MP to discuss [redacted] the Health Service in the West Midlands. 18 February 1988.

And subsequent meetings

PRIME MINISTER

December 1987.

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
~~19.2.88~~ ~~8.3.88~~ ~~8.4.88~~ 24.5.91							

PREM 19/3490

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Treasury Chambers, Parliament Street, SW1P 3AG
071-270 3000

4 June 1991

Dominic Morris Esq
Private Secretary to the
Prime Minister
10 Downing Street
LONDON
SW1A 2AA

Prime Minister

Sir Hal will probably reiterate some of the concerns about the budget effects on the motor industry which he raised in late April with the Chancellor. Record of that meeting at flag A. The latest motor registration figures were pretty dire. It will pick up for August but not last year's levels

Dear Dominic

PRIME MINISTER'S MEETING WITH SIR HAL MILLER

... I attach briefing for the Prime Minister's meeting with Sir Hal Miller on 6 June about the car industry. It focuses on the car industry and taxation, but includes a separate brief (prepared by DTI) on other contentious issues currently concerning the industry.

I am copying this to Martin Stanley (DTI).

Yours

Kate

MISS K GASELTINE
Private Secretary

CAR INDUSTRY AND THE BUDGET

Budget priorities: defeating inflation and help for business

- Defeat of inflation remains priority. Budget continued tight fiscal stance: RPI inflation set to fall to 4 per cent by end-1991.

- Interest rates reduced by 3½ points since last autumn and 2½ points this year. Will help car industry by both reducing costs and stimulating demand.

- Budget helped business to weather recession and invest for future. Carmakers benefit from general business measures, including:

  - cut in corporation tax to 34 per cent for 1990-91; reduces business tax bills by £380 million;

  - further cut to 33 per cent for 1991-92; makes extra £830 million available for investment;

  - carry-back of losses extended from 1 year to 3 years; gives £250 million of tax back in 1992-93 to temporary loss-makers.

Car industry weathering recession

- Car industry remains vital sector of economy. Government has welcomed transformation of industry over last 10 years.

- Recognise current difficulties in domestic car market. But basic health of industry shown by export-led response to recession:

  - production up 6 per cent in first 4 months of 1991 over same period last year;

  - despite domestic registrations down 22 per cent over same period;

  - but surge in exports: massive 101 per cent increase in cars produced for export over same period. 27 per cent increase in commercial vehicles produced for export.

VAT/CC switch

- VAT increase should not be seen in isolation. Part of switch from local to central taxation.

- Will not reduce overall consumer demand. In 1991-92, CC reduction puts more money into pockets than VAT increase takes out.

- No reason for exempting cars alone, of VAT-rated goods, from increase. Overall tax on cars (VAT and car tax) now 27.4 per cent: not out of line with most EC states.

Fuel duties and VED

- All road fuel duties raised by 15 per cent, but vehicle excise duties on cars and lorries frozen. combined effect: 11.4 per cent.

- Higher road fuel duties give added incentive to fuel efficiency: further move to taxing car use rather than car ownership.

Company cars

- Income tax car scales increased by 20 per cent. In real terms, lowest rise in last 4 years. Previous increases:

  1988 - 100 per cent

  1989 - 33 per cent

  1990 - 20 per cent

- Aim is broad equity between taxes on company cars and cash payments. Do not accept cars already fully taxed.

- Employers' NICs on company cars: tackles significant incentive for employers to pay in cars not cash.

- Cars not first benefit-in-kind to be subject to NICs: gilts brought in to NICs in 1988. But cars and fuel are largest benefit-in-kind: 75 per cent of all benefits by value.

- First employers' NICs payment only due in June 1992.

CAR INDUSTRY AND TAXATION - DEFENSIVE

Car industry singled out for discriminatory treatment?

- No. Budget gave help to business generally. Measures on company cars continue move to more neutrality between cars and cash.
- But, when framing next Budget, Chancellor will consider state of industry (including effect of this year's measures).

Budget measures hit domestic demand?

- Wrong to attribute fall in demand to Budget: was falling anyway due to recession.
- What matters to car industry is production: dramatic shift to exports means this has kept up well. Up 6 per cent in first four months of 1991 over same period last year.

Abolish car tax?

- No. Car tax (10 per cent on new cars in addition to VAT) not changed by Budget. Raises £1.3 billion in revenue.
- UK taxes on new cars not out of line with EC. Five states have additional sales taxes similar to car tax; others have luxury rates of VAT.
- Only Germany, Greece and Luxembourg impose significantly lower taxes on new cars.
- Before car tax and VAT introduced in 1973, purchase tax on cars was 25 per cent.
- Car tax and VAT not applied to exports. Imports face same taxes as cars made in UK.

Unblock VAT input tax on cars?

- Would require complex system for putting VAT on private use of company cars.
- Blocking input tax where significant private use, is common throughout EC. Has existed in UK since 1973.

Encourage diesel for environmental reasons?

- Already lower duty (21.9p/litre) than unleaded petrol (22.4p/litre) and leaded (25.9p/litre).
- Fuel economy of diesel engine 20-30 per cent better than petrol engines: so fuel costs of diesel cars already significantly cheaper.
- Environmental case not clear-cut:
  - diesel contains 14 per cent more carbon per litre than petrol, so generates more CO_2 (greenhouse gas);
  - Diesel engines dirtier, because tend to emit carbon particulates.
  - Petrol engines emit more of other pollutant exhaust gases, but not once catalytic converters made compulsory for new cars from late 1992.
- Car scales: diesel engines have to be 20-30 per cent bigger to produce same power as petrol engines. But main band of car scales very wide: few diesel cars pushed into higher band.

Company cars - already over-taxed?

- Do not accept present scales tax significant benefit of private use too highly on average.
- No evidence yet of widespread 'cashing out' of cars for higher salaries.
- Budget increase reflects wide range of factors, including contract hire rates and other information from motor industry. Increase is lowest in real terms since 1988.
- Tool of the trade cars: cars used for more than 18,000 business miles already pay only 1/3 of perk car. National Travel Survey evidence suggests tool of trade cars still used for significant private use.

fp.js/briefs/3.3.6

CAR INDUSTRY - BACKGROUND NOTE

Sir Hal Miller is likely to repeat concerns he has already expressed to the Chancellor in letters and the meeting on 24 April. A note of the previous meeting is attached.

Additional briefing on non-tax issues is attached separately.

State of the industry

At 1.295m units, UK car production last year was only marginally lower than the 1989 level (1.299m) which was the highest level since 1977. At 457,503 units, car production in the first four months of this year is up by over 6 per cent on the same period last year, mainly because of the increase in production for export. With Toyota and Honda setting up car plants in the UK as Nissan has done, most industry analysts predict that UK car production will reach the 2m mark by the late 1990s.

The export drive of UK car and commercial vehicle (CV) manufacturers has been in part a result of the fall in domestic demand over the last 6 months. In the first four months of this year UK car sales were down 22 per cent at 583,318 on the same period last year, with domestic CV sales down nearly 32 per cent (at 79,457) over the same period. In that time, there has been a 101 per cent in cars being produced for export, and a 27 per cent increase in CVs for export.

Despite the increase in exports, which has up to now compensated for the fall in domestic demand, most UK manufacturers are now feeling the effects of the recession. Most recently, Rolls Royce announced 500 job losses (making a total of 1,200 for the company this year), and Ford announced at the end of April that it plans to reduce its European salaried workforce by 2,500 over the next 3 years.

In addition, of the main car manufacturers, Rover, Peugeot-Talbot and Jaguar have all announced lay-offs in the past 3 months, as have Foden, Iveco Ford, Seddon-Atkinson and Leyland Daf in the CV sector.

The fall in domestic demand has, however, led to a decline in imports. Car imports accounted for 54.6 per cent of the UK market in the first four months of this year compared with over 57 per cent in the same period last year. CV imports have declined from over 39 per cent of the market to under 36 per cent in the same period.

Budget measures on cars

The Budget increased all fuel duties by 15 per cent, raised income tax car scales by 20 per cent and levied employers' NICs on employer-provided cars available for private use. The VAT increase applied also to cars, as to all other standard-rated goods.

The car industry has claimed to be surprised by the Budget measures. It had hoped for an increase in the tax differential between diesel and petrol on environmental grounds. It also claimed to have shown that company cars were, before the Budget, already fully taxed. The VAT increase only reminded the industry of its longstanding grievance against car tax.

The Chancellor and the Secretary of State for Trade and Industry met Sir Hal Miller and representatives of Ford, Rover, Vauxhall and Peugeot on 24 April. The Chancellor emphasised the Government's appreciation of the importance of the industry, and the transformation it had undergone in the last decade. He stressed that he did not wish to return to the 1960's when the industry was used as an economic regulator. The Budget measures were neutral and equitable. He did, however, say that when framing next year's Budget, he would bear in mind the impact of employers' NICs on company cars (the first payments are not due until June 1992).

PRIME MINISTER'S MEETING WITH SIR HAL MILLER: 6 JUNE

EC/JAPAN CARS/MMC ENQUIRY AND THE UK VRA

Line to take

- Commission have put forward new proposals; but the precise detail of these is not yet clear.

- In any case, UK demands remain unchanged.

- UK continues to lobby for a firmly liberal agreement with real commitment to early and substantial progress towards liberalisation of the restricted markets.

- In particular we are stressing that we could not accept any arrangements, express or implied, which would restrict the commercial freedom of Japanese-owned companies operating in the EC now or in the future. It is essential that any agreement offers guaranteed free circulation for such vehicles and a clear assurance that they will not be linked in any way to the ceilings set for direct exports from Japan during the transitional period.

- [if raised] The UK has not yet taken a decision on the future of its own VRA with Japan. We will look again at the issue when the EC-wide position becomes clearer.

- [if raised] The Monopolies and Mergers Commission are currently looking at the VRA in the context of their investigation into car pricing in the UK. They are due to report in August and we await their conclusions with interest.

Background

EC/JAPAN CARS

1 After a long stalemate in negotiations to agree an EC line on the lifting of restrictions after 1992 on EC imports of cars manufactured in Japan, the Commission outlined a new set of proposals at the start of May. It is not clear as yet what these proposals are, but we understand that the Commission have not put forward any figures at this stage.

2 The Commission proposed last September an absolute ceiling for 1998, with import growth allowed in the most restricted markets but not over the EC as a whole. This would only apply to imports from Japan, not from EC-based, Japanese-owned manufacturers("transplants"). The new proposals are reported to feature a link between sales of so-called "transplant" cars and ceilings set for direct imports from Japan during the transitional period. Such a proviso would be totally unacceptable to the UK. The Secretary of State has contacted the Commission to reiterate our concerns and to ask for assurances in writing that our demands on the treatment of the "transplants" will be met.

3. In addition, the UK is concerned that any transitional period towards full liberalisation should be as short as possible and involve early and substantial progress towards liberalisation. We are also arguing that any transitional restraints should apply only to those countries which currently have restraints and which wish them to continue, and should not be EC-wide. Our stance is supported by other liberal member states, notably Germany, Luxembourg, the Netherlands and Ireland, whilst France, Italy , Spain and Portugal are lobbying hard for a protectionist outcome to discussions. The French have proved particularly intransigent and with the appointment of Mme Cresson as Prime Minister their hardline protectionism looks set to continue.

MMC ENQUIRY/UK VRA

5. The cars VRA is currently being looked at by the MMC in the context of their investigation of the UK car market and car pricing in the UK. They have provisionally found that the VRA may constitute a complex monopoly, but have not yet taken a view on whether it operates against the public interest. Ther has been considerable Press and public interest in the issue, but it would not be appropriate to comment substantively until the MMC reported formally in August. Ministers have been considering the VRA in the light of the enquiry and the current negotiations on EC/Japan cars but have not yet taken a view on its future.

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MEETING OF THE CHANCELLOR OF THE EXCHEQUER AND THE SECRETARY OF STATE FOR TRADE AND INDUSTRY WITH SIR HAL MILLER MP AND REPRESENTATIVES OF THE MOTOR INDUSTRY - 24 APRIL 1991

Those present:	(Also present)	
The Chancellor of the Exchequer	Mr Wilson	HMT
The Secretary of State for	Miss Rutter	
Trade and Industry	Miss Gaseltine	
	Mr Curtis	
Sir Hal Miller MP	Dr Robinson	
Mr Derek Barron (Chairman, Ford)	Mr Ross Goobey	
Mr George Simpson (MD, Rover)		
Mr Paul Tosch (MD, Vauxhall)	Mr Lane	DTI
Mr Geffrey Whalen (MD, Peugeot)	Mr Bridge	

Sir Hal Miller began by thanking the Chancellor and the Secretary of State for Trade and Industry for agreeing to the meeting, the purpose of which was to keep the Government abreast of the state of the industry and to seek clarification of the Government's attitude to it. This was important because there was a number of investment decisions outstanding. The industry felt concerned that the Budget had singled cars out for additional taxation, that it had been unhelpful when demand was running down anyway, and that Budget measures appeared at odds with earlier discussions with the Financial Secretary and with other departments. They had four areas of concern for discussion: the state of the market, the burden of taxation, company cars, and Japanese/UK/EC VRAs and the MMC investigation.

The Chancellor expressed his admiration for the transformation achieved by the industry over recent years and said he was conscious of its long-term potential. The Budget, which had been carefully constructed, was neutral and equitable. He noted the

industry's concerns on company car scales and NICs, adding that the latter would not, however, become payable until next year, and the former was less than some might have expected. He expressed his appreciation of the value of the industry. He did not want to return to the sixties when the industry was used as a regulator.

Mr Derek Barron spoke of his company's recent high level of investment, and his concern for dealerships, some of whom were experiencing severe problems due to the downturn in domestic demand. He felt the Budget was at odds with the direction of recent talks with the FST on the industry. He expressed surprise at the Budget measures on vehicles and thought they indicated a change in the Government's attitude to the industry; he cited the car scale decision and the singling out of car benefits for NICs. These were additional to three existing factors: that cars were the only business expense where VAT was not reimbursable; special car tax; and vehicle excise duty. The SMMT had calculated that 28% of the revenue raised by the Budget changes was on vehicle-related items. He expressed concern at the drop in domestic sales and the inevitable consequential job losses, and feared the Budget measures might necessitate a review of future investment plans.

Mr George Simpson addressed the specific tax issues.

He considered it appropriate to seek the abolition of the special car tax as it was clearly discriminatory and placed the UK (27.3%) above France (22%) and Germany (14%) in overall car taxation terms.

Mr Simpson said he had heard that there was a current EC proposal for 50% deductibility of VAT on cars and thought the Government should not wait for EC legislation but should adopt the scheme early. On diesel fuel he noted that Germany was now resuming its promotion of diesel fuel following recent health monitoring of emissions, and thought the UK should therefore re-assess its policy towards the diesel/petrol differential and reduce diesel duty.

Finally, he regretted the perceived discrimination against vehicles shown in the Budget.

Mr Paul Tosch considered a strong domestic market and improved competitiveness essentials for building exports, and both of these required Government support. Although exports were high at the moment, this could not be depended on in future, eg in Germany, where a forecast downturn could affect the current export boom.

Mr Tosch noted that the company car market, which constitutes 55% of total UK sales, would be affected by the VAT increase, NICs, and the rise in fuel duties, and that employees faced higher income tax. He claimed that moves to payments in cash rather than cars, which were already apparent, would be inflationary and would adversely affect the balance of trade by increasing imports (by 7%) and reducing fleet sales as private purchasers tended to prefer foreign-made cars. Mr Tosch said the major manufacturers wanted to be able to continue to invest in vehicle production in the UK but might decide to move investment overseas.

The areas of specific need outlined by Mr Tosch were the reduction of scale charges for essential business users, fairness in NICs treatment and 50% deductibility of VAT. He thought there had been agreement that the pre-Budget scale charges had matched contract hire rates.

Mr Geoffrey Whalen reported on his recent meetings with Japanese counterparts, which covered, among other subjects, the principle that any EC-wide Japanese import VRA should not include Japanese-owned European manufacturers (whose cars count as European by virtue of sufficiently high local component content). Talks also covered non-targetting of specific national markets by the Japanese. Mr Whalen said his delegation had convinced the Japanese that the Government's attitude to the industry was not changing; the industry now sought reassurance from the Government that this remained the case.

On the MMC investigation, **Mr Whalen** expressed concern at what were perceived as attacks on price levels at a time when profits will already be badly hit.

The Chancellor thanked the delegation for expressing its views. He confirmed that there was no change in the Government's attitude to the industry and that cars were a key component of UK industry; he was pleased to see how the industry had transformed itself over recent years, and was in good shape for the nineties. He reaffirmed the neutrality of the Budget; however, the switch towards indirect taxation was bound to result in increased indirect taxation of the motor industry. He would bear in mind, when assessing future car scales adjustments, the impact next year of the introduction of the NICs measure announced in the last Budget.

Sir Hal Miller pointed out that a £9000 new car includes £4000 of tax.

The Chancellor said the motor industry was not being "singled out" for benefits-in-kind taxation; but cars were the largest benefit-in-kind and the Government had made clear its view that in principle benefits should be taxed as cash. He did not rule out extending NICs to other benefits. He would look carefully at the effects of the new car scales and would be interested in evidence of "cashing-out". Past increases in car scales had not resulted in a diminution of the company car market.

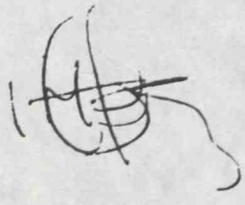
On special car tax, he had never accepted the case for its abolition; in comparing overall vehicle taxation levels to those in Europe, we were not "out of step"; a number of countries had higher overall rates than the UK (eg Netherlands, Ireland, Spain). On diesel, its fuel efficiency was reflected in the unit price. Drivers paid less duty per mile. It was right that the polluter should pay. He would be very willing to look further at the right differential between duty on diesel and leaded.

The Secretary of State for Trade and Industry reinforced the Chancellor's positive points on the car industry's efforts in recent years. He added that the Government had applauded these efforts publicly. On the MMC investigation he affirmed its independence; he could not comment until its finding were available. He agreed that EC-based Japanese manufacturers should have free access to the market; there was no room for compromise on this. On imports from Japan, he favoured gradual liberalisation in preference to any sudden unilateral move.

Mr Simpson said the delegation shared the Chancellor's view that the future for the industry was bright; its wish was that the Government's approach should be supportive of this; its concern was that it perceived the Budget not to be so.

The Chancellor said he had heard the case loudly and clearly. He would watch developments very closely and would reflect on the points made. He would be mindful of the NICs decision when framing next year's Budget. He was always available to listen to the industry's representations.

Sir Hal Miller thanked the Chancellor and the Secretary of State for meeting the delegation.



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IAE2

PM: meeting with Hal Miller MP

Dec 87

FILE
DA

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

24 May 1991

Sir Hal Miller is coming in to see the Prime Minister at 4.00 p.m. on 6 June to raise with him concerns about the motor industry. No doubt this will be a reprise of the concerns he raised with the Chancellor and Mr. Lilley about Budget measures and the MMC inquiry.

I shall be grateful if you could let me have a brief for the Prime Minister to reach here by close of play on Tuesday 4 June.

I am copying this letter to Martin Stanley (Department of Trade and Industry) who will presumably provide the brief on the MMC inquiry and on the current state of the motor industry.

DOMINIC MORRIS

Jeremy Heywood, Esq.,
HM Treasury.

C06/4208

CONFIDENTIAL

cc PS
1. Mr. Addison - to see
2. PA

Treasury Chambers, Parliament Street, SW1P 3AG

The Rt Hon Tony Newton OBE MP
Minister for Health
Department of Health and Social Security
Richmond House
79 Whitehall
London
SW1A 2NS

Prime Minister
You will wish to see this exchange following your recent meeting with Hal Miller.
PRCG 8/4

8th April 1988

Dear Minister,

PRIVATE FINANCE FOR NHS CAPITAL PROJECTS

Thank you for your letter of ~~16~~ May March.

As you will appreciate, it is difficult for me to respond in any detail to the points made by Hal Miller, not having been at the Prime Minister's meeting. But if you have specific proposals to put forward, the Treasury will be ready to consider them as we have in the past. In the absence of any examples it is, if I may say so, a little difficult to respond to concern about the "extreme rigidity" of the way the rules are being applied. On the contrary, I think the guidance we have worked up on contract energy management shows that the Treasury is willing to reach sensible and workable solutions to complex problems.

In approaching public sector projects financed by private borrowing, there are two points to which we attach importance. The first is that public sector projects must be set up in such a way as to give the best value for money to the taxpayer. To replace public borrowing by private borrowing with no change in management incentives would not be good value for money, since the taxpayer would be faced with higher capital charges: borrowing on effectively hire purchase terms is more costly. Indeed, this is a point which John Moore explicitly recognised in his letter to me of 21 March about the Cyclotron Trust when he said "there seem to be no advantages to us in the Trust borrowing money on our behalf". I agree with that. But where there is a package on offer including private sector finance,

management skills and innovation, which offers better value for money overall than a public sector solution, it would be acceptable. There are practical examples of this in the health area, such as the North West Thames Region's energy management contract with EMSTAR and North West Region's embargo line agreement with ICL, both of which the Treasury approved last year.

The second point is that, where a decision is taken to finance a project privately, we would normally seek an offsetting reduction in planned capital expenditure. This ensures that a project is considered on its merits and according to true priorities, not simply because the payments are less in the early years. For the NHS, the taxpayer has to repay the capital however it is financed. As you say, the local authorities offer a graphic illustration of the dangers of continuing to spend today while building up commitments for the future. But again I would not accept that we have applied this presumption too rigidly. It is of course open to Ministers to agree that the priority attached to a particular project is such that it should be additional to the existing programme, as happened in the case of the Dartford Crossing. But a decision to allocate more resources to a particular programme should be taken separately from the decision about the method of finance and preferably in the survey.

I am copying this letter to the Prime Minister.

Yours sincerely,

pp JOHN MAJOR

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

Pm: Mtg with H. Miller. MI.

Dec 87.

CONFIDENTIAL

cc BG

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Minister for Health

The Rt Hon John Major MP
Chief Secretary to the Treasury
H M Treasury
Parliament Street
London SW1P 3AG

16 MAR 1988

Dear John.

I recently attended a meeting which Hal Miller MP had with the Prime Minister to discuss difficulties faced by the West Midlands Regional Health Authority. An outcome of the meeting was that I was asked to write to you about the present restrictions on health authorities' access to private sector finance.

Overall, health authorities remain seriously short of capital, despite the success of their land sales programme in recent years. Major new schemes, which offer potential for savings from rationalisation, are not able to go ahead as quickly as they should in managerial terms, and there is considerable political pressure to move more quickly. There is a serious backlog of maintenance and an even worse problem over equipment, where we fall short of standards achieved in most developed countries. We are also unable to take advantage, on anything like a satisfactory scale, of opportunities for savings through energy conservation, or the use of the information technology to improve managerial efficiency. Now, too, we are becoming aware that shortage of capital is restricting the scope for income generation schemes. There is also, as you know, a particular problem of transitional costs associated for example with our programme for closure of large mental illness and mental handicap hospitals, which will in time yield both substantial capital sums and revenue spending, but which require an interim capital investment and a period of double running costs.

Our policy objectives depend on an adequate level of capital investment, and we are not achieving this. The money which the Exchequer has been making available for health authorities capital spending has been falling in real terms. Land sales have helped, and there remains potential for at least the next two or three years for income from this source. Authorities themselves for a number of years supplemented their capital allocations by transfers from revenue, but the forecast for 1987/88 is for a lower transfer than in previous years, and the short-term programmes for 1988/89 show that for the first time authorities envisage being obliged to transfer from capital to revenue in order

E.R.

to balance their books. If anything, therefore, capital spending is set to fall, despite the benefits that are potentially available from higher capital spending.

Against this background it is doubly frustrating to health authorities to observe a greater willingness than ever before from the private sector to invest capital in the health service which is being frustrated by the rigidity of the Treasury rules on so-called unconventional finance. Indeed that rigidity is so apparent that most authorities, recognising the cost in managerial time of trying to work up a case to be considered by the Treasury, have regretfully to turn down an offer of capital without even putting it to the test.

There are, as we see it, three obstacles to be overcome before a scheme can qualify under the present rules. First, except in a de minimis situation, the Treasury rules require an offsetting reduction in publicly financed provision. Thus by definition the problems arising from shortage of capital finance are not addressed. Secondly, a full investment appraisal has to be carried out in order to demonstrate that the privately financed scheme provides better value for money than one financed by the public sector; this, even if there is a prospect of public money being available, which is usually not the case, means that any element of profit or recovery of interest costs in the privately financed scheme will rule it out regardless of its potential contribution to future efficiency. Thirdly, the requirement for case-by-case consideration by the Treasury acts as a major deterrent to the investment of managerial effort.

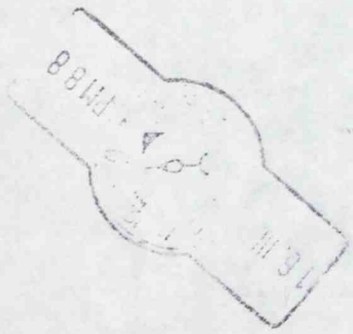
I fully understand the Treasury's wish to ensure that other parts of the public sector do not follow the example of those local authorities which exploited unconventional forms of finance in order to borrow money to sustain levels of revenue spending that they could not afford. I think, however, that the extreme rigidity of the rules now being applied goes well beyond what is necessary, and simply acts to frustrate the Government's wider policy objectives of improving harmonisation between the public and private sectors in an area, such as the National Health Service, where we surely agree that the outcome of greater private sector involvement can only improve the management efficiency of the service. It should suffice to operate an approval mechanism on the basis that health authorities wishing to take advantage of private capital should be able to demonstrate that the scheme fits within their overall strategy and that they would have the means to meet whatever revenue costs ensue. If we make this change it would follow that there would not need to be any offsetting reduction in publicly-financed capital but we should have the benefit of both private capital and flair at an acceptable cost to the taxpayer. The NHS and the Government would undoubtedly benefit.

I am sending a copy of this letter to the Prime Minister.

Yours ever,
Tony

TONY NEWTON

YdS/D.27



Prime Minister (2)

This is the follow-up on cottage hospitals from the Hal Miller meeting.

MEA 9/3

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

From the Minister for Health

Hal Miller Esq MP

- 8 MAR 1988

Dear Hal,

At our recent meeting I promised I would let you have a note which sets out in general terms what the Department sees as the valued characteristics of small hospitals. I thought you might find it helpful to have these in the form of the attached list which also includes some of the disadvantages of cottage hospitals.

Clearly in considering any proposal which involves a closure of a small hospital we need to weigh carefully both sides of the argument. How much weight we give to each of the points listed will of course depend on local circumstances which will also determine whether there are any other issues we need to take into account.

Yours ever.

Tony

TONY NEWTON

KW/DNo.25

Advantages of Small Hospitals

Relationships with local people and primary care services are easier where the hospital is seen as part of the local community being served.

Recruitment of some categories of staff (though not medical staff) may be easier - less travel and familiarity with the hospital, the services it provides and staff already working there.

Not all in-patients will need the full range of investigation and treatment.

Journeys and access will be easier for relatives and friends as well as for patients themselves.

Encourages local voluntary support.

Communications between management and staff are less complex.

Disadvantages of Small Hospitals

Will not have the full range of diagnostic equipment, support services and specialised treatment which may be required if complications develop and patients may then have to be moved. Neither is it possible to provide 24 hours consultant (or even senior registrar) cover in small, scattered hospitals.

May lead to uneconomic duplications of services and specialised staff on a number of different sites. It is therefore difficult to reproduce the higher throughputs of a single site.

May not provide all the experience and variety of training nursing staff require, leading to lack of recognition of nurse training courses.

May not provide all the experience junior medical staff require as part of their training, leading to Royal College's withdrawal of training recognition of posts and consequent medical staff shortages.

Staff costs are higher where there is travel between two or more sites because medical and other specialised staff are only on site part-time. This could result in reduction of quality of clinical services.

Risk that staff may become professionally isolated and inward looking.

File

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SUBJECT CC MASTER

10 DOWNING STREET

LONDON SW1A 2AA

19 February, 1988.

From the Private Secretary

The Prime Minister yesterday met Hal Miller, M.P. Your Minister was also present. The meeting arose out of a letter from Hal Miller dated 3 December to which you provided a draft reply on 20 January. We subsequently decided it would be better not to write at that stage, but to arrange a meeting which Hal Milller could come to on his own.

I attach a copy of the letter the Prime Minister has sent Mr. Miller following the meeting. It was agreed that your Minister would follow up two points set out in the letter on (i) commercial finance and (ii) cottage hospitals. A number of other points were also covered at the meeting which are not, I think, worth recording separately.

On (i) above, your Minister said he would get in touch with the Chief Secretary to pursue the general point about the possibility of health authorities having more freedom to make use of commercial financing deals. The Prime Minister said she thought this deserved a closer look. I should be grateful if you would send us a copy of Mr. Newton's letter to Mr. Major.

Bf 11

M.E. Addison

Miss Jenny Harper,
Office of the Minister for Health.

10 DOWNING STREET

Prime Minister

I have cleared this visit

Tony Newton.

MEA 19/2

10 DOWNING STREET

LONDON SW1A 2AA

THE PRIME MINISTER

19 February, 1988.

Dear Hal,

I am grateful to you for coming to see me yesterday and setting out your concerns so constructively and forcefully. I have taken careful note of the points you made in your letter of 3 December, and of what you said at our meeting.

Since you wrote, of course, Tony Newton has announced an extra allocation of funds, £75 million for health authorities in England, to help authorities meet the particular pressures they are facing this year. We have also more recently announced a wide-ranging review of the health service, with particular emphasis on the hospital service. I hope you and your West Midlands colleagues welcome this in view of the request set out in your letter for a new look to be taken at the health service and its financing. I know that John Moore and Tony Newton would welcome any submissions or ideas you may wish to put forward for their consideration.

There were two particular points you raised at our meeting which Tony said he would consider further and write to you about. The first concerns the region's proposals for adopting commercial finance schemes in some areas. The second concerns smaller hospitals which might not offer a full range of medical care but which would be easier for people to get to, and the part they might have to play in meeting local needs.

I thought our meeting was a very useful one, and I hope you did too. I have asked Tony Newton to keep me in touch.

Yours ever

Margaret

H.D. Miller, Esq., M.P.

(2.)

PRIME MINISTER

Hal Miller wrote to you in December asking for a meeting, and Archie has been in touch with him since then, about the health service in the West Midlands. He had wanted to bring a large delegation of local MPs, but has agreed to come on his own, and then convey the result to his colleagues.

Since Mr. Miller wrote, Tony Newton has announced the extra £100m for this year. The review is also, of course, now underway. You will therefore wish to listen to Mr. Miller's concerns and ideas, and suggest that if he and his colleagues have any particular proposals to put forward, they should keep in touch with Tony Newton.

You do not need to go through this lengthy brief. You will wish however to look at Mr. Miller's letter at Flag 6, and at the first four pages at Flag 5, setting out some facts and figures in the West Midlands health service.

Tony Newton will be at the meeting.

Duty Clerk

pp Mark Addison
16 February 1988

JA2AXS

Mr McHugh A/PS MS(H)

From: Terry Ewington FA1A
Date: 12 February 1988

Copies: Mr D Clark PS
Mr Green FA2A
Miss Mithani FB2A } without item 5
Mr Oates RL2B

MEETING BETWEEN THE PRIME MINISTER AND HAL MILLER MP

I attach briefing as follows on the issues raised in Hal Miller's letter of 3 December:

1. Unconventional capital financing

2. Funding of GP services and acute hospital services

3. HCHS Current spending plans for 1988-89

4. NHS Review

5. Local issues - Bromsgrove and West Midlands

Terry Ewington
Rm 629 ARH
Ext 4432

UNCONVENTIONAL CAPITAL FINANCING

1. Most assets used by the public services are acquired by outright purchase, funded by taxation or by government borrowing. "Unconventional finance" (sometimes called "third party finance") is an umbrella term used to cover a wide range of arrangements which enable assets to be acquired immediately but permit the cost to be spread over a period; but where the arrangement is so structured that it is not defined as "borrowing" in the strict sense. Examples include deferred payment or purchase, hire purchase, leasing and sale and leaseback.

2. Whilst NHS authorities are not precluded from using unconventional finance, any authority wishing to do so must demonstrate that it represents value for money and is not simply a means of getting around cash limit controls. In accordance with the Government Accounting rules all unconventional finance proposals have to be approved by Treasury. Health authorities wishing to resort to any scheme which involves unconventional finance must, therefore, submit a fully justified case via the DHSS, comparing the true Exchequer costs and benefits of unconventional finance with outright purchase.

3. Any unconventional finance proposal is likely to involve a financing cost which arises because the scheme involves borrowing by a third party. Since the government can normally borrow directly to finance its general expenditure at lower interest rates than other borrowers, it is unlikely that any intermediate body could lend to government organisations at a rate lower than the cost of conventional government borrowing. In some cases, the private sector cost may appear to be lower, but this may be because the private sector organisation is able to take advantage of tax reliefs which enable it to demand a lower rate of return. It is important, however, to adjust such costs to take full account of taxation so that the appraisal identifies the real resource costs to the Exchequer of the unconventional finance proposal.

4. It is also necessary to ensure that unconventional finance is not simply a means of getting around Public Expenditure controls imposed by cash limits. Health authorities capital expenditure is subject to central government control, as part of the general process of managing the economy. If health authorities were to be allowed unrestricted access to unconventional finance, this would lead to undeclared capital expenditure, which would have an affect on the Government's planned level of public sector spending.

5. Furthermore Treasury have indicated that where a scheme which involves the use of unconventional finance is accepted as representing value for money, they may impose a control total adjustment to ensure that there is no overall increase in public expenditure and no cash limit benefit is obtained by an authority.

6. West Midlands RHA are fully aware of the above conditions. Most of the proposals set out in Hal Miller's letter have already been rehearsed with the Department and have been found to be mainly a device for getting around public expenditure controls. The region have not yet come up with a scheme which demonstrates that unconventional finance offers better value for money than outright purchase in Exchequer terms.

More money given to GP services than to acute hospital services

It is true that funding of Family Practitioner Services (FPS) has grown faster than hospital services (HCHS) funding. FPS gross current spending grew by 43% in real terms to 1987-88 compared with 28% for HCHS current spending. HCHS still accounts for some 70% of all NHS current expenditure. Spending on acute services will have grown more slowly than this, but that is a reflection of:

(a) health authorities' decisions on priorities;

(b) improvements in efficiency and lower unit costs in the acute sector.

Line to take

FPS is a demand-led service, not cash-limited like the HCHS, and is composed of many small units. The larger HCHS has grater scope for efficiency savings. Improvements in the FPS, eg smaller GP lists, are also of indirect benefit to the HCHS and the NHS as a whole. Demand on the Family Practitioner Services is also affected by the increase in the number of elderly people and other groups who are increasingly being treated in the community.

HCHS current spending plans for 1988-89

The Public Expenditure White Paper gross spending plans for 1988-89 are for £12,091 million, compared with £11,471 million in 1987-88, an increase of 0.9 per cent above general inflation. This takes account of the extra £75 million for 1987-88 announced in December. Cost improvements must also be taken into account - expected to be roughly £150 million or 1.2 per cent of gross spending in 1988-89. Health authorities are expected to fund pay and price increases from within their pool of cash allocations and cost improvements.

Line to take

HCHS current spending is £1,050 million higher in 1987-88 than in the previous year, an increase of 5.6 per cent in real terms (above general inflation). Further increases of nearly 1 per cent in real terms are planned in 1988-89 to reach record levels of spending.

NHS REVIEW: POINTS TO MAKE

MS(H) may wish to make the following points as necessary on the NHS review:

- The Government are undertaking an internal review of the National Health Service, with special emphasis on the hospital service.

- The review will be wide-ranging and fundamental. At this stage we are not ruling out any proposals for reform. Each will be considered on its merits.

- We remain fully committed to the principle that anyone in need of health care should receive it, regardless if their ability to pay.

- We shall be looking at ways of getting more money into health services, for example through insurance schemes.

- There is no fixed timetable for the review. But we are keen to bring forward proposals as soon as we can.

- Although the review is an internal one, we would welcome constructive proposals from interested organisations and individuals, including NAHA.

- I cannot commit the Secretary of State or myself to meeting the Association, but would be happy to consider doing so when we have received your ideas.

Background:

See Hansard of Oral Questions on 9.2.88 below.

Health Service, I do not consider the hon. Gentleman's suggestion to be a productive way of moving forward the current debate on health issues.

Mr. Cohen: Did not recommendation 112 of the 1979 Royal Commission on the National Health Service say that there was a firm case for a gradual but complete extinction of charges? Have not the Government done exactly the opposite? Have not the new eye test charges and higher dental charges been overwhelmingly condemned? Is not the policy of the Government, tax cuts for the rich paid for by making charges on the sick?

Mr. Newton: The answer is no. The reason why we have not accepted the Royal Commission's recommendation is that we do not agree with it.

Mr. Heathcoat-Amory: Does my right hon. Friend agree that the 1946 constitution of the National Health Service is becoming increasingly difficult to fund because of the explosive demands of new technology and new courses of treatment? When he examines these recommendations, will my right hon. Friend make explicit what doctors already know—that we must allocate priorities in the National Health Service and keep it open to all but narrower in its scope?

Mr. Newton: I am grateful for my hon. Friend's constructive comments, which echo much of the general comment of the Royal Commission, to which the original question referred. Our resource management initiatives are directed to the point my hon. Friend has in mind.

Mrs. Clwyd: As a former member of the Royal Commission—the only such hon. Member—I should tell the Government that they would not be in the mess that they are in now with the National Health Service if they had implemented the recommendations of the Royal Commission. Does the Minister agree that the numbers of late abortions would have been considerably reduced if he had implemented the recommendation of the Royal Commission, that 75 per cent.—rather than the present figure of 46 per cent.—of abortions on resident women in Britain should be carried out by the National Health Service?

Mr. Newton: I simply do not accept the general presumption of the hon. Lady's supplementary question, which is that a good deal of progress has not been made on the general recommendations of the Royal Commission. Great progress has been made in streamlining the administrative structure, by cutting out a tier, and in the development of services such as cancer screening and a number of other important developments.

Mr. Jessel: The Royal Commission referred to the use of hospital beds. Does my right hon. Friend realise how many hospital beds are being wasted because patients are admitted for operations a full day or more before their operations are carried out, principally to ensure that they do not eat anything? In view of the length of waiting lists, can action be taken in appropriate cases to ask patients to certify that they have not eaten anything?

Mr. Newton: I shall consider my hon. Friend's suggestion. He will be aware that there have been considerable improvements in the efficient use of beds. The performance indicators that we publish—a new set is due shortly—will facilitate comparisons between the performances of different health authorities.

Ms. Harman: Will the Government withdraw their plans to charge patients for screening examinations of their eyes, teeth and mouths? Why do the Government persist in thinking that they are right to press ahead with those plans, when everyone else, including family practitioner committees, the British Medical Association, health authorities and consumer associations think the Government are wrong?

Mr. Newton: Because we believe that those proposals are a reasonable way of contributing a relatively modest sum to the much larger increase in expenditure that we plan on family practitioner services generally, with the emphasis on preventive care.

Mr. Burns: Does my right hon. Friend agree that one of the most telling points of the Royal Commission's report was that the demand for resources in 1979 was so great that we could quite easily have spent the whole of our gross national product on the Health Service?

Mr. Newton: Yes indeed. As I said a moment ago, the Royal Commission made some sensible comments about the relationship between demand and resources. It is in that spirit that we have been seeking to tackle the problems of the Health Service.

National Health Service

4. **Mr. David Winnick:** To ask the Secretary of State for Social Services what progress has been made in the Government's consideration of the National Health Service; and when he now expects to bring forward proposals for consultation.

The Secretary of State for Social Services (Mr. John Moore): The Government have now embarked on an internal review of the National Health Service. We shall bring forward our proposals in due course.

Mr. Winnick: Why does the Secretary of State not admit that the Government's real purpose is to prepare the ground for the private sector to take over much of the National Health Service? Is the right hon. Gentleman aware that the British public certainly do not require impertinent lectures from the Parliamentary Under-Secretary of State, the hon. Member for Derbyshire, South (Mrs. Currie), about paying for health care? People pay through their taxes and national insurance contributions, and they expect the National Health Service to be adequately funded by whichever party happens to be in government.

Mr. Moore: The British public will share my admiration of my hon. Friend the Parliamentary Under-Secretary of State for the sensible way in which she addressed the nation about the issues and values that face a free society that, by choice, spends £17 billion on alcohol.

Beyond that, the gravamen of the point made by the hon. Gentleman related to the review. As I have told him in a written answer, the review will be wide-ranging and fundamental. It is clear that we are concerned with the development of the Health Service to meet the country's needs in the years to come. We shall look at all alternatives that allow us to ensure what we care most about—the health of our country.

Dame Jill Knight: May I suggest to my right hon. Friend that many thousands of people are aware from their own personal experience that today the Health

Service is treating and curing people who, only two or three years ago, would have been sent home to die? When my right hon. Friend considers long-term plans, may I suggest to him that the vast majority of people in Britain are willing to pay more money for health services and care, provided that whatever schemes are adopted—and there are many—the money goes to the Health Service and not to the general exchequer?

Mr. Moore: My hon. Friend is quite right. That is why we must look so carefully at the way in which resources are used. We must ensure that they are spent on patient care, and not unnecessarily wasted. My hon. Friend was right to identify something that should unite both sides of the House. It is extraordinary that in the past year about 32 million of our citizens have used hospital services in Britain. That is an astonishing example of the achievement, for which we should give credit to all those who work in the Health Service.

Mr. Galbraith: Has the Secretary of State's review made him aware that a more efficient use of resources, such as operating theatres and beds, will require an increase in resources? Therefore, will the Minister guarantee to make more funds available so that we can utilise beds and operating theatres more efficiently?

Mr. Moore: We will consider everything. Obviously, we shall consider the way in which increased efficiency improves the ways in which the Health Service can treat more patients. However, as the hon. Gentleman knows from his experience in Scotland, where a greater percentage of GDP resources has been expended on health care, that has not improved the relative ratios of waiting times compared with England. Therefore, it is a matter not simply of resources, but of the way in which those resources are effectively used in patient care.

Mr. Sims: There is no question of privatising the NHS, as the hon. Member for Walsall, North (Mr. Winnick) implied, but will my right hon. Friend confirm that there have been many examples of co-operation between the NHS and the private sector to their mutual advantage? Will his Department collate those examples and circulate them to some of the authorities which, for political or ideological reasons, refuse to use that co-operation for the benefit of patients?

Mr. Moore: My hon. Friend is absolutely right. We are concerned with patient care, which means co-operation in the use of all the resources that we have. I draw his attention to an excellent article in the King's Fund, which illustrated the way in which the private and public sectors are already working together. We should encourage that because, as I keep saying, our only concern should be patient care, not sterile politics.

Mr. Redmond: Will the Secretary of State tell the House what monetary value he places on human life?

Mr. Moore: If it is pure money that we are talking about, the Secretary of State and the Government place greater value on human life than did the Labour Government when they reduced the proportion of GDP that they spent on health care. However, if we talk in that kind of sterile language, we shall not rationally find a way to improve the health of our country.

Sir Peter Hordern: Will my right hon. Friend confirm that his review will not be confined to the role of the NHS alone, but will review the other means of providing health services to our people, including possibly a form of national health insurance scheme?

Mr. Moore: Like my hon. Friend, who served for many years on the Public Accounts Committee and who has noticed so many times the way in which we do not necessarily use our resources as effectively as we might, I shall ensure that we examine each and every alternative. All alternatives will be considered on their merits so that we can ensure that our prime goal of improving the health of our nation is uppermost in our minds.

Mr. Robin Cook: Will the Secretary of State now answer the questions that I have put to him twice in writing? What opportunity will there be for the public to join in the review of their Health Service? How do the professional organisations which work in the Health Service get a hearing in the review? Why do Ministers propose to consult us only when they have made up their minds? Can we be told even the terms of the review? Does the Secretary of State not appreciate that the NHS belongs to the public and that its future cannot be disposed of in a basement in Downing street, still less in a dining room at the Carlton club?

Mr. Moore: Perhaps I could draw the hon. Gentleman's attention to the answers to the written parliamentary questions that were addressed to his hon. Friend the Member for Walsall, North (Mr. Winnick), who asked the question, in which I made it absolutely clear that any submissions brought forward would be considered. It might also be of interest to the hon. Gentleman to discuss this matter with the Trades Union Congress, most of the general secretaries of which came to see me, because again I made it absolutely clear—they obviously have not communicated it to the Opposition Front Bench—that I look forward to any and all submissions from the TUC and from any other reputable body.

Benefits (Uprating)

5. **Mr. Hanley:** To ask the Secretary of State for Social Services what is his estimate of the cost of the current year's social security uprating.

The Parliamentary Under-Secretary of State for Health and Social Security (Mr. Michael Portillo): We estimate that the benefits uprating which takes effect from April 1988 will add more than £1·3 billion to social security expenditure in 1988-89.

Mr. Hanley: While recognising that the uprating represents the most thorough and substantial review of the social security system ever, and that it makes the system simpler to understand, may I ask my hon. Friend to guarantee and confirm to the House that those most in need will be the people targeted by the reforms, and that families with children will benefit even more than they would have done by a simple uprating of child benefit?

Mr. Portillo: My hon. Friend is absolutely right to draw attention to this simplification of the system, which is important, and to the extra money going to families. The sum of £200 million is going to family credit over and above what is available for family income supplement. Another £100 million is going to families on income support, which compares with the £120 million that it would have cost to uprate child benefit.

BRIEFING FOR MEETING BETWEEN THE PRIME MINISTER, TONY NEWTON AND HAL MILLER MP: THURSDAY 18 FEBRUARY

Casualty services in Bromsgrove

Mr Miller's letter raises the issue of casualty services for Bromsgrove. Briefly, the casualty service currently provided from the cottage hospital in Bromsgrove is due to close temporarily on 21 March until a decision is reached following the consultation on permanent closure. The casualty service is run by local GPs and the DHA has argued that the GPs should have no difficulty in reproviding the service from their own surgeries as is common practice elsewhere. Moreover, patients with more serious injuries can go to the newly opened Alexandra Hospital in nearby Redditch. In common with other West Midland's districts, Bromsgrove and Redditch is under pressure to make a significant level of savings in 1988/89 if it is to avoid overspending. Reasonably enough, it considers that the provision of a "walking wounded" service in Bromsgrove is not a major priority.

MS(H) may wish to:-

- stress that if the casualty service, and indeed any other facility, is to be closed permanently, the proposal must be subject to the usual consultation procedures. The proposal is in fact out to consultation now, which ends at the end of April. If the CHC objects, Ministers' agreement is necessary. At that stage we will consider carefully all the local arguments.

- add however that with a newly opened £25 million DGH in Redditch and a £7 million Community Hospital in Bromsgrove in 3 years' time, (protected from the RHA's capital "moratorium"), it is difficult to argue that the DHA is being unfairly treated.

February 1988

RL2B

WEST MIDLANDS REGION : POSITIVE POINTS

Patients treated

1. More patients being treated than ever before in all categories. Between 1978 and 1986, numbers of in-patients treated, up by 24%, out-patients by 17% and day cases by 79%.

Waiting Lists

2. A success story. There are now some 13% fewer people waiting for treatment than there were in 1979. The number of people waiting for more than a year for treatment has fallen by 10,000 or a third since 1979. These figures do not include the full effect of Norman Fowler's waiting list initiative from which West Midlands is getting over £3 million.

Manpower

3. Total number of staff up by 7% between 1978 and 1986 : number of doctors and dentists increased by 19%; nurses and midwives by 12%.

Finance

4. Spending has increased by an estimated 30% in real terms since 1978/79.

5. Next year, (1988-89) West Midlands allocation is going up by a further 6.2% (compared with 5.7% nationally) to over £1.2 billion.

6. RAWP Target : 6.2% below in 1978/79. 2.2% below in 1987/88.

7. Capital : West Midlands has embarked on the largest hospital building programme in its history : £850 million over 10 years. By 1994-95 every district will have built or be in the process of building a modern acute hospital base. Includes brand new DGHs in Tamworth, Telford, Solihull and Redditch.

85261/1/60-15

WEST MIDLANDS REGION: DEFENSIVE BRIEFING

GENERAL

1. Rescheduling of Operational Capital Programme.

Because of overspending, West Midlands has rescheduled its 10 year capital programme: some major schemes eg Worcester, Tamworth DGH and the Birmingham Children's Hospital have been delayed between 2-3 years.

Line To Take:

The management of capital programmes is the responsibility of the Regional Health Authority. The West Midlands' programme at £850 million over 10 years remains the largest in the country. When the programme was assembled, it was deliberately overcommitted to allow for expected slippage. This has not happened and the RHA has had to put back the start date of a number of new schemes. This is a prudent and flexible approach to protect the integrity of future developments.

2. Use of "BUPA" Waiting List Money

The allocation of £240,000 to the West Midlands for a BUPA-led initiative has had a rough ride in the press.

Line To Take:

This project has demonstrated the scope for the negotiation of cost effective terms for the treatment of patients from NHS waiting lists in the private sector. [I am aware the region has expressed some doubts about these costs, however, it is not always easy to make direct comparisons between costs in the NHS and the private sector. For example cost effectiveness depends not just on what is theoretically achievable but on whether given the same amount of money, there is spare capacity in the right specialty and the right place to treat the additional patients].

Reference to Health Service Ombudsman

I am of course aware of the moves to refer the West Midlands regions decision to spend £63,000 to treat patients in the private sector to the health service Ombudsman. Obviously I am in no position to comment on the outcome. There is, however, nothing new in health authorities purchasing treatment from the private sector to benefit NHS patients.

OTHER ISSUES

3. Hospital Closures in Shropshire

Shropshire HA has recently issued a consultation document proposing the closure of 10 cottage hospitals as part of the rationalisation of acute hospital services following the opening of the new Telford DGH in spring 1989. The consultation period ends in April but local opposition has already been fierce.

Line To Take

Any proposal involving the closure of a hospital must be subject to the usual consultation procedures. If the CHC objects to what is proposed, the closure can only be effected with the agreement of the RHA and Ministers. At that stage we will consider carefully all the local objections [although with 23 cottage hospital units in Shropshire some degree of rationalisation appears inevitable].

4. Future of the Whitley Hospital, Coventry

Coventry HA is proposing to sell the Whitley Hospital to a charitable housing association who will assume responsibility for the care of 124 elderly people currently in long stay geriatric wards elsewhere in the district. Coventry HA argues that this will sbustantially improve the quality of care for these patients - it will also reduce the DHA's overheads by transferring part of the cost to social security. Officials are studying the proposal in detail.

Line To Take

A proposal was submitted to the Department in October which officials are now studying in detail. Ministers will want to consider all the arguments very carefully before reaching a decision.

5. Renal Services in Birmingham

As part of Central Birmingham's savings package, renal consultants at the Queen Elizabeth Hospital were told in september that no new patients could be taken on for dialysis treatment because the unit had already exceeded its budget. Following discussions between MS(H) and the Regional Chairman, West Midlands RHA agreed to divert £250,000 from its allocation of waiting list money to the renal units at Central and East Birmingham HAs to enable new patients to continue to be treated.

Line To Take

Following discussions between the Ministers for Health and the Chairman of the West Midlands RHA, the RHA agreed to divert £250,000 from the waiting list money already allocated to it by the Department to the units in Central and East Birmingham Health Authorities to enable more renal patients to be treated. This means that West Midlands RHA will now be investing an additional £900,000 in renal services this year.

HEALTH SERVICES IN BIRMINGHAM:
"GOOD NEWS" POINTS

ACTIVITY

Between 1982 and 1986, the number of inpatients treated has gone up by 11,000 (6.6%), day cases by 4,000 (23%) and day patient attendances by 11,000 (5.5%).

WAITING LISTS

Between 1983 and 1987, the total number of patients on Birmingham's waiting lists has fallen by 15% and those waiting for more than a year by 19%. In addition, this year Birmingham is getting £1.3 million from the National Waiting List Fund established by Norman Fowler. This will enable a further 7,800 patients to be treated above planned levels.

MANPOWER

Between 1982 and 1986, the number of "front line" staff (including doctors and nurses) has increased by 143 whole time equivalents. There are now over 800 more nurses employed in Birmingham than in 1979.

CAPITAL DEVELOPMENTS

The most important feature of the RHA's capital strategy for the city is its major development programme to rationalise its acute services. At present many of Birmingham's single specialty hospitals are housed in cramped Victorian buildings in isolation from the back-up facilities they often need. The RHA plans to reprovide their services in new buildings on DGH sites.

Examples of this strategy are:

Service	Planned Provision	Cost £000
Ear, Nose and Throat (ENT hospital)	In-patient units at 4 DGHs (Queen Elizabeth, Dudley Road, East Birmingham, Selly Oak) and out-patient unit at Good Hope	Capital cost of 3,282
Trauma & Burns (Birmingham Accident Hospital)	New specialist trauma, burns and plastic surgery unit at Selly Oak Hospital	Capital cost of 20,823
Paediatrics (Birmingham Children's Hospital)	To be relocated on the Queen Elizabeth Hospital site	Capital cost of 27,700

BIRMINGHAM CHILDREN'S HOSPITAL: KEY FACTS

ACTIVITY

1. Activity at the Children's Hospital Birmingham has increased substantially in recent years. Between 1979 and 1986, the number of in-patient cases went up by 15 per cent, the number of out-patient cases by 16 per cent and the number of day cases by a staggering 121 per cent. Detailed figures are given below:

	1979	1982	1986	% increase 1979-1986
In-patient cases	7770	8411	8943	15
Day cases	463	1235	1025	121
Out-patient cases	40785	42287	47396	16

2. Within these figures is a significant rise in the number of high technology specialist treatments that were not available even a few years ago. The Children's Hospital provides specialised paediatric liver services and oncology services as well as neonatal and infant cardiac surgery. Since the cardiac unit was first designated by DHSS in 1984 as a supra regional centre 569 open heart operations have been performed.

SUPRA REGIONAL FUNDING

3. The DHSS funds certain specialised services directly on the advice of the Supra Regional Service Advisory Group. The Birmingham Children's Hospital is receiving £988,000 this year for neonatal and infant cardiac surgery. In addition, Central Birmingham health authority is receiving £179,000 for specialised paediatric liver services and over £1 million for liver transplantations which covers provision for children as well as adults. (Jemma Hamilton who received a liver transplant earlier this year is one example of the benefits of this programme.)

TASK TEAM REPORT

Following talks between DHSS and NHS officials, the Chairman of the West Midlands Regional Health Authority has announced a programme of action to ensure that children waiting admission to Birmingham Children's Hospital do not wait for long periods for cardiac surgery. This includes examining whether more intensive care facilities can be provided either at the Children's Hospital or by making arrangements with other health regions or private hospitals. The Regional Health Authority is anxious to ensure that no obstacle is put in the way of finding an early solution to the Hospital's difficulties. A copy of the RHA's Press Notice is attached.

PAEDIATRIC INTENSIVE CARE NURSE TRAINING

Work is in hand for a new nursing course of paediatric intensive care to start later this year, the first of its kind outside London. A tutor has already been appointed. Contrary to some press reports, the course has not been delayed because of a lack of money. 12 post-graduate students will train each year at a cost of about £120,000.

141. BROMSGROVE AND REDDITCH DISTRICT HEALTH AUTHORITY :

WEST MIDLANDS RHA

POSITIVE POINTS

General	
	- The new £24 million District General Hospital opened in 1986 is providing more services to patients in better accommodation.
Finance	
- Revenue	- Initial cash allocation (1987/88) up by 33.6% since 1985/86 (cash terms).
Manpower	- Front line staff up by 17.2% since 1982.
Patient Activity (1982-1986)	- Up on all fronts: In-patients up by 5.9% Out-patients attendances up by 7.9%.
Capital Building	
Completed	- £24 million new District General Hospital at Redditch, opened 1986, 415 beds.
Waiting Lists	- With the opening of the new District General Hospital, the district is now funded to treat 25% more acute cases than before - this will soon have an effect on waiting lists. Extra from waiting list fund of £120,000.
Non-capital service developments	- Plans to appoint Health Visitors to combat child abuse.
Other	- Number of persons treated by Home Nurses up by 55.6% between 1982/86.
	- Number of visits made by Health Visitors up by 132.9% between 1982/86.

January 18, 1988

BROMSGROVE & REDDITCH

PROFILE OF BROMSGROVE & REDDITCH DISTRICT HEALTH AUTHORITY

141.01 16.6.87.

(issue: March 1987)

RHA: West Midlands

CHAIRMAN: Mrs D Price
Date of Birth: 26/02/38
Appointed from 04/86 to 03/90

DGM: R I Spencer
Date of Birth: 12/08/45
Appointed from 02/85 to 02/88

LOCAL MP

Name	Party	Constituency	Maj
Eric Forth	Con	Worcestershire-Mid	14,911
Hal Miller	Con	Bromsgrove	16,685

LOCAL AUTHORITIES
Bromsgrove District Council
Redditch District Council
Wychavon District Council
Hereford & Worcester County Council

FPC: Hereford & Worcester

POPULATION

	Resident Population		Population Served	
1985	162,700	(Estimated)	~	(Estimated)
1995	177,300	(Projected)	~	(Projected)

The RHA are unable easily to supply deatils of catchment population.

Resident population data supplied by OPCS via SR6(D) and updated annually in December.

PROFILE OF BROMSGROVE & REDDITCH DISTRICT HEALTH AUTHORITY

141.02

MAJOR HOSPITALS

Name	Number of Beds	Type
Barnsley Hall Hospital	350	Mental Illness
The Alexandra Hospital	415	Mainly Acute

1 Major hospitals are those having more than 100 available beds.

2 Data taken from "The Hospitals and Health Services Year Book - 1987" and updated annually in April/May.

16.10.87.

% OCCUPANCY

	1982	1983	1984	1985	1986
All Specialties	78.3	79.8	79.2	79.8	77.2
General Medicine	88.1	87.3	86.8	86.6	91.2
General Surgery	76.9	77.3	76.4	73.8	66.1
ENT	8.5	4.9	12.5	100.0	60.0
Trau & Orth	65.0	59.2	64.2	61.0	60.5
Gynaecology	70.0	70.5	70.9	67.6	67.1
Ophthalmology	56.9	42.7	86.2	100.0	87.0

1 % occupancy is the number of occupied beds expressed as a percentage of available beds.

2 Data is supplied by SR2 and updated annually in September.

PROFILE OF BROMSGROVE & REDDITCH DISTRICT HEALTH AUTHORITY

141.03 15.12.87. CAPITAL SCHEMES

SCHEMES UNDER CONSTRUCTION

Name of Scheme	Capital Cost £M (1)	Planned Completion Date	Content
~			

SCHEMES WITH BUDGET COST APPROVAL
(i.e. firmly accepted - design work well advanced)

Name of Scheme	Approved Budget Cost £M (1)	Provisional Content
~		

Continued...

PROFILE OF BROMSGROVE & REDDITCH DISTRICT HEALTH AUTHORITY

141.04 15.12.87. CAPITAL SCHEMES - CONTINUED

SCHEMES WITH APPROVAL IN PRINCIPLE
(i.e. - agreed for the preparation of detailed design)

Name of Scheme	Approval in Principle Cost £M (1)		Provisional Content
Bromsgrove Community Hospital	A	5.6	Acute / Geriatric / Outpatients / Support Services

1 The costs, which are approximate, represent the cost at the stage indicated by the code letter:

A: Approval in principle cost B: Budget cost D: Design cost
**: Not yet classified P: Planned cost T: Tender cost

In all cases they exclude fees and equipment etc which will increase basic costs by 30-40%.

2 Information supplied by HBD and updated quarterly.

PROFILE OF BROMSGROVE & REDDITCH DISTRICT HEALTH AUTHORITY

141.05 6.11.87. MANPOWER

At Sept 30th	All Staff	% Change Over Previous Year	Front Line Staff (1)	% Change Over Previous Year	Other Staff	% Change Over Previous Year
1982	1,957	--	1,303	--	648	--
1983	1,994	1.9	1,354	3.5	640	-1.1
1984	1,967	-1.3	1,350	-0.3	617	-3.6
1985	1,987	1.0	1,389	3.6	598	-3.1
1986	2,190	10.2	1,527	9.9	663	10.9
% CHANGE 1982-86:		11.9		17.2		2.3

1 Front line staff are: medical and dental staff (including Hospital Practitioners, Clinical Assistants and Locums), nursing and midwifery staff and professional and technical staff.

2 On 1/4/84 Operating Department Assistants were reclassified from the Ancillary to the P & T staff group. These figures have not been adjusted for this change.

3 On 1/4/85 Family Practitioner Committees became independent employing authorities. Figures after that date therefore exclude FPC staff.

4 All WTE figures are rounded to nearest whole number.

5 Data supplied by SR7 and updated annually in October.

PROFILE OF BROMSGROVE & REDDITCH DISTRICT HEALTH AUTHORITY

141.06 21.1.88. FINANCE - REVENUE

Year	Gross Revenue Expenditure (000s)	% Growth Over Previous Year Cash	% Growth Over Previous Year Real Terms (1)	Distance From RAWP Target (2)
1982/83	18,144	--	--	-12.4
1983/84	19,736	8.8	4.0	-13.0
1984/85	21,441	8.6	4.1	-15.9
1985/86	23,196	8.2	2.0	-11.6
1986/87	27,243	17.4	14.0	

% Growth from 1982/83 to 1986/87 Cash	Real Terms
50.1	25.9

Year	Initial Cash Allocation (3) (000s)	% Change Over Previous Year	Distance From RAWP Target (2)
1985/86	20,084	--	--
1986/87	23,243	15.7	-8.1
1987/88	25,823	11.1	-3

1 % growth in real terms measured against movements in the GDP deflator.

2 Regions have varying methods of allocating funds to their Districts and therefore Districts can only be compared within their respective Regions and not with other Regions' Districts.

3 These figures are not comparable with the out-turn gross expenditure figures for earlier years. Cash limits can fluctuate significantly throughout the financial year (e.g. due to transfers between revenue and capital, inter authority transfers and central adjustments). Cash limits also exclude income from charges which can make a significant contribution to the level of gross expenditure.

4 Expenditure figures supplied by FA2B from the DHSS summarised accounts and updated annually in August. Allocation figures supplied by the Region and updated annually in March.

PROFILE OF BROMSGROVE & REDDITCH DISTRICT HEALTH AUTHORITY

141.07 12.5.87. FINANCE - CAPITAL

Year	Gross Capital Expenditure - Cash (1) (£000s)
1982/83	1,156
1983/84	6,622
1984/85	10,317
1985/86	7,135

Year	Initial Capital Allocation (2) (£000s)
1986/87	5,395
1987/88	1,372

1 Comprises DHA capital expenditure plus capital spent by the RHA on DHA projects.

2 These figures are not comparable with the out-turn gross expenditure figures for earlier years. Cash limits can fluctuate significantly throughout the financial year (e.g. due to transfers between revenue and capital.)

3 Expenditure figures supplied by FA2B from the DHSS summarised accounts and updated annually in August. Allocation figures supplied by the Region and updated annually in March.

PROFILE OF BROMSGROVE & REDDITCH DISTRICT HEALTH AUTHORITY

141.08 16.10.87. PATIENT ACTIVITY

Year	In-Patient Cases	% Change Over Previous Year	Day Cases (1)	% Change Over Previous Year
1982	14,998	--	1,592	--
1983	14,888	-0.7	1,601	0.6
1984	14,777	-0.7	1,668	4.2
1985	15,329	3.7	1,537	-7.9
1986	15,880	3.6	1,737	13.0
% Change from 1982 to 86:		5.9		9.1

Year	Out-Patient Attendances	% Change Over Previous Year	Day-Patient Attendances (2)	% Change Over Previous Year
1982	69,424	--	24,348	--
1983	72,515	4.5	23,296	-4.3
1984	78,240	7.9	23,043	-1.1
1985	84,740	8.3	24,530	6.5
1986	74,940	-11.6	33,221	35.4
% Change from 1982 to 86:		7.9		36.4

1 Day cases are persons who attend for investigation, treatment or operation under clinical supervision on a planned non-residential basis and who occupy a bed in a ward or a day case unit.

2 Regular day patients include both patients admitted to a hospital on a planned regular basis (e.g. intermittent dialysis) and patients attending a day care facility which is not equipped with hospital beds (e.g. psychiatric and geriatric patients who regularly attend day care facilities).

3 A breakdown of the figures shown above, by specialty, appears on the following pages.

4 All patient activity data supplied by SR2A and updated annually in August (provisional figures) & October (final figures).

PROFILE OF BROMSGROVE & REDDITCH DISTRICT HEALTH AUTHORITY

141.09 16.10.87. IN-PATIENT CASES - BY SPECIALTY

	1982	1983	1984	1985	1986	% Change 1982 - 1986
General Medicine	1,729	1,926	2,135	2,093	2,180	26.1
General Surgery	2,311	2,376	2,404	2,190	2,043	-11.6
ENT	75	73	51	42	48	-36.0
Trau & Orth	1,089	1,028	1,022	1,103	1,455	33.6
Ophthalmology	452	451	579	571	589	30.3
Gynaecology	1,492	1,490	1,506	1,627	1,564	4.8
Obstetrics	1,813	2,088	2,250	2,456	2,411	33.0

OUT-PATIENT ATTENDANCES - BY SPECIALTY

	1982	1983	1984	1985	1986	% Change 1982 - 1986
General Medicine	9,248	9,950	10,117	8,833	7,081	-23.4
General Surgery	13,545	13,676	15,779	13,006	11,947	-11.8
ENT	5,011	5,578	6,008	6,213	5,822	16.2
Trau & Orth	7,109	6,712	6,119	7,060	7,636	7.4
Ophthalmology	9,090	9,544	10,378	10,468	10,118	11.3
Gynaecology	3,470	3,704	3,749	4,105	4,627	33.3
Obstetrics	5,963	5,473	6,697	7,362	6,741	13.0

PROFILE OF BROMSGROVE & REDDITCH DISTRICT HEALTH AUTHORITY

141.10 16.10.87. DAY CASES - BY SPECIALTY

	1982	1983	1984	1985	1986	% Change 1982 - 1986
General Medicine	199	183	109	46	54	-72.9
General Surgery	1,055	1,043	1,144	939	955	-9.5
ENT	54	51	65	62	41	-24.1
Trau & Orth	154	176	171	223	246	59.7
Ophthalmology	62	44	56	58	50	-19.4
Gynaecology	49	88	82	103	110	124.5

DAY CASES IN 1986 AS A PERCENTAGE OF DISCHARGES, DEATHS AND DAY CASES

DISTRICT FIGURES 1986 (1)

General Medicine	2.4	(2.2)
General Surgery	31.9	(30.0)
ENT	46.1	(59.6)
Trau and Orth	14.5	(16.8)
Ophthalmology	7.8	(9.2)
Gynaecology	6.6	(6.0)

NATIONAL FIGURES 1986 (1)(2)

	Bottom 10%	Median	Top 10%
General Medicine	2.2 (1.1)	12.2 (10.6)	25.0 (24.8)
General Surgery	10.2 (9.8)	19.2 (20.4)	32.6 (32.5)
ENT	2.0 (0.8)	12.2 (11.6)	29.9 (30.7)
Trau & Orth	4.2 (4.2)	13.7 (12.0)	25.3 (25.5)
Ophthalmology	4.0 (3.7)	13.8 (14.3)	28.1 (33.6)
Gynaecology	3.1 (2.1)	15.2 (12.9)	32.5 (30.6)

1. Figures relate to 1986 with those for 1985 figures in brackets.

2. Districts where no day cases and no discharges and deaths were recorded have been excluded from the above figures, as have the Special Health Authorities.

PROFILE OF BROMSGROVE & REDDITCH DISTRICT HEALTH AUTHORITY

141.11 7.12.87. COMMUNITY ACTIVITY

Year	Number of Persons Treated by Home Nurses	% Change Over Previous Year
1982	3,927	--
1983	3,963	0.9
1984	3,733	-5.8
1985	5,481	46.8
1986	6,112	11.5

% Change 1982-1986: 55.6

Year	Number of Visits Made by Health Visitors	% Change Over Previous Year
1982	38,733	--
1983	36,163	-6.6
1984	63,662	76.0
1985	63,662	0.0
1986	90,209	41.7

% Change 1982-1986: 132.9

1 Data supplied by SR2B and updated annually in October.

PROFILE OF BROMSGROVE & REDDITCH DISTRICT HEALTH AUTHORITY

141.12 23.10.87. IN PATIENT WAITING LISTS

TOTAL

NUMBER OF PATIENTS ON WAITING LIST AT:	GRAND TOTAL	URGENT CASES		NON-URGENT CASES		
		All	On list more than one month	All	On list more than one year	On list more than one year as % of grand total
31 Mar 1984	2,225	91	67	2,134	512	23.0
31 Mar 1985	2,407	43	4	2,364	534	22.2
31 Mar 1986	2,219	41	2	2,178	556	25.1
30 Sep 1986	2,003	25	2	1,978	369	18.4
31 Mar 1987	2,052	44	4	2,008	406	19.8

SPECIALTY: GENERAL SURGERY

NUMBER OF PATIENTS ON WAITING LIST AT:	GRAND TOTAL	URGENT CASES		NON-URGENT CASES		
		All	On list more than one month	All	On list more than one year	On list more than one year as % of grand total
31 Mar 1984	613	56	56	557	183	29.9
31 Mar 1985	453	26	0	427	148	32.7
31 Mar 1986	405	39	0	366	141	34.8
30 Sep 1986	401	23	0	378	156	38.9
31 Mar 1987	306	35	0	271	114	37.3

SPECIALTY: ENT

NUMBER OF PATIENTS ON WAITING LIST AT:	GRAND TOTAL	URGENT CASES		NON-URGENT CASES		
		All	On list more than one month	All	On list more than one year	On list more than one year as % of grand total
31 Mar 1984	8	0	0	8	1	12.5
31 Mar 1985	16	0	0	16	0	0.0
31 Mar 1986	10	0	0	10	0	0.0
30 Sep 1986	2	0	0	2	0	0.0
31 Mar 1987	0	0	0	0	0	0.0

1 Information supplied by SR2A and updated twice yearly in March and September.

PROFILE OF BROMSGROVE & REDDITCH DISTRICT HEALTH AUTHORITY

141.13 23.10.87. IN PATIENT WAITING LISTS CONTINUED

SPECIALTY: TRAUMATIC & ORTHOPAEDIC

NUMBER OF PATIENTS ON WAITING LIST AT:	GRAND TOTAL	URGENT CASES		NON-URGENT CASES		
		All	On list more than one month	All	On list more than one year	On list more than one year as % of grand total
31 Mar 1984	364	0	0	364	78	21.4
31 Mar 1985	411	0	0	411	76	18.5
31 Mar 1986	433	2	2	431	68	15.7
30 Sep 1986	450	2	2	448	37	8.2
31 Mar 1987	397	0	0	397	7	1.8

SPECIALTY: OPHTHALMOLOGY

NUMBER OF PATIENTS ON WAITING LIST AT:	GRAND TOTAL	URGENT CASES		NON-URGENT CASES		
		All	On list more than one month	All	On list more than one year	On list more than one year as % of grand total
31 Mar 1984	471	0	0	471	130	27.6
31 Mar 1985	553	0	0	553	182	32.9
31 Mar 1986	454	0	0	454	155	34.1
30 Sep 1986	417	0	0	417	92	22.1
31 Mar 1987	439	0	0	439	72	16.4

SPECIALTY: GYNAECOLOGY

NUMBER OF PATIENTS ON WAITING LIST AT:	GRAND TOTAL	URGENT CASES		NON-URGENT CASES		
		All	On list more than one month	All	On list more than one year	On list more than one year as % of grand total
31 Mar 1984	467	23	5	444	99	21.2
31 Mar 1985	501	6	3	495	112	22.4
31 Mar 1986	530	0	0	530	178	33.6
30 Sep 1986	468	0	0	468	84	17.9
31 Mar 1987	694	0	0	694	213	30.7

1 Information supplied by SR2A and updated twice yearly in March and September.

141.14 OUT-PATIENT WAITING LISTS

	General Surgery min/max	Traumatic & Orthopaedic min/max	Gynaecology min/max	Ophthalmology min/max	ENT min/max
1982	2/ 4	19/ 19	9/ 13	4/ 16	3/ 3
1983	3/ 6	13/ 13	9/ 11	8/ 10	9/ 9
1984	6/ 9	10/ 10	13/ 23	8/ 15	17/ 17
1985	1/ 2	4/ 13	2/ 9	5/ 6	6/ 6
1986	2/ 6	~/ ~	~/ ~	~/ ~	~/ ~

1 These figures show the range of delay, in weeks, for non-urgent (routine) first appointments.

2 Data supplied by the RHA and, where figures are available, updated annually in March.

141.15 26.10.87. DEATHS

STANDARDISED MORTALITY RATIO
SERIALISED OVER THE PERIOD 1982 - 1986 (1)

District SMR: 105.6
Regional SMR: 105.2

1 An SMR compares the number of deaths actually occurring in an area with those that would have been expected had the national mortality ratios by age and sex been applicable to the population of the area concerned.

2 Data supplied by SR6D and updated annually in October.

DEATHS FROM MAIN KILLER DISEASES IN 1986 (3)

	Number of Deaths		Deaths per Thousand of Population			
	DHA		DHA		Nationally	
	Male	Female	Male	Female	Male	Female
All Causes	742	761	9.1	9.2	11.7	11.4
Neoplasm: Digestive Organs & Peritoneum	44	52	0.5	0.6	0.9	0.7
Neoplasm: Trachea, Bronchus & Lung	57	21	0.7	0.3	1.0	0.4
Ischaemic Heart Disease	237	158	2.9	1.9	3.6	2.7
Cerebrovascular Disease	73	119	0.9	1.4	1.1	1.7
Chronic Obstructive Pulmonary Disease	51	28	0.6	0.3	0.8	0.4

3 Care should be taken when considering annual data of deaths by cause at DHA level as they may be based on a small number of events at this level.

4 Data supplied by SR6D and updated annually in July.

10 DOWNING STREET
LONDON SW1A 2AA

29th January, 1988

Dear Hal

I am delighted to confirm that the Prime Minister is looking forward to seeing you at 3.45pm on Thursday, 18th February. The meeting will take place in her room at the House of Commons.

I am sorry that we have not been able to find an earlier slot.

Yours ever

Archie

ARCHIE HAMILTON
Parliamentary Private Secretary

Hal Miller Esq MP

10 DOWNING STREET

LONDON SW1A 2AA

27th January, 1988

Dear Tony

The Prime Minister is delighted that you will be able to attend the meeting which she is having with Hal Miller at 1545hrs on Thursday, 18th February.

As you may know, this meeting is in connection with Hal's interest in the West Midlands Health Region, and follows a letter which Hal wrote to the Prime Minister on 3rd December. I attach a copy of Hal's letter for your information. He has not received a reply because I have been in touch with him personally about his request for a meeting, but you may wish to know that a draft reply was supplied by Edward Scarlett on 20th January (ref: PO/1694/351).

I should be most grateful if you could ask your officials to supply some briefing for the Prime Minister in advance of her meeting with Hal Miller.

Yours ever

Archie

ARCHIE HAMILTON
Parliamentary Private Secretary

The Rt Hon Tony Newton OBE MP

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

PO/1694/351

Ms Janice Richards
10 Downing Street
LONDON
SW1

20 JANUARY 1988

Dear Janice,

Thank you for the letter of 4 December from Mark Addison. I enclose a draft reply.

Yours Sincerely
E. Scarlett

EDWARD SCARLETT
Private Office

ENC

CN/0732p

PO(9)1694/351

Hal Miller Esq MP

Thank you for your letter of 3 December in which you express your concern about recent difficulties in the West Midlands health region. I am sorry for the delay in replying.

I hope that Tony Newton's announcement on 16 December of increases in health authority cash limits for 1987-88 will have helped allay ~~many of~~ your anxieties. We have recognised the pressures in the current year and responded to them. The Public Expenditure White Paper published yesterday shows that we shall be spending £1·1 billion more on the health service next year, and there are further increases planned in later years.

For the future, ~~we must~~ welcome the ~~wide-ranging~~ debate now taking place about the provision and financing of health care in this country. This is not simply a question of funding, but also ~~of the efficiency of service provision and of public expectations. If the debate is to be constructive, all of these elements must figure in it.~~ ensuring that the resources made available by the taxpayer are used to the best possible effect. That is one area we must focus on.

I hope that recent short-term problems can be kept in proportion ~~and we all have a part to play in this.~~ Our record on growth in NHS services - in all regions - is extremely good. We clearly need to ensure a better understanding of the real challenges now facing the NHS and of how we intend to tackle them.

[In view of your recent meeting with Tony Newton and subsequent events I do not think that it would be helpful at this time for there to be a further meeting. I shall nevertheless continue to take a close interest in this matter.]

[I would be glad to have a short meeting with you and colleagues when this can be arranged.]

In view of your meeting with Tony Newton, and the announcement of 16 December, I ~~do not think we should~~ hope you will agree that a meeting is not now needed. I should of course be very happy to meet you and one or two colleagues if you wish, though I think a large scale meeting of the kind you first suggested would be something ~~much better~~ for Tony Newton or John Moore to take on.

Hal MILLER MP
18/12

1) 5/1
2) 12/1
3) 19/1

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

4 December 1987

I attach a copy of a letter the Prime Minister has received from Hal Miller, M.P.

I should be grateful if you could let us have a draft reply for the Prime Minister to send, to reach us by Friday 18 December.

Mark Addison

Mrs Flora Goldhill
Department of Health and Social Security.

AH has had a telephone call hoping for a meeting. Agreed he will regard [illegible] pushing the conduct of [illegible] forward to the New Year, or [illegible] pressure [illegible].

MEA 7/12

R 4/12

HOUSE OF COMMONS
LONDON SW1A 0AA

FROM: H. D. MILLER, M.P.

The Rt. Hon. Mrs. Margaret Thatcher M.P.,
The Prime Minister,
10 Downing Street,
London, S.W.1.

CURTIS

3rd December 1987

Dear Prime Minister

WEST MIDLANDS HEALTH REGION.

When I left Central Office you asked me to busy myself on behalf of the Party in the West Midlands and to keep you in touch with any significant political developments.

I now write to bring to your attention the political consequences of the present financial difficulties affecting the West Midlands Health Region and its 22 Health Districts. I led a delegation of 20 West Midlands Conservative MPs to see Tony Newton on Monday 23rd November. All shades of Conservative opinion ranging from Jill Knight to David Knox were agreed that a new look needed to be taken at the Health Service and its financing, but that in the meantime some more of the public's money would have to be made available to the Region for acute services and to help the Region over the hump in its capital programme over the next 2 years.

The capital programme has admittedly been over committed and therefore mismanaged. The Region has, however, put forward proposals for mitigating this by adopting commercial methods such as vehicle hire, sale and leaseback and joint ventures, but these proposals are meeting Treasury resistance.

The success of the drive to shorten waiting lists has brought the acute services sharp up against their cash limits. The acute services are cash limited, while G.P. services are not and more money proportionately was allocated to G.P. services in the Autumn Statement than to the acute services, where the need is greater and the political effects more visible and more damaging - you will remember the case of the Barber baby. The inevitable consequence is that waiting lists will lengthen again and we shall swiftly lose the credit for our achievements.

The Autumn Statement will not even hold the position and can be portrayed as misleading in that it does not fund either pay or prices. My own Health District is having to close additional services, over closures already announced, to save a further £400,000 as a result of the Autumn Statement. Some of these had earlier ministerial assurances of support

HOUSE OF COMMONS
LONDON SW1A 0AA

FROM: H. D. MILLER, M.P.

backed by some cash. Other Health Districts have yet to put forward proposals for dealing with this shortfall, so the adverse publicity will continue. These difficulties in the Health Service fit ill with our econonmic success and the public perception of growing prosperity.

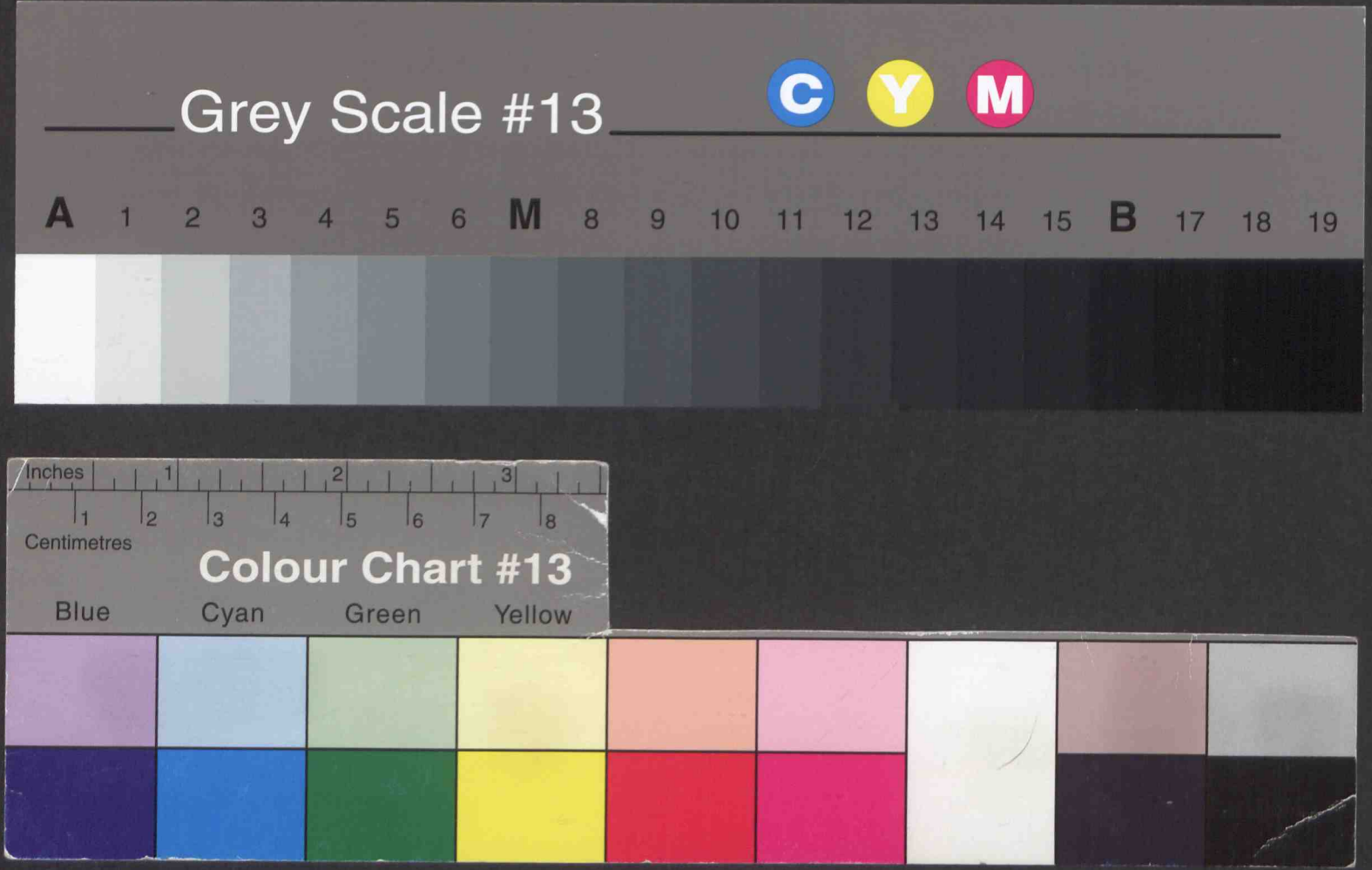
The Midlands anxieties were firmly expressed on both sides of the House in the Health debate last Thursday. I do have to advise you that in my opinion the reductions in services now being imposed and the further postponement of long promised capital projects are eating into our political capital and threatening to weaken support for other measures we all wish to see taken in the fields of schooling, housing and inner cities. Public concern is heightened by the low morale which pervades the Health Service and affects nurses in particular and is not just a matter of pay. The low morale and shortage of funds have led to some unacceptable behaviour by consultants who have paraded their patients on TV and before the press.

The public wants the Health Service to succeed and we believe is prepared to pay more for it to thrive. The Health Service should be a success story for our Party and for you but is increasingly seen as our Achilles heel. We need to look again at priorities in health care, how decisions are made, what level of care is in fact needed and wanted and how consultants are to be managed. All this will take time, but in the meantime there will have to be some more public money. The amount concerned in our Region is in fact marginal, as one example the underfunding of pay and medical costs over the last four years totals £11mn, which is just 1% of the current year's budget (although this sum would run a new District General Hospital or build a new Community Hospital). I know my colleagues would welcome the opportunity of discussing the situation with you, if you could find time to see us. A copy of this letter goes to them.

30m

Yours sincerely
Mal Miller

H. D. Miller


Grey Scale #13
C
Y
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A 1 2 3 4 5 6 M 8 9 10 11 12 13 14 15 B 17 18 19
Inches 1 2 3
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Centimetres
Colour Chart #13
Blue
Cyan
Green
Yellow